

**Responding to Sexual assault:  
A Study of Practices of Health Professionals in A  
Public Hospital**

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# Contents

ACKNOWLEDGMENTS .....	v
PREFACE .....	vii
EXECUTIVE SUMMARY .....	ix
I. INTRODUCTION .....	1
II. METHODOLOGY .....	7
III. PROFILE OF SURVIVORS .....	10
IV. INFORMED CONSENT .....	12
V. HISTORY, EXAMINATION, EVIDENCE COLLECTION, DOCUMENTATION .....	18
VI. PRESERVATION OF EVIDENCE AND CHAIN OF CUSTODY .....	30
VII. PROVIDING A MEDICAL OPINION .....	32
VIII. MEDICAL TREATMENT AND PSYCHOLOGICAL SUPPORT .....	37
IX. CAPACITY BUILDING OF HEALTH PROFESSIONALS .....	42
X. CONCLUSION AND RECOMMENDATIONS .....	44
REFERENCES .....	53
ANNEXURES	
Annexure 1: Key-informant Interview Guide .....	55
Annexure 2: Consent form .....	57

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## Preface

The role of health professionals and health systems in responding to sexual assault has been plagued with biases and insensitivity. Rape was the issue that galvanized the Indian women's movement in the 1980s which led to changes in the rape law in the country and also raised concerns over the response of health professionals in collecting medical evidence. Since then there have been efforts made to study the inherent biases in the health system, including medical text books.

CEHAT has been working towards sensitizing health professionals on the issue of VAW for more than a decade. As part of this endeavour, it has developed a gender sensitive protocol to aid examination, evidence collection and treatment of survivors of sexual assault. It has been advocating for a comprehensive health care response from health facilities for sexual assault survivors.

Sama has been actively involved in initiatives for developing perspectives and capacities towards recognition of violence as a public health and rights issue; strengthening health sector response to survivors of violence, through workshops with community based organizations and networks, health workers, lawyers, and health professionals.

This study "Responding to Sexual Assault: A Study of Practices of Health Professionals in a Public Hospital" undertaken by CEHAT and Sama has found several gaps in both the medico-legal as well as therapeutic response to sexual assault survivors. Some of these stem from a dearth of knowledge, the absence of guidelines and protocol, as well as the lack of gendered perspectives in responding to sexual assault. The preoccupation with medico legal aspects was quite evident often at the cost of provision of care and treatment. Generally, hospitals merely follow directions of the police even at the cost of violating the survivor's right to refuse a medical examination.

The study underscores the need to evolve gender sensitive protocols for documentation of history of assault, evidence collection, treatment and follow up care. The complete absence of "care" for survivors is evident from the absence of guidelines for treating immediate and long

term health consequences of sexual assault. There is a need to assert the right to treatment and care for survivors of violence and make health systems responsive to their specific needs.

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## Executive Summary

For most survivors of sexual assault, contact with health care providers is inevitable. Sexual assault has various health ramifications and therefore health care providers are required to provide treatment and care to survivors. They are also required to collect medical evidence and record detailed examination findings and history which could support the survivor's testimony in the court of law. However, the inadequacy of the health sector in fulfilling this role is well documented. This study aimed to understand the procedures followed and services provided in cases of sexual assault at a public tertiary care hospital, and examine them from a lens of gender and rights. The method adopted for conducting the study was that of in-depth interviews with health care providers and others who come in contact with a survivor of sexual assault or are involved in handling of forensic evidence.

The study showed that there are several gaps in both the medico-legal as well as therapeutic response of the hospital to sexual assault survivors. As far as the medico-legal role of health providers is concerned, we find that there are no uniform protocols for seeking consent, history, conducting examinations or for evidence collection and hence there is a lot of variation between the practice of various doctors. There is no protocol for how, from whom and for what consent needs to be sought and coercion was evident in certain types of cases. Doctors also articulate the lack of skills vis-à-vis seeking history from children and building rapport with survivors which serves as a barrier to eliciting thorough history. The doctors' narratives with regard to interpretation of examination findings, indicate undue emphasis on the absence of injuries, integrity of the hymen and laxity of the vagina. The chain of custody, which ensures storage and preservation of medico-legal evidence, was found to be undermined. None of the swabs were being dried prior to packing and sealing, thus, jeopardizing crucial evidence. Moreover, after the evidence was dispatched with the police, it was kept in the store house, and not immediately dispatched to the laboratory. Reports of chemical analysis did not return to the hospital for the doctors to provide a final opinion.

The study also suggests that health care providers, in cases of sexual assault, perceive their role to be largely medico-legal rather than therapeutic. Despite the fact that this is a large tertiary care hospital, apparently equipped to provide comprehensive care to survivors of sexual assault, the nature of care provided was limited when looked at against the guidelines

provided by WHO. There was no component of psychological support provided to survivors at all. Providers looked upon these cases as police cases that had been brought to them only for a 'gynaecological opinion'. The entire process of referrals to varied departments for treatment was co-ordinated by the police. This overwhelming role of the police even in the context of treatment raises serious concerns. Shadowing of the survivor by the police stigmatizes the survivor and makes her unnecessarily conspicuous.

A lot of the problems stem from a dearth of knowledge vis-à-vis the response to sexual assault, lack of gendered perspectives on the issue of sexual assault and a lack of guidelines and protocols in place for responding to the same. There is a need to develop gender sensitive protocols for obtaining consent, seeking history, examination, evidence collection, preservation of evidence, maintaining chain of custody, provision of treatment and psychosocial support, and liaison with external agencies. Capacity building of health care providers is required, that not only provides knowledge and skills, but also builds gender-sensitive perspectives on sexual assault. It is essential that providers understand the circumstances in which sexual assault occurs, so that preoccupation with injuries and procedures such as the two-finger test are eliminated. Further, provision of psychosocial support at the hospital and referral to external agencies for legal or other support to survivors is absolutely crucial for survivor's well-being.

## I. INTRODUCTION

The term 'sexual assault' refers to a range of acts including touching another person's body in a sexual way without the person's consent, forced or coerced sexual intercourse ('rape'), oral and anal sexual acts, child molestation, incest, fondling and attempted 'rape'. It affects women worldwide, irrespective of age, marital status, socio-economic status, ethnicity or appearance. In India, there were an estimated 22,172 reported survivors of rape<sup>1</sup> as per data from the National Crime Records Bureau (NCRB, 2010). The data show that rape occurs in all age groups and among both sexes, but it is predominant among women in the age group of 18 to 30 years. It also occurs across the country, with Delhi recording the maximum number of rapes among India's various cities, followed by Mumbai and Bhopal. While the term 'sexual assault' is often used interchangeably with 'rape', it is important to bear in mind that there are several other forms of sexual assault such as inappropriate touching, attempted rape, oral and anal acts. Indian rape law recognises only non-consensual peno-vaginal sexual intercourse as 'rape' and all the other forms are relegated to lesser offences such as 'molestation with the intent to outrage modesty'. Therefore, 'rape' is given a minimum punishment of 7 years, but there is no such minimum punishment for 'molestation'. In 2010 in addition to the estimated 22,172 cases of rape reported, there were also 40,613 cases of molestation. The rate of conviction in cases of sexual assault is also known to be poor. For cases of rape it is 28 percent while that for molestation is 30 percent (NCRB 2010). Given the poor legal outcomes, several barriers that impede prosecution and the nature of stigma attached to the crime of rape, the very act of reporting it is extremely difficult. Therefore reporting of the crime is low.

The above figures take into account only reported cases; national level household surveys and research studies provide a more accurate picture of prevalence. As per the third National Family Health Survey (NFHS 3), nine percent of women between the ages of 15 and 49 reported having experienced sexual violence, including ten percent of ever married and one percent of never married women. A National Study on Child Abuse conducted by the Ministry of Women and Child Development showed that more than 53 percent children across 13 states reported facing some form of sexual abuse while twenty two percent faced severe sexual abuse. (Kacker, Varadan and Kumar, 2007) Another study conducted in Goa among teenage higher secondary students found that a third of them had been sexually abused in the year preceding the study, with more than half the perpetrators being older students. (Patel and

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<sup>1</sup> The term 'rape' has been used as this data draws from the NCRB, which is how the crime is defined.

Andrew, 2001) Thus, although these surveys reflect a high prevalence of the crime, given the associated stigma, a large burden of sexual assault continues to remain hidden and the numbers may actually be much higher.

For most survivors reporting sexual assault, contact with health providers is inevitable. Sexual assault has various health consequences and therefore health providers are required to provide treatment and care to survivors. They are also required to collect medical evidence and record a detailed documentation of injuries in cases of sexual assault, which could support the survivor's testimony in the court of law. Research from other countries shows that documentation of injuries by health providers significantly increases the possibility of charge-sheeting and conviction. (McGregor; DuMont and Myhr, 2002) The Indian Criminal Procedure Code (Section 164 CrPC) too, invests in the doctor, the responsibility to document a survivor's history, examination findings, collect and preserve crucial forensic evidence and provide a reasoned opinion. However there is evidence that the health sector falls short of fulfilling the expected role, as mandated by law.

In the following sections we look at the evidence from the Western and Indian contexts of problems in the response of health systems to survivors of sexual assault, as well as engagements to address these.

### **Engaging with the Health Sector: Experiences from the West**

The problems in the response of health systems to survivors of sexual assault have been documented by women's groups in the West from the 1970s through the 1990s. Studies have shown that sexual assault survivors often do not get the same quality of care in emergency departments as other patients do. They are made to wait for a long period of time in public places, without being allowed to urinate, drink water or wash themselves. (Speck and Aiken, 1994) The health staff was reported to be ill-trained to conduct rape examinations and provide expert testimony in court. While medical needs were met, emotional support was not provided and victim-blaming by health providers was reported.

At various points during this period, feminists have engaged with the health system in improving its response. In the seventies and the eighties, the Rape Crisis Centre movement emerged in the United States, Canada and the United Kingdom, which attempted to reform the practice of various agencies involved in responding to sexual assault. This included medical services in addition to mental health care, law enforcement and community-based services. It led to the

setting up of hospital-based rape crisis centres as well as in-service training for health providers towards ensuring a comprehensive as well as sensitive response to survivors.

The late seventies saw the development of the first Sexual Assault Nurse Examiner (SANE)<sup>2</sup> programs to improve efficiency and sensitivity in responding to sexual assault. However, these did not grow in number until the nineties. (Ledrey, 1999) It is important to note that these strides by the health system in the West to respond to sexual assault involved the active participation of health providers, particularly nurses and nursing associations. Forensic Nursing was recognized as a speciality by the nursing profession and Sexual Assault Nurse Examiner (SANE) programs continued to grow and receive funding through the Violence Against Women Act, 1994 in the United States. They were also subsequently adopted by other countries such as Canada and South Africa.

Preliminary studies conducted to evaluate these programmes showed that they were helpful in improving the quality of forensic evidence and documentation, promoting psychological and physical recovery of survivors, providing better expert testimony and improving the interface of the health system with various other agencies such as law enforcement, community advocates and the judiciary. (Campbell; Patterson and Lichty, 2005) SANEs, for instance, have been observed to collect better quality medical evidence than non-SANE programs. (Sievers; Murphy and Miller, 2003) However there is little data on follow-up and legal outcomes, which has made it difficult to evaluate the effectiveness of these programs. (Ciacone... [et al.], 2000)

### **Experiences in the Indian Context**

The issue of sexual assault was brought into public consciousness in India by the Feminist Movement in the 1980s. This period saw a growing agitation, largely in relation to 'rape' either by police or landlords. One such case was that of Mathura, a tribal girl who had been raped in police custody. After the assault, Mathura had been taken to a doctor for medical examination, but was asked to file a complaint first. Eventually, the examination was carried out twenty hours after the incident and the doctor at the facility recorded nothing more than an 'old tear' of the hymen and opined that she was 'habituated' to sexual intercourse. The girl was said to have an immoral character, and the Supreme Court ruled that it could therefore not be considered a case of rape. The case gave rise to a nation-wide campaign, which eventually led to changes in the law, wherein 'custodial rape' was recognized as a category and consent in such cases considered irrelevant.

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<sup>2</sup> SANEs are nurses who are specially trained to conduct medical examinations, collect and document evidence in sexual assault cases. They also served as an interface for the hospital with rape advocates and law enforcement agencies.

Although the health sector also received much criticism during the Mathura case, as it came to be known, there was no substantial intervention made to change the practice in this sector. Both health and women's rights activists involved in investigations of cases of sexual assault in the eighties and nineties continued to point to the improper collection and documentation of medical evidence that was carried out by health providers. A study conducted by Shally Prasad in 1996 (Prasad, 1999) documented the perspectives of survivors, legal agencies as well as health providers and found that health providers were often hesitant to get involved in cases of sexual assault. The study showed that doctors would often not ask about the cause of injuries to avoid it. They also raised doubts over women's allegations and provided very little by way of medical care or counseling. The lack of training, the study concluded, provided room for personal biases to creep in and allowed the health care provider to get away with no fear of retribution or accountability. The study led to certain recommendations to institute a rape protocol, conduct training for health professionals and provide long term comprehensive care for survivors.

Agnes, in a feminist critique of forensic medicine text books, raises similar concern about the manner in which health care providers are indoctrinated to view every woman who reports sexual assault, with suspicion. (Agnes, 2005) The textbooks, Agnes shows, disguise their anti-woman bias in the name of neutrality and this is what doctors carry with them. She demonstrates how even after two decades of the feminist movement in India, the textbooks are not abreast with the changes in the law that are pro-women, pointing to the lack of engagement of the movement with the health system.

The first direct intervention with the health system came about only in 2008 when CEHAT partnered with the Municipal Corporation of Mumbai to implement a comprehensive health care response to sexual assault. At that time, CEHAT had already established a hospital-based crisis counselling center called 'Dilaasa' (meaning reassurance) at a peripheral hospital of the Municipal Corporation of Greater Mumbai. Through this effort, health professionals underwent routine sensitization trainings that helped them to identify women facing domestic violence and refer them to a hospital-based crisis counselling department. A group of sensitive, highly motivated health professionals who had emerged from this endeavour, were able to identify the need for improving the response to sexual assault survivors at their hospitals. Two hospitals, who received the maximum number of cases of sexual assault among peripheral hospitals, were identified for implementing a model comprehensive response, comprising of the following components:

- Obtaining informed consent of the survivor
- Comprehensive collection and documentation of evidence
- A clear and fool proof chain of custody
- Providing medical care
- Providing psychological support
- Liaison with legal and other agencies
- Co-ordination with police and media

Implementation of an exhaustive Sexual Assault Forensic Evidence Kit (SAFE Kit)<sup>3</sup> protocol ensured that documentation of history and examination findings was detailed and that evidence collection was exhaustive. However the experience of implementing this model also highlighted that providers were preoccupied with forensic evidence collection and procedures. There were several issues arising out of obsolete hospital procedures, insensitive attitudes, lack of services and poor co-ordination with law enforcement agencies and the forensic science laboratory. The need to formulate standard operating procedures and on-going training of health care providers was underscored.(Contractor and Rege, 2009)

At around the same time, in April 2009, the Delhi High Court passed an order that laid down specific guidelines for different agencies like the police, hospitals, child welfare committees and courts in responding to survivors of sexual assault. The court recognized the collective responsibility of multiple agencies in responding to sexual assault and ruled that the response to sexual assault must be multi-sectoral. With regard to the health system, the court ordered streamlining of the process of examination and evidence collection for survivors of sexual assault. It ruled that all hospitals in Delhi must use a SAFE kit for this purpose. While the Delhi High Court order was a positive step, it restricted reforms in the health system to the mere implementation of a kit. Several efforts in addition to this, such as implementation of standard operating procedures, developing gender sensitive protocols and capacity building of health care providers would be required in order to implement a comprehensive health sector response. (Jagadeesh et.al. 2010)

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<sup>3</sup> In an effort to address some of these issues, CEHAT in 1998 developed the Sexual Assault Forensic Evidence (SAFE) kit. This was the first time that such a kit had been developed to ensure better evidence collection and documentation. It consisted of a detailed proforma for documenting history, examination findings, evidence collected and opinion. It also contained all the paraphernalia required for conducting a sexual assault examination. It was deliberated upon extensively by experts from the fields of law, medicine and women's rights and endorsed by them.



## **Rationale for this Study**

There have been few studies in the Indian context that have looked specifically at the responses of health systems to survivors of sexual assault. Typically, these have taken the form of a situational analysis and have used a survey method to ascertain how ‘comprehensive’ the response is. This includes information about available protocols for medico-legal examination, nature of evidence collected, infrastructure available, treatment protocols and training received. While they have been useful in obtaining a snapshot of what the level of preparedness of facilities is, they do not provide an in-depth understanding of the practice of responding to sexual assault at a given facility. They do not explore the actual procedures that a woman who has faced sexual assault goes through at the hospital, the manner in which doctors make decisions about cases, the dynamics around seeking consent, or the quality of treatment provided to survivors.

Having adequate infrastructure, a standard procedure for obtaining consent, seeking history, conducting examination and collecting evidence does not necessarily ensure that comprehensive health services are provided to survivors of sexual assault. For instance, one study assigned a score of 100% to a facility on the indicator of ‘Use of Standard Proforma’, despite the fact that said proforma asks providers to ascertain how many fingers pass through the vaginal opening – a fundamentally archaic, biased and unscientific practice. Further, it received a score of 6 (100%) on the indicator of medico-legal evidence collection, but provided no insight into the relevance or exhaustiveness of samples collected. (Pitre and Pandey, 2010) Another study conducted in multiple cities of India and Bangladesh found that there was no uniformity in the nature of evidence collected, and that some hospitals collect ‘more evidence’ than others. (Khan et.al. 2008) However the basis on which health care providers decide which evidence to collect was not explored. Further, collection of ‘all evidence’ does not necessarily mean that all of it is relevant. Studies that use such an approach are also not able to uncover biases that providers might have, that inform the manner in which survivors are treated.

We hence felt the need to conduct a study that bridges this gap and provides a more textured understanding of the actual practice of health care providers in responding to sexual assault survivors. This needed to be done using a qualitative method that provides us with the opportunity to explore how health care providers understand their role in responding to survivors of sexual assault, the manner in which they make decisions in these cases, the rationale for conducting or excluding certain procedures, and the perspectives of different levels of providers on such cases. Such an enquiry would be effective in informing the health system about required changes towards a comprehensive response to sexual assault survivors.



Towards understanding the existing response to sexual assault survivors, CEHAT collaborated with Sama, a Delhi based resource group working on women's health and rights. Sama had been actively involved in initiatives for developing perspectives, capacities and leadership to address gender based violence and its health consequences as well as in public and policy advocacy efforts against communal and state violence.

A facility-based research study was initiated at a tertiary care public hospital with the following objectives:

- To understand the existing procedures followed and services provided in cases of sexual assault.
- To identify perceived training needs of health professionals and recommendations to improve the response.

## **II. METHODOLOGY**

The method adopted for conducting the study was that of in-depth interviews with health care providers engaged in responding to sexual assault. Since the purpose of the study was to identify gaps in the response, mapping the response was extremely important. This would enable us to identify specific areas where intervention was required. Therefore in-depth interviews were considered the best method, as opposed to a checklist or survey method.

### **Profile of the Respondents**

The respondents included health care providers who came in contact with a survivor of sexual assault or were involved in handling forensic evidence. Fourteen interviews were conducted in all. This included 4 specialists, 2 Casualty Medical Officers (CMO), 4 Senior Residents (SRs) and 3 nurses from the department of Obstetrics and Gynaecology. The department is made up of three units and each unit has about 6 senior residents. We selected the most senior ones among these for the interviews, as they would have dealt with the maximum number of cases. All the senior residents had about two years of experience post-MD and had seen about five to seven cases of sexual assault each. The specialists and CMOs, whom we interviewed, had 20-30 years of experience; they had, however, seen cases of sexual assault only when they were SRs, which was more than ten years prior to the interviews in all cases. The nurses had been working in the Receiving Room (RR)<sup>4</sup> for five years. Since they were posted in RR

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<sup>4</sup> The Receiving Room (RR) of the department of Gynaecology and Obstetrics functions 24 hours a day and all emergency Obs/Gyne complaints are seen here.

continuously (as opposed to SRs who have one month rotation in the RR), they had seen many more cases of sexual assault than the senior residents.

In addition to this, the casualty police constable was also interviewed. However, after a brief meeting with him, it was clear that he did not have much of a role to play and hence we were directed towards an Assistant Commissioner of Police (ACP) and finally to an Assistant Sub-Inspector (ASI) of one of the police stations from where sexual assault cases were brought to hospital.

<b>Profile of the Respondents</b>	
Category	Number
Sr. Specialist	4
CMO	2
Sr. Resident	4
Nurses	3
Assistant Sub-inspector	1

### **Gaining permission to conduct the study**

When we approached the hospital to conduct the study, we did so through the Medical Superintendent. However, there was very little support from his end, to initiate such an endeavour. We then contacted the Department of Obstetrics and Gynaecology, where, owing to dynamic leadership and a committed association of health professionals, we were able to impress upon them the importance of such a study and were provided permission to conduct it. However, interviews with the medical records office and social worker, outside the department's jurisdiction were not possible. Interactions with the doctors and nurses in the course of the study, clarified that the social worker in most instances does not play a role in responding to the health care needs of survivors of sexual assault.

### **Conduct of Interviews**

The interviews were conducted in the period between May and August 2010. An interview guide was used (Annexure 1) that addressed the following themes: process, roles, specific practices with regard to the medico-legal and therapeutic role, barriers encountered while performing this role, inter-agency co-ordination, nature of documentation maintained, nature of training received and perceived training needs and finally, recommendations for improving the response to sexual assault survivors reporting to the hospital.

Before commencing fieldwork, there was a training of the researchers in qualitative research methods, specifically that of in-depth interviews. Training included that on techniques for interviewing such as asking questions in a simple manner and use of probes to elicit information. Ethical issues such as seeking informed consent and ensuring privacy while conducting interviews were discussed. Mock interviews were conducted which enabled the interviewers to hone their interviewing skills. Each interview, after it was conducted, was reviewed. The team conducting the interview received feedback on the style of interviewing, and gaps if any, in the information received. In two instances where data gaps had been identified, the team went back to the respondents to seek the required information.

Before the interview, the team met with each respondent, gave them a letter of introduction and explained the purpose of the study. Appointments were then scheduled, ensuring that the respondent would be relatively free at the time and would be able to give at least one hour for the interview. On the day of the interview, the consent form (Annexure 2) was read and signed before commencing the interview. The interviews were conducted by two researchers one conducted the interview and the other documented it verbatim.

The findings that emerged from the study have been organized in this document. It consists of nine chapters followed by annexures. The chronology of the chapters attempts to follow the sequence of the response to sexual assault by the hospital. Chapter one provides the background context of the health sector response to sexual assault and the rationale for the present study; chapter two presents the methodology of the study; chapter three details the profile of survivors accessing services at the hospital, of sexual assault cases that the hospital receives, as well as the pathways through which they access the health system. Chapters four to seven describe the different roles of the health system and the existing practices in the hospital highlighted by the study for informed consent, seeking history, examination, evidence collection and documentation. Preservation of evidence and the chain of custody as well as issues with regard to medical opinion are also discussed in these chapters. Chapter nine deliberates available as well as necessary infrastructure and services for the provision of treatment including psychological support. The final chapter presents recommendations to be followed up at different levels by diverse actors, towards a comprehensive health care response to sexual assault, that have emerged from health providers, police, as well as from organizations involved in conduct of the study.

### **III. PROFILE OF SURVIVORS**

#### **Socio-economic profile**

The average number of cases seen as per the respondents was about ten to twelve a month. Only women survivors of sexual assault were brought to or came to the department of Ob/Gyn in the hospital. At least half of the survivors were children (under the age of 12 years) or young adolescents (between 12-20 years). Majority of the adult women survivors were between 20 and 30 years; survivors who were older, had rarely accessed services at the department. Most of the survivors were from the lower socio-economic strata, living in (slums).

#### **Nature of sexual assault reported**

Peno-vaginal penetrative assault was the only type of assault that respondents reported seeing. Some, on probing, said that they had seen cases of anal penetration. However, despite probing, none of the respondents reported having seen cases of fingering or oral penetration. A senior doctor explained that assaults like oral and finger penetration may accompany peno-vaginal penetration, but as doctors did not ask about it routinely, they were perhaps not reported. Another doctor said that such cases probably were not reported as they may not have required immediate medical attention. She opined that peno-vaginal penetrative assault may be considered more serious by the survivor or her family, and hence these cases were reported. That various forms of sexual assault were not probed as the providers had a restrictive understanding of sexual assault, which recognized only peno-vaginal penetrative assaults.

#### **Cases of ‘consensual sex’**

One specific case that both doctors as well as nurses reported seeing was that of adolescent girls who had ‘eloped’ with their boyfriends. These cases reportedly formed the bulk of cases coming to the department of ObGyn. In these cases, when the parents found out about the affair, they lodged a police complaint and that was why a ‘rape’ case was filed. Following this, the girls were brought to the hospital for a medical examination. At the hospital, the girls reported consensual sexual intercourse, which was recorded in the medico-legal case (MLC) register. Most of them consented to an examination, so it was done.

Doctors and nurses said that about half of the cases reported were of this sort. It thus seemed that a history of sexual assault was not a pre-requisite for conducting an examination. Even in

instances, where women clearly state that no sexual assault occurred, examinations were conducted on requisition from the police, unless the girls refused.

### **Other cases**

Other than this, there were mentally challenged women who were brought by the police to ‘rule out rape’. These women were usually unaccompanied, destitute, who were reportedly ‘picked up from the road’ and brought to the hospital. Doctors were unsure of whether these women had a history of sexual assault, and hence the providers conducted the examination.

### **Potential loss of cases**

In addition to those survivors, who directly report sexual assault, the hospital also receives survivors who report other complaints. Interviews with providers suggested that these ‘cases’ were usually ‘lost’, unless incidentally identified.

A few doctors reported cases that they had seen in the Receiving Room (RR) or in the Out Patient Department (OPD) that also had a history of sexual assault. These survivors would often report genital injuries caused by a supposed ‘fall’, which was subsequently revealed to be sexual assault. One doctor narrated the case of a woman, who had reported with a ‘fall on bucket’ in the casualty department. There was bleeding from the vagina and she was admitted. After admission, the accompanying relative revealed that she had been sexually assaulted; a MLC was registered and the family lodged a first information report (FIR). Doctors also reported having seen women, who had come with a complaint of unwanted pregnancy, seeking abortion and had a history of sexual assault. When asked about what was done in such cases, doctors reported that these women were usually reluctant to reveal a history of assault as they did not want to register a formal complaint. Therefore, only medical treatment was provided. Despite recognizing that sexually abused women reported to the hospital with a range of symptoms, there was no policy or practice in place that recommended screening for sexual assault among women, who reported to departments other than the Ob/Gyn department in the hospital with different kinds of complaints. The result was that the identification of such cases was purely incidental. Further, apart from immediate medical treatment, no other psychosocial support or legal information was provided to these women.

## IV. INFORMED CONSENT

Informed consent in the context of sexual assault, assumes great importance not just because it is a legal requirement, but because the act of sexual assault itself is a disempowering one. All efforts must therefore be made to preserve the survivor's autonomy and help her to gain a sense of control by providing her with information about the procedures that are going to be performed, explaining their importance and answering queries related to the same. This is also legally binding, as per Section 164 (A) CrPC, which clearly states that the consent of the 'survivor' or consent by any other person, who is competent to give consent on the survivor's behalf must be taken.

Survivors of sexual assault may approach the health facility for different reasons and under different circumstances. While some survivors have an express intention of pursuing a legal case, there may be others who may be unwilling to do so. The reasons for this are varied – fear of stigma, assault by a person within the family, fear of repercussions of filing the case. Survivors may also need some time to make a decision regarding whether want to pursue legal action or not. Taking these circumstances into account, it is important that the survivor be given the opportunity to make a decision regarding the nature of services that she wants, without coercion from either the police or the health care provider. Therefore, in cases of sexual assault, consent must be sought at the following three levels:

- Treatment.
- Documentation of history, examination findings and evidence collection.
- Intimating and providing information to the police for purposes of investigation.

Consent must be sought prior to initiating any response. The nature of examination that will be carried out and its importance should be explained to the survivor and/or guardian. They must also be informed that they may refuse any part of the examination at any time and that such refusal would not impact their access to treatment in any way. Only when complete information is provided to the survivor, would s/he be able to make a decision about the nature of services s/he requires.

In this chapter, we describe the process of seeking consent at the hospital and discuss it in the light of the above mentioned 'ideal'.

### ***i. Consent a formality***

Consent at the hospital is taken, merely by asking the survivor if she is willing for examination or not and informing her that the examination would aid her in her legal case. What gets recorded is that the ‘patient is willing for examination’ or that the ‘patient is not willing for examination’. This is recorded in the MLC register where the survivor or her guardian’s signature is taken. There is no protocol to give the woman details about what will be done as part of the examination, she is neither assured confidentiality nor is she informed that she has the right to refuse any part of the examination.

Consent for revealing the findings of the examination to law enforcement agencies is not sought separately. This is deemed unnecessary since most of the cases come through the police, following the registration of a complaint. Regarding survivors who report directly to the hospital, the doctors felt that the fact that they reveal a history of sexual assault implies that they have come with the intention of filing a case. They felt that survivors are usually prepared for what is going to be done, and hence the ‘problem of refusal’ is seldom encountered. It is important to note here that even on probing, none of the doctors reported seeing cases of survivors, who came to the hospital for examination and refused to inform the police. One doctor maintained:

*If they come to the hospital, they usually have the intention of making the case. They are prepared in their mind. So we inform the police constable and he registers the case. (Senior Resident)*

Consent, as sought in the hospital, therefore seems cursory, something that is viewed largely as a legal requirement. The woman is neither provided sufficient information before she consents nor is she provided with the opportunity to refuse.

### ***ii. Consent taken only for examination***

Findings suggest that consent is sought only after recording the history. History is recorded from the survivor irrespective of whether she is willing to be examined or not. The need to take consent before initiating any response is not followed. As pointed out by one of the doctors, when it is a police case, a survivor cannot refuse to give history:

*See I have to write the history in any case, even if they are not willing for an examination. I do take consent first. I have to write, 'I am willing for examination'. But in any case I have to write the history because I have to fill the MLC register. (Senior Resident)*

*She cannot refuse that. It is a police case. If she is conscious and oriented, she has to give the history. (Senior Resident)*

From the narratives of doctors and nurses, it is clear that the process of consent is activated only at the stage of examination. Providers seem to think that only examination of the private parts of the survivor warrants consent – the roots of this could be traced back to the manner in which medical education addresses consent in cases of sexual assault. Forensic medicine textbooks advise caution towards women reporting rape, stating that if consent is not sought prior to the procedure, the doctor may be levied with a charge of rape. Consent, then, is viewed as a method of protecting a doctor from unscrupulous women reporting rape. While this may not be the intention with which providers seek consent, it has informed the practice of routinely seeking consent from sexual assault survivors.

## ***ii. Capacity to provide consent***

An important criterion, for consent is the ‘capacity’ to make the decision and understand the consequences. The law excludes minors, mentally challenged or persons with mental health issues from directly giving consent and expects guardians, caretakers as well as health providers to act as proxy. As per Section 89 of the Indian Penal Code (IPC), consent must be “taken from the guardian/parent if the survivor is under the age of 12 or if the survivor is unable to give his/her consent due to reasons of mental disability”. Any person above the age of 12 can give consent for examination, treatment and other issues with regard to sexual assault.

Findings suggest that there is confusion among the health care providers regarding the age of consent. Some of the responses given by the doctors and nurses about the age of consent for examination and evidence collection were 12 years, 15 years, 16 years and 18 years. There seems to be no standard protocol regarding taking consent in the case of the mentally challenged persons, unconscious survivors and unaccompanied minors. In such cases, the providers stated that they take the consent from the police, if the survivor is not accompanied by a relative. In some instances, the chief medical officer’s (CMO) consent has also been taken.



### *iii. Consent in the case of young girls*

Responses of doctors, regarding the person from whom consent should be sought in the case of young girls was inconsistent. Some mentioned taking consent only from the survivor when she is over the age of consent, some stated that they took ‘signatures’ even from the police, and others mentioned taking consent from the parents, though the girl was 18 years of age or even older. One doctor mentioned:

*The age of consent is eighteen. Consent from the guardian is taken if she is less than 18 years. Even if she is above the age of 18, consent is taken from the guardian as well. This is how it works in our context. (Senior Specialist)*

Approaching the parents or guardians for consent derives from social perceptions of parental control over the body and sexuality. This may be one of the reasons for doctors’ insisting on taking the parents’ consent before conducting a genital examination, even in the case of young girls who are over the age of consent.

### *iv. When cases of sexual assault are filed by the ‘survivors’ parents*

A common type of case that all providers reported seeing was one where the complaint of sexual assault had been lodged by a parent, following ‘elopement’ and probably ‘consensual sex’ of girls with their boyfriends. This was the only instance when doctors spoke of a survivor refusing to provide consent for examination. These cases are invariably brought by the police following registration of a complaint and most often the girls are at the borderline age of 17 – 18 years. A Medico-Legal Case (MLC) is recorded automatically as the case is a police case. The girl is then referred to the gynaecology department for examination where the same process as for any other sexual assault case is followed – the history is recorded and consent is sought for examination. Doctors acknowledge that a majority of the girls do not refuse examination; however, police and parental pressure may be the reasons for their consent. A Senior Resident maintained:

*Most of them are willing for examination. Once they have filed a complaint, the police say that examination is compulsory. No one refuses after that – who will refuse the police? So we have had no problems with consent in those cases. We just write in the history that she gave a history of consensual sex. (Senior Resident)*

If there is no apparent refusal, the examination and evidence collection is carried out even though the girl in her history clearly states that there was no assault.

However, sometimes girls refuse examination on the grounds that there has been no sexual assault, even though there is pressure from the parents. When faced with this situation, doctors reported trying to ‘counsel’ the survivor so that a consensus is reached between the parent and the survivor. Usually, this means that the girl eventually consents to examination. As one doctor explained:

*Sometimes if she has eloped voluntarily, she might refuse. Girls elope with their boyfriends and the parents bring them here, then she says it is not rape.*

*What do you do in such cases? We counsel the girl. We tell her that she has to make a decision about what she wants to do. We give priority to the girl’s decision, of course. But the parents are very, very insistent that the case be filed. So we have to make sure there is consensus between the girl and her parents. Usually they (girls) consent after that. (Specialist)*

A nurse remarked that “Everyone tries to counsel them - the police, the doctor and the nurse.”

The police too reported having faced similar problems. The Assistant Sub Inspector (ASI) said that in such cases, the FIR is lodged at the behest of the parents. The process after that varies depending on the age of the girl. If the survivor is under 18 years of age then she has to be examined as this is what the parents demand. However, if she is above 18 years of age, then the FIR is lodged, her refusal to examine is documented, and she is produced in court the next day, where she takes back her complaint.

### **Emerging Issues**

- A cursory one-line consent, that is treated as a technicality rather than an opportunity to provide information about the details of examination and evidence collection is not something that is peculiar to this hospital, but has been observed in other settings as well. Existing perceptions and attitudes about informed consent is one of the biggest challenges. Not just in cases of sexual assault but also otherwise, informed consent is perceived either as a

formality or as a legal requirement to mitigate the accountability of the provider or health facility, which requires a signature on a consent form rather than an on-going process. (Bal, 1999) Merely obtaining a signature on a written and dated consent format is popularly understood and accepted as consent. Refusal to consent is perceived as a 'barrier' to the processes of examination and collection of evidence, requiring 'convincing' in many instances.

- What makes the situation worse is the lack of standard protocol for the procedure of consent - when should consent be taken, for what should consent be taken and from whom should consent be taken. In the absence of such protocol, the decision of who is authorized to provide consent is arbitrary. Some doctors preferred to take as many 'signatures' as possible (from the parents, from the survivor, from the police). One reason for this is the lack of knowledge about legal provisions with regard to age of consent.
- More importantly, it stems from the manner in which consent is viewed by providers. Instead of being a way of empowering the survivor to make an informed decision, it is expected to ensure that they do not 'get into trouble', and to reduce any liabilities for them and the hospital. Having a policeman's 'signature' on the consent form, therefore, is expected to serve as evidence that the examination was carried out at the request of legal authorities. At the cost of jeopardizing the survivors' autonomy, the parents' consent is sought even when the survivor herself is capable of providing consent. This reflects a certain sanction of the health care provider towards the notion that the woman's body and sexuality are controlled by the parent, and therefore consent needs to be sought from them. This lack of respect for women's autonomy is seen in other aspects of medical practice as well. For instance, research shows that consent is routinely sought from the spouse for abortion and sterilization procedures, even though this is not required by law. In fact, women report 'insistence on the husband's signature' as an important factor that dissuaded them from accessing abortion services. (Gupte; Bandewar and Pisal, 1999) In a study on sterilization conducted in Chennai, 73 percent of the clients reported that a third party signature had been sought, most often from the husband. On exploring providers' perceptions regarding this insistence, the study found that even though providers were aware of the law, they preferred to take the counter signature of the husband or close relative as they feared repercussions from the family. (Rajalakshmi, 2007)
- The manner in which 'consent' is sought in cases of elopement raises questions about the role of the hospital and the manner in which the doctor decides which cases warrant examination. The role of the doctor is expected to be neutral and independent. However,

even in cases where girls clearly report that they have had consensual sexual intercourse, examination is carried out because the case has been brought by the police. When some of these girls refuse examination, the doctor tries to ensure that she does undergo examination as her parents and the police demand. Further, while such cases many not fall within the category of ‘sexual assault’, the ‘survivor’ in such situations may also require health care services, including referral for counseling and sexual health education, which should in fact be the focus of the health system.

## **V. HISTORY, EXAMINATION, EVIDENCE COLLECTION, DOCUMENTATION**

The legal case of sexual assault rests on several sets of evidence and testimonies, that of the doctor being an important one. Section 164 (A) of the Criminal Procedure Code invests in the Registered Medical Practitioner, the responsibility of documenting the particulars of the survivor, history of the assault, any marks of injuries and of collecting transitory evidence. Documentation of history, of examination findings as well as the analysis of forensic evidence collected, becomes a key component of the legal trial. This entire documentation by the doctor then forms a part of the legal case and can support the survivor’s testimony.

This chapter discusses the existing practices and related concerns and gaps vis-à-vis the medico-legal process in situations of sexual assault as implemented by the hospital. Section A presents the process of seeking history and its documentation. Section B discusses examination of the survivor, and Section C discusses the collection of evidence. Section D looks at the documentation maintained and gaps in the same.

### **Section A**

#### **Seeking history of sexual assault**

Seeking history of sexual assault assumes crucial value in a case of sexual assault. In addition to serving as an account of the assault, the process of history seeking also provides direction to the nature of examination to be done and the nature of forensic evidence to be gathered. History should ideally be recorded as articulated by or in the actual words of the survivor in order to reduce the scope of misinterpretation. Survivors are often reluctant or embarrassed to reveal detailed history and hence, a milieu in the hospital that ensures privacy, promotes sensitivity, is non-threatening and induces confidence is of primary importance.

### *i. Ensuring a safe and private space*

A separate space within the RR was available in the Department of ObGyn for history taking, examination and other processes related to sexual assault. While history in a majority of instances was taken in this room, the practice was not always adhered to. While doctors articulated the importance of maintaining privacy, they also reported that in a situation when there were too many persons waiting in the RR, a ‘short’ history was taken in the waiting area of the RR, followed by examination and evidence collection inside the designated room.

Responses with regard to persons permitted, in addition to the doctor, to be present at the time of history taking differed across providers, with most doctors stating that the police was not allowed. The presence of a woman police constable during history taking was, however, reported by one respondent, while a few others reported allowing the nurse or the mother or female guardian of the survivor.

The presence of the police during the process of seeking history raises concerns because it may cause undue pressure on the survivors, which could severely impact the quality of history the process of history seeking and recording:

*They try to dictate to us what we should write (in the history) – I have seen this happening three or four times. This was not a recent case, but the police had come and said that it will take only five minutes in this case (paanch minute hi lagenge is case mein). ‘These two were living together, they have been having consensual sex, they had a fight and that is why the girl called 100 and said that she had been raped. There is nothing to it (Kuch hai hi nahin) – we have enquired with the neighbour. Just write that nothing happened (Kuch hua hi nahin, aise likh do).’ I said, ‘You don’t have to dictate to me what I should do.’ I wrote what the girl was telling me. She said she had been raped, so I wrote the history as she said it. Maybe she was lying, but that is not my look out. (Senior Resident)*

*Most of the time, the police want the doctors to change the history. They say, ‘The girl has given this history and now she is telling you something else.’ They try to force us to write what they want. (Senior Resident)*

Although most of the doctors denied that the police were present at the time of taking history and that they ensured that survivors were alone with them, it was clear that there was no fixed protocol that stipulated who could or could not be present, and was completely dependent on the doctor's discretion.

### ***ii. Relevance of a detailed history***

The need for a detailed history cannot be overemphasized given that it dictates the nature of examination and evidence that is to be collected subsequently. An inadequate history, therefore, could jeopardize subsequent steps.

The findings reflected gaps in eliciting history from the survivors. When probed about the language used to elicit history, details about whether penetration was completed or attempted were not asked. Some of the specialists, commenting on the opinion that 'all the cases received are those of peno-vaginal penetration', stated that this could be due to the manner in which history was sought; non identification of non penetrative sexual assault may be because such history was not sought routinely, although survivors with such history may come to the hospital.

### ***iii. History seeking in the case of children, mentally challenged survivors***

In the case of children, history was usually sought from the person accompanying them. However, doctors also expressed challenges in communication and language used in the process of seeking history from children. Doctors expressed concern about the inability of children to understand what doctors were asking and the difficulty that they may face in articulating the incident(s) or experience(s). One doctor shared:

*Usually they have trouble saying what happened. They will usually refer to the assailant as 'Uncle'. They say uncle came, beat me, scared me, took me into the dark and did something (Uncle aaye, mujhe maara, daraaya, andhere mein leke kuch kiya). They don't know what has happened. Only later when the mother sees blood on the clothes, she comes to know what has happened. Or they say, 'he kept shouting angrily, kept abusing and did something and I felt pain' (daant daant ke kuch kiya aur dard hua).*

Doctors preferred to take the history from the mothers or accompanying relatives as children cried when history was being elicited. The use of props or body charts for children in the process of history taking was not mentioned by any of the respondents; no practice was followed for ensuring the presence of a person with skills to communicate with child survivors. Doctors also expressed the challenges in history taking in the case of mentally challenged women who were brought by the police with an ‘alleged’ history of sexual assault. History in such situations was usually elicited from the police who accompanied the survivor, or in other cases, from the accompanying relative or guardian. One of the doctors mentioned:

*Invariably, they are not able to give the history so history is taken from the relative and then it is written by us that ‘this history might not be relevant because it is being taken from the relative’.*

However, the study showed that most of the women, who were mentally challenged and had accessed the hospital, were brought by the police to “rule out rape” and were unaccompanied. In such situations, the history given by the police was recorded and an examination was conducted. There was no involvement of any person or expert who was equipped to communicate with persons who were mentally challenged.

## **Section B**

### **Examination of Survivors of Sexual Assault**

A ‘head to toe’ general examination and detailed genital examination are crucial components of the doctor’s role in cases of sexual assault. Such examination would help to assess any harm caused to the survivor’s body during or as a result of the assault, which serves not just to strengthen the legal case, but is also crucial in order to provide appropriate treatment for health consequences resulting from the assault. Additionally, other factors such as age that may have a bearing on the case must also be estimated through physical, dental and radiological examination.

#### ***Practice at the hospital***

The examination procedure in the hospital is conducted in a private space. As per the information given by most of the health care providers, only the Senior Resident and the nurse are present while conducting the examination. In the case of child survivors, the mother or a female relative



may be present. A general and local examination of the survivor is carried out as part of the examination procedure according to most doctors. General examination includes checking vitals, followed by inspection of the body for presence of external injury marks such as bite marks on the breast area, bruises, abrasions, nail marks and other 'marks of struggle'. This is followed by a genital examination wherein the presence of injuries like tears in perineum, anal area, para-urethral area, hymen, presence of semen, stray hair, blood or any other foreign body like stains and mud are looked for. A per-vaginal (PV) or per-speculum (PS) examination is carried out in the case of adults for better visualization of internal injuries. During PV/PS examination, the vagina and cervix are examined for the presence of bleeding. If injury is suspected, the uterus may also be examined.

The examination procedure and subsequent documentation, however, also point to reporting of findings that have no bearing on the case:

***i. The finger test to assess whether penetration had occurred or not***

Some of the doctors, including the Senior Residents and the specialists, spoke of commenting on the size of the vaginal opening (measured as one or two fingers) to assess whether penetration had occurred or not. When probed further, one of the senior residents said that she does this only for unmarried women. When she finds that the survivors' vagina is 'unusually' large or admits one or two fingers then it indicates that she might be 'habitual'. When asked what she means by 'unusually large', the doctor said that she knows this by looking at the vagina and it is as per her judgment. In the opinion, she would write that 'there is a possibility of the survivor having habitual intercourse'. However, she would not do the two finger test in case of married women. This sentiment was echoed by two specialists as well, one of whom said:

*There are cases in which the girl elopes with her boyfriend, the parents find out and report it to the police saying it is rape. The police brings her here. But the vagina is lax, two fingers go in easily. With one incident of coercing, the vagina cannot become lax like that, so we know it is consensual.*

Findings such as the laxity of the vagina or size of the vaginal introitus have no forensic value or any bearing upon the case of sexual assault. Further, laxity of the introitus and absence of the hymen can be caused by a whole lot of activities other than sexual intercourse. And, even if the woman was in fact sexually active, it does not automatically imply that the sexual intercourse was consensual. That these findings are used in judicial proceedings frequently against the



survivor, reiterated also by a recent study (HRW, 2010), highlights the need for discontinuation of the finger test in the context of evidence in sexual assault.

## *ii. Interpretation of absence of injuries*

A large part of the examination in sexual assault rests on the looking for injuries and signs of use of force on the survivor's body. The stereotype of 'sexual assault invariably resulting in injuries' determines how doctors interpret these findings. The presence or absence of injuries (along with the status of the hymen and laxity of vagina), is often looked upon as the deciding factor to ascertain whether sexual assault has occurred or not:

*When I examined, there was no hymen so I knew she had had intercourse, but I couldn't say 100 percent that she had been raped because there were no injuries or anything like that. (Senior Resident)*

Doctors felt that sometimes, patients exaggerate the episode of violence because they do not see injuries on the body. One of the doctors shared the history of a 14 year old girl, which was not corroborating with her physical findings, due to which the doctor thought that she might be exaggerating:

*Often children cover up things. The things that they tell us don't match with the physical examination. They say things like held my hand (hath pakda), slapped me (chata mara), scratched me (nakhun mare). But on examination there are no marks and no bruises. Makes you feel that they are exaggerating. (Specialist)*

Presence of injuries, particularly those like bite marks are considered more 'authentic':

*She was a multi-parous lady, so there would be no injuries. Her hymen was torn - like an old tear. But I remember she had bite marks. You cannot fake injuries like that. (Senior Resident)*

It is evident from the above section that there is a lack of gendered understanding and that perceptions are situated in stereotypes that survivors of sexual assault, must present with injuries. This, despite the fact that literature shows that only one-third of the women who have been sexually assaulted show injuries.

### *iii. Examination of person accused of sexual assault*

In addition to examination and evidence collection from survivors, examination of the person(s) accused of sexual assault is also an integral part of the process.

In the hospital, this examination is not conducted in the same department as the survivor; he is examined in the department of Forensic Medicine. The reports of the examination of the accused are not referred to by the doctor examining the survivor, implying the loss of opportunity to corroborate findings from both (the accused and the survivor), which is an important part of the medico-legal investigation.

### *iv. Estimation of age of survivor*

Estimation of age assumes importance in cases of sexual assault because it has implications for legal as well as punitive action.

At the hospital, estimation of age was required when the age is disputable, such as in the case of girls in their teens. One doctor said that she usually sent all women who report their age to be between 15 and 20 for age estimation, particularly if they were unmarried. This was because in case of married women, they were certain that the survivors were over 18 years of age.

Ideally, estimation of age should include three methods – physical age, dental age and radiological age estimations. This ensures that the ‘range’ of age estimated is narrower and hence more accurate. Because facilities such as x-rays may not be available in the department of Ob/Gyn, it was expected that survivors would be referred to other departments for this. However, there seemed to be some amount of confusion regarding where patients were to be sent for age estimation. While some doctors said that they referred cases to the radiology department for age estimation, others said that they were referred to the forensics department in the hospital. Regarding the process of age estimation, the doctors said that it was probably done through radiographs and hence they referred the case to the above-mentioned departments. However, they were unsure of the exact process that was followed.

The survivor, following evidence collection, was taken by the police for estimation of age. This was usually done on the day following the examination. However, no uniform process was followed with regard to estimation of age and according to the police, two types of age estimations were done. In some cases, opinion regarding age was provided based on radiographs by the radiology department on the direct request of the police. In other cases, estimation of age was

done by the department of forensics, directly referred by the doctor. In such situations, a 'medical board' is set up consisting of a radiologist, a dentist and a forensic doctor who collectively estimate the age of the survivor.

## **Section C**

### **Collection of evidence**

Evidence collection, preservation, documentation and medical opinion are important for any legal course of action that the survivor may wish to pursue. The doctor is responsible for the collection of samples from the body of the survivor as well as for the documentation. Similar samples from the body of the alleged perpetrator also need to be collected. These samples include any material that may have been exchanged during the assault (body fluids, epithelial cells, stray strands of hair) as well as samples of blood or urine that would help ascertain if the survivor had been under the influence of drugs or alcohol, thus negating consent. However, forensic evidence in cases of sexual assault must be gathered judiciously, avoiding collection of irrelevant evidence.

#### ***Practice at the hospital***

The responses by specialists and the residents differed in terms of what was collected in the evidence. The specialists mentioned collection of vaginal swabs, pubic hair and clothes as evidence. Some of them were of the impression that evidence collection had become a more elaborate process in recent times as compared to earlier. The residents stated that they collected nail clippings, scraping from the nails, matted pubic hair, undergarments, vaginal swabs, cervical swabs, perineal swab and any other foreign body that may be present. If there are bite marks then a swab of saliva from that area is taken.

#### ***i. Ascertaining relevance of evidence***

The evidence collected is dictated by the type of assault and therefore, only those samples, which are relevant must be collected. For instance, when a survivor gives no history of penetrative assault, taking swabs and other specimens from the genitals is unnecessary. Similarly, the time frame within which evidence can be collected is rather limited. Because survivors engage in activities that might lead to loss of evidence (such as urination, washing, douching of the genitals) evidence may not be available by the time she reports to the health facility. The relevance of the

evidence, given the passage of time and activities such as bathing, douching, etc. that may have caused loss of evidence, needs to be taken into account prior to collection of evidence.

Some doctors said that often, the survivor changes her clothes, bathes and then comes to the hospital, or she comes after a considerable lapse of time – ranging from a few hours to 3-5 days to a week, or even months. However, it is important to note that even when survivors came after a lapse of three days or a week, vaginal swabs and pubic hair were collected as evidence. Two of the doctors even stressed the futility of collection of samples after a time lapse of more than 72 hours, when the survivor has had a bath, but most of doctors' responses indicated that they collected the 'evidence' despite being aware of the futility of their efforts:

*After one week it might be of no use, but I would still take a vaginal sample. It will most probably come negative. (Senior Resident)*

*After 3-4 days it is difficult to get anything, but I still take the sample. I would give it the benefit of doubt. If I am examining a case, I might as well do it properly and take samples. But I will also write that she has taken a bath. Lack of evidence might weaken her case, but it is better to take a sample. (Senior Resident)*

While all doctors recognized that it may not be useful to collect evidence after three days have passed and if the survivor has washed and bathed, they nevertheless collect vaginal samples, not wanting to 'take any kind of risk or not miss any evidence, being a medico-legal case'. Thus, the process of carrying out routine collection of evidence without considering the time lapse, interim activities like bathing, passing urine, etc., makes the entire effort futile, and even invasive and traumatic for the survivor. Further, it has the potential to jeopardize the case because if these samples do not show any positive findings, it will be interpreted in the court of law as 'negative' medical evidence.

## **Section D**

### **Documentation**

Four forms of documentation were reported through the interviews - the MLC (Medico-legal case) register, the RR paper, the RR register and a special register where sexual assault cases are documented.

The doctors' responses varied with regard to copies of the various documents and who had custody of these copies. The findings showed that the original copy of the MLC register goes to the police, who then submit it in court. Although the carbon copy of the MLC register remains in the hospital, it is unclear where it is placed. Some doctors said that the copy was sent to the Casualty, while others said it was sent to the Medical Records Office (MRO) in the hospital. There are two copies of the RR paper; however, there was no uniformity on where the copies went. Some doctors and nurses said that one copy was sent to the police and the other to the MRO. Others said that one copy was given to the survivor and the other was kept in the hospital.

In addition to these, the nurses reported that for the past few years, a separate 'sexual assault' register was being maintained as well. This register was reportedly the exact same as the MLC register. After the senior resident makes an entry in the MLC register, the nurse who is assisting in the process notes down everything in the sexual assault register. Nurses said that the register was started because doctors faced problems in retrieving records from the MRO when they received court summons.

*i. Survivors' rights to a copy of the documentation of evidence*

As with any other medical document, survivors also have the right to receive a copy of the documentation of the evidence in cases of sexual assault. Access to such documentation is important to follow up longer term medical treatment, as well as in pursuing legal action.

According to the findings, however, the only documentation that is provided to the survivor by the ObGyn Department is the OPD paper, which, too, is subsequently handed over to the police. The survivor does not get a copy of the MLC register where the examination findings are actually documented.

The survivor is sometimes given (because in some instances the respondents have reported giving the RR paper to the police) a copy of the RR paper, which includes a record of the treatment provided. The practice of not providing a copy of the medical records and documentation of evidence to the survivor creates barriers to the pursuance of legal remedies by the survivor and is a gross violation of her right.

## Emerging Issues

- The lack of privacy makes it difficult for women to reveal details of the incident. It has a bearing not only on the quality of history that is elicited but also becomes a violating experience for the survivor, compounding the trauma that she may experience while narrating the history of the sexual assault.
- The process of history seeking from the accompanying police or relative, when the survivor is mentally challenged, in the absence of skills to communicate with them or availability of any person who may do so, compromises the accuracy of history with serious implications for the survivor quest for justice.
- The lack of protocol or their mode of operation in the medico-legal process in responding to sexual assault emerges strongly from the study. This creates barriers for standardizing the response to sexual assault by the hospital, leaving it to the discretion of health providers. The absence of protocol particularly in exceptional situations, for example, when the survivor is a child or is mentally challenged, unconscious, etc. often compromises the quality of response received and has serious implications for legal action.
- The undue emphasis by health providers on the presence or absence of injuries, integrity of the hymen and laxity of the vagina, finds no place for survivors' experiences of sexual assault that may often not leave signs of any injuries. Other literature too has commented on biased and stereotypical understanding that the health care providers bring to their practice. Given that they are considered 'experts', this can be extremely detrimental. Baxi, (Baxi, 2005) for instance, demonstrates how the 'medicalization of consent' by putting undue emphasis on the presence or absence of injuries, pronouncing women 'habitual' based on physical examination findings, brings into the trial of sexual assault doubts related to whether the crime has occurred or not. Such practices reflect the larger social context, which frequently expresses its disbelief when women survivors articulate that they have been sexually assaulted. All efforts are made to collate evidence to 'test the veracity' of the survivor's narrative. The implications for the woman, however, are not considered at all. In the past, it has been noted that such unreliable interpretation of examination findings has led to survivors being pronounced 'loose'. For instance, in the case of the murder of two nuns, in Mumbai in 1990, the doctors on post mortem examination found the vagina to be patulous, the hymen showed an old tear and some 'warts' were also seen. All of these findings led the doctors to conclude that the women were 'habituated to sexual intercourse' and reported so to the press. Thereafter, the focus shifted from murder to the character of the women. (Solidarity for Justice, 1990)

- Lack of clarity of the role of the health providers in the medico-legal process to respond to sexual assault survivors causes reluctance in being involved and a defensive response due to lack of knowledge and/or concerns about the legal consequences for them and the hospital. As a consequence, even examination and collection of evidence that is not relevant, continues to be carried out.
- Existing knowledge, attitudes and perceptions of providers makes them defensive in assessing the need for procedures, carrying them out even when there is no relevance, encouraging extremely unethical practices. Development of perspectives and skills among health care providers to respond to sexual assault is essential. Although initiatives for this have been started by the hospital, regular and independent reviews of the content and practice are very important. The existing biases among providers with regard to gender and sexuality evident among some providers have to be addressed in order to prevent aggravation of trauma experienced by the survivor as a result of her interface with the health care system.
- A problem articulated particularly by senior residents is that of the lack of dedicated staff to respond to sexual assault survivors. At present, generally, there is only one senior resident at a time in the RR who has to attend to waiting patients. In such a situation, there is need for substitute doctors to be available to attend to other cases while the sexual assault case is attended to. Human resources in the department of ObGyn should be increased as the present shortage impacts and delays the response to survivors of sexual assault.
- The role of nurses in the entire process currently is extremely peripheral, which should be reviewed and possibilities of greater involvement should be considered. Global experiences have highlighted the potential role that nurses could assume in responding to sexual assault.
- Findings also suggest the lack of knowledge and clarity among health care providers about documenting evidence of sexual assault in the hospital. This brings to the fore, the urgent need for systems for safe-keeping of forensic evidence and facilitation of easy retrieval in case of need. Documentation of evidence along with its collection forms, the basis on which any medico-legal case is founded, requires strict adherence. Improved co-ordination between departments in the context of documentation is necessary to streamline the process and prevent the unnecessary burden of multiple sources of documentation due to difficulty in accessing documentation across departments within the hospital.



## **VI. PRESERVATION OF EVIDENCE AND CHAIN OF CUSTODY**

The systems that facilitate safe keeping and accountability vis-a-vis the forensic evidence are collectively known as the 'chain of custody'. These are necessary to ensure that the evidence collected is packed appropriately and preserved in optimal conditions until sent for chemical analysis. Further, a well-defined chain of custody ensures that evidence is not tampered with; if there is any indication of tampering, it could render the evidence unusable in court.

Following collection at the hospital, the evidence should be sealed and handed over to the police for analysis in a forensic laboratory. From the point that the evidence is collected till its analysis by the forensic laboratory, the protection of the evidence to prevent tampering or degradation must be ensured. It is essential to dry the evidence, such as swabs and clothes before packing, as natural deterioration of samples may occur due to bacterial and fungal growth if samples are kept in warm, humid conditions or stored without being sufficiently dried. The collected samples should be labelled and sealed in the hospital and stored in a secure place before being handed over to the police. Any handing over of the evidence from one 'custodian' to the other requires maintenance of a log. Following the handing over process, the evidence should be taken immediately by the police to the forensic science laboratory (FSL) for analysis. In case of any delay in forwarding the evidence to the forensic laboratory either by the hospital or by the police, the evidence should be stored under appropriate conditions.

### ***Practice at the Hospital***

After collection, the samples are placed in vials or bottles, which are labelled with the pertinent details, MLC number, registration number, and the specimen taken. The process of packing and labeling is done by the nurses. The packed evidence is stamped and signed by the doctor to ensure that the sealing is done in his/her presence. The handing over process of the evidence and copy of the MLC register is done by the nurse in the presence of the doctor. The name and badge details of the police are recorded and his/her signature is taken. The evidence is not stored within the RR or the hospital. It is handed over immediately to the police constable accompanying the survivor.

#### ***i. Improper handling***

The responses of the doctors and nurses did not reflect that the evidence was air dried before it was packed, similarly, the clothes were packed in paper bags but not air dried before packing.



This is a major gap and might lead to decomposition of the evidence rendering it unfit for chemical analysis.

*ii. Delay in evidence reaching the forensic science laboratory*

Interaction with the Assistant Sub-Inspector (ASI) of police, indicated that it was only after the accused was arrested, that the evidence was sent to the Forensics Science Laboratory (FSL) for testing. Till then, the evidence is kept in the (store room) ‘*maalkhaana*’ of the police station. The ASI mentioned the seal getting stuck sometimes because of the long duration for which it was stored. The procedure of evidence collection, therefore, might be completely futile, if the evidence was ‘stored’ for a long period of time without the necessary infrastructure nor care. The delay in sending the evidence to the FSL and subsequent receipt of reports was recognized as a problem by the ASI who suggested that the tests be conducted within the hospital itself, rather than being sent to the FSL.

*iii. Chain of custody not defined, in case evidence needs to be stored in the hospital*

While the practice at the hospital is to hand over evidence to the police immediately after evidence collection, this may not be possible if the police is unavailable when evidence collection is completed. This is most likely to happen in cases when the survivor is not brought to the hospital by the police, but instead reports on her own. In such situations, there must be some protocols and chain of custody towards ensuring storage and safe-keeping of the evidence in the hospital.

**Emerging Issues**

- A comprehensive evidence collection procedure loses its relevance unless it is followed by sound systems for its preservation and prevention from tampering. Findings highlight the total absence of any processes to ensure that the evidence is properly stored and tampering prevented. As a result, it seems like that the evidence may actually be for naught as it would decompose.
- While the doctors take efforts in gathering evidence, once it is handed over to the police, the hospital does not have any information about it. There is an inordinate delay by the police in transporting evidence to the FSL which is a cause of concern. In case such a delay is inevitable, better storage of evidence must be ensured. It has been clarified by the court

that in case appropriate facilities for preserving evidence are not available with the police, and if there is an inevitable delay in transporting evidence to the FSL, then the evidence must be stored by the hospital.

- While the practice at the hospital was to hand over evidence to the police immediately after evidence collection, this may not be possible if the police is unavailable when evidence collection is completed. This is most likely to happen in cases when the survivor was not brought to the hospital by the police, but instead reports on her own. In such situations, there is need for protocol to be developed by the hospital to ensure preservation and safe keeping of collected evidence. There is no defined chain-of-custody in the hospital for handling of the evidence, in the event that police is not available for receiving the evidence. Designating health care providers in the department who will play the role of ‘custodians’ till the evidence is handed over, is extremely critical.

## **VII. PROVIDING A MEDICAL OPINION**

Based on the medical examination and analysis of samples, doctors are required to provide a reasoned opinion - provisional and final - about the case of sexual assault. A provisional opinion is initially provided based on history, examination findings, and inspection of a wet vaginal smear. The opinion of the doctor at this stage, consists of the interpretation of findings, that is, the doctor comments on whether there are any signs of force, simultaneously pointing out that lack of such signs does not rule out sexual assault. This can be done by corroborating the findings with the history of survivor. Further, if inspection of the wet smear shows presence of spermatozoa, then the doctor may be able to conclude that there are signs of recent sexual intercourse. Once samples collected have been analyzed by the FSL, the doctor is required to corroborate chemical analysis reports with the history and examination findings and provide a reasoned final opinion. Further, the doctor will also be called upon during the trial, to testify regarding his/her opinion provided in the reports.

In this chapter, we describe and discuss how provisional and final opinions are provided by doctors in the hospital, as well as their experience of testifying in cases of sexual assault in court.

***i. Provisional opinion: Interpreting findings after examination***

In the hospital, there are no standard guidelines and the practice of documenting provisional opinion varies from doctor to doctor. All doctors mentioned that they did not examine wet vaginal smears for spermatozoa before providing a provisional opinion. Therefore, they were not able to comment on whether recent sexual intercourse had occurred or not.

When asked about whether doctors write an opinion at the end of the examination, all of them said that they do not comment on whether 'rape' occurred or not as this was not the job of the doctor. However, when probed further about whether they make any comment after the examination, the responses were varied. Some doctors said that they do not make any comments. They were of the opinion that without seeing the chemical analysis reports regarding the presence of semen on the swabs, it was impossible to give any opinion.

*R<sup>5</sup> : No, we don't give any opinion. We just write the history and examination findings. We don't say anything like 'sex can or cannot be ruled out'. I have not seen anyone else write it either.(Senior Resident)*

*I: Do you write a provisional opinion after the examination, evidence collection, investigations, etc.?*

*R: Whether sexual assault occurred? No.*

*I: Ok, but do you comment on anything based on your findings? Regarding the assault?*

*R: No, we can't comment on that because only the results of analysis of the swabs from the lab can say if there is any evidence of sexual assault. (Senior Resident)*

Others, who said that they give an opinion said that they cannot make a direct comment on whether 'rape' occurred or not, but they do comment on presence of injuries, hymen and laxity of the vagina:

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<sup>5</sup> R=Respondent; I=Interviewer

*We also opine on whether penetration has occurred or not. If hymen is torn, is actively bleeding, there is a probability that penetration has occurred. If the vagina is lax, then we write that she is used to regular sexual intercourse. (Specialist)*

*We don't write rape has occurred or not. We write that the introitus is lax or tight, whether hymen is there or not, and injury is there or not. We present our overall interpretation in the court. (Specialist)*

That such comments are irrelevant to the case of sexual assault and the implications of statements reflecting the past sexual history of the woman, need to be clearly understood.

***ii. No final opinion provided***

Once the evidence samples have been analysed by the FSL, the chemical analysis report is supposed to be returned to the doctor, who is then required to corroborate the results, with the history and examination findings, and provide a final opinion. However in practice, these were never returned to the doctor. As a result, a final opinion is never provided. In fact, even when testimony is provided in court, chemical analysis results are never brought to the attention of the doctor. This was raised as a major drawback for health providers' role in the legal process. The following quote illustrates the implications of non-receipt of FSL reports:

*There were some findings on general examination, but even if the hymen is torn, it is usually an old tear. These are not fresh tears. They (survivors) have changed clothes. So the findings are not conclusive. Samples should be seen under a microscope for spermatozoa. But we do not have a microscope. Circumstantial evidence will prove but we don't get back forensic evidence, so we cannot prove. When we go to court we need forensic evidence. I did not see forensic evidence. (Senior Resident)*

Most of the doctors have lament that the receipt of the forensics reports will help them testify better in court. One of the specialists also seems to indicate that the forensic reports may be accessed by the hospital through strengthening its efforts:

*(About getting the forensics reports) No, probably in court we can get them. Maybe if we try we can also get them here. But how does it help? If our samples were faulty or inadequate, then we should be told about that. ....It might help in court if we know the results of the test. But it doesn't help us as a medical professional really. It would make the case stronger in court, yes. (Specialist)*

### ***iii. Interface with the judiciary: Providing 'expert testimony' in the court of law***

The doctor's statement in court, in cases of sexual assault is given substantial weightage in a court of law. However, the processes followed presently (discussed earlier), do not facilitate their playing the role satisfactorily. The reports of the chemical analysis of forensic samples should, ideally, be available to the doctor before s/he goes to court, so that s/he may be able to provide a final opinion by interpreting the history, examination findings and Chemical Analysis (CA) reports jointly. This, however, does not happen.

Further, there is a constant pressure on the doctor to 'prove rape' based on medical evidence and findings. The tussle between the doctors and the defence lawyer, who asks them recurrently to prove whether rape has occurred or not is illustrated in the following quotes:

*It was a 4-5 year old girl and the boy tried something on her. There was swelling of her genital area;, I remember examining in the operation theatre (OT). They were trying to make me say that the injuries could be caused by other things. I was sure it was caused because he had tried penile penetration. They kept saying 'but can this happen because of other things?' I was young then, professionally very young, I was very disturbed. They had made it political - it was some political thing. The boy was from a certain political party or something like that. I was very sure it was attempted rape. No child will create bruises like that on her private parts. But they kept asking 'Can it be created?' I felt very bad. I was called for opinion, but not given the FSL reports. (Specialist)*

*'Can you prove it is rape?' I said I cannot prove it is rape. 'On the basis of torn hymen can you say it is rape?' I said I cannot say for sure. They asked me 'what other causes can be there for hymenal tear'. So I told the causes - there can be so many like cycling, aerobics, horse-riding. There*

*is dearth of material - only if I have the facility to demonstrate spermatozoa in the slides then I can say. If I have forensic evidence, only then I can say conclusively. (Senior Resident)*

The above quotes illustrate that even when doctors cited signs that could be suggestive of use of force, they were asked to conclusively attribute them to sexual assault. Often doctors expressed discomfort regarding this during cross-examination.

### **Emerging Issues**

- The absence of provisional opinion has serious implications for the survivor in a court of law. While a well drafted provisional opinion is not expected to be conclusive, it imparts critical direction and draws attention to the probability of sexual assault, explaining the circumstances or context that bears this out. However, a provisional opinion by the health care provider that reflects irrelevant and stereotypical conclusions about the past sexual history of the survivor (as has been reported by some doctors), may only cause the evidence to weaken.
- The fact that chemical analysis report never reaches back to the doctor and a final opinion is not provided raises concerns about the role of the doctor in the legal process. The primary reason for forensic examination, evidence collection, preservation and analysis is to support the judicial process in advancing the survivor's right to justice. The current lack of coordination between the police, FSL and hospital undermines this role as doctors are expected to testify without sufficient evidence.
- The experiences of providers in the court of law point to the problems in how doctors are questioned as well as their obvious inability to defend their opinion under pressure. Questions such as 'can you prove it is rape?' are impossible for a doctor to answer based on medical examination and collection of evidence. This must be respected and such questions should not be permitted in court rooms. Thus, building perspectives and capacities of the different actors, apart from health care providers - lawyers, judges, police, forensic experts - who have significant roles to play in cases of sexual assault, emerges as a very critical area for future intervention.

## **VIII. MEDICAL TREATMENT AND PSYCHOLOGICAL SUPPORT**

Sexual assault results in tremendous physical and psychological health consequences for survivors. Some of these may manifest immediately while others may surface after long periods of time. Physical, including genital injuries, are known to be sustained during a sexual assault. Apart from these, unwanted pregnancy and transmission of infections such as gonorrhoea, chlamydia, HIV, syphilis, etc. are some of the other physical consequences of sexual assault that have been reported. Psychological consequences of sexual assault have been well documented as well. Rape trauma syndrome is a well-established entity and it is known to occur after sexual assault. In addition to this, Post-Traumatic Stress Disorder, anxiety, suicidal ideation and depression are also known to occur in the short-term. As far as long-term consequences are concerned, sleep disturbances, eating disorders, sexual dysfunction and menstrual irregularities are some of the documented consequences. Among children, cognitive impairment, loss of social competence, inappropriate sexual behavior, body image concerns and substance abuse have been reported as long term consequences.

The WHO guidelines for medico-legal care of victims of sexual assault stressing on the psychological consequences of sexual assault mention that these consequences have the potential to ‘influence and radically alter a person’s entire life course.’ It is this grave impact of sexual assault that makes the therapeutic role of health care providers the primary and most crucial component of responding to survivors. Immediate psychological first-aid, treatment for injuries and emergency contraception and provision of prophylaxis for prevention of sexually transmitted infections, including for HIV, can greatly reduce the risk of long-term consequences and can play a significant role in the survivor’s path to recovery. Counseling, in addition to reducing the risk of long-term consequences also prepares the survivor for examination, evidence collection and other medical procedures, thus reducing the possibility of secondary traumatization. Keeping this in mind, the WHO recommends that the following be made an integral part of the response of health systems to survivors of sexual assault:

- Treatment of physical injuries
- Pregnancy prevention
- STI prophylaxis (including that for HIV)
- Provision of information regarding risks of pregnancy and STIs
- Counseling and psychosocial support
- Follow-up consultations

In the following paragraphs, we look at the provision of therapeutic care at the hospital under consideration, vis-à-vis cases of sexual assault and discuss its implications.

*i. Treatment provided by the hospital*

Treatment, at the hospital, was largely provided to survivors of sexual assault when there were obvious physical injuries, such as perineal, anal or rectal tears. However, most women and girls reporting sexual assault did not have such injuries. Doctors themselves acknowledged that it was mainly in children that injuries were seen and even then, they were rare.

When severe injuries were sustained, the survivor was admitted and the necessary surgical intervention was carried out. Apart from this, emergency contraception was reported to be provided if the survivor reported within 72 hours of the incident. Regarding HIV prophylaxis, and examination for STIs, providers said that the survivor was called for these tests as an ‘out-patient’, but none were aware of whether they actually followed up. There was ambiguity expressed by doctors with regard to the protocol for STI prophylaxis in such cases. While some did not offer any STI prophylaxis prior to testing, others routinely provided broad spectrum antibiotics or prescribed a Pelvic Inflammatory Disease (PID) kit. Whether HIV prophylaxis was to be provided, and with what indications too was unclear.

*ii. Providers’ perceptions: Therapeutic role*

Providers did not view provision of care as their primary responsibility in cases of sexual assault and considered their role to be mainly medico-legal. As one doctor said:

*See, with sexual assault cases, it is like this. The police brings the case. They want gynaecology opinion, radiology opinion, and forensic opinion. If it is our own case we will get reports. This is not our own case – they only come to us for gynec opinion. (Senior Resident)*

In keeping with the perception that they are required merely to provide a ‘gynaecology opinion’, the role of doctors gets limited to medico-legal examination and evidence collection. By way of treatment, all that is done is to advise referrals and tests, but no effort is made to implement them as part of a comprehensive treatment protocol.



### *iii. Absence of psychological care*

Provision of psychosocial support for survivors of sexual assault reporting at the hospitals was virtually absent. Most of the doctors mentioned that counseling services were not available in the hospital, and that they had never referred patients for counseling anywhere else as such. However, they did recognize the importance of psychosocial support:

*I think psychological counselling is very important. Not just of the child, but also the mother. The mothers are very agitated and vulnerable when such things happen to the children. They feel 'how did something like this happen to my child?' They need to be spoken to also. (Specialist)*

*There should be counselling services in the hospital and the survivor should be systematically followed up by going to the house of the survivor, etc. The first thing is the medical attention, but subsequently counselling and support services are important especially for young children. (Specialist)*

Recognizing the importance of some form of psychological support, several health care providers recommended that such services be provided at the hospital. Some doctors mentioned that they talk to the survivors themselves. However, they expressed constraints such as lack of time for not being able to do this. One specialist explained that she sometimes spoke to survivors and their parents when she saw them in OPD:

*Actually, we are doing counseling ourselves. The other day, I was in the OPD, there was a lady who looked very depressed. I asked her what happened... Her daughter had been sexually assaulted. She said it was by the son of the sarpanch. She has three daughters; the one who was assaulted was in Standard 12. The mother was not allowing her to go for the exam. She said that they have a police escort because the sarpanch is pressurizing them, saying that he will give them money if they withdraw the case. She is also not allowing her other daughters to go to school now. I asked her 'Do the other girls in the village go the school?' She said yes. So I told her that she should also let her girls go to school and let the girl appear for her Standard 12 examination. So we do counseling like that. (Specialist)*

There is a social work department that caters to the need of the entire hospital. The number of medical social workers according to some of the respondents, was limited and their role restricted to providing financial aid and other such requirements for patients. They are not involved in any way in caring for survivors. Respondents recommended that the social workers could be involved in providing psychological support. There was also one recommendation that there should be a specialized clinic in the hospital

*As far as facilities are concerned – there is need for development of a department – a separate department like a sub branch of gynaecology affiliated with other departments. Gynaecology, forensic, psychiatrist should carry out examination of the victim. The forensic lab should be available at a nearby place. The report should be made available and the team (of above-mentioned experts) should give opinion collectively. Special clinics should be available for survivors of sexual assault. Maybe they can be called survivor clinics. Doctors - forensic, psychiatrist, gynecologist, etc. should collectively treat the patient –in the assigned room. The case should be followed up till the reports come. (Specialist)*

Forging linkages with service providers outside the hospital was also discussed by some respondents. They recommended that the hospital should build links with private counsellors to whom sexual assault survivors could be referred.

In addition to psychological support, doctors and nurses also saw the need to build linkages with legal and other organizations who could follow up cases and ensure that they get justice.

*There needs to be a follow up of these cases. Someone should make sure that they have enough social support and that they don't take back the case. Then they need legal help so that the judgments are good. They need counselling. We cannot provide all this. Unless judgments are given in favour of such cases, this crime will not stop. And to get that, there needs to be a lot of follow up that we cannot do. (Senior Resident)*

Building awareness especially among young people was also reported as a need in order to prevent sexual assault. In addition to the awareness building, it was also felt that they should learn life skills to be assertive and to say 'NO'.

#### *iv. Systems for referrals*

Since most survivors were not admitted (unless requiring surgical intervention), all further tests like HIV, x-ray and STI testing was through referrals to other departments within the hospital. The survivors are accompanied by the police to the different departments for these tests, based on the referrals advised, causing further stigma and making the survivor unnecessarily conspicuous.

Doctors reported that they communicated to the police the need for follow up, particularly in cases of gang rape where the likelihood of transmission of STIs, including HIV was greater. After this, it was the police who co-ordinate the referrals. While investigations that were mandatory from a medico-legal perspective (x-rays for age determination, for instance) were conducted, there was, no way of knowing whether the referrals were followed as none of the reports came back to the department of ObGyn. The providers expressed concern that the referrals that had implications for the woman's health may not be followed up.

This creates barriers to ensuring continuity of care for the survivors and implies reduced access to health care for the survivor.

#### **Emerging Issues**

- What emerges clearly from the above findings is that despite the fact that this is a large tertiary care hospital, apparently equipped to provide comprehensive care to survivors of sexual assault, the nature of care provided is limited when compared with existing standards and guidelines, such as the one provided by the World Health Organization (WHO).
- There is a clear need for protocol in ensuring that optimal care is provided to survivors. This will ensure that treatment practices do not vary from doctor to doctor, but that these services are uniformly provided to all patients reporting sexual assault. Based on the nature of assault and after assessing the patient, HIV prophylaxis, STI prophylaxis, treatment for injuries and emergency contraception must be part of the treatment package offered.
- The dearth of health services for survivors needs to be addressed urgently. Besides necessary basic treatment and prophylaxis, providing counseling and psychological support are important components of 'care'. Literature shows that although a very small percentage of women access health facilities after an assault, they are more likely to develop

psychopathology as compared to those who do not, and therefore immediate interventions to address this are in order.(WHO, 2007)

- Lack of continuity of care emerges as one of the important factors that hampers provision of care to survivors. As of now, the whole system of responding to survivors is ‘police-centric’, with the survivor in most instances, being brought to the hospital by the police; with an overwhelming presence of the latter during the process of history taking, and even in the context of treatment. The entire process of referrals to various departments for treatment is co-ordinated by the police. All these procedures create a fragmentation in the approach to the survivor. Moreover, the constant presence of the police throughout this process is stigmatizing as it draws unnecessary attention towards the survivor.

## **IX. CAPACITY BUILDING OF HEALTH CARE PROVIDERS TO RESPOND TO SEXUAL ASSAULT**

The nature of training received by providers is one of the important factors affecting the quality of care provided to survivors of sexual assault. In order that survivors receive sensitive and comprehensive care, providers need to be specifically trained to respond to cases of sexual assault and are required to update their skills and knowledge with the changing scenario. In this context, we explored with our respondents, the nature of training that they have received to perform their role vis-à-vis sexual assault as well as specific areas which they feel require further capacity building. We also asked for recommendations for how best such training could be provided.

### **Nature of Training Received by Doctors and Nurses**

All respondents mentioned that the only formal training they had received in sexual assault examination was during their under-graduate course in Forensic Medicine. This was part of their medical curriculum in their second year of medicine and included information regarding the different samples that needed to be collected and the kinds of examination findings that needed to be noted. Practical instruction in this regard, however, was absent.

In practice, skills with regard to conducting examinations were acquired from seniors. Post-graduate students in the department of ObGyn learned from ‘what they saw the Senior Residents do’. In the absence of any defined protocol for management, they relied primarily on the seniors for resolving problems faced while conducting examinations of survivors of sexual

assault. In case of ambiguity with regard to procedure, the senior most resident was contacted for guidance. A few respondents reported having attended seminars on medico-legal management of sexual assault, but this was largely based on personal interest.

While doctors reported receiving at least some training, there was a complete absence of any instruction among nurses in this regard. Most nurses, too, learnt the procedure from their seniors.

### **Recommendations for Building Capacities**

Acknowledging that the trainings that they had received for management of sexual assault cases were insufficient, providers recommended several areas that required further strengthening. Trainings, they opined, would be useful and should be carried out through regular workshops. The content of these workshops should include practical knowledge and skills and should respond to the problems that doctors and nurses routinely face in managing these cases. Some of the areas identified were as follows:

- ***Practical instruction on medico-legal examination and evidence collection:*** Senior residents who were involved on a routine basis in examination and evidence collection expressed the need for more practical inputs on how examinations should be carried out and what evidence should be collected. With the introduction of the SAFE kit, many felt the need for trainings in using the kit and protocols. Some also felt that there was a need to impart training on use of newer equipment like colposcopes which could improve identification of injuries.
- ***Legal awareness:*** Providers expressed the need to understand the legal process and their roles better. They felt ill-equipped when called as expert witnesses in court and felt that they could do more in court to ensure justice, if they were provided with more information in this regard.

*There needs to be more information about how doctors can help in getting justice. Some lawyers can be involved. Unknowingly we can do wrong things. We want to help. We might not be aware of the language to be written in documents like we might have to write certain words which we don't. (Senior Resident)*

- **Communication Skills:** The need for better communication skills was voiced by specialists who felt that this was a weak point, not just in of their response to survivors of sexual assault but also otherwise. Communication and maintaining privacy was something that was crucial with survivors of sexual assault and also with other patients. Lack of rapport with survivors was identified as a barrier by some doctors who expressed the need to acquire skills in rapport building.

*You see, the victims who come, do not have confidence in doctors on their first visit. Then they are accompanied by the police and parent(s), so they might not reveal everything. It is not easy to build rapport. History taking is a problem. So building rapport with these patients is very important. The patient might not have confidence in the doctor. Some of them open up, some of them don't. They might be holding something back. That is a barrier. (Specialist)*

Training on use of specialized equipment: Some felt that there was a need to impart training on use of newer equipment like colposcopes which could improve identification of injuries.

## **X. CONCLUSION AND RECOMMENDATIONS**

This study clearly highlights several gaps in both the medico-legal as well as therapeutic response of the hospital to sexual assault survivors. The nature of treatment provided to survivors reporting at the hospital is far from adequate and not in consonance with the guidelines provided by the WHO. Provision of psychosocial support, a crucial aspect in healing and recovery of sexual assault survivors, is completely absent. The implications of these inadequacies in the response of the hospital, for the health and well-being of the survivor, are tremendous.

Even the medico legal role is not streamlined, leading to a lot of variations in practice in the hospital. Doctors also articulate the lack of skills vis-à-vis seeking history from children and building rapport with survivors, which are barriers to eliciting thorough history. The doctors' responses with regard to interpretation of examination findings indicate undue and unscientific emphasis on the presence of injuries, integrity of the hymen and laxity of the vagina, all of which are rooted in archaic forensic textbooks. The chain of custody, which ensures storage and preservation of medico-legal evidence is undermined. There are also serious problems in coordination between the hospital and external agencies such as the forensic science laboratory. The gaps in the medico-legal response, including collection of irrelevant evidence, lack of

preservation of evidence, recording of irrelevant ‘findings’ like laxity of the introitus, commenting on ‘habituation to sexual intercourse’ and the like, can seriously jeopardize a survivor’s case in the court of law. Lack of standardized and sensitive protocols and procedures for seeking consent jeopardizes the survivor’s autonomy; she may not have the right to make a decision about whether she wants to undergo an examination or file a police case. The entire encounter with the health system, therefore, may end up re-traumatizing the survivor, rather than providing relief.

The problems that we have encountered and documented in this study are rooted in the perspective with which health care providers view a survivor of sexual assault, their understanding of the issue of sexual violence, and the role of the health system in responding to it. This provides an important insight into the kinds of changes that are required in order to make the system more comprehensive and sensitive in its response. Quite erroneously, the understanding of a ‘good’ response by the health system is often reduced to the presence of a ‘kit’ which can aid in mechanical aspects of evidence collection, but does nothing to build perspective on the issue of sexual assault. Our findings suggest that there is a need for a more fundamental change in perspective of the role of the health system in cases of sexual assault, in order to affect change. Equipping providers with the knowledge, skills and perspective towards sexual assault survivors is extremely crucial in this regard. As of now, the involvement of nurses in the response is negligible. Utilization of nursing personnel in provision of care would be important in a low resource setting such as ours.

In this context, it is worth looking at international experiences where the treatment and care of sexual assault survivors receives primary attention. Protocols for sexual assault examination have moved beyond focusing on the past sexual history of the survivor, and the recording the laxity of the introitus is non-existent in most countries. With regard to provision of comprehensive services to survivors, there are several models for responding to sexual assault survivors through the health system that integrate services for survivors of violence into clinical practice or provide referrals to external agencies. Lessons from initiatives such as these can certainly provide direction for this hospital, as well as the health system to strengthen and streamline its response to sexual assault survivors.

Towards this end, is an overall need to:

- Strengthen response to health consequences of sexual violence and accord priority to provision of health care, not limited to medico-legal aspect alone.
- Develop a model health sector response to sexual assault.



The recommendations are organized as per the focal areas where intervention is required and also by the multiple actors and agencies that need to initiate the recommended action:

### ► **Building Capacities**

The need for capacity building initiatives was articulated as a requirement by respondents and also emerged as an urgent need from the analysis of the data. Capacity building initiatives should aim to build perspectives, knowledge and skills on an ongoing basis and in conjunction with protocol that need to be developed by health facilities towards a comprehensive response for survivors of sexual assault.

#### *A. Building capacities of health care providers in the hospital*

Although, trainings have been started for senior residents of the Department of ObGyn, who are involved in implementing the SAFE kit, regular and independent reviews of the content and practice are important. Some of the broad areas in which capacities need to be built include:

#### □ **Perceptions / Attitudes**

- Expanding the understanding of sexual assault.
- Addressing stereotypes and misconceptions among providers; consolidating gendered perspectives, prevention of problematic correlations drawn with injuries, hymen, laxity of the vagina, sexuality, etc. and sexual assault.

#### □ **Skills**

- For eliciting history of the sexual violence in a sensitive manner from survivors, particularly children and persons who are mentally challenged.
- For implementing informed consent processes, documentation including provisional opinion, etc.
- For documentation of injuries, seeking history, age estimation – recording what is essential, and NOT recording what is irrelevant.
- Knowledge about the Legal process and testifying in court



- Capacity building initiatives should reach out to different levels of health care providers – doctors including senior residents, senior specialists, medical officers, medical graduates, as well as nurses from the department of ObGyn.
- Capacity building of perspectives, knowledge and skills should be expanded to reach health care providers from other departments – forensics, radiology, dental medicine, etc. which are also involved in the medico-legal process for sexual assault.

### ***B. Capacity building of health providers in other government and private hospitals***

Building capacities of health care providers from other health facilities is also extremely crucial given the prevalent perspectives, knowledge and skills among health care providers in responding to survivors of sexual assault. Professional medical bodies can play a significant role in initiating such efforts.

### ***C. Building perspectives, knowledge and skills of the police***

The police currently play a central role in the medico-legal aspect of cases of sexual assault and are involved from the registering of an FIR, till the Judiciary. Therefore, the need for training of police is critical. Civil Society Organizations with experience in this area, may be involved in building capacities.

## **► Strengthening Protocol and Setting Standards for Response to Survivors of Sexual Assault**

### ***A. Formulation and Adherence to Protocol and Guidelines in the Hospital***

Development of institutional (hospital) guidelines for establishment of systems, to be followed within the Department of ObGyn as well as protocol for strengthened coordination between different departments of the hospital with regard to consent, examination, evidence, documentation, treatment, etc., is extremely important. Protocol needs to be developed to ensure:

- Informed consent and provide guidelines for the process of consent, including in exceptional situations. For example, consent in the cases of children, mentally challenged survivor, in cases of ‘elopement’, etc.

- Diagnosis and treatment for survivors, including counseling, HIV testing and prophylaxis, prescription of emergency contraception, STI testing and treatment, etc.
- Clear chain of custody and clarity of roles in this regard within the department of ObGyn, between departments of the hospital as well as with external agencies such as the police and Forensics Science Laboratory (FSL).
- Implement routine screening processes for sexual assault across departments in the hospital to facilitate identification and provision of care for survivors of sexual assault who may access the health facility for other health issues.

#### ***B. Protocol Guidelines by State Health Authorities/State Bodies***

- Ensure that violating practices such as the two finger test, which has no relevance in cases of sexual assault, is discontinued immediately by health facilities and providers.
- Ensure that examination of the survivor and accused of sexual assault is done at the same facility so as to allow corroboration of findings between the two.
- Formulate protocol in dealing with different external agencies such as the police, FSL, etc. For example, the timeframe within which the evidence should be sent to the FSL by the police and returned to the hospital needs to be stipulated to avoid delays and loss of evidence.
- Protocols should be developed through a participatory and transparent process, involving health care providers as well as civil society organizations that are engaging on these issues. Evidence-based interventions to improve the health sector response to sexual assault must be adopted.

#### **► Creation of Streamlined Systems for Treatment and Psychosocial Support**

##### ***□ Services in the hospital***

- Ensure that emergency contraception, treatment for injuries, STI testing and prophylaxis are made available to all survivors of sexual assault. Clear guidelines for their provision must be formulated. Referrals for treatment of survivors must be co-ordinated by health care providers rather than the police.

- Provide counselling to all survivors of sexual assault, within the hospital. Make operational systems for referral so that the survivor can access social and legal support from other agencies and organizations if necessary.
- Deploy discrete human resources in the hospital for responding to survivors of sexual violence - for provision of medical care as well as psychological support.
- Ensure availability of necessary infrastructure including discrete physical spaces to ensure privacy for the survivor in the process of counseling, examination, etc. as well as for safe keeping and preservation of evidence.

International experience describes several models for responding to sexual assault survivors through the health system that integrate services for survivors of violence into clinical practice or provide referrals to external agencies.

The ‘Haven’, for instance, is a specialized center for survivors of sexual violence located in London, at the sexual health department of a hospital. It provides a large examination and counseling space for survivors to access services, and a range of such services is offered 24-hours a day.

Another model provides a full range of services and also enables survivors to access other departments of the hospital in areas where it does not provide services itself.

These models are preferred to routine emergency-department based services because they provide priority-based care to survivors. They employ specially trained staff who can provide undivided attention to survivors as opposed to emergency department staff who are often rushed. (WHO and SVRI, 2007)

In India as well, there have been initiatives such as Dilaasa, a hospital-based crisis center that responds to women facing domestic violence, by integrating services for abused women such as psychological support, legal support and social support into the existing hospital set up. Providers are trained to screen women facing violence and refer them to the center.

#### □ *Civil Society Organizations*

- Provide referral resources in the area/city to health institutions to facilitate referrals by providers.
- Organize interface between health institutions providing services for survivors and civil society organizations providing psychosocial support to survivors of violence to maximize survivors’ access to diverse services that they may require.

► **Multisectoral Coordination**

Coordinated service delivery programs improve response to survivors. They facilitate communication between different kinds of services providers, keep the interests of the survivor at the forefront and “promote an understanding of sexual violence as a social issue based in gender inequality and power differentials”. (Campbell and Ahrens, 1998)

□ *Strengthening of interface with multiple actors /agencies by the hospital*

- For the health system to be able to perform the role that is expected of it in an efficient manner so that the survivor has access to rehabilitation and justice, it is imperative that the hospital establishes collaborative relationships with other agencies, clearly demarcating roles, channels of communication, etc. between them.
- Improved coordination with the police, FSL assumes utmost importance in responding to survivors of sexual assault and ensuring justice.

□ *The Role of State Health Authorities/State Bodies in strengthening Coordination*

Develop modalities for identification and interface/coordination between diverse actors. State bodies such as the Ministry of Women and Child Development (MWCD) along with the National Commission for Women can assume a central role in establishing systems and their implementation for improved coordination.

## **Recommendations specific to each Stakeholder**

### **State Bodies**

- Ensure that a practice such as the two finger test, which has no relevance in sexual assault, is discontinued immediately by health facilities /health care providers.
- Adopt protocol for sexual assault that has emerged from larger consultative processes and uphold the dignity and rights of survivors.
- Ensure improved coordination between multiple agencies involved – hospital, police, FSL. Facilitate interface between agencies on a regular basis to review processes.
- Implement periodic reviews (by external experts) to strengthen existing systems.
- Ensure provision of discrete personnel and care for survivors.
- Develop protocol towards ensuring standardized and ethical processes for consent, treatment, examination, evidence, etc.
- Provide necessary infrastructure for analysis of evidence that can be more easily coordinated with the hospital.

### **Hospital / Health Care Providers**

- Ensure capacities (perspectives, knowledge and skills) are strengthened of health care providers in the ObGyn department as well as providers from other departments in the hospital.
- Ensure processes of informed consent at different points of the response. Discontinue the process of taking blanket consent.
- Develop / strengthen existing protocol and guidelines for screening, management of treatment and medico-legal aspects vis-à-vis sexual assault.
- Streamline systems within the hospital to minimize trauma to the survivor in accessing care.
- Create a discrete space or department with human resources with diverse expertise required the respond to sexual assault comprehensively, to respond to survivors of sexual assault as well as other forms of violence.
- Establish systems for regular review of existing systems towards strengthening them.
- Streamline the process and system of maintaining documentation and records and their retrieval.

**Police and Forensics Laboratories**

- Ensure timely despatch of the evidence to the FSL and its return to the hospital/ health care provider for his/her final opinion.
- Ensure safe keeping and preservation of evidence received from the hospital.

**Civil Society Organizations**

- Create public awareness about sexual assault, available care and the role of different agencies in responding to it.
- Build capacities of different actors involved – health care providers, police, judiciary, etc.
- Watch the responses of multiple actors to survivors of sexual assault and conduct regular and systematic reviews to recommend revisions or improved systems.

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# ANNEXURES

## Annexure 1: Key-informant Interview Guide

### Key Informant Interview Guide for Doctors/Nurses

#### A. Background of respondent

Name:                      Designation:

a) For how long have you been working in this hospital? In what capacity?

#### B. Process

a) Are you involved in responding to cases of sexual assault or rape in your hospital?

b) In the past month, how many cases of sexual assault have you seen?

c) Are you involved in responding to

- Adult female survivor,
- Adult male survivor,
- Child female survivor,
- Child male survivor

d) In brief, can you explain the process that is being followed when a case of sexual assault comes to the hospital? (Prepare a flowchart)

- What is the process followed when a case is brought by police and when the survivor comes directly to the hospital?

e) Which of the steps in the above process/processes are you involved in? (Circle mark on the above flowchart/charts)

f) Could you please describe your role/roles in each of the above step/steps in detail.

- Consent
- History taking
- Examination and evidence collection
- Drying, labeling, sealing
- Handing over to police
- Medical Treatment
- Counselling
- Maintaining case records
- Discharge and follow up

#### C. Co-ordination with other agencies

a) Have you ever had to interact with the press in certain cases? What has been your experience?

b) Have you ever had to interact with the police in certain cases? What has been your experience?

- c) Have you ever gone to the court for testifying for a case of sexual assault? What has your experience been like?
- d) Which other departments do you liaise with? (radiology, forensics, surgery, psychiatry) What are the issues that you come across while doing that?

D. Documentation

- a) What is the documentation involved during the process?
- b) What documentation is kept in the hospital? For how long?
- c) What documentation gets handed over to patient and to the police?

E Training:

- a) What kind of training, if any, did you undergo for responding to cases of sexual assault? Please describe the nature of training.
- b) In which areas do you think training is required? How can this best be provided?

F. Barriers and Recommendations:

- a) What kinds of problems do you face, if any, while performing your role in responding to sexual assault cases? (probe - examining, evidence collection, treatment, counselling, documentation, inter-departmental co-ordination, dealing with police, labs or press, etc)
- b) How could these best be rectified?
- c) What, if anything, could be done to better the response of the hospital to cases of sexual assault?

Key Informant Interview with the Police

- a) What is your role in dealing with cases of sexual assault?
- b) Why do you have to interact with the health system in these cases? Please explain.
- c) What is the procedure that you follow?
  - To which hospitals do you take cases of sexual assaults reported at this police station? How do you decide which case is sent where?
  - How often do you bring a survivor of sexual assault to this hospital?
  - How often are you called by a Doctor who wants to report a case of sexual assault to you?
- d) Which departments in the hospital do you interact with? What has your experience been like? Have there been any problems in dealing either with the hospital staff or the survivor at the level of the hospital?
- e) What is the nature of documentation that you collect from the hospital? What documentation do you provide them with?
- f) Do you hand over any documentation to the survivor/relatives/accompanying persons? If yes, what?
- g) Do you have any recommendations to improve co-ordination between the health and police systems?

**ANNEXURE 2 : Consent form**  
**Centre for Enquiry into Health and Allied Themes**  
**Sama-Resource Group for Women and Health**

Dear.....

We are ..... and .....,researchers working with Centre for Enquiry into Health and Allied Themes (CEHAT), and Sama-Resource Group for Women and Health (Sama).

CEHAT is a Mumbai based non profit organization that is conducting research in the field of health and health related issues. Our team is made up of people from different sectors and different disciplines. In the past CEHAT has conducted research in the area of women's health, people's access to health care services, quality of healthcare available, health expenditure etc. CEHAT shares its findings with as many people possible, including the government people's groups etc.

Sama is a Delhi based resource group, working on issues of women and health. Sama seeks to locate the concerns of women's health in the context of socio-historical, economic and political realities and finds linkages of women's well being with livelihoods, food, violence and other larger issues that affect their lives. Sama has been working closely with community based organizations, health networks, people's movements, women's groups across the country, primarily through building capacities, action research and advocacy.

For the past several years, CEHAT has also been conducting research in the area of violence against women. As part of its work in this area, CEHAT has designed a SAFE kit (Sexual Assault and Forensic Evidence kit) which streamlines the process of examination and evidence collection in a survivor of sexual assault. This kit was implemented in two municipal hospitals in Mumbai.

Currently we are conducting a needs assessment study of health care staff at all levels in \_\_\_\_\_hospital to understand the current practices and procedures in responding to survivors of sexual assault who come to \_\_\_\_\_Hospital. By conducting this study we hope to gain a better understanding of what your role has been in responding to cases of sexual assault and the problems that you come across while performing your roles. You have been selected for the study as you have handled a lot of such cases in your time here. We will be conducting interviews with you, where two or three people will interact with you for about 40 minutes. In order that we do not miss out on documenting any information that you provide us with, we request that you allow us to take notes while we conduct the interview.

We would like to assure you that the information you share with us will remain confidential and will be used only for the purpose of the study. A summary of the findings will be shared with you and will contribute to improving the response of health care staff to survivors of sexual assault. The report will not contain any personal information and identification, nor will any individual or group be named. Your name or identity will also not be divulged to anyone and all data will be shared only with the research team. There is no compulsion for you to share any information that you do not feel comfortable sharing. You have the right to refuse to be interviewed, and also to stop the interview at any point. We assure you that no action will be taken even if you refuse to participate.

We seek your cooperation in conducting the study. If you have any questions, clarifications and suggestions, please feel free to talk to us. You can contact

Sana Contractor at ..... Yashashree Keni at .....  
Deepa V. at..... Renuka Mukadam at .....

I have read and understand the above and I consent to participating in the study.

Name:

Date:

Signature:

Place: