

CEHAT Working Paper No 1

A Comprehensive Health Sector Response to Sexual Assault Does the Delhi High Court Judgement Pave the Way?

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Centre for Enquiry into Health and Allied Themes

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Preface

Research in the social sciences begins with a question and an enquiry, moves through discovery, the gathering and interpreting of evidence, drawing conclusions and reporting answers and resolutions to the problem posed in the beginning. Unfortunately, the last stage, the reporting of evidence and analysis constituting a considered and reasoned response to the problem posed, is often neglected. In CEHAT the dissemination of research findings, especially to the participants of a study is an incontrovertible mandate, so that, all research studies do complete the final stage of the process of research. Over its years in health studies CEHAT has produced an enviable library of research output, many of which are pioneering works in the field. It has also successfully ensured that its research has systematically contributed to people's campaigns on health care, reading and re-reading its research to discover and extract the evidence base for such campaigns.

However, in the hurly burly of the practical world of 'doing research' relevant to social concerns it has so far not created an avenue for research output that looks beyond the immediate research project, or contextually reflects on the research outcome. Clearly, CEHAT as a research institution has to ensure that its work is channelized to add to the body of literature in the areas of its inquiry, even as it supports and enhances the knowledge base of people's movements and campaigns in the field.

In launching the Working Papers series CEHAT is offering its researchers a space for further rumination on past and ongoing research and to engage with problems only touched upon in the research studies. Most importantly, it allows its faculty to go beyond the immediate questions and explore the many dimensions of social research. In sum, the Working Papers series will, it is hoped, present the tentative as well as definitive, and both exploratory and the explanatory work of its faculty for wider intellectual exchange.

This first paper in the CEHAT Working Papers series draws from its collective action research experience over the years in addressing the issue of sexual assault. The Paper presents its reasoned conviction on the importance of a multisectoral approach to the issue particularly in the context of the Delhi High Court mandate on the responsibilities of the many agencies involved in dealing with incidents of sexual assault. Even as it underlines the fact that only such an approach can make for a humane and effective response to cases of sexual assault, it makes a case for further research on the modalities of expanding the scope of the judicial mandate.

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ABSTRACT

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In April last year the Delhi High Court passed a judgment mandating guidelines on the appropriate response to sexual assault from the different concerned agencies. It is a path-breaking ruling asserting for the first time the necessity of a multisectoral response and laying down specific guidelines for different agencies. However, it falls short of addressing relevant health system related issues. For instance, the introduction of a protocol for streamlining evidence collection does not alone ensure a good documentation of the history, nor does it change the way providers behave with survivors, nor reduce the secondary trauma caused by interaction with the health system. It also does not ensure that the survivor gets essential and comprehensive medical and psychological care. While the Delhi High Court judgment is an invaluable first step towards recognizing and streamlining the response of health systems towards sexual assault, it does not ensure a comprehensive response to survivors. In order that this is made possible, the emphasis of the health sector must go beyond its medico-legal role to a more holistic one of providing care. In this paper we draw from our experience of introducing the Sexual Assault Forensic Evidence (SAFE) kit, developed to ensure correct collection of evidence, in two public hospitals in Mumbai to examine the provisions in the judgement and explore ways to expand its impact.

I. Introduction

On April 23, 2009, the Delhi High Court, in its judgement in the Delhi Commission for Women vs. Delhi Police case laid down specific guidelines for responding to survivors of sexual assault for different agencies like the police, hospitals, child welfare committees and courts... The judgement is a welcome one for several reasons.

The judgement for the first time uses the term 'sexual assault' in addition to 'rape', thereby including a wide spectrum of sexual offences. This is the first time that a High Court has ruled that the response to sexual assault must be multisectoral, thereby recognising the collective responsibility of multiple agencies in responding to sexual assault. It also recognises that a survivor requires support in addition to legal aid, and has issued guidelines for providing care and healing to survivors of sexual that encompass the involvement of agencies such as Child Welfare Committees and the setting up Crisis Intervention Centres.

The judgment has also ruled that examination and evidence collection for survivors of sexual assault be streamlined in the health sector. This is a good starting point for regularising sexual assault evidence collection and for formulating and implementing uniform procedures for the same. The judgement has prescribed the mandatory use of Sexual Assault Forensic Evidence (SAFE) Kits for all public hospitals in Delhi Hospitals have also been asked to provide a room dedicated for examination so as to provide privacy to survivors.

Notwithstanding all this and the fact that the judgment addresses important issues in relation to the response of the health sector to sexual assault, it does not address issues concerning the comprehensive response to survivors of sexual assault. With regard to defining the role of health systems it concentrates only on evidence collection, specifically the SAFE Kit to be used for this purpose. This is a limited response that does not qualify as a sufficient health care response to survivors of sexual assault.

This paper will look at some issues with regard to the SAFE kit and why, while it is a sufficient response, does not constitute a comprehensive response to cases of sexual assault. The paper draws from our experience in piloting a SAFE kit in two public hospitals of the Municipal Corporation of Greater Mumbai which point to several issues outside evidence collection and having to do with the role of health systems that in fact impact on the process.

II. The SAFE kit

The SAFE Kit was developed by CEHAT to address the lack of a comprehensive, systematic health sector response to sexual assault in India. It was adapted from the Ontario Police Force kit used in Canada, and was developed after consultations with several forensic experts, gynaecologists, public health experts and women's rights groups in 1998. The kit comprises the following:

- All necessary equipment required to conduct a thorough medical examination and collection of evidence for survivors of rape.
- 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 survivors.
- 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 the law.

Pilot testing

In 2008-2009 CEHAT implemented the SAFE kit in two public hospitals that together receive 1-2 cases of sexual assault in a month. Health professionals were not only trained on the use of the kits, but also benefited from systematic perspective building on the issue of sexual violence, sensitisation and capacity building of health professionals on the issue of sexual violence. Introducing participants to the broad definition of sexual assault which includes more than rape and addressing common myths regarding sexual violence were part of this training. The administrators had to engage with various agencies like the forensic science laboratory and the police to ensure acceptance of the kit. The project was envisaged as an action research project and entailed analysing documentation from used SAFE kits, seeking feedback about the kit from the health care providers as well as documenting the intervention methods applied in individual cases of survivors. These are what form the source of data for this paper. In the past year, we have responded to 20 cases of sexual assault at these two hospitals. Our experience of having implemented the kit throws up several issues in handling cases of sexual assault, that introduction of a uniform protocol could not address.

1. Neglect of documentation of history:

In addition to collecting forensic evidence, a critical component of the doctor's medico-legal role is to ensure accurate recording of the history of the survivor and a thorough examination. Medical evidence can be useful only in cases where a penetrative assault has been attempted or completed *and/or* when the survivor has been able to put up resistance *and/or* if she reports to a centre/facility within a 72 hours. Even in case of penetration, if the

assailant has used a condom, there will be no evidence of semen. If a lubricant has been used or if the vaginal canal is broad, there will be no evidence of genital injuries either. In such cases in particular, documentation of the history is critical. This, the kit protocol can facilitate, but not ensure. We found that health care providers are particularly inept at communicating with survivors. Their inhibitions and discomfort in asking questions regarding penetration or masturbation become barriers in eliciting and documenting an accurate history. Moreover, because of their limited understanding of sexual assault as peno-vaginal intercourse, they are pre-occupied with looking for evidence rather than documenting the incident.

2. Problems in seeking consent:

Survivors of sexual assault approach the health system through three pathways: They report to the hospital themselves to access treatment for injuries sustained as a result of the assault; they may be brought by the police for medical examination and treatment, or, the hospital might receive a requisition from the court for examination of a survivor. In order to protect the woman's autonomy in all scenarios, the SAFE Kit protocol has mandated that the woman's consent be sought at three levels:

- only for treatment;
- for examination and collection of evidence but not for informing the police, or
- for examination, collection of evidence and also for informing the police

In other words, the protocol mandates that if a survivor of sexual assault approaches a hospital, she must be able to choose the extent of services she wants. For example, if a woman has reported to the hospital herself and wishes to get only emergency care but does not wish to file a complaint with the police, she must be given that option and her wishes must be honoured. However, in reality, when women refuse to give consent for any of the above procedures, doctors do not know how to respond. They either refuse to examine the survivor, or seek police help informing the survivor that she must obtain police clearance for the examination even without filing an FIR. In consequence, although the seeking of consent in the protocol is for the benefit of the woman, in practice, hospital procedures and the doctors' tendency to protect themselves against possible charges of inaction ensures that it is not operationalised.

3. Hospital procedures:

Mandatory Admission: As per hospital procedure, every survivor of sexual assault must be admitted to the hospital for at least a day, even if her condition does not warrant admission. This is because the examination is often carried out by a junior doctor and the final endorsement of the report of medical examination has to be signed only by the honorary (senior) doctor, who is not present at the hospital 24/7. However, women who are not in need of medical treatment obviously do not want to be admitted to hospital even for a day. For those who may not have informed their families about the incident, hospital admission would warrant that explanation to their families. Given the stigma attached to rape, there

may be hesitation in doing so. As things are, the rule puts the survivor and her family in a bind with no choice but to comply with the rules.

Multiple examinations: Despite the fact that Supreme Court judgments and subsequent amendments to rape law in the Criminal Procedure code have clarified that any registered medical practitioner is authorised to conduct forensic examination of a rape survivor, the practice of mandating only a gynaecologist to do so is still doggedly adhered to in the name of 'hospital protocol'. In all cases, women are asked to wait until a gynaecologist is available. In one of the hospitals we explored, where a gynaecologist is not available, the patients are shuttled between hospital and maternity home. In such cases, the casualty medical officer at the hospital records a cursory history and conducts a superficial examination in order to make an MLC, and then refers the patient to a gynaecologist at the maternity home. Not only does waiting for a gynaecologist result in needless delay in responding to the survivor, but also, she unnecessarily comes in contact with and recounts her history to many more players than is necessary. The lack of a team approach to sexual assault cases is evident in such instances.

4. Chain of Custody:

After examination and evidence collection is complete, the kit is stored in the ward where the patient is admitted. The sister-in-charge is responsible for the evidence and the kit. But who is to follow up with the police and ensure that it is transported to the laboratory securely is ill defined. This task is performed by the Resident, or the medical records officer or by the sister in-charge. Since only the MRO is designated to seal the kit, the evidence collected by the gynaecologist on duty remains unsealed until it reaches the MRO, exposing the evidence to possible tampering or contamination of all sorts or even destruction with so many people involved in the process of collection, sealing and transport. The evidence collected therefore lies open to tampering as so many people are involved and the time gap between collection and sealing. The chain of custody, an important factor in the collection and preservation of evidence is ill defined and unclear.

5. Lack of co-ordination with police and forensic laboratory:

Even though doctors are pre-occupied with their medico-legal role while dealing with cases of sexual assault (often at the cost of their therapeutic role), this does not ensure that their forensic role is fulfilled completely. We observed that although they took great efforts to fill out the SAFE kit protocol for examination and evidence collection, once the samples were sent to the Forensic Laboratory, the case was forgotten. The laboratory results were not sent back to the examining doctor to enable her/him to provide a final opinion. Often, because of this gross lack of co-ordination between the laboratory, police and hospital system as a result, the only opinion that the doctor provides at the end of an extensive examination is 'reserved pending receipt of laboratory results'. Moreover, for proving a charge of rape with the aid of medical evidence, it is essential to corroborate physical and material evidence



found on the survivor with that of the accused and vice versa. In the cases that we saw, the accused and survivor were taken to different facilities for examination by the police, so that the doctor had no opportunity to corroborate evidence from both, to enable him/her to form an informed opinion.

6. Attitudinal problems:

The first instinct of health care providers on encountering a survivor of sexual assault is to ascertain the veracity of her story. This means that an element of bias comes into play at the time of collection of evidence. Opinions are formed on such superficial observations as the demeanour of the survivor. For example, a woman or child reporting sexual assault is expected to be depressed and non co-operative during examination. If they are not, then the veracity of the complaint is held in doubt. 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 was probably habituated to sex. And 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 injuries, if she was gang raped?" Even if these comments do not get documented on the doctor's notes that are presented in court, the biases could impact on the examiner's neutrality during examination and they certainly affect the manner in which the survivor is treated by providers.

7. Lack of comprehensive care for survivors:

The emotional trauma resulting from sexual assault can be tremendous. Survivors struggle with feelings of self-blame, shame and anger, which must be addressed. Provision of immediate psychological support goes a long way in helping survivors to deal with the crisis situation. Because women reporting sexual assault are viewed as medico-legal cases, they often do not get adequate and appropriate care and support. While medical treatment is generally provided to all, psychological support, which is required right from the time the survivor is received, while she is narrating the history of the assault and when evidence is being collected, was conspicuous by its absence.

III. Limits of the Delhi High Court Judgment

Health professionals have a dual role to play while responding to survivors of sexual assault – one forensic and the other therapeutic. On the one hand, they must conduct a thorough examination and collect crucial medical evidence and on the other, they are required to provide immediate therapeutic care to survivors, both medical treatment and psychological support. Our experience of piloting the SAFE kit shows that many gaps that exist in the system in addition to evidence collection, which thwart both these roles of the health system. While the judgment is an invaluable first step towards recognizing and streamlining the

response of health systems towards survivors of sexual assault, it falls short of ensuring a comprehensive response to survivors of sexual assault.

With regard to defining the role of health systems the judgment concentrates only on evidence collection, specifically the SAFE Kit to be used for this purpose. Mandating the use of a kit for evidence collection can only achieve uniformity in the medical evidence collected. It does not ensure a good documentation of the history, nor does it change the way providers behave with survivors, nor reduce the secondary trauma caused by interaction with the health system. The judgment fails to address the myriad procedural and attitudinal issues arising out of obsolete hospital procedures and poor co-ordination between law enforcement agencies and the hospital. It also completely ignores the therapeutic role that health professionals are required to play. There are no guidelines to ensure that the survivor receives timely medical and psychological care, which is the primary responsibility of a health system.

The judgment takes into consideration provision of psychosocial support through Rape Crisis Centres (providing legal aid) and Crisis Intervention Centres (providing other support services), both of which are linked closely to the police system. The formulation of guidelines to set up a Crisis Intervention Centre is certainly a welcome step. However, the judgement has defined a 'Crisis Intervention Centre' as an agency appointed by the Delhi Police and the Delhi Commission for Women that will be called upon to provide assistance (counselling and support services) to survivors of rape *at the police station*. Such a conceptualization of a crisis intervention center assumes that all women who have been sexually assaulted will report or want to report the incident to the police. It is well-known that given the nature of crime and the stigma associated with it, several women do not report sexual assault. If the Crisis Intervention Center is tied in so closely with the Police, it will be out of reach for these women.

IV. Towards a Comprehensive Health Sector Response to Survivors of Sexual Violence

The definition of a comprehensive health system response must go beyond doctors' medico legal responsibilities and the implementation of a kit for medical evidence collection. A more holistic approach is needed in responding to sexual assault. . The various aspects of written informed consent, providing necessary medical as well as first contact psychological support and validation after a traumatic experience, maintaining a clear and fool-proof chain of custody, and referral to appropriate agencies for further help must be an integral to the role played by the health system in the situation. Hospitals must lay down clear roles and administrative procedures related to the handling of survivors, ensuring that these procedures do not cause further inconvenience the survivor.



The use of the kit must be accompanied with training of health care providers in dealing with survivors of sexual assault. While the judgment directs all police, welfare and probationary officers and support persons to be provided special training and sensitization for dealing with cases of sexual assault, it does not mandate the same for health professionals. Health professionals must acquire the skills required to communicate with survivors of sexual assault so that they may be better equipped to elicit sensitive history. Such training is as essential for their forensic role as for the therapeutic role.

The preoccupation with medico-legal requirements of handling such cases must be replaced by an emphasis on providing holistic care to survivors. The hospital must be required to provide both medical and psychological support to survivors.

What have been the international experiences of health systems in responding to sexual assault? The 1970s and 80s that witnessed a rape crisis centre movement in countries like the United States, Canada, the UK and Australia (Koss and Harvey, 1991). These centres were successful in galvanizing a transformation of the standard practices of local medical, mental health and law enforcement agencies and evolved into a social movement that challenged prevailing social values, and notions of rape ushering in much required public policy reforms. Koss and Harvey note that the medical field was the least amenable to change. Even after several years after the rape crisis centre movement, survivors are not always given the opportunity to make their own choices but are often subject to procedures without sufficient explanation. This resistance to change has been attributed to the patriarchal values that health care providers carry with them as well as the inherently hierarchical nature of the medical profession, which makes it difficult for patients to exercise their autonomy (Bart, 1979).

The experience in these countries in sensitising the health system to the issue of sexual assault is not drastically different from our own. Several studies have noted the insensitivity of the health system in dealing with survivors of sexual assault. . In a 1990s study, Prasad found that disbelief and victim-blaming attitudes were rampant among health professionals (Prasad, 1999). Agnes, in her critique of textbooks of medical jurisprudence, points to how practitioners are cautioned to beware of women levying ‘false charges’ of rape (Agnes, 2005). Given the manner in which medical education reinforces these myths, the behaviour of providers comes as no surprise. Moreover, responding to survivors of violence is not considered an important part of medical education. So it is not surprising that health care providers are ill-equipped to deal with cases that they see in the course of their practice.

However, despite these barriers many rape crisis centres in the West have been able to transform the way hospitals receive and treat survivors. Beth Israel hospital in Boston and Miami General Hospital in Florida, for example, has hospital-based rape crisis centres that provide emergency and follow-up crisis intervention services to survivors. Both programmes also provide training to medical interns, residents, mental health, social service and law

A Comprehensive Health Sector Response to Sexual Assault : Does the Delhi High Court Judgement Pave the Way?

enforcement personnel in dealing sensitively with survivors of sexual assault (Bart 1979). The Sexual Assault Nurse Examiner (SANE) initiative that was implemented in the United States and Canada introduced a cadre of staff that was specifically trained to provide services to survivors of sexual assault. These services included good evidence collection and documentation of the assault; private rooms for examination of survivors; information access about the procedures of examination; necessary psychological support, and adequate linkages with other organisations for further help to the survivor. Subsequent research has shown that the quality of medical evidence collected by physicians and nurses trained in the SANE curriculum was higher than those who were not trained.

Closer to home, the experience of setting up a hospital-based crisis intervention department for women facing domestic violence – *Dilaasa* – shows that a public hospital, however unfriendly and hierarchical can be sensitised to the issue of Violence Against Women. Currently, there are two such crisis interventions departments that are being run independently by the Municipal Corporation of Greater Mumbai and are managed by staff of the hospital. Nurses in both the hospitals provide crisis intervention services to survivors of Domestic violence. The exceptionally high number of survivors accessing services of this department is evidence that hospital based crisis intervention services increase access for survivors of violence.

Conclusion

To enhance and thus expand the impact of the Delhi High Court judgement, it is imperative that features outside the purview of the ruling, but necessary, be established.

A model health sector response to sexual assault must be developed in India and established. Such a model must include the following elements:

- Informed consent of survivor: Before collecting evidence, the entire procedure of examination and evidence collection (both body and genital) must be explained to the victim in the language that s/he understands and the importance of such an examination must be explained to her.
- Collection and documentation of evidence using a standardized protocol: Collecting forensic evidence and documentation of injuries is one of the major responsibilities of the health system. Such evidence can help the victim get justice and must be collected without any delay, in a meticulous and unbiased manner.
- A clear and fool proof chain of custody: All evidence collected must be stored and protected until it is analysed by the forensic science lab, since it forms crucial evidence for the case. The players who will ensure this chain of custody (doctors, nurses, medical records officers) must have clarity regarding their roles.
- Providing medical care: All medical care including testing and treating for STIs, emergency contraception, treatment of immediate injuries and long term complications must be provided by the hospital.

- Providing psychological support: The emotional trauma resulting from sexual assault can be tremendous. Victims struggle with feelings of self-blame, shame and anger which must be addressed. Provision of immediate psychological support goes a long way in helping victims to deal with the crisis situation.
- Liason with legal and other agencies: In addition to health services, victims also require other forms of legal and social support as part of rehabilitation. The health system must be able to put the victim in touch with these services so that all her needs are met.
- Co-ordination with police and media: While responding to sexual assault victims, the health system has to co-ordinate with both law enforcement agencies as well as the media. Health professionals must be trained to affect such co-ordination without compromising their ethical and legal responsibilities towards the victim.

For such a model response to be operationalised, protocols must be laid down by health facilities that clearly state the roles and responsibilities of each person who will come in contact with the survivor, or the evidence. This must be accompanied by the training of hospital staff so that they may be able to respond to victims in a sensitive and efficient manner. The Delhi High Court judgement provides the necessary impetus for advocating that such an intervention, which provides holistic care and support services to sexual assault survivors, be set up at the health system.

Notes :

1. *Dilaasa* is a hospital-based crisis counseling department providing psychosocial support for women facing domestic violence. It is run by the Municipal Corporation for Greater Mumbai in two hospitals – K.B. Bhabha Hospital Bandra and K.B. Bhabha Hospital Kurla. <http://www.cehat.org/go/Dilaasa/Publications>

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