

Developing Protocols for Medical Examinations

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A 21-year-old girl who was raped and bleeding was seen by a doctor at a premier hospital after six hours. No painkiller or first aid was provided as it was a medico-legal case.

A 15-year-old girl was brought by her mother with a complaint relating to fondling of the breasts, and the doctor insisted on examining her genitals as this was part of medico-legal procedures.

A 5-year-old girl who was brutally raped and had suffered severe injuries was taken by her mother to a hospital where she was asked to first file a police complaint. So she went to the local police station, where the police refused to file an FIR [first information report] saying that it needed to be filed where the incident had taken place.

A woman who was pregnant as a result of rape came in for an abortion. She reported that a medico-legal examination had been done a month ago, but no EC [emergency contraception] was given.

A child was brought to a hospital as she was suffering pain during micturition. The mother said the child had been raped, and that she was examined by a doctor the previous day, but no medication had been given.

These are not isolated examples but reflect the common experience of rape victims and survivors in India. They highlight how their right to treatment is systematically violated, and point also to another important aspect: the problems in forensic practice.

Since the 1980s, activists in the women's movement in India have campaigned and lobbied hard to draw attention to the question of violence against women. They have demanded the setting up of counselling centres and shelters and the provision of legal aid for survivors; they have critiqued coercive population policies, highlighted the complete lack of gender sensitivity within the system and the insensitive responses to rape, and more. Despite this, however, the role of the health sector in responding to and mitigating violence has not become a focal point. Health professionals and health systems have a critical role in providing care for survivors of sexual assault, as well as in documenting the assault and collecting relevant evidence. However, there are several gaps in the provision of care as well as in medico-legal responses that need our attention. Violence against women is not recognized as a public health issue, and it is absent in health policy and programmes. Surprisingly, medical and nursing curricula too do not include this subject. Where treatment is concerned, health providers often fail to document current and past episodes of violence and limit their role to treating its physical symptoms. Deep-rooted biases within forensic medical practice are reflected in medico-legal examinations in cases of sexual violence, as seen in the continued use of the two-finger test, the preoccupation with

hymenal status and other unscientific procedures. There is a need to change such practices and to work towards creating an enabling environment, such that survivors feel they can speak out about abuse without fear of being blamed, and where they can receive empathetic support in their struggle for justice and in rebuilding their lives (Bhate-Deosthali 2013).

The health sector has certain legal obligations in responding to violence against women. The domestic violence law (Protection of Women from Domestic Violence Act, 2005) recognizes health facilities as service providers and mandates that all women reporting domestic violence must receive free treatment and information as well as appropriate referral services. The Criminal Law (Amendment) Act, 2013 (CLA 2013), now makes it mandatory for all public and private hospitals to provide free treatment to survivors of sexual violence. Dilaasa, a redesigned 'one-stop crisis centre' model in Mumbai, focuses on training hospital staff to respond to violence against women and to understand the need to deal with violence against women as part of their roles and responsibilities. The model also includes violence support services currently missing in the health sector, namely, crisis intervention and psychosocial support. Dilaasa has implemented sexual violence protocols based on World Health Organization (WHO) guidelines that include informed consent for examination, treatment, evidence collection and informing the police; use of gender-sensitive pro forma that do not record the status and type of the hymen or measure the size of the vaginal opening or make any comment on the sexual habits of the survivor; a chain of custody for management of evidence collected; and immediate first aid and follow-up care. Doctors have been equipped to provide reasoned medical opinion and explain the absence of injuries and/or absence of forensic evidence that could help survivors in courts.

HEALTH SECTOR RESPONSES TO SEXUAL VIOLENCE

Survivors of sexual violence may report directly to hospitals, or may be brought to the hospital by the police. As any incident of sexual violence is a criminal offence, doctors have an obligatory forensic role in the documentation and collection of medico-legal evidence in addition to their primary responsibility of providing treatment and care to survivors. Intervention research carried out by the Centre for Enquiry into Health and Allied Themes (CEHAT) and a situational analysis conducted by WHO in three states in India show that the current response of the health sector to these issues is fraught with problems on both fronts—therapeutic as well as forensic. Some of the problems that have been pinpointed include the following.

Mandatory Police Requisition for Examination in Cases of Sexual Violence

Despite a Supreme Court judgment (*Manjanna v. State of Karnataka*) that made it mandatory for doctors to provide treatment to rape survivors, and not wait for or demand a police requisition, hospitals across the country demand police requisitions, paralysing the entire process. Those who reach the hospital directly for treatment are not provided treatment until they get a police requisition, thus violating their right to treatment.

Inertia in Responding

Interviews with multiple stakeholders highlighted that when a case of rape is reported, there is a reluctance on the part of the providers to respond. This is in contrast to other cases that come to the emergency department, such as assault, burns, suicide, poisoning and so on, where medical treatment is initiated immediately.

This inertia in responding to survivors is reflected in long waiting periods, delays, multiple referrals and a sense of chaos. The actual examination may be completed in less than 20 minutes, but the process of delay, waiting, questioning, information gathering and so on takes a couple of hours.

A senior gynaecologist referred to this response as 'batting', where each doctor wants to avoid performing such examinations. No one wants to take responsibility for the medico-legal examination because they are reluctant to appear in court during rape trials.

No Informed Consent

Informed consent means seeking the person's consent after providing complete information about medical procedures. This has been made a legal requirement for all medical procedures, but in most places no consent is sought from the rape survivor. Providers who were interviewed said that this happens because many doctors believe that in medico-legal cases there is no need to seek consent. As a consequence, the rape survivor has no clue about what the examination entails, what its purpose is and so on.

A dominant perception among health professionals is that consent is not necessary in medico-legal cases. Providers reported that it is implicit that a survivor reaching the hospital after an assault knows why she has come there; thus, there is an assumption of consent on her part. Most activists working with survivors reported that no information was given to the survivor; a signature or thumb impression of the victim or her parent was taken in the case of children. An observational study conducted in one government hospital in Mumbai found that consent was sought by a clerk, who asked the woman whether she was 'ready for examination by a male doctor or not'. The clerk also sought the history of the sexual assault while sitting in a corridor (Contractor 2009).

No information or rationale for the examination was provided, nor were the benefits of such an examination explained. In other settings too, the consent sought was often 'blanket', and survivors were not given the option of refusing any part of the examination, nor did they have the choice of only availing treatment.

Focus on the Survivor's Past Sexual Conduct

The current procedure lays undue emphasis on the survivor's past sexual conduct as part of the medico-legal examination. There is a focus on examining and commenting on hymenal status as an assessment of virginity, and the 'two-finger test' is commonly carried out to determine the size and laxity of the vaginal opening. The forensic examination is centred around determining whether the survivor is sexually habituated or a virgin. So, irrelevant 'findings' such as old tears in the hymen, the size of the vaginal introitus and comments on 'habituation to sexual intercourse' are recorded in the medico-legal papers.

Thus, it is common to find comments such as:

'The finger does not go in so there is no sign of sexual abuse.'

'She is not a virgin.'

'She is habituated to sexual intercourse.'

There is no scientific basis for reaching such conclusions after an examination of the hymen or the size of the vaginal opening. Such conclusions are also inadmissible in Indian law. The Indian evidence law disallows any reference to the past sexual history of the survivor in cases of rape. An analysis of court judgments shows that such 'findings' in medico-legal papers are often used in courts to raise questions about the survivor's character or to pronounce the survivor 'promiscuous' (Human Rights Watch 2010).

The examination of the hymen is often looked upon as the most important part of medical examination in cases of rape. It is

believed that the integrity of the hymen can determine whether or not sexual intercourse took place. However, research shows that an intact hymen does not rule out sexual assault, and a torn hymen does not prove previous sexual intercourse, as hymens may be torn due to other activities like cycling, horse riding, masturbation and so on. In a widely acclaimed study that attempted to diagnose, on the basis of physical examination, whether a woman had previously engaged in sexual activity, the researchers found that they had misdiagnosed 'virgins' in 50 per cent of the cases (Underhill and Dewhurst 1978). Among 20 of the 55 sexual assault cases in Mumbai who reported completed peno-vaginal penetration, 13 had no assault-related finding (such as bleeding, oedema, redness or tenderness) with respect to the hymen. Yet, the myth of the hymen continues to be relied upon by health professionals.

Build, Gait and Emotional Status

Forensic examination also includes comments on the build of the survivor—based on the idea that if a woman is well built, she can resist sexual violence. So women with above-average weight or height are considered to be stronger, and it is therefore assumed that if they are reporting rape, they are likely to be lying. This notion does not take into account the fact that there may be circumstances in which women are unable to resist, or that they may face threats or become numb when assaulted. The other common misconception is that the survivor who is raped will not be able to walk properly and will therefore be unsteady on her feet. So doctors record the gait of the victim. This is problematic, and unscientific: we know that when there is severe genital injury, survivors are likely to find it difficult to walk, but in other circumstances this is not necessarily so.

Medico-legal forms also record the emotional condition of the survivor. It is not uncommon to find phrases such as 'doesn't

appear distressed', or 'is calm and composed', and so on. None of these has any scientific basis and all descriptions are subjective. The presumption is that if a woman is raped, she will be completely shattered and distraught.

Preoccupation with Injuries

Doctors look for injuries to establish the lack of consent, and if they do not find them (which is often the case—only one in three women has them, according to WHO [2003]), they opine that rape did not occur. The fact that the survivor may have been unable to resist because of threats, use of restraint or administration of intoxicants is not taken into account at all. While there is adequate evidence that most survivors of sexual violence may not report any injury on the body or genitals, this bias continues to inform medical practice.

Anti-women Attitudes among Providers

Forensic textbooks are full of biases against women reporting rape. They warn doctors that 'rape is an easy allegation to make but very difficult to prove,' then inform them that certain types of women are likely to resist rape, such as women who are well built, educated, working. Instructions on how to differentiate between women who are sexually active and those who are not are provided, which have no scientific basis. The books claim that on mere examination of the hymen, the clitoris, the labia majora and minora and the shape of the breast, doctors must first determine whether the woman is habituated to sex or not. Large sections in these books focus on false allegations, citing examples such as 'women may put frog's blood to fake injury, egg white on clothes to fake semen' (Modi 2012; Nandy 2010; Parikh 1999; Reddy and Murty 2013). There are gaps between the theory and the practice

of forensic medicine, as changes in the law have not been included in the books. Further, the examinations are informed by stereotypes and misconceptions about sexual assault.

Mechanical Examination

The medico-legal examination is usually carried out irrespective of the nature of assault. Survivors are rarely asked about the nature of the sexual assault, for example, whether it was vaginal, anal or oral, whether penetration was by an object or the penis or a finger, whether it was a non-penetrative assault, and so on. Information on activities such as bathing, urinating or douching which may lead to loss of evidence is not sought from survivors. Providers reported that they just collected all swabs and whatever evidence was available as they did not want to take any risks. This practice implies that a survivor might report forced oral penetration, but the doctor often insists on the collection of vaginal swabs, as that is part of the examination. Or the doctor may not seek the history and merely collects vaginal swabs even though the victim had been assaulted with forced anal penetration. In another case, a woman who came in for an abortion, and reported that her pregnancy was due to having been raped by her cousin two months earlier, still had to undergo all the tests as the doctor said they had to be done.

Gaps in Health Care for Survivors

One of the things that emerged across the board was the pre-occupation with medico-legal procedures and a complete neglect of the therapeutic needs of survivors. Though the WHO in its *Guidelines for Medico-legal Care for Victims of Sexual Violence* (2003) states that 'the overriding priority in cases of sexual assault must always be the health and welfare of the patient,' this is far from true in the Indian context. There are no standard guidelines

for treatment of sexual assault survivors, and health professionals have no training in identifying the health consequences of sexual violence. The medico-legal forms have no space for 'treatment', which often results in neglect if the survivor does not have serious physical injuries. Studies have found that in some facilities no treatment is provided at all; only the medico-legal examination is conducted (see, for example, Bhate-Deosthali 2014).

Even in tertiary care hospitals studied in two metro cities, two cities and one state capital, in spite of having state-of-the-art medical facilities, there is no standard treatment protocol for sexual assault survivors, and several patients are not provided the essential package of health services (Bhate-Deosthali 2014). In CEHAT's interventions in hospitals, we met several survivors who had reported to a public hospital where medico-legal documentation was done but no treatment was provided. As a result of this neglect, they were forced to go to another hospital, for an abortion (as no emergency contraception had been provided) or burning micturition (as this was not treated) or for infections (no treatment provided).

In hospitals in a state capital, providers were of the view that it was their job to give information about referral and follow-up services to the police, and it was up to the police's discretion what they did with this information. This included advice on treatment further tests to be conducted and follow-up services—this information was, oddly enough, provided to the police and not to the survivor herself. If the police thought it important, they would take the survivor for all the treatments and tests. But if they did not, these aspects would be neglected (Contractor et al. 2011).

Sexual assault may result in pregnancy or in sexually transmitted infections including HIV. The right to treatment must not be neglected at any cost. Often the health professional's medico-legal role is given precedence over that of care, and there have been

several instances where immediate treatment was not provided for infections, pain, pregnancy prophylaxis and so on.

When we take rape victims to the hospital, no treatment, no follow-up treatment, no advice is given. In one of our cases, the woman was brutally raped and was injured. The doctors gave an ointment and discharged her. She could not even urinate so we asked the doctor if she can be admitted till she recovers so he was angry and said 'Who is the doctor? You or me?' Her condition was bad and we had to later take her to a private hospital where she had to undergo a surgery. Can you imagine? (Social worker, Lucknow, May 2013)

If a victim is accompanied by activists, then they may give the treatment but they still don't give medicines. We have to buy them. (Child rights activist, New Delhi, April 2013)

Given the gaps in the provision of immediate treatment, the total absence of any psychosocial support by health professionals is not surprising. Providers, lawyers, social workers and interventionists working with women and children who have accompanied survivors to hospitals reported that psychosocial services were not provided. The cities where situational analysis was carried out were large cities with well-equipped hospitals that had social workers and psychologists, but no such services were available for survivors when they reported to the facility.

Absence of 'Medical Opinion'

The biggest contradiction in the current response is the absence of any opinion provided by the doctor. Opinion refers to a doctor's conclusion or findings based on the patient's history, clinical examination and forensic evidence. A doctor cannot opine on

whether sexual assault took place or not, as that is a legal term. As illustrated earlier, the medico-legal form has little scope for recording relevant details as reported by the survivor, and so it is left to the discretion of the individual doctor to record what the victim reports and what the doctor finds. As there is no training on how to do this, and the form to be filled is not comprehensive, important facts are often not noted. The examining doctor makes no correlation between the history as reported by the survivor, the clinical findings, the delay in reporting, factors such as use of threats/condom/lubricants, intoxication and so on, which impact the presence or absence of forensic evidence. All that is noted is 'awaiting FSL [forensic science laboratory] reports'.

There is often a time lapse between the examination and the court appearance. If they have to appear in court, doctors may not remember much, and they may not even have the important facts documented on paper. So they base whatever they say on an incomplete piece of paper, which does not in any case have the full information on it. Then, there is also the fact that sometimes the doctor appearing in court may not be the same doctor who treated the survivor. The incomplete report is presented in court, and specific parts or single statements in it get picked up by the defence lawyers. As a senior advocate said, 'The sad part is that there is no opinion or conclusion by the doctors in rape cases. In medico-legal reports of injuries and other complaints, there is a clear formulation of injury and clinical findings but here there is no affirmation of the opinion' (interview, New Delhi, April 2013). She gave an example of a case where a woman had a tear in the posterior fourchette, which is known to be due to sexual assault, but the doctor did not write a conclusive opinion. What then, was the use of the medical examination?

Evidence is collected and sent without any mention of whether the survivor has washed herself. In such cases when semen is not found, this piece of information is not available and the doctor does

not correlate this with the PSL report. There is no one else who can put these two facts together and say that the survivor had washed herself and therefore there was no likelihood of finding semen. The medico-legal case therefore does not help the victims/survivors at all. A lawyer told us about an instance where she had seen the medico-legal case papers where medicines were prescribed which were painkillers, but the doctor had not mentioned anywhere in the report that the survivor was in pain. Thus, the whole exercise seems to be a useless one.

There are several cases where medical evidence has been interpreted by the sessions court, high court and Supreme Court very differently. For example, a hymen rupture was interpreted by the trial court as evidence of sexual assault, but was interpreted in the high court as the survivor having been habituated to sexual intercourse. Finally, the Supreme Court upheld the order of the trial court. If a doctor does not interpret and state a conclusion or medical opinion, then each fact on the medico-legal report is subject to interpretation (Modi 2012).

The preceding section has reported the most common responses to sexual violence in different health facilities in India. It is important to note that these are systemic issues and are rooted in the nature of medical education.

NO CLEAR DIRECTIVES IN HEALTH POLICY AND PROGRAMMES

Although there is a legal and ethical obligation on the part of the health system to respond to and care for survivors of violence, the absence of clear directives in policy and programmes hinders the implementation of such a directive. With regard to the forensic role of health providers, there are no uniform protocols for conducting a medico-legal examination. Indeed, every hospital

and even doctors in the same hospital may follow a different practice in dealing with sexual assault survivors. The Government of Maharashtra set up a committee in response to a public interest litigation filed in 2010 for uniform protocols and guidelines for dealing with sexual violence. The CEHAT-Anusandhan Trust intervened in favour of uniform protocols that are scientific and gender-sensitive and for the right to health care. However, the Government of Maharashtra's protocols and guidelines perpetuate biases based on factors such as the height and the weight of victims/survivors, and place undue emphasis on hymenal injuries such as the type and position of tears and the elasticity of the vagina. There are no guidelines for first-line psychological support, among other problems ('Battle for Sensitive Rape Medical Test Nears End' *The Times of India* 2014).

LACK OF UNDERSTANDING ABOUT MEDICO-LEGAL EVIDENCE AND ITS LIMITATIONS

The medico-legal examination, which is often referred to as the 'medical test', is presumed to be some kind of a litmus test that will provide evidence about whether rape has occurred or not. This assumption is based on the notion that the accusation may be false and the 'medical test' will reveal the truth. The focus therefore is on so-called 'evidence' and not 'care' for a victim/survivor of rape. Having said that, the limitations of medical evidence are seldom understood or highlighted.

One of the issues related to medical evidence in rape cases is that there is rarely any medical evidence found. A systematic review of medico-legal evidence in sexual violence cases found that evidence of injuries, of semen and other material was most commonly not found in rape cases (Du Mont and White 2007). It is important to note the circumstances of the incident of sexual violence and

the factors that are likely to lead to loss of evidence, such as time lapse and activities undertaken by the survivor post-assault. This approach will ensure that in most cases where medical evidence is negative, the reasons for this are explained by the doctor, so that the courts can then rely on the survivor's testimony alone and not interpret medical evidence as either supporting or contradicting her testimony.

The presence or absence of semen in the genital swabs is often considered the deciding factor in cases of sexual assault. But if one were to consider the profile of sexual violence cases reported, it is simply clear that evidence of semen is more likely to be negative than positive. This is because not all sexual assault involves peno-vaginal penetration, and not all peno-vaginal penetrative assault will result in ejaculation inside the survivor's body. Ejaculation outside the body (not on other body parts) or use of a condom would eliminate the possibility of finding spermatozoa or semen in the samples. Evidence is also lost with time: evidence of semen is likely to be found only within 72 hours of the assault. Further, evidence is lost through activities such as bathing, douching, washing private parts or urinating, that the survivor may engage in after the assault. The most basic reaction of any survivor is to wash herself, and a considerable amount of evidence is lost in this manner.

The chain of custody is a process by which collected evidence is dried, packed and sealed, and handed over to the FSL. This is an important part of the entire process of medical examination and evidence collection so as to prevent tampering or destruction or degradation of evidence. This is often not clearly spelt out in hospitals. Samples are collected and left unattended for long periods of time. As the documentation too is weak, the entire procedure is open to manipulation. The process of collection and preservation too is an issue of concern. The swabs and clothes collected need to be dried and sealed, but there is no written protocol on this, and

it is possible that much of this evidence putrefies if not properly dried and preserved.

Considering the reality of how sexual assault occurs, it is therefore, unreasonable to expect that medical evidence will be able to 'prove rape'. Yet, court trials invariably rely heavily on this evidence in order to make a judgment of rape.

A COMPREHENSIVE HEALTH CARE MODEL

Based on the understanding that health care settings offer a unique opportunity for health providers to respond to violence against women, CEHAT collaborated with three hospitals run by the Municipal Corporation of Greater Mumbai (MCGM) to demonstrate a comprehensive and gender-sensitive response to sexual violence. The MCGM had already established a hospital-based crisis centre dealing with domestic violence in 2000 (Dilaasa); therefore, initiating a response to sexual violence seemed opportune and appropriate. The sexual assault response focused on 'care' without compromising on scientificity. While upholding the principle of health care, efforts were made to steer clear of a biomedical approach. The components of the model were evolved in keeping with medical ethics, international standards for health care set by WHO, and the Indian law.¹ This model has been operational since 2008. The following table sets out the key components of the model.

Informed consent	<ul style="list-style-type: none"> • Enables survivors to exercise autonomy before embarking on a medico-legal examination • Gives survivors the opportunity to understand the procedures and steps pertaining to medico-legal examination • Enables them to voice apprehensions and receive complete information about the examination and evidence collection procedures
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Gender-sensitive medico-legal documentation

Relevant medico-legal examination and evidence collection

Provision of medical opinion

Medical treatment and psychosocial support

- Age of consent for examination and treatment is specified as 12 years. This age is crucial especially in the context of incest.
- A copy of the medico-legal examination report is given to the patient.
- The documentation format ensures that no information can be sought on the past sexual life of the survivor.
- The history-seeking format enables survivors to narrate forms of sexual assault such as licking, sucking, forced masturbation and so on, as against mere 'peno-vaginal assault'.
- Evidence collection is based on the time that has lapsed between the assault and its being reported to the hospital. Genital and physical evidence is collected only if the survivor reports to the hospital within four days of the assault.
- Body examination includes looking for evidence of injuries, blunt trauma, tenderness, semen stains and so on. The genital examination notes only injuries related to assault, and not old tears to the hymen or the size of vaginal introitus.
- The focus of the medical opinion is on whether the assailants can be identified by any means, whether there is evidence of assault in the form of injuries, the time that has lapsed between the assault and the victim's reaching a medical facility, the actual age of the survivor in the case of minor survivors under 12 years, and reasons provided for absence of injuries and negative forensic science reports. Examining doctors are also apprised of the problems with using terms such as 'rape occurred or did not occur', as 'rape' is a legal term and outside the purview of an examining doctor.
- The protocol for treatment includes prophylaxis for sexually transmitted infections including HIV, pregnancy prophylaxis and management (including emergency contraception, pregnancy testing and abortion if required), surgical management, analgesics and tetanus toxoid for injuries.

Chain of custody

- Psychosocial support focuses on demystifying medical procedures, and addressing fears and concerns that survivors may have about their lives post the assault. It also involves carrying out a dialogue with families and friends to help them deal with the aftermath of the assault and create an enabling environment for healing from the effects of assault.
- The model includes a step-by-step protocol for managing the collected evidence till the time it is dispatched to the FSL. This is done from the perspective of ensuring that evidence is dried, sealed and dispatched in a foolproof manner.

Operational Elements

The components of the model were operationalized through collaboration with municipal hospitals. This involved capacity-building workshops for examining doctors, nurses and support staff. The objective of involving all the staff was to create a positive and therapeutic approach free of biases, prejudices and loose comments across the hospital, and not just the examining room. Training content involved discussions related to the dynamics of sexual violence, its health consequences and pathways by which survivors approach the hospital. The providers were given a step-by-step manual that contained all information on aspects such as recording history, examination findings, evidence collection, age estimation, medical opinion and treatment. A system of coordination with the FSL and the police was created in order to receive feedback about the samples dispatched. A monitoring committee was set up in the hospital comprising examining doctors, nurses and administrators. External experts from the forensic science laboratory, senior forensic medicine specialists and gynaecologists with experience of working on the issue were invited periodically to conduct such training.

Learnings from the Field

- Forty five per cent of sexual violence survivors reached the hospitals voluntarily between 2008 and 2012. They reported to the hospitals to seek treatment for the health-related consequences of sexual violence.
- Detailed history seeking brought to light the fact that more than half of the survivors reported violence that involved non-penile penetration (55 per cent).
- It was seen that 38 per cent of survivors had taken a bath, which is often the immediate reaction of a survivor, 28 per cent had douched and 67 per cent had urinated before reaching the hospital and post the assault. This helped the examining doctors provide explanations for why no positive evidence was found on the survivor.
- Evidence from the examination of 94 survivors showed that only 18 of the 94 (19 per cent) survivors reported bodily/physical injuries and only 36 of the 94 survivors (38 per cent) presented genital injuries. This finding was consistent with the WHO guidelines for medico-legal care in sexual assault, which showed that as few as 33 per cent of women report any genital/physical injuries. Hence, evidence from the model dispelled the myth that sexual violence must lead to injuries.
- Learnings from crisis intervention services showed that positive messaging, such as dealing with rape as severe physical assault, uncovering feelings of shame, helplessness, hopelessness and linking them to the social context in which rape occurs, helped in reducing self-blame. With carers of children, discussions were conducted on helping the survivor understand good and bad touch, and caregivers were encouraged to speak to children about their fears and apprehensions. The negative consequences of restricting

mobility were also discussed with caregivers. Consistent dialogue with families and follow-up for psychosocial support helped them in dealing with the rigmarole related to filing police complaints, court calls and dealing with community responses (CEHAT 2012).

Legal and Policy Changes

The definition of rape was expanded in the CLA 2013 to include all forms of sexual violence—penetrative (oral, anal, vaginal), including by objects/weapons/fingers, and non-penetrative (touching, fondling, stalking, disrobing and so on). The act recognized the right to treatment for all survivors of sexual violence by public and private health care facilities. Failure to treat is now an offence under the law. The law further disallows any reference to past sexual practices of the survivor. A strong case is made by CLA 2013 for transforming the response of the health sector to sexual violence. An evidence-based model set up by CEHAT and MCGM that had provided comprehensive care and treatment to a large number of rape survivors was discussed at various fora. A written submission was made by CEHAT along with the Lawyers Collective to the Justice Verma Committee (JVC); CEHAT also worked consistently with the media and other fora to focus on the need to upscale this model.

Taking cognizance of the lack of uniform protocols and gaps in provision of medico-legal care to survivors of sexual violence, and the recommendations of the JVC, CLA 2013 and the Protection of Children from Sexual Offences Act 2012, the Ministry of Health and Family Welfare set up a national committee of experts to formulate a uniform protocol and guidelines for health professionals to respond to sexual violence. In doing so, international standards, especially the WHO's *Guidelines for Medico-legal Care* (WHO 2003) and its *Clinical and Policy*

Guidelines for Responding to Intimate Partner Violence and Sexual Violence (WHO 2013) were referred to. The committee has drawn from the available evidence from health sector interventions, legal and other expert opinions and the voices of survivors. This is the most significant achievement, as it is the first national directive for the health sector with regard to responding to sexual violence.

However, the legal amendment brought in mandatory reporting of all cases of sexual violence by health professionals. Such mandatory reporting severely compromises the role of health professionals in instances where a survivor only wants medical treatment and care, but does not wish to register a complaint. Once the survivor is informed of the mandatory reporting requirement, she may decide not to seek health care at all, thereby jeopardizing her own health; this amounts to denying her health services. On the other hand, a health professional who does not abide by the mandatory reporting rule may invite punishment by the law enforcement machinery. This is a major challenge which has been resolved to some extent by the Ministry of Health guidelines of 2014 (MOHFW 2014) by bringing in the aspect of 'informed refusal', to be documented in cases where the survivor does not wish to inform the police.

Challenges

An appropriate response to survivors reporting sexual violence requires several agencies to work in conjunction with each other. The prosecution, police, judiciary, child welfare committees (CWCs), forensic laboratories and health system among others need to play a role in ensuring care and justice to survivors. An equally critical role is that of shelter homes, counselling centres and community-based organizations. However, the CEHAT experience shows that there are several gaps in the current response of other government agencies.

The Police

The police continue to be ill informed of the provisions under laws pertaining to dealing with sexual violence (POCSO 2012, CLA 2013). Delays in recording FIRs and refusal to record them have been discussed by survivors and their families. In case a survivor reaches a police station, police invariably delay her medical examinations, and often detain survivors and their families at the police station. Instances of women police constables being present during medico-legal examinations have been reported.

As far as their understanding of medical evidence is concerned, it is somewhat narrow, restricted to the presence or absence of injuries. A survivor is also subjected to repeated medico-legal examinations from different hospitals if the police do not find the medico-legal examination report useful. Often the police insist on getting health providers to comment on whether 'rape' occurred, whether the 'survivor [is] habituated to sexual intercourse', and the like.

The Judiciary

The judiciary too is not well versed in the aspect of medico-legal evidence and its limitations. The understanding of evidence is restricted to injuries. Health consequences such as pain during urination or defecation, tenderness or blunt trauma post-assault are not appreciated as medical evidence. There is an overemphasis on genital and physical injuries, and health providers are pressurized in the courtroom to answer unscientific questions. Several providers cited examples of such questioning, for example, 'What is the status of the hymen?', or 'Can the injury have occurred due to a fall?' Thus, even when injuries are consistent with sexual violence, courts tend to disbelieve such evidence and claim that they could have occurred because of other reasons such as a fall.

When there are no injuries, there is a tendency to state that the act could have been consensual and as a result there were no injuries. Efforts were made to understand the role of medical evidence in the courtrooms and whether it played a role in either acquittal or conviction. Only 14 judgments could be acquired, and these pre-dated the change in the laws pertaining to rape. There were eight acquittals out of the 14. Among the acquittals, health providers were not called as expert witnesses in court in at least two cases, neither could the public prosecutor (PP) offer a reason for the lack of medical evidence. In instances where the survivor was menstruating, the PP failed to mention this as a reason for the lack of medical evidence; the scientific fact that evidence is lost with menstrual blood was not even brought to the notice of the judges. Similarly, aspects such as delayed reporting to the hospital or the use of a condom, and therefore negative FSL results, could not be explained by the prosecutor. Neither were efforts made by the PP to bring in the examining doctor as expert witness. In instances of non-penile penetrative assault, the prosecution failed to bring to the court's notice the lack of relevance of semen or spermatozoa.

As mentioned earlier, these cases pre-dated the new law. Thus, in an offence involving finger penetration of a survivor, the police registered a case under the section on rape. However, the previous rape definition under Section 376 of the Indian Penal Code did not cover this offence. The chances of getting a conviction were thus substantially reduced because of having framed a charge under an inappropriate clause.

As far as the convictions go, examining doctors were called in to testify in 6 out of the 14 cases. Here too, most survivors did not have either genital or physical injuries, except in one case. Doctors were able to provide reasons for the lack of medical evidence, such as the use of a condom, delay in reporting to the hospital, or the nature of the assault itself, which may have involved the forced fondling of body parts, and therefore could account for the lack of

collection of relevant evidence in such instances. In one instance, when asked whether the injury in itself could be from a sexually transmitted infection (STI), the doctor responded that the nature of the injury did not indicate an STI but was a genital injury. Public prosecutors were also well versed in the nature of medico-legal findings and their limitations in these cases.

Child Welfare Committees (CWCs)

The main role of CWCs in instances of child sexual abuse is to provide children and families with care and protection. But the interface of the health sector with the CWCs has brought forth the biases and victim-blaming attitudes of CWC members. They were often found to blame the parents of sexually abused children and to push for the institutionalization of these children. No efforts were made to assess and monitor the safety of the child in her place of residence, and institutionalization was suggested as the only option to keep survivors safe. For many child survivors, this aggravated their fears and those of their family members. It was also noted that the CWC did not have specific mechanisms to investigate the offence; neither did they have a set procedure for communicating with children. These concerns added to the agony of the survivors as well as their caregivers.

SEXUAL VIOLENCE IN CONFLICT

The response of the health sector to sexual violence in conflict situations is worse than in 'normal' circumstances due to the specific context of conflict, whether it is armed conflict, state repression, riots and so on. Armed conflict has a serious impact on the accessibility and availability of health care services. Migration of trained health professionals from conflict zones, breakdown in

the health infrastructure, along with restricted movement of health professionals due to curfews, affect health care delivery. In all such situations, attacks on health professionals and health facilities have been reported. The political environment further acts against health professionals, as it compromises their capacity and duty to be neutral.

Abuses, murders and harassment of medical professionals drive many of them out of these regions, often resulting in the large-scale migration of trained health personnel from conflict regions. Reports point out that, like all other social services, health services too tend to collapse particularly in areas of prolonged conflict. Where infrastructure exists, personnel are often unwilling to work due to political instability and fear for their lives.

A recent fact-finding report describes the case of a government sub-district hospital in Pattan, Kashmir, which attended to several civilians who had been injured in police firing during a protest. While doctors were busy attending to the medical needs of the injured, the Central Reserve Police Force forcibly entered the hospital and threatened them with rifles (Vij 2010). They destroyed medical equipment, broke doors and windows and terrorized the hospital staff. This case illustrates how hospitals, which are meant to be safe, neutral spaces, have been turned into battlegrounds. Similar reports emerged from the communal riots in Gujarat 2002, where hospitals were attacked and victims/survivors were prevented from accessing health services. Health professionals were attacked based on their religious identity.

In Nagaland, Manipur, Assam and other states of the Northeast and in Jammu and Kashmir, the Armed Forces Special Powers Act is in force. This act gives impunity to army personnel and grants them powers to use force on the slightest doubt in the name of national security. It gives army officers legal protection for their actions. There can be no prosecution, lawsuit or any other legal proceedings against anyone acting under the law. Any complaints

against army personnel for atrocities are accepted and tried only in military courts. There is a lack of transparency around such trials, which prevents civilians from filing cases. The fundamental freedoms of citizens living in areas of armed conflict are suspended as there are prohibitions on mobility, curfews, bans and search operations. Violence against women during conflict is often not recognized, or is understood as an inevitable by-product of conflict. This notion constitutes a barrier in the registering of such crimes and prevents women from reporting them. In the north-eastern states, such crimes are used as a weapon to crush struggles for autonomy and self-determination. In the states of Chhattisgarh, Odisha, Jharkhand, Andhra Pradesh and parts of West Bengal and Maharashtra, the Central Armed Police Forces are engaged in anti-Maoist operations.

The cases of Soni Sori in Chattisgarh, Neelofar and Asiya in Kashmir and Manorama Devi in Manipur highlight several lacunae in the health care system and violations of health rights, as well as lacunae in the gathering of forensic evidence. Differing or rather contradictory medical opinions and poor documentation of clinical findings of torture and violence point to the erosion of medical neutrality and lack of accountability of the medical profession.

Health professionals are often under pressure to issue reports that do not reveal human rights violations. This is particularly true in cases of rape and sexual violence. Whether perpetrated by insurgent groups or by security forces, there is always an attempt to 'hush up' rape. This is further compounded by the lack of any standard operating procedures, protocols or access to the medico-legal papers of the patient/victim.

Health professionals therefore must recognize that all victims/survivors of sexual violence in conflict areas are entitled to immediate treatment and care. Their duties must be carried out regardless of the nature of the conflict, the identity of the victim

or rank and status of the perpetrator. They must ensure that the actions or instructions of police/state functionaries do not interfere with the provision of medical treatment to the survivor and the documentation of the reported incident.

In order that health professionals are able to ethically perform their duties towards survivors of violence, it is crucial that their safety be ensured and that they be allowed to function free of pressure. The 1949 Geneva Conventions clearly states:

Medical workers shall be respected, protected, and assisted in the performance of their medical duties. The sick and wounded shall be treated regardless of their affiliations and with no distinction on any grounds other than medical ones. Medical workers shall not be punished for providing ethical medical care, regardless of the persons benefiting from it, or for refusing to perform unethical medical treatment. Medical workers shall have access to those in need of medical care, especially in areas where civilian medical services have been disrupted. Similarly, people in need of medical care shall have access to such services.

CONCLUSION

The health system has to become more sensitive to the special needs of victims/survivors of violence, and this means that the entire hierarchy needs to be motivated to have a spirit of service. Health professionals should be exposed to the concerns of victims/survivors of violence. Training has been found to lead to positive changes in provider knowledge, attitudes and beliefs about sexual assault (Donohoe 2010; Milone et al. 2010). It is also important to provide training on how to prepare medical reports so that such reports can be legally relevant.

In India, the campaign against sexual violence has demanded national protocols and guidelines that are victim-centred and that

respect the right to health care for survivors of sexual violence. The amendments to the rape law (CLA 2013) where 'consent' is defined as an unequivocal agreement to engage in a particular sexual act, clarifying further that the absence of resistance does not imply consent, is most welcome, and the medical profession must accordingly make a shift in its practice. There needs to be more awareness about the amendments, and such awareness must be translated into specific directives for health professionals and the judiciary. The protocols must be made gender-sensitive on an urgent basis and the focus must shift from evidence to care in responding to sexual assault. The Ministry of Health and Family Welfare set up a national committee and issued national protocols and guidelines for responding to sexual violence in April 2014. Some states have adopted them and have issued directives for implementation. This needs to become a norm for all health professionals and facilities across the country.

NOTE

1. Section 164(A) of the Criminal Procedure Code mandates that informed consent is to be sought by a health provider for a sexual assault examination. It directs the physician to seek specific consent for each component of the examination and evidence collection, as against blanket consent. It also states that the medical examination report must state the reasons for each conclusion in the medico-legal report.

Section 89 of the Indian Penal Code states that a person who is 12 years and above is empowered to provide consent for examination and treatment.

Section 146 (Indian Evidence Act) states that past sexual conduct of the victim and comments about 'habituation to sexual intercourse' are irrelevant. Therefore, such history should neither be sought nor recorded for medico-legal purposes. This section made the two-finger test inadmissible in the courts.

The Indian Constitution recognizes the right to health as a fundamental right, judicially recognized as emanating from the right to life, Article 21.

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