TECHNICAL OPINION

In response to the request of:

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by

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I. Background

Ms. Padma Deosthali, Coordinator for the Centre for Enquiry into Health & Allied Themes (CEHAT) contacted Dr. Claudia Garcia-Moreno of the Department of Reproductive Health and Research, World Health Organization (WHO) for a WHO technical opinion on guidelines for medico-legal care for victims of sexual violence in connection with a 2009 Public Interest Litigation (PIL) filed with the Nagpur Bench of High Court[1]. The PIL raised concerns about the quality of medical examination and evidence collection being carried out in cases of sexual violence in the state of Maharashtra, India. The court directed the Directorate of Health Services (DHS), Maharashtra, to set up a *committee (High Court Committee)* to formulate a standard protocol for examination of sexual violence cases, which would be implemented across the state. The proforma and manual were issued by the committee set up by the DHS, Maharashtra. [2], [3]

On the 8th September 2010, CEHAT represented by the Lawyers Collective, intervened in the PIL, putting forth its concerns with the proforma and manual. CEHAT has set up interventions in three municipal hospitals in Mumbai, which provide a Comprehensive health care response to sexual violence. In February 2011, the court asked the *committee* to study this model intervention, submit a report based on the visit and redraft the proforma and manual. Visits to these hospitals were conducted by the committee in March 2011 after which revised manual and proforma were drafted and submitted to court on 27th April 2011. The court, on 8th June 2011, accepted the revised proforma and manual and ordered that it be circulated to all hospitals in Maharashtra for implementation.

CEHAT has reviewed the revised proforma and manual and continue to express concern that several provisions in the proforma and manual compromise the health needs and rights of survivors of sexual violence. On July 28 2011, this matter was argued in the court by Advocate Anand Grover (Lawyers Collective), and the court has asked the *committee* to look into the issues raised by CEHAT regarding the proforma and manual developed by the *committee*. DHS, Maharashtra has called a meeting on 6th August 2011 with CEHAT and others.

CEHAT has requested WHO to provide a technical opinion on the following aspects covered in the revised proforma and manual. This technical opinion is based on the WHO guidelines for medico-legal care for victims of sexual violence (2003)[4] and WHO/UNHCR Clinical management of rape survivors (2003)[5], which have been developed based on the scientific evidence, public health, medical and international human rights standards. The expert opinion will cover:

1 The Public Interest Litigation was filed with the Nagpur Bench of the High Court on 9th Sept 2010 by Dr.Ranjana Pardhi and others against Union of India in 2009 seeking to streamline the medico-legal response to sexual assault.

2 Manual for Forensic Medical Examination of Cases of Sexual Assault", 2011. High Court Committee, Maharashtra

3 Proforma: Forensic Medical Examination Report of Alleged Victim of Sexual Assault. 2011. High Court Committee Maharashtra.

4 World Health Organization, Guidelines for medico-legal care for victims of sexual violence, 2003, Geneva, Switzerland. http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/index.html

5 World Health Organization/United Nations High Commissioner for Refugees, Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons -- Revised ed. 2004. Geneva, Switzerland.

1. Informed consent for medico-legal examination of sexual violence survivors
2. Medical history including history of sexual offence
3. Examination and recording of injuries
4. Evidence collection and documentation
5. Importance of including treatment and follow up care protocol
6. Establishing services in appropriate settings

II. Overview[6], [7]

- Sexual violence is a widespread problem globally - occurring in every culture, in all levels of society and in every country of the world. It is a public health problem and a violation of women's human rights.
- In some parts of the world at least, one in every five woman has suffered an attempted or completed rape by an intimate partner during her life time and up to one-third of women describe their first sexual experience as being forced.
- Although the vast majority of victims are women, men and children of both sexes also experience sexual violence.
- Sexual violence takes place within a variety of settings, including the home, the workplace, schools and the community. In many cases, it begins in childhood or adolescence. Population-based studies conducted in such diverse locations as Cameroon, the Caribbean, Peru, New Zealand, South Africa and Tanzania show that between 9% and 37% of adolescent females, and between 7% and 30% of adolescent males, have reported sexual coercion at the hands of family members, teachers, boyfriends or strangers.
- Sexual violence has a significant negative impact on the health of the population. The potential reproductive and sexual health consequences are numerous – unwanted pregnancy, sexually transmitted infections (STIs), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/ AIDS) and increased risk for adoption of adoption of risky sexual behaviours (e.g. early and increased sexual involvement, and exposure to older and multiple partners).
- The mental health consequences of sexual violence can be just as serious and long lasting. Victims of child sexual abuse, for example, are more likely to experience depression, substance abuse, post-traumatic stress disorder (PTSD) and suicide in later life than their non-abused counterparts.
- Persons who have experienced sexual violence often seek or are taken to a health care facility for examination and treatment and need comprehensive, gender-sensitive health care to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event.
- Health workers who provide care to survivors of sexual violence often lack training in sexual violence and forensic evidence collection. Conversely, people who report a sexual assault to the police may undergo a forensic medical examination without their other health needs being addressed.
- To help ensure that people who have been sexually abused have access to adequate care, WHO began an initiative in 2001 to strengthen the health sector response to sexual violence. This initiative includes the development of guidelines for providing

6 ibid 4

7 http://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/index.html

care to sexual assault survivors and the development of a framework to guide health sector policies related to sexual violence.

III: General principles and human rights standards guiding provision of medico-legal care to survivors of sexual violence[8]:

When caring for victims of sexual violence, the overriding priority must always be the health and welfare of the patient. The provision of medico-legal services thus assumes secondary importance to that of general health care services (i.e. the treatment of injuries, assessment and management of pregnancy and sexually transmitted infections (STIs).

Performing a forensic examination without addressing the primary health care needs of patients is negligent. Concern for the welfare of the patient extends to ensuring that patients are able to maintain their dignity after an assault that will have caused them to feel humiliated and degraded.

In addition, medical and forensic services should be offered in such a way so as to minimize the number of invasive physical examinations and interviews the patient is required to undergo. Regardless of the setting (i.e. hospital-based or community-based) and location (i.e. urban, suburban or rural area), care should be ethical, compassionate, objective and above all, patient-centred. Safety, security and privacy are also important aspects of service provision. Ideally the medico-legal and the health services are provided simultaneously - that is to say, at the same time, in the same location and preferably by the same health practitioner.

The following outlines the human right obligations that governments have a legal obligation in putting in place appropriate measures to ensure:

- Right to health for survivors of sexual violence by providing and ensuring accessibility of quality that quality health services equipped to respond to sexual violence are available and accessible to all.

- Right to human dignity of persons who have been raped including ensuring patients' privacy, confidentiality informing patients and obtaining their informed consent before any medical intervention, and providing a safe clinical environment. Further details about essential requirements to provide informed consent are provided in Annex 1.

- Right to non-discrimination including by ensuring that they are not denied services on the basis of sex, age, ethnicity, race or other social origin.

- Right to self determination including ensuring that don't force or pressure survivors to have any examination or treatment against their will

- Right to information including providing information about the full range of choices and options legally available to them (e.g. if woman becomes pregnant then abortion, keeping the child, adoption) and supporting women to make informed choices about their options for medical care and legal help.

8 ibid 4 and 5

- Right to privacy so that only people whose involvement is necessary to deliver care are present during examination; and

- Right to confidentiality in ensuring that information related to the survivor be kept private including from members of family unless the person consents and/or information needs to be shared with people who need to provide medical care.

All of these human rights are enshrined in some of the key international and regional human rights treaties that are ratified and signed by Government of India including the: International Covenant on Civil and Political Rights (1976)[9]; International Covenant on Economic, Social and Cultural Rights (1976)[10]; Convention on Elimination of all Forms of Discrimination Against Women (1981)[11]; Convention on the Rights of the Child (1990)[12]; the Programme of Action of the International Conference on Population and Development (1994)[13]; Fourth World Conference on Women: Action for Equality, Development, and Peace, Beijing Declaration and Platform for Action (1995)[14];

The above are the general principles and human rights standards that need to be ensured in provision of services to survivors of sexual violence. In addition, the specific considerations with respect to the revised proforma and manual submitted by the *committee* are outlined below.

4. Specific consideration regarding provisions of the proforma and manual proposed by the Government of Maharashtra (DHS Maharashtra) constituted committee

4.1. Informed consent for the medico-legal examination of sexual violence survivors

Suggestion 4.1.1: Reconsider the "all-or-none consent approach" in the proforma.

Currently the proposed proforma by the committee does not include provision to decline consent for any one part of the medical examination procedure. For instance, the victim may be hesitant to consent for photography but may not have the scope to refuse that part of the examination as entire examination and treatment may be linked to an all or none consent approach.

The WHO guidelines [15]recommend the following process for informed consent:

9 International Covenant on Civil and Political Rights, adopted 16 December 1966 (entry into force, 23 March 1976).

10 International Covenant on Economic, Social and Cultural Rights, adopted 16 December 1966 (entry into force, 3 January 1976).

11 Convention on Elimination of all forms of Discrimination Against Women, adopted 18 December 1979 (entry into force, 3 September 1981).

12 Convention on the Rights of the Child. General Assembly Resolution 44/25. UN GAOR 44th session, Supp. No. 49. UN Doc. A/44/49, adopted 20 November 1989 (entry into force, 2 September 1990).

13 United Nations. Report of the International Conference on Population and Development, Cairo, 5-13 September 1994. New York: United Nations, 1995.

14 United Nations. Report of the Fourth World Conference on Women, Beijing, 4-15 September 1995. New York: United Nations, 1996.

15 ibid 4 and 5

1. Review the consent form with the survivor. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form. Once it is ascertained that she understands the form completely, ask her to sign it.

2. It is important to make sure that the patient understands that her consent or lack of consent to any aspect of the exam will not affect her access to treatment and care she can refuse any aspect of the examination she does not wish to undergo. she will be asked to sign a form which indicates that she has been provided with the information and documents what procedures she has agreed to.

Text Box 1 provides example of a separate consent for each aspect of the examination and treatment is provided for consideration.[16]

Text Box 1: EXAMPLE OF CONSENT FOR A MEDICAL CONSULTATION

. . . . . (insert health worker* s name) has explained to me the procedures of examination, evidence collection and release of findings to police and/or the courts.

I . . . . . (insert patient* s name) agree to the

following:

(Mark each n that applies)

___ Examination, including examination of the genitalia and anus.

____Collection of specimens for medical investigations to diagnose any medical problems.

____Collection of specimens for criminal investigation.

____Photography.

____Providing a verbal and or written report to police or other investigators.

____Treatment of any identified medical conditions.

Suggestion 4.1.2: Reconsider the use of this statement in the informed consent: *"In this event I shall be responsible for any problem arising in the process of crime investigation and court trial."*

WHO guidelines[17] suggest the following:

[16] ibid 4 and 5, page 118

1. The recommended approach to obtaining informed consent means explaining all aspects of the consultation to the survivor including the examination, collection of evidence to diagnose medical problems, collection of evidence for criminal investigations, photography, reporting to police/ other investigators.

2. It is crucial that that the survivor is given enough information about these aspects to make informed decision about her care.

3. It is equally important that the survivor's sense of control is returned to her when in medical care.

Therefore, the above statement can be intimidating and disempowering for the survivor.

4.2. Medical history and history of sexual offence

Suggestion 4.2.1: Reconsider the inclusion of : *history of alcohol/drug abuse [voluntary/forceful] in the personal history section.*

Whether or not alcohol or drugs were used during the offence is recommended as part of the section on the history of the sexual assault and focused to the use of alcohol and drug intoxication at the time of the assault. The patient's past history of alcohol/drug use is irrelevant to the actual assault and can be misleading in that it may perpetuate the notion that she is somehow to blame for inviting assault because of drinking or drug use in the past. It also perpetuates a myth that women of loose moral character do get raped or invite rape.

As evidence on myths related to sexual violence shows such myths can negatively affect the way in which society responds to rape and rape survivors. Such myths can result in supporting, justifying and even condoning sexual violence by blaming the victim for inviting to be raped, instead of holding the perpetrator responsible for the behaviour. It can discourage survivors from seeking medical and legal help and undermine their ability to recover from their traumatic experience.[18]

Suggestion 4.2.2.: Reconsider the omission of *"past medical and surgical history" from the medical history section.* The proforma includes "gynecological history, allergies and current medications" but not past medical and surgical history.

The primary purpose of taking a medical history is to obtain information that may assist in the medical management of the patient or may help to explain subsequent findings, e.g. easy bruising or loss of consciousness or memory loss. Therefore, in addition to the gynecological history, allergies and current medications, it is important to document past medical and surgical history .

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17 ibid 4 and 5

18 32. Girardin BW et al. Color atlas of sexual assault. St Louis, MS, Mosby, 1997.

Suggestion 4.2.3. Reconsider the omission of *"probes for recording the different types of sexual assault, whether or not condoms were used, objects were used etc from the proforma.*

These probes and the responses to these probes have a bearing on the examination findings and evidence to be collected. Vital facts may be missed by the doctor, for example - the use of condoms by the perpetrator if not probed for and recorded may lead to the mistaken conclusion that absence of semen on lab investigation indicates no penetration occurred. Moreover the probes allow the person recording the details to be thorough in a situation where the survivor may omit details of the assault that are vital for providing medical care and establishing the evidence because of trauma or feelings of embarrassment and shame at their experience. This may for example include details about oral sexual contact, anal penetration and other relevant details about the assault. Therefore, it is important to include the probes (see Text Box 2 for a checklist of questions that should be specified in the proforma as probes) and explain to the survivor the reason for asking these questions.[19], [20]

The history of the last intercourse should be limited only to the to a week prior to the assault or between the assault and examination. This is done with the intent to rule out sperm or semen from a consensual act and therefore, a revision in the manual may need to be considered with respect to guidance on asking about the history of the last consensual intercourse within the week prior to the assault or between the assault and examination.

19 Hampton HL. Care of the woman who has been raped. New England Journal of Medicine, 1995, 332:234–237.

20 ibid 4, pages 36-37.

Text Box 2: Checklist for inclusion as probes

- the date, time and location of the assault, including a description of the
- type of surface on which the assault occurred;
- the name, identity and number of assailants;
- the nature of the physical contacts and detailed account of violence inflicted;
- use of weapons and restraints;
- use of medications/drugs/alcohol/inhaled substances;
- how clothing was removed.

Details of actual or attempted sexual activity should also be carefully recorded, in particular whether or not the following occurred:

- vaginal penetration of victim by offender's penis, fingers or objects;
- anal penetration of victim by offender's penis, fingers or objects;
- oral penetration of victim by offender's penis or other object;
- oral contact of offender's mouth with victim's face, body or genito-anal area;
- forced oral contact of victim's mouth with offender's face, body or genitoanal area;
- ejaculation in victim's vagina or elsewhere on body the victim's body or at the scene.
- were condoms and lubricant used.

Any subsequent activities by the patient that may alter evidence, for example, bathing, douching, wiping, the use of tampons and changes of clothing, should also be documented.

4.3. Examination and recording of injuries

Suggestion 4.3.1: Reconsider the omission of body charts to record and document the injuries.

The WHO guidelines[21] recommend the following with respect to recording of the injuries:

- Without accurate documentation and expert interpretation of injuries any conclusions drawn about how injuries occurred might be seriously flawed. This will have profound consequences for both the victim and the accused.

- Injury interpretation is entirely dependent on the accuracy and completeness of the recorded observations of wounds.

[21] ibid 4 and 5

- Adoption of a systematic approach to describing and recording the physical characteristics of wounds will ensure that none of the critical elements is omitted.

- Information about injuries and patterns of injury is often vital in cases of sexual assault. In the event of a case proceeding to criminal prosecution, health workers may be required to answer questions about injury patterns and to draw inferences from injury patterns about the circumstances surrounding the alleged assault, either in court or in the form of a written report.

- Documentation of the history and of injuries can be greatly aided by recording notes and use of diagrams during the consultation to make this more accurate.
- Example of a body charts is available in Annex 1 of the WHO guidelines[22] on medico-legal care for victims of sexual violence.

Suggestion 4.3.2. While accurate recording of injuries is important, undue emphasis on injuries both in the proforma and manual needs to be qualified with caution.

The manual states the following in relation to sexual intercourse: "*due to the natural difference in the size of the male and female genital organs and element of resistance and force used, there will be characteristic injuries in the vulva, hymen and vagina".* The proforma provides provisional opinion in relation to evidence of injuries

- *Evidence of injuries related to non penetrative assault.*
- *Evidence of injuries suggesting application of force / restrained with age of injuries.:-*

A common myth associated with sexual violence is that rape leaves obvious signs of injury. The fact is that most rapes do not involve a significant amount of force there may be no physical injuries. Just because a person has no physical injuries does not mean they were not raped. Therefore, following caution needs to be explicitly included in the manual in relation to injuries:

1. Evidence suggests that not all women who allege sexual assault will have genital injuries that are visible on examination performed without magnification. Indeed, in many cases, none would be expected.

2. If a mature, sexually active woman does not resist, because of fear of force or harm, and penile penetration of her vagina occurs, then it is likely that no injury will be sustained. This finding does NOT disprove her claim of sexual assault.

3. Most studies indicate that less than 30% of premenopausal women will have genital injuries visible to the naked eye after non-consensual penetration. This figure increases to less than 50% in postmenopausal women. An

[22] ibd 4 and 5, pages 116-135

understanding of this issue is of fundamental importance in sexual assault medicine.[23],[24]

Suggestion 4.3.3. Consider the *exclusion of specific details related to the hymen included in the proforma such as whether the hymen is intact or not, tears, age of tears etc.*

While it is important to record genitoanal injuries, evidence shows that an intact hymen does not rule out sexual assault, and a torn hymen does not prove previous sexual intercourse. The hymen may be torn due to other activities like cycling, horse-riding etc, and therefore, should be treated like any other part of the genitals while documenting examination findings in cases of sexual assault. Emphasis on the status of the hymen can perpetuate a myth that status of hymen can determine virginity or lack thereof. Therefore, observations about the hymen should be limited to those that are relevant to the sexual assault such as fresh tears, bleeding, edema etc.

*Suggestion 4.3.4: Consid*er *exclusion of "built and nutrition" of the survivor from the general physical examination section of the proforma.*

The proforma recommended by WHO guidelines as well as the adaptations of the WHO guidelines in other low income country settings such as Kenya[25] don't recommend asking for information about built and nutrition, as it is not relevant to the medical management and collection of forensic evidence. In particular, a concern is that such information can be misinterpreted to wrongly conclude that well built women cannot be sexually assaulted.

Suggestion 4.3.5. Consider exclusion of the guidance in the manual on the probing the survivor about the "relative position of victim to accused".

The WHO guidelines[26] recommend the following regarding asking about the sexual assault incident itself:

1. The main aims of obtaining an account of the violence inflicted are to:
    - detect and treat all acute injuries;
    - assess the risk of adverse consequences, such as pregnancy and STIs;
    - guide relevant specimen collection;
    - allow documentation (the history should be precise, accurate, without irrelevant information that may result in discrepancies with police reports);
    - guide forensic examination.

23 Biggs M, Stermac LE, Divinsky M. Genital injuries following sexual assault of women with and without prior sexual experience. Canadian Medical Association Journal, 1998, 159:33–37.

24 Bowyer L, Dalton ME. Female victims of rape and their genital injuries. British Journal of Obstetrics and Gynaecology, 1997, 104:617–620.

25 Ministry of Public Health and Sanitation, Ministry of Medical Services, Government of Kenya, Medical Management of Sexual Violence in Kenya, 2nd Ed. 2009. Nairobi, Kenya. http://www.svri.org/nationalguidelines.pdf

26 Ibid 4 and 5

2. When interviewing the patient about the assault, ask her to tell you in her own words what happened to her.
3. Document her account without unnecessary interruption; if you need to clarify any details, ask questions after your patient has completed her account.
4. Avoid questions that could imply blame towards the victim and use non-leading questions, while being thorough as possible.
5. Always address patient questions and concerns in a non-judgmental, empathetic manner.
6. The following details about the alleged assault must be documented, preferably in an examination proforma:
    - the date, time and location of the assault, including a description of the type of surface on which the assault occurred;
    - the name, identity and number of assailants;
    - the nature of the physical contacts and detailed account of violence inflicted;
    - use of weapons and restraints;
    - use of medications/drugs/alcohol/inhaled substances;
    - how clothing was removed.

Therefore, as per the above recommendations, it is not relevant to document the "relative position of the victim to the accused". It can also be misconstrued as being judgmental and blaming of the victim.

4.4. Evidence collection and documentation

Suggestion 4.4.1. Consider inclusion of clear guidelines on use of the photography and establishing a chain of custody in the hospital to ensure photographs are not tampered with in the manual. Currently these guidelines are missing.

WHO guidelines recommend that the survivor should be given an explanation as to how photographs may be used. Photography is useful for court purposes and should NOT include images of genital areas. Detailed guidelines for photography should be provided including identification, scale, orientation, chain of custody, security and sensitivity.

Suggestion 4.4.2. Consider inclusion of clear guidelines on which samples need to be collected in what situations to avoid collection of samples indiscriminately, without taking into account factors such as the nature of assault. For example, if there is no history of forceful oral sex, and oral swab need not be collected. Similarly, genital evidence is not likely to be found after 96 hours and therefore, may not need to be collected if a survivor reports after this period.

Currently, the manual *does not* rovide any such guidance.

As recommended in the WHO guidelines[27]:

[27] ibid 4 and 5

- The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places.

- On the basis of the information provided by the patient and investigators, the health worker must decide which specimens to collect. It is important to be mindful of what purpose the specimen will serve, what link is potentially going to be established and whether such a link may assist investigation of the case.

- Health workers should be aware of the capabilities, requirements and limitations of their forensic laboratory; and there is no point collecting specimens that cannot be tested.

4.5. Importance of including treatment and follow up care protocol

Suggestion 4.5.1: Strongly consider the inclusion of clear guidance on treatment of injuries, STI assessment and prophylaxis, pregnancy assessment and appropriate counselling, care/referral in the manual as well as documenting it in the proforma.

Currently the manual excludes guidance on treatment for injuries, STI assessment and prophylaxis, pregnancy assessment and prophylaxis or counseling. Health care providers may be unaware of the various components of management/treatment of injuries and health needs arising from sexual assault. Hence they might miss out on some aspects if not explicitly provided with the guidance. Absence of such guidance may result in treatment and care not being provided to sexual assault survivors.

A prime focus of the WHO guidelines[28] is to ensure that treatment is provided to the patient for the range of health consequences of sexual assault. For example, the recommendations include the following:

- The key guiding principle of responding to survivors of sexual assault is the overriding priority to be given to addressing the health and welfare of the patient. The provision of medico-legal services thus assumes secondary importance to that of general health care services i.e. the treatment of injuries, assessment and management of pregnancy and sexually transmitted infections (STIs)).

- *Performing a forensic examination without addressing the primary health care needs of patients is negligent.*

- Comprehensive care must address the following issues: physical injuries; pregnancy; sexually transmitted infections (STIs), HIV and hepatitis B; counseling and social support; and follow-up consultations.

- Detailed guidelines are provided for medical management of each of the above health consequences, including investigations required, standard drug

[28] ibid 4 and 5.

regimens for treatment and prophylaxis, protocol for follow-up visits in Chapter 6 of the WHO Guidelines on medico-legal care for victims of sexual violence.

- Counselling and referral services to be provided need to be specified in depth to ensure that all needs of the survivor may be addressed, particularly the long-term consequences of the assault.

- The proforma in the WHO guidelines (Annex 1 of the document)[29] includes documentation on the nature of medication provided, hospital pathology investigations performed, follow-up arrangements and referrals to other health workers made. It is important that these details are part of the documentation of the case.

4.6. Establishing the Services in appropriate settings:

Suggestion 4.6.1. Reconsider exclusion of primary health centres (PHC) from the manual as centers for examination.

WHO Guidelines recommend that

- The location should be such that survivors have immediate access to medical care and without delay, which can result in loss of therapeutic opportunities, changes in physical evidence and loss of forensic evidence.

- It is recognized that ideally, consultations should take place at a site where there is optimal access to the full range of services and facilities that may be required by the patient, for example, within a hospital or a medical clinic, or somewhere where there is immediate access to medical expertise.

- However, in practice, victims of sexual violence present at any point or sector of the health care system. Therefore, all health care facilities*(including primary health care facilities)* should be in a position to recognize sexual abuse and provide services to victims of sexual violence (or at least refer patients to appropriate services and care), irrespective of whether a forensic examination is required. If not already in place, health care facilities need to develop specific policies and procedures for dealing with victims of sexual violence.

- The guidelines on essential equipment required for responding to survivors of sexual violence are outlined on pages 26-28 of the WHO guidelines[30]. The list includes ideally desired equipment as well as minimum requirements marked by an *. The minimum requirements of the equipment corresponds to the standard minimum equipment required by the first level or primary health care level facilities in most countries.

[29] ibid 4 and 5 pages 116-137
[30] ibid 4, pages 26-28.