

Implementation of Protocols to Respond to Sexual Assault: Experiences from the Field

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ABSTRACT

This study provides an insight into our experiences of implementing the Sexual Assault Forensic Evidence collection Kit (SAFE Kit), a comprehensive protocol for evidence collection developed by Centre for Enquiry into Health and Allied Themes (CEHAT), for one year in two public hospitals in Mumbai, India. A protocol was implemented for evidence collection for cases of sexual assault accompanied by sensitization and capacity building of health professionals on the issue of sexual violence. Support services were also provided to the victims. The handling of victims of sexual assault in these hospitals was documented and several gaps in relation to obtaining consent, recording of history, preserving confidentiality of victims and provision of care were noticed even after comprehensive protocol had been implemented. The introduction of protocols ensured meticulous collection of medico-legal evidence and health care providers were enthusiastic about implementing them. However, the response was far from adequate when it came to providing the victim with holistic care, despite the fact that sensitization training had taken place along with implementation of the protocol. The forensic role of health care providers took precedence in cases of sexual assault; therefore the aspect of care took a back seat.

Solely an introduction of protocols will not substantially change the manner in which victims of Gender-based Violence (GBV) are treated by the health system. One time capacity building is also not

sufficient to change attitudes and undo biases. This requires a more fundamental change in the way medical education treats sexual assault. The preoccupation with medico-legal requirement of handling cases of sexual assault must be replaced by an emphasis on providing holistic care to victims. Moreover, fear of the legal system and administrative rigmarole thwart the efforts of even sensitive providers. Demystifying legal obligation and modifying administrative procedures related to handling of victims and provision of holistic care will aid this process and make it easier for providers to respond sensitively.

INTRODUCTION

Health care providers are required to play a dual role while responding to victims of sexual assault. Their foremost responsibility is to provide immediate therapeutic care to victims, both medical treatment and psychological support. The second is to conduct a thorough examination and collect crucial medical evidence that could support the victim's testimony in court, should she choose to pursue a legal course of action. The inadequacy of the health system in India, in fulfilling both of these roles is well known¹. Health and Women's Rights activists who have been involved in investigations of cases of sexual assault in the 80s and 90s have pointed out the improper collection of medical evidence that is carried out by health professionals, who are both insensitive and ill-trained. For example, a team investigating the custodial rape of a deaf-mute girl in an observation home in Mumbai in the year 1997 found that inadequate response by health professionals had resulted in crucial medical evidence being lost². Moreover, they noted that very little medical and no psychological care was provided to the victim. Organizations responding to and advocating for victims of sexual assault have also documented the insensitivity of health systems not just in India, but also abroad.

The SAFE Kit was developed to address this lack of a comprehensive, systematic response to sexual assault in India³. It was adapted from the Ontario Police Force kit used in Canada. After consultations with several forensic experts, gynaecologists, public health experts and women's rights groups, the kit was finalized in 1998. Thereafter, it has been used for educational purposes and advocacy was under way to have it implemented as the protocol of choice for examination of sexual assault victims. It has been put to use for forensic examination of victims only in 2008. The kit consists of: (i) all necessary equipment required to conduct a thorough medical examination and collection of evidence for victims of rape; (ii) a detailed proforma for recording consent, medical history, general examination, history of the assault, the nature of injuries, prompts for all evidence that must be collected, age estimation and treatment of the patient; (iii) a manual that provides details of how consent must be taken, how an examination must be carried out, in what conditions it must be carried out and other information relevant to medical practitioners vis-à-vis rape law.

As part of this project, we implemented the SAFE Kit in two peripheral municipal hospitals in Mumbai. One of these is a 500 bedded hospital and the other a 100 bedded maternity home. Together, they receive about 1-2 cases of sexual assault every month. Implementation of the kit was accompanied by sensitization and capacity building of health professionals on the issue of sexual violence.

Training consisted of building perspective on sexual violence as well as demonstrating use of the kit. Defining sexual violence, addressing common myths regarding sexual violence and using case studies to demonstrate an appropriate response to a victim reporting sexual assault, were part of this training.

We committed to assist health care providers with using the SAFE Kit protocol; as well as providing crisis intervention services to victims. The handling of victims of sexual assault in these

hospitals was documented and we noticed several gaps in relation to obtaining consent, ensuring privacy, respecting confidentiality of victims and provision of care, even after the comprehensive protocol had been implemented.

Profile of Cases and Procedure of Response

Since the implementation of the SAFE Kit in the year 2008, we have directly intervened in 15 cases of sexual assault in both these hospitals. Amongst these 15 women, 8 were under the age of 18 years, and none exceeded the age of 24. It was seen that at least 9 women had known the assaulters well. These known people were teachers, neighbours, shop keeper, guardian, boy friend, friends, and school security. Among the 15 cases that we responded to, 8 women were brought by the police because their parents or relatives had filed a complaint in the police station; the rest were brought by their relatives directly to the hospital for treatment of injuries.

In this section, we describe the procedure that is followed when a sexually assaulted women is brought to the hospital. All women reporting sexual assault are taken to the Casualty Department, which is responsible for registering a medico-legal case. It is the Casualty Medical Officer (CMO) who records the first statement and registers a medico-legal case, but does not conduct examination. The gynaecologists who have been trained to use the kit read out the contents of consent form, explain them to the patient, and then conduct examination. The examination and evidence collection is done in the labour ward for both the minor girls and adult women. A nurse is present along with the doctor while examination is carried out. Evidence collected is kept in the SAFE Kit box, which is sealed by the Medical Records Officer (MRO) and later handed over to the police who take it to the Forensic Science Laboratory. Until it is received by the police, the box is kept with the Sister-in-Charge of the Gynaecology Ward. In three cases, it was seen that after the examination and evidence collection, the honoraries of the specific unit were expected to give the 'final signature', before the kit was sealed.

After the examination is over, the woman is admitted in the gynaecology ward, until the collected evidence is handed over to the police. This admission is mandated as per hospital procedure, irrespective of whether the victim's injuries warrant admission. HIV and VDRL tests are performed and in adult cases who report immediately after the assault, emergency contraception is prescribed. While the woman is admitted in the hospital, the police calls upon her in the ward in order to record her statement and make an FIR. This is for those women who come to the hospital with their relatives or parents and have not yet lodged an FIR. Among the 15 cases that we handled, none of the women received a copy of the statement given by them to the police, without intervention by us. Once the police have taken the evidence, the woman can leave the hospital, unless, of course, she requires further treatment. There is neither provision for any kind of psychological support at the hospital (apart from the services provided by us), nor is there any referral to such services.

PROBLEMS IN PROCEDURE

Mandatory Admission

As per hospital procedure, every woman who reports sexual assault must be admitted to the hospital for at least one day, even if her condition does not warrant admission. Several reasons have been cited by doctors for this. First, the final endorsement of the report of medical examination has to be signed only by the honorary doctor, who is not present at the hospital 24 hours /7 days. Second, doctors are too afraid to take responsibility for the evidence and so they prefer that the woman remains in the ward until the evidence is taken away by the police – as if to say that the woman is the custodian of the evidence until then. Third, keeping the woman in the hospital for 24 hours allows the police enough time to take cognizance of the case and lodge an First Information Report (FIR). Doctors are afraid

that if women are sent away, they may not file an FIR and the doctors will be held responsible for not reporting the case to the police. Hence, in order to protect themselves from all these 'legal hassles', doctors prefer to admit the woman. However, women who are not in need of medical treatment obviously do not want to be admitted. They would rather go to a place that they feel comfortable in. Moreover, being admitted means that they are required to inform their families, which might be socially detrimental, given the stigma attached to rape. But as this is posed as mandated by law, the victim and her family are left with little choice. They are in no position to negotiate this with the hospital and they have to get admitted.

Seeking Informed Consent

Keeping in mind the fact that victims may not always want to report the case to the police and they often need some time to decide on whether they want to file a police complaint or not, the SAFE Kit protocol has mandated that the woman's consent be sought at three levels: (i) consent only for treatment; (ii) consent for examination and collection of evidence but not for a police complaint; and (iii) consent for examination, collection of evidence and also for police complaint.

In other words, the protocol mandates that if a sexually assaulted woman approaches a hospital, she must be able to choose the extent of services she wants. For example, if a woman wishes to only get emergency care but not file a complaint with the police, she must be given that option and her wishes must be honoured. However, in reality, when women access the hospital, a medico-legal case is filed which automatically activates the police machinery. Moreover, because admission is mandatory for rape victims, the police have the time to come to the hospital and force the woman to file an FIR, unlike other medico-legal cases where the police does not take cognizance because they are not admitted. Hence, whether the victim wants it or not, she is forced to file a police complaint

even if she doesn't want to pursue the case. She is given no time to make this very crucial decision.

Therefore, although seeking of consent in the protocol is for the benefit of the woman, yet in practice hospital procedures, the law and the need for doctors to protect themselves prevent it from being operationalized.

No Option of Partial Evidence Collection

Given the intrusive nature of examination and evidence collection, women may be apprehensive about undergoing a per vaginal examination. Sometimes, they are certain that penetration has not occurred and therefore they do not see the need to do an internal examination. Moreover, the consent form clearly states that the victim can withdraw consent for examination or evidence collection at *any time* during the procedure. However, in practice, doctors are afraid that if they fail to collect all the evidence, the court may point to it as a lapse on their part, and they will be held liable for it. They do not seem to understand the fact that consent is required for collection of evidence at every stage. Irrespective of the actual number of swabs collected, the victim's history and circumstantial evidence hold significance in court and can prove her case. Hence, providers either try to coerce the woman into allowing complete examination and evidence collection, or they refuse to collect anything at all.

Examination only by Gynaecologist

Despite the fact that Supreme Court judgements and subsequent amendments to the Criminal Procedure Code have clarified that any registered medical practitioner is authorized to conduct forensic examination of a rape victim, the practice of mandating that only a gynaecologist can do so is still vehemently adhered to in the name of 'hospital protocol'. In all cases, women were asked to wait until a gynaecologist was made available, or they were shuttled from

hospital to maternity home because a gynaecologist was not available at the hospital. Not only does waiting for a gynaecologist result in needless delay in responding to the woman, but also the woman unnecessarily comes in contact with and recounts her history to many more players than is necessary. Instead, if there is one person designated to conduct the examination who is responsible for registering the Medico-legal Case (MLC) and is available at every hospital, it would reduce the number of players that the woman has to deal with.

Lack of Privacy

There is no room dedicated to examining victims of sexual assault in the hospital. All examinations are carried out in the labour ward where deliveries are performed – possibly the worst site in the hospital where such a procedure should be undertaken. Already traumatized women are subject to the din of women screaming in labour, and gynaecologists have to shuttle between the patients in labour and the victim. The only ‘privacy’ offered to the woman is by a curtain that is not always drawn. After examination, the woman is admitted in the general gynaecological ward where no attempt is made to protect her identity. With the police, doctors and social workers visiting her every now and then, all patients and staff alike know the identity and details of the ‘rape case’.

Custody of Evidence

After examination and evidence collection is complete, the kit is kept in the ward where the victim is admitted. The sister-in-charge is responsible for taking care of the kit. There is ambiguity around who is responsible for following up with the police so that the kit is collected from the hospital and taken to the lab. This task is performed by the resident, or the medical records officer or by the sister in charge. Since the MRO is designated to seal the kit, the evidence collected by the gynaecologist on duty is kept unsealed until it reaches the MRO. Moreover, because MROs do not

understand the importance of the evidence, often sealing of the kit is not proper. All these lapses in procedure leave room for evidence to either get destroyed or be tampered with.

Police Pressures

It must be noted that health facilities are routinely pressurised to act in a certain manner by the police machinery. This play has been seen quite openly in cases where age determination of the victim is crucial. The age of the victim decides which section of the Indian Penal Code the case will be filed under, which subsequently affects the sentence that an accused will be given. It is a matter of great importance for the police. One way of determining age is through X-rays of the wrist. There is hence a lot of pressure on doctors to determine the age accurately. Succumbing to this pressure, we have seen doctors take as many as 5 to 6 radiographs of the wrist of one girl so that they may be able to confirm whether she was an adult or not.

At times when the hospital refuses to follow police procedure, they also face a lot of criticism from the police. In one case of a woman who reported directly to the hospital, the hospital honoured her request for treatment and medical evidence collection and did not force admission. They did register a medico-legal case although the woman had not taken a decision about whether she wanted to pursue a legal case, but because admission did not take place the police did not come to the hospital to register an FIR. Two days later, she made a police complaint and informed them that evidence had already been collected at the hospital. At this time, the hospital received a lot of criticism from the police for their 'inaction'. The police also tried to take the woman to another hospital for evidence collection again, alleging that evidence collected before filing an FIR was invalid. The woman resisted this move and eventually, the evidence collected by the hospital was honoured. However, this whole experience of standing up to the police and justifying their stand was unnecessarily harrowing for the hospital. Hence, in the

next case that came to the hospital, they promptly admitted the victim.

Lack of Belief in Women's Histories

Suspecting a victim's history if she doesn't fit the 'profile' of a rape victim is still common, despite efforts to address this during training. Because providers expect that a woman or child reporting sexual assault should be depressed and non co-operative during examination, they are surprised when she is not. In one case of an 11 year old girl who had been sexually assaulted, the fact that she spread her legs without the provider's instructions to do so elicited a comment from the nurse that she is probably habituated to sex. This, despite the fact that the girl had abrasions and lacerations on her thighs.

In another case of a 14 year old girl who had been gang raped by three men, the examining doctor remarked "How is it possible that there are no signs of struggle or any internal injuries, if she was gang raped?"

INTERVENTIONS

Due to the fact that we had introduced a new protocol in these hospitals, we realised that providers wanted assistance in its implementation. This worked well for us because along with the demonstration of the use of this protocol, we also got an opportunity to provide the woman with reassurance as well as inform her about the examination process while it was being conducted.

We had to demonstrate ways in which consent is operationalized for providers conducting examination, because previous hospital procedures did not have that scope. We had to keep discussing these issues repeatedly with them so that we are truly able to operationalize the protocol. Parallel to this procedure was the entire dilemma of compulsory admission and police statement; which had to be negotiated with the hospital authorities

to circumvent such unnecessary procedures. Often, this took up a lot of energy given the reluctance of providers to modify procedures.

An important aspect of providing comprehensive care to victims of sexual assault, is not just restricted to the facilitation of examination and evidence collection, but also includes provision of basic psycho-social support and information. In the 8 cases of sexual assault against children, we spoke to their mothers. We were able to assist the parents to find a language of communicating with their child about the assault. This is because often parents restrict the child from engaging in outdoor activities because of the shame, and honour issues and curb the child's mobility. As interventionists, we provided them with means of opening a dialogue with their children about the sexual assault, educating them about good and bad touch, as well as explaining the legal procedures related to their case. This is important to be done in the hospital itself because most of the patient population comes from lower socio economic strata; therefore it is extremely difficult for them to follow up at the hospital for any form of counselling/therapy.

Similarly with adult women, we encouraged them to talk about the incident of sexual assault, and reinforced that rape was inescapable, and that having survived the sexual assault was more important than the incident itself. It is crucial for a survivor of sexual assault to shift the blame from herself to the perpetrator. As interventionists, we also encourage women to face the outside world and prepare her to deal with the stigma that accompanies.

Besides this form of support, we saw that none of these women could afford private lawyers that can act as "Watching Advocates" when the case proceeds to the court. In such cases we linked them to the lawyers who are sensitive to this issue, while in some cases helped them to file an FIR.

However, we saw that none of the women followed up for legal redress or emotional support. This may be due to the fact that they belong to economically underprivileged class and therefore even

commuting to a certain agency for seeking support may not have been a priority. This highlights that a first contact comprehensive health care response needs to be sensitive and holistic - one that takes into account all these compulsions.

DISCUSSION

Our experience demonstrates that solely an introduction of protocols will not substantially change the manner in which victims of gender-based violence are treated by the health system. While providers were not averse to implementation of the SAFE Kit (quite the contrary), they picked from the protocol only that which was convenient for them. A systematic protocol for documentation of injuries, and the availability of all equipment required to conduct an examination made their forensic role easier and was hence readily adopted. However, those aspects of the protocol that dealt with consent, ensuring privacy, protecting confidentiality and providing treatment to victims were ignored. In large part, this was because doctors looked at sexual assault victims as medico-legal cases rather than patients in need of care. We have seen that broadly, two factors colour the behaviour of providers towards victims of sexual assault.

The first is the prejudice that providers themselves carry, against victims of rape. As discussed in the previous section, lack of external injuries leads doctors to speculate that the rape might be 'fake', despite specifically tackling this myth during training. Given the manner in which medical education reinforces these myths, the behaviour of providers comes as no surprise¹. Agnes, in her critique of textbooks of medical jurisprudence, points to how they caution practitioners to beware of women levying 'false charges' of rape. She further concludes:

"It is little wonder that young doctors, who pass out from medical colleges fed on this doctrine, make unwarranted comments about the conduct and character of a rape victim, based on the level of elasticity of her vagina. The woman's chastity, morality and virginity is put in the dock"⁴.

Even if these comments do not get documented on the doctor's notes that are presented in court, the biases could impact neutrality during examination and they definitely affect the manner in which the victim is treated by providers.

The second is the providers' fear of the law in general and their own legal obligations in particular. This is reflected in the fact that doctors do everything and more to protect themselves, often at the cost of re-traumatizing the victim. Unnecessary admission, insisting that only a gynaecologist do the examination because they are the 'experts', informing the police without the woman's consent, are all manifestations of this fear. Some of the fears are unfounded and arise from the misconceptions that health care providers have about their legal role. For example, the notion that only a gynaecologist can conduct a forensic examination is blatantly false and has been addressed in our training as well. Even if individual providers are convinced about their legal role and they do agree in principle that they could do the examination themselves instead of waiting for a gynaecologist, these fears would still play out in the same manner because they have been institutionalised into hospital protocol.

It would be unfair to peg the blame on providers' preoccupation with self-preservation alone. There are certain aspects of the kit which are not operationalized completely because, although in keeping with ethics are in direct contradiction to hospital procedures. For example, the protocol of seeking consent is patient friendly and in consonance with medical ethics. However, the moment a provider registers the case as a medico-legal case, it automatically implies that he/she has informed the police who is then required to take cognizance. Hence, if a provider wished to truly operationalize consent the way it has been described in the kit protocol, he/she would have to desist from registering a medico-legal case and in the process, would be violating existing procedures. Of course, in such a situation where providers are expected to fulfil a medico-legal role specified by the state, this tension cannot be

resolved at an individual level but needs to be addressed at the systemic level.

In this regard, it is worth taking a look at the measures that other countries have taken in order to reduce barriers to victim's reporting of sexual assault. In the United States of America for example, as per a federally mandated law, anonymous rape examinations called 'Jane Doe Rape Kits' are to be mandatorily provided as an option to women reporting sexual assault at the health facility⁵. This means that if a victim so desires, she could undergo forensic examination and evidence collection immediately after the crime occurs but can wait (for a defined period that varies from state to state) to press charges. Such a provision recognizes that given the nature of crime, women may not always want to report to the police immediately, but because forensic evidence may be lost, they should be allowed to undergo an examination and later make a decision regarding reporting to law enforcement. As of now, such a provision does not exist in Indian law, but must be considered.

CONCLUSIONS

Experience of responding to sexually assaulted women has highlighted the myriad ways in which they get retraumatized by the health system. Some have called the contact with responding agencies – both law enforcement and medical – the 'second rape'⁶. It is ironic that a system that is meant to be therapeutic towards a victim of rape actually ends up traumatizing her further. Moreover, a brutal first contact with the health system can put women off trying to pursue a legal case altogether. This is not to say that if the medical response was ideal, all women would be open to prosecuting their assailants. There are many other social and economic factors that also affect women's decisions. However, a sensitive response from the health sector will at least not traumatize them beyond what they have already been through.

This definition of a sensitive response must go beyond doctors' medico-legal responsibilities. The aspects of informed consent,

providing necessary medical as well as first contact psychological support and validation after a traumatic experience, and referral to appropriate agencies for further help must be an integral part of the health system's role.

Some of these problems can easily be fixed through clarification of roles and repealing obsolete protocols. Fear of the legal system and administrative rigmarole thwart the efforts of even sensitive providers. Demystifying legal obligations and modifying administrative procedures related to handling of victims and provision of holistic care will aid this process and make it easier for providers to respond sensitively.

Other issues need a more concentrated effort. One time capacity building can introduce providers to a more progressive discourse on sexual assault, but it is not sufficient to change attitudes and undo biases. This requires a more fundamental change in the way medical education treats sexual assault. The preoccupation with medico-legal requirements of handling cases of sexual assault must also be replaced by an emphasis on providing holistic care to victims.

Going beyond the health system alone, there is a need for multi-sectoral collaboration whereby the health system, the police and the legal machinery are able to co-ordinate in order to ensure that they do not traumatize a victim any further and can provide justice. This requires developing of guidelines for all three systems so that ambiguous roles can be clarified, as well as mandatory sensitization of all those engaged in dealing with sexual assault.

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