

**Manual for  
Medical Examination of  
Sexual Assault**

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For additional Copies of this report, please contact:

Centre for Enquiry into Health and Allied Themes (CEHAT)

Survey Number 2804 & 2805,

Aram Society Road,

Vakola, Santacruz (E),

Mumbai – 400055.

Tel: (91) (22) 26673154, 26673571

Fax: (91) (22) 26673156

Email: [cehat@vsnl.com](mailto:cehat@vsnl.com)

Website: [www.cehat.org](http://www.cehat.org)

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**Manual for Medical Examination of Sexual Assault**

# **Message From the UN Special Rapporteur on Right to Health**

Sexual Violence is a significant cause of physical and psychological harm and suffering among women. It takes various forms and the perpetrators range from strangers to state agencies to intimate partners and members of the family. The health of women, including survivors of sexual violence, is a core concern of the right to health.

The right to health is recognized as a fundamental right in India, and it is enshrined in a number of international instruments, including the International Covenant on Economic, Social and Cultural Rights and the Convention on the Elimination of Discrimination against Women, both of which have been ratified by India.

The right to health requires the state to not only implement laws for the elimination of discrimination and the protection of survivors of sexual violence, but also to ensure appropriate physical and mental health services are available, accessible, acceptable and of good quality. This includes medical treatment for physical injuries, prophylaxis and testing for sexually transmitted infections, emergency contraception, and psychosocial support. Moreover, health care workers must prioritize the health and well-being of survivors of sexual violence over the provision of medico-legal services. The right to health also requires informed consent prior to all testing and treatment. Health care workers are thus required to obtain the full and informed consent of the survivors of sexual violence prior to conducting medical examinations or initiating medico-legal investigations. In addition, all medico-legal examinations and procedures consented to must respect the privacy of the victim, and must not extend beyond that which is medico-legally required.

To realize the right to health of survivors of sexual violence, healthcare workers must be trained to respond appropriately to their needs, in a sensitive manner respectful of the dignity and autonomy of each survivor. In most cases, however, health professionals do not receive such training. Medical textbooks often contain archaic and insensitive passages related to the examination of victims of sexual assault. Moreover, several changes in the law in India related to informed consent and the voluntary reporting of sexual assault have not been incorporated into current procedures and protocols. There is further evidence from India indicating that focus on medico-legal procedures takes

precedence over the provision of health care. Making matters worse, medico-legal processes are wrought with insensitive and degrading procedures.

The Centre for Enquiry into Health and Allied Themes and the Lawyers Collective are engaged in legal advocacy aimed at ensuring the protocols and procedures utilized at health facilities to examine and treat survivors of sexual violence are gender sensitive and that their right to health is realized in all instances. This manual is part of the effort to achieve these goals. Written based on the experiences of an ongoing intervention in three public hospitals in Mumbai, the manual provides step-by-step instructions for responding to the needs of survivors of sexual violence, from the point of their entry into the health facility, to their exit and follow-up care. It highlights the process of seeking informed consent, discerning the victim's history, forming a medical opinion and conducting a medical examination, collecting and preserving forensic evidence, and providing medical treatment and psychosocial support. The manual also includes: a proforma model for documentation; information on laws related to the appropriate role of health care workers in the examination and treatment of survivors of sexual violence; and evidence from intervention research addressing the nature of sexual assault, factors leading to the loss of evidence, and the limitations of medical evidence, such as the absence of genital injuries.

This manual aims to equip health care workers with an appropriate understanding of sexual violence and the needs and rights of survivors of sexual violence, and to highlight the dual responsibilities—both medical and forensic—health care workers have toward survivors. I encourage health administrators, educators, obstetricians, gynaecologists, paediatricians and forensic medical examiners to read this manual and adopt its approach in their practices. Reducing health risks faced by women and ensuring respect for the dignity and autonomy of each woman is central to the realization of the right to health. This manual provides critical support for these endeavors and is thus a welcome contribution to the promotion of women's health and the right to health in India.



**Anand Grover**

UN Special Rapporteur on the Right of Everyone to the Highest attainable standard of physical and mental health

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# Acknowledgement

This manual has been written based on the experiences of a pilot intervention for developing a comprehensive health care response to sexual assault in two public hospitals in Mumbai. We would like to thank Dr. Seema Malik, Chief Medical Superintendent (Peripheral Hospitals) MCGM, and Dr. Nikhil Datar (Honorary Obstetrician and Gynaecologist, Oshiwara Maternity Home) without whose support, implementation of this model response along with the Sexual Assault and Forensic Evidence (SAFE) Kit would not have been possible. We thank all the doctors who used the kit for the first time and lent their experiences to developing this manual. Specifically we thank Dr. Parmar, Dr. Meenal, Dr. Ranjit, Dr. Ambereen, and Dr. Reshma from Rajawadi Hospital and Oshiwara Maternity Home where the pilot project was carried out. Finalization of this manual took place through several consultations with forensic specialists, gynaecologists, women's rights activists and those working in the field of public health. We thank Manisha Gupte, Renu Khanna, Sarojini N.B., Dr. Walter Vaz, Dr. Amar Jesani, Dr. S. Mohite, Dr. Shubhangi Parkar, Deepa V. and Dr. Patil for their valuable inputs in this regard. The expertise that they brought to these consultations has helped fine tune the manual and make it a better product. We would also like to thank a fellow team member Dr. Yashashree Keni, who, with her experience of helping doctors in conducting these examinations provided several useful inputs. Ujwala Kadrekar provided feedback during the revision of this manual. We are grateful to Dr. Padma Prakash for language editing this document. Many thanks to Ara Johannes for design and layout of this manual, and to Margaret Rodrigues and Priyanka Shukla for their efforts in printing. We would also like to thank Dr. Adriaan van Es (Director, International Federation of Health and Human Rights Organizations) and Dr. Claudia Garcia-Moreno (Coordinator, Gender, Rights, Sexual Health and Adolescence, Department of Reproductive Health and Research, World Health Organization) for reviewing and opining on the manual. Finally, we express our gratitude to Padma Deosthali, Co-ordinator, CEHAT for her detailed inputs and constant support in the making of this document.

CEHAT

Sangeeta Rege  
Sana Contractor

Consultants

Dr. N. Jagadeesh  
Dr. Padmaja Samant

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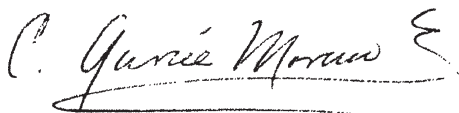
# Foreword

Sexual assault can have long lasting emotional, physical and social effects on survivors and is a violation of a person's human rights. Survivors of sexual assault need comprehensive and caring services that address their physical and mental health needs and provide them with the necessary psychosocial and other support in order to help them recover from a traumatic event.

Health providers have an important role to play in this as they will often be one of the first points of contact after the event. In addition to providing the best possible health care, they are well placed to collect and document the evidence that is necessary to corroborate the assault and identify the perpetrator. This evidence is crucial for the prosecution of sexual assault cases. It is therefore essential that health providers have the knowledge and skills, as well as the understanding needed to respond appropriately and sensitively to sexual assault survivors.

This manual is an important contribution to strengthening the knowledge and understanding of providers in India on how to respond to sexual assault survivors. It should contribute to better care and better outcomes for victims/survivors, who are primarily women and children. The encounter with the health provider can contribute to the healing process or conversely can be an experience of re-victimization. The more providers understand the issues surrounding sexual violence, and the psychological and physical needs of survivors and are able to provide the basic care and psychosocial support, and carry out a sensitive forensic examination when appropriate, the more likely they can help the survivor in the healing process. Where this is not possible, clear referral pathways should be established to ensure survivors can access the necessary care and support.

There is a need to invest in building the capacity of health providers to provide care and support to survivors of sexual assault. As we improve care for survivors of sexual assault, we must also continue our efforts to build more gender equitable societies and prevent sexual assault from happening in the first place.



Claudia Garcia Moreno  
Coordinator, a.i. Gender, Reproductive Rights Sexual Health and Adolescence  
Department of Reproductive Health and Research  
World Health Organization

\* The views expressed are those of the author and not necessarily those of the Organization

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# Preface

Women's liberation and emancipation, one of the most revolutionary changes that took place in the 20th century, has found a strong basis in international law. Several covenants and other human rights instruments emphasize the inalienable right of women to physical, mental and social autonomy, and freedom from servitude, discrimination and violence. For health workers, physicians, midwives and nurses in particular, it is of paramount interest to understand the Right to Health, including the Rights to Sexual and Reproductive Health and to promote and monitor its implementation. In their daily work, health workers witness the violations of these rights, particularly of vulnerable and marginalised groups, women and children.

As sexual and reproductive rights are among the most controversial and sensitive issues in international law, they deserve particular attention by health professionals. Sexual and reproductive rights explicitly include the right to control one's health and body and freedom from sexual violence, such as rape, forced pregnancy, forced abortion and sterilization, female genital mutilation, forced marriage. They include the right to health protection, including accessible and affordable health care of good quality. While we may be conscious of these rights, we - especially health workers - are painfully unaware of the daily reality of millions of vulnerable groups.

A particularly disturbing form of violence is sexual assault and rape, of which mostly women and girls are the victim. Mass rape is increasingly being practised as a weapon of war, suppression and social destruction, and has been declared a war crime. As doctors and nurses we witness the magnitude of the suffering of women survivors, we see the physical and psychological wounds, we perceive the silent pain and fear of social exclusion after rape when kept secret. In cases of sexual assault which do reach health care or law enforcement (police), it is of utmost importance that the survivors are treated in a respectful and humane way, in line with medical ethics, and in line with the provisions of international law. Dignity of the survivor, professional secrecy, avoiding unnecessary, harmful, stigmatizing and disrespectful treatment are crucial. Especially in a sensitive area such as sexual assault, protocol approach is essential. International professional bodies of physicians (World Medical Association WMA), nurses (International Council of Nurses ICN) and gynaecologists (International Federation of Gynaecologists and Obstetricians FIGO) promote the use of a protocol that includes the above mentioned elements, and that is in line with medical ethics and international law.

Physicians, midwives and nurses have a role to play in the implementation of the Right to Health and in Sexual and Reproductive Rights; society expects this from us, and as health care providers we owe this to our patients. This Manual, written and tested by CEHAT, meets these requirements, and should be recommended as a model protocol in all health facilities, police stations, and in the curriculum of medical and nursing schools.

A handwritten signature in black ink that reads "Adriaan van Es". The signature is written in a cursive style and is underlined with a single horizontal stroke.

Adriaan van Es, MD

Director, International Federation of Health and Human Rights Organisations (IFHHRO)

## I. Introduction

There were an estimated 22,172 reported survivors of rape in India, as per data from the National Crime Records Bureau (NCRB, 2010). The data shows that rape occurs in all age groups and among both sexes, but predominant in the age group of 18-30 yrs. In the same year, there were also 40,613 cases of molestation reported, which includes other forms of sexual assault that do not involve peno-vaginal penetration. While there is evidence of a steady rise in the reporting of rape, other forms of sexual violence such as sexual harassment at work place, eve teasing and marital rape go largely unrecorded. Moreover, in spite of the rising numbers, these form only the tip of the iceberg and the crime remains largely hidden, given the stigma attached to sexual assault. A National Study on Child Abuse conducted by the Ministry of Women and Children in 2007 showed that more than 53% children across 13 states reported facing some form of sexual abuse while 22% faced severe sexual abuse. (Kacker, Varadan and Kumar 2007)

Sexual assault, like any other form of violence, results in physical and psychological consequences. Thus, health care providers have a dual responsibility vis-à-vis survivors of sexual assault. The first is to provide the survivor with the required medical and psychological treatment and care, while the second is to assist the survivors in their medico-legal proceedings by collecting evidence and doing good quality and thorough examination and documentation. However, it has been seen time and again that medical professionals carry certain biases about survivors reporting sexual assault similar to those in general society. Text books on medical jurisprudence continue to perpetuate these biases. Flavia Agnes, a leading advocate in her critique of the text books related to medical jurisprudence points out that these text books create a picture that women falsely allege rape and therefore doctors should exercise caution while conducting such examinations. Neither medical text books nor medical education equips a doctor completely in understanding the issue of “sexual violence”. Therefore the entire medico legal practice in cases of sexual assault hinges on defensive practice by health professionals. Further, the public health system lacks a uniform protocol for management of a sexual assault survivor whether it is about examination, documentation or treatment guidelines.

The SAFE (Sexual assault forensic and medical evidence collection) kit was developed by Center for Enquiry into Health and Allied Themes (CEHAT) in 1998 to fill this gap. Though the kit was endorsed by several well known gynaecologists, forensic doctors, experts from the law enforcement agencies, forensic laboratories and women’s rights

activists, its use remained restricted to a teaching tool at the level of medical colleges. In 2000, CEHAT collaborated with the Municipal Corporation of Greater Mumbai (MCGM) to set up India's first public hospital-based crisis centre to respond to women facing Domestic Violence. As a part of this project, health care providers (HCP) were trained to understand the association between Domestic Violence and its health consequences. Eventually a trained cadre of doctors, nurses and para medical staff emerged. Doctors trained as a part of this project felt that the current management of sexual assault survivors needs to change, given the lack of sensitive protocols for responding to these survivors. Under the leadership of Dr. Seema Malik, the Project Director of Dilaasa and Chief medical superintendent (Peripheral Hospitals), a comprehensive health care response to sexual assault is being implemented in three municipal hospitals since 2008.

The components of the implementation include creation and implementation of a gender sensitive protocol for examination and evidence collection (via use of the SAFE kit and its proformas), equipping health care providers in responding to sexual assault survivors, and helping them acquire a perspective on sexual violence, and providing psychosocial support to survivors. This experience has highlighted the dearth of knowledge among providers and the dilemmas that they encounter while responding to such cases. While the training that CEHAT provided made doctors confident in using the paraphernalia of the kit, there were several other issues that they struggled with, such as seeking history of different types of sexual assault, negotiating informed consent, etc, that our interventionists has to step in and negotiate. (Jagadeesh et.al. 2010) This learning prompted us to develop a manual that would provide the examining doctor with a step-by-step approach to what should be done when a survivor of sexual assault reports to the hospital. This manual has equipped health care providers to respond to survivors with ease and confidence. It provides detailed information on:

- seeking informed consent in consonance with relevant laws
- how sexual assault history must be elicited,
- specific signs that should be noted during the examination,
- how injuries must be recorded and dated,
- nature of evidence that needs to be collected,
- treatment guidelines and psychosocial support required by survivors
- drafting a medical opinion at the end of such an examination
- answers to doctors about dilemmas that they encounter in day to day practice with reference to relevant laws.

We also draw on our own experience of having handled 82 cases of sexual assault from these three hospitals, to provide evidence on various aspects related to the types of assault and findings seen in these cases. In addition to this, we have also provided a sample proforma and standard operating procedures that could be implemented at health facilities.

Simultaneously, CEHAT has also been an intervenor in a public interest litigation filed in the Nagpur Bench of the Bombay High Court. The PIL had been filed with the purpose of introducing uniformity in protocols for examination of sexual assault. CEHAT's intervention specifically was to ensure that the uniform protocols that are implemented are gender sensitive, and that the right to treatment of survivors is upheld. Evidence from CEHAT's work in these three hospitals that are implementing the model (of which this manual is a part), has informed the preparation of new protocols by the Govt. of Maharashtra.

Given the absence of training on managing cases of sexual assault and the dearth of information on the issue in medical curricula, we hope that this manual will be able to fill a significant gap.

## II. Learning Objectives

This manual is intended to be used as a guide for examination and evidence collection in cases of sexual assault. The learning objectives of the manual are as follows:

- 1) To provide the examining doctor with an understanding of the various types of sexual assault, and the role of the doctor in responding to them.
- 2) To provide an understanding about the health consequences of sexual assault
- 3) To provide step by step instructions for seeking consent, history, examination, evidence collection, providing an opinion and treatment in a case of sexual assault
- 4) To acquaint the doctor with various laws pertaining to the examination of a case of sexual assault

## III. Definition of Sexual Assault

The World Health Organisation (WHO) defines Sexual Violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments/ advances and acts to traffic, or otherwise directed against a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim in any setting, including but not limited to home and work." (WHO, 2003) Sexual assault, a form of sexual violence, is a term often used synonymously with rape. However, sexual assault could include anything from touching another person's body in a sexual way without the person's consent to forced sexual intercourse (rape), sodomy (oral and anal sexual acts), child molestation, incest, fondling and attempted rape.

Types of Sexual Violence include:

- coerced sex in marriage and dating relationships,
- rape by strangers
- systematic rape during armed conflict, sexual slavery
- sexual harassment,
- sexual abuse of children
- sexual abuse of people with mental and physical disabilities,
- forced prostitution and sexual trafficking,
- child marriage,
- denial of the right to use contraception,
- forced abortion and forced sterilization
- violent acts against the sexual integrity of women, including female genital cutting and obligatory inspections for virginity
- forced exposure to pornography

Until 2012, the Rape law in India only recognized peno-vaginal sexual intercourse as 'rape'. However, in April 2013, with the passage of the Criminal Law Amendment Act, this definition has been considerably broadened. 'Rape' as per section 375 of the IPC



now includes non-consensual insertion of the penis, any object or part of the body (not being the penis) into the vagina (including the labia majora), urethra or anus OR, applying the mouth to the vagina, urethra or anus OR manipulating the woman's body in order to cause penetration. The explanation of consent too has been expanded to include that "a woman who does not physically resist to the act of penetration shall not by the reason only of that act, be regarded as consenting to the sexual activity." Section 354 (outraging modesty) has also been expanded to include physical contact or advances which include unwanted sexual overtures, request for sexual favours, showing pornography against will, making sexually coloured remarks, disrobing, voyeurism and stalking.

One of the limitations of the new law however, is that it still does not recognize forced sexual intercourse by a man with his wife as 'rape'. Further, it also does not include males as possible victims of rape.

"Another law "The Protection of Children from Sexual Offences Act", pertaining specifically to children under the age of 18 years, was also enacted in 2012. It defines various forms of sexual violence against children - penetrative, sexual assault, sexual harassment and use of pornography - and corresponding punishments for them. Penetrative assaults include penetration of vagina/anus/mouth/urethra of a child with penis/object/any other body part, manipulation of any body part to cause penetration of any of these orifices, applying mouth to the penis, vagina, anus, urethra of a child or making the child do so. Other forms of sexual assault defined in the act include touching of the vagina, anus, penis of a child without causing penetration, using objectionable language or gestures towards the child, making the child exhibit his/her body, forcing the child to watch pornography or participate in it and following the child. Each offence is regarded as 'aggravated' under certain circumstances. (Details of the law provided in Annexure 1).

#### **IV. Health Consequences of Sexual Assault**

Sexual assault, in addition to being a violation of human rights, is also an important public health issue as it has several direct and indirect health consequences. As a health care provider one must be aware that survivors of sexual assault might present with varying signs and symptoms. For those survivors who do not reveal a history of sexual assault, these signs and symptoms should prompt one to suspect the possibility of sexual abuse/assault.

*Physical Health Consequences:*

- severe abdominal pain
- burning micturition
- sexual dysfunction
- dyspareunia
- menstrual disorders
- urinary tract infections
- unwanted pregnancy
- miscarriage of an existing fetus
- exposure to sexually transmitted infections (including HIV/AIDS)
- pelvic inflammatory disease
- infertility
- unsafe abortion
- mutilated genitalia, and
- self-mutilation as a result of psychological trauma

*Psychological Health Consequences:*

Short term psychological effects:

- fear and shock
- physical and emotional pain
- intense self-disgust, powerlessness
- worthlessness
- apathy
- denial
- numbing
- withdrawal and
- an inability to function normally in their daily lives

Long term psychological effects:

- depression and chronic anxiety
- feelings of vulnerability
- loss of control
- emotional distress
- impaired sense of self
- nightmares
- self-blame
- mistrust,
- avoidance and post-traumatic stress disorder
- chronic mental disorders
- committing suicide or endangering their lives

## *Rape Trauma Syndrome:*

"Rape Trauma Syndrome" was first described by Burgess and Holmstrom in the year 1974. (Burgess and Holmstrom 1974) The identification of this syndrome by them was based on the analysis of 92 adult women rape survivors whom they interviewed and followed up. They delineated the symptomatology of this syndrome into two phases.

Phase 1, the acute phase, is one of disorganization. The survivor feels shock and disbelief regarding the rape. They may initially react in two ways:

(1) in the expressed style, survivors display anger, fear, and anxiety, and often cry and  
(2) in the controlled style, the survivor remains calm and composed and displays little outward emotion. Often, the controlled survivor needs permission to express her emotions.

This phase can last from 6 weeks to a few months. Doctors should anticipate either reaction and provide appropriate support and encouragement.

Phase 2, the reorganization phase, is a long-term process in which the survivor develops certain coping mechanisms. Reorganization may include stages of outward adjustment, personal integration.

However, it is important for doctors to realize that there is no set of specific and predictable responses that survivors of sexual assault will exhibit. Not all survivors will have similar kinds of symptoms; some may exhibit a more severe form of symptoms thereby constituting the syndrome, some might have few while others might have no symptoms at all. The reactions of sexual assault survivors vary based on several factors such as her age, circumstances surrounding the assault and relationship to the assailant. The distress faced by survivors is also exacerbated by the reaction of the family, police, hospital and courts, which the medicalization of psychological responses to sexual assault tends to obscure. Further, studies have shown that the reactions displayed by survivors of sexual assault are also similar to that of others who have experienced severe stress reactions. The use of Rape Trauma Syndrome as 'evidence' in courts of law, therefore, has come under criticism. (Dobbin and Gatowski, 1998)

## **V. Role of Health Care Providers**

Health care providers play a dual role in responding to survivors of sexual assault. The first is to provide the required medical treatment and psychological support and the second is to assist the survivor in their medico-legal proceedings by collecting evidence

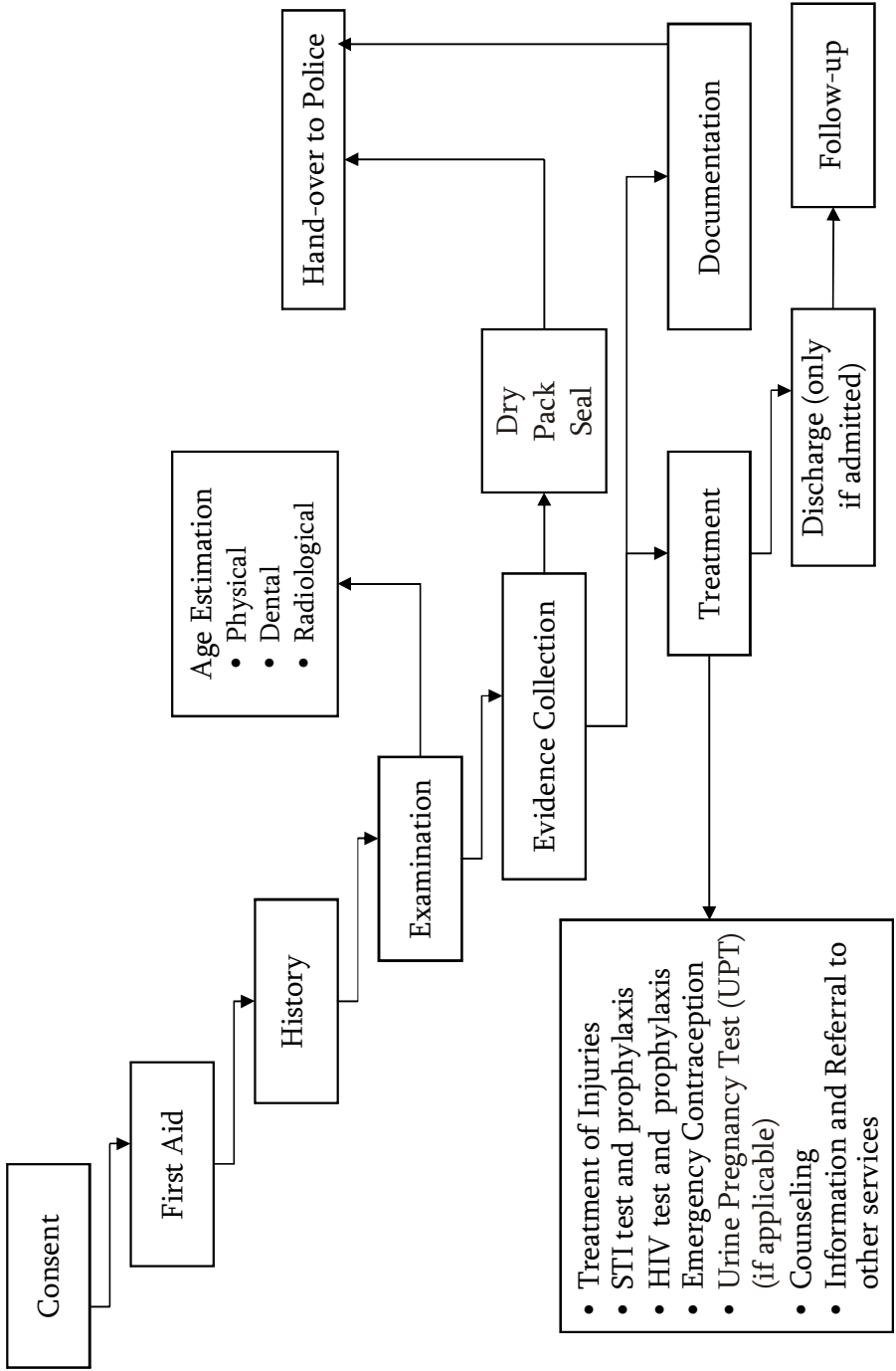
and ensuring good quality documentation. After making an assessment regarding the severity of sexual assault, the first responsibility of the doctor is to provide medical treatment and attend to the survivor's needs. While doing so it may be pertinent to remember that the sites of treatment would also be examined for evidence collection later. The Criminal Law Amendment Act 2013, in section 357C says that both private and public health care providers are obligated to provide treatment. Non-treatment of sexual assault survivors is punishable under Section 166 B with imprisonment for a term which may extend to one year or with fine or with both.

The ultimate goal of the health care providers should be to establish a "Comprehensive Response to Survivors of Sexual Assault".

The components of the Comprehensive Response are as follows:

- Providing necessary medical support to the survivor of sexual assault
- Establishing a uniform method of examination, evidence collection by following the protocols in the SAFE kit
- Informed consent for examination and evidence collection and informing the police procedures.
- First contact psychological support and validation after the traumatic experience
- Maintaining a clear and fool-proof chain of custody and
- Referral to appropriate agencies for further help (eg. legal support services, shelter services etc.)

The diagram below represents the components of your role as a health care provider.



## **VI. Purpose of the Medical and Forensic Examination**

The purpose of the medical and forensic examination of the survivor is to establish the following:

- Whether a sexual act has been attempted or completed. A sexual act may not only be penetration by the penis but also slightest penetration of the vulva by the penis, such as minimal passage of the glans between the labia with or without emission of semen or rupture of the hymen. Sexual acts include genital, anal or oral penetration by the penis, fingers or other objects as well as any form of non-consensual sexual touching.
- Whether such a sexual act is recent.
- Whether such an act was forcible. Any harm caused to the survivor's body is documented through examination. This could include injuries inflicted on the survivor by the accused and by the survivor on the accused. However, absence of signs of struggle does not imply consent.
- If validity of consent is questionable. Verifying age of the survivor in case of pre-pubertal/adolescent girls/boys. Ascertaining influence of alcohol or drugs administered to the survivor.
- Providing treatment for sequelae of the assault and appropriate referrals for the survivor.

## **VII. Prerequisites at the Health Facility**

- The examination should be carried out in a non-threatening, quiet, and private place.
- Adequate waiting space should be made available for relatives accompanying the survivor.
- Sufficient lighting and a comfortable examination table are necessary for a thorough examination.
- Sufficient space should be present on a table or platform for laying out all equipment required to conduct the examination and for taking notes.
- It is the prime responsibility of the medical facility to provide proper care, examination and psychosocial treatment to the survivor of sexual assault. Section 164(A) Criminal Procedure Code explains the legal requirements for medical examination of a victim of rape. The facility should lay down clear procedures and protocols to be followed in cases of sexual assault and these should be made available to all providers. This includes assembling all the contents required for a medical examination in one place.

- The facility should designate staff for examination of survivors and collection of evidence. They should be trained on the issue of sexual violence and its impact on physical and mental health. They should also have the necessary training and experience to carry out an examination appropriately.
- It is not mandatory that only a gynaecologist must examine the survivor of sexual assault. As per 164 A Criminal Procedure Code (CrPC), any Registered Medical Practitioner can and should conduct the examination.
- In case a female doctor is not available for the examination of a female survivor, a male doctor should conduct the examination in the presence of a female attendant. In case of a minor/person with disability, his/her parent/guardian/any other person with whom the survivor is comfortable must be present.
- Unless the survivor requires indoor stay for treatment or observation admission should not be insisted upon.
- There must be no delay in conducting an examination and collecting evidence in cases of sexual assault as evidence is lost with time. The urgent nature of the examination cannot be over-emphasised.
- In a situation of mass violence (caste, communal or armed conflict) various forms of sexual assault are perpetrated against women and girls. Doctors working in such situations should therefore look for signs/evidence of sexual assault amongst all girls and women who come to the hospital, whether they are brought dead or alive. The State must provide security to its health professionals under such circumstances so that they may be allowed to carry out their duties without fear or external pressure.

### **Materials Required:**

- Paper envelopes
- Sterile swabs and swab guards
- Bags for storing clothes
- Catchment Papers
- Comb
- Nail Cutter
- EDTA vaccutainer
- Plain vaccutainer
- Sodium fluoride vaccutainer
- Syringe and needle
- Distilled water

- Disposable Gloves
- Glass slides
- A pair of small scissors
- Lac Stick for sealing

### **Infrastructural requirements for the examination of survivor**

- Torch
- Microscope
- Colposcope
- Disposable Speculum
- 2% 30 gm tube of sterile lignocaine jelly
- Cytotfix spray
- Surgilube
- Spirit Lamp
- Toluidine Blue
- Polaroid camera
- UPT Kit

**The Term 'Survivor':** A person (male / female / transgender) against whom an assault is perpetrated is termed as a survivor. This term gives a positive hue to the self of the person; it conveys that s/he has managed to pull him/her self together in spite of what s/he went through. We have not used the term "victim" as this takes away from the person's agency. We also do not use "patient" as this is a general term used for a person with a disease. Sexual assault is not a disease but a violation of human rights.

### **VIII. Consent**

- A survivor may approach a health facility under three circumstances:
  1. On his/her own;
  2. With a police requisition after police complaint;
  3. With a court directive.

In all three circumstances, seeking informed consent for examination and evidence collection is mandatory (Section 164 (A) CrPC).

- Consent of the survivor should be taken for the following purposes:
  1. Examination
  2. Collection of the evidence
  3. Treatment



- The consent form must be signed by the person him/herself if s/he is above 12 yrs. of age. Consent must be taken from the guardian/ parent if the survivor is under the age of 12 years or if the survivor is unable to give his/ her consent by reason of mental disability. (Section 89 IPC)
- The consent form must be signed by the survivor, a witness as well as the examining doctor.
- Any major 'disinterested', mentally sound person may be considered a witness. In the hospital set-up this could be a nurse or other hospital employee. The police or a relative of the survivor cannot be considered a witness.
- Please note that the survivor or guardian may refuse to give consent for any part of examination. In this case the doctor should explain the importance of examination and evidence collection. It should also be explained that refusal for such examination will not affect/compromise treatment. Such informed refusal for examination and evidence collection must be documented (Section 164 (A) CrPC).
- Survivor and her relative/ guardian should be explained that at any stage during examination and evidence collection she may ask the doctor to stop and that it will not have any effect on the quality of her treatment.
- Even if the survivor refuses consent to evidence collection, she should be made aware that if at a later date she changes her mind and wants to pursue a legal course of action, the collected evidence may be useful to seek justice.
- The Cr Law Amm Act 2013 makes it obligatory to report all cases falling under section 376 to the police. However, sexual assault has health consequences and several survivors do come to the hospital only for treatment; they may not want to pursue a criminal case but it is their right to get treatment. In case the survivor does not want to pursue a police case, an MLC must be made and she must be informed that she has the right to refuse to file an FIR. Neither court nor police can force the survivor to undergo medical examination. It has to be with the survivor/parent/guardian's informed consent (depending on the age).
- Voluntarily reporting to health facility: In the past sexual assault survivor examination was only done after receiving a police requisition. Now Section 357© of the CrPC in the Criminal Law Amendment Act 2013 has made it mandatory for all health facilities private or public to provide services to survivors of sexual assault immediately. In the year 2000, the Supreme Court had also clarified in case of Manjanna v State of Karnataka that police requisition is not mandatory for a sexual assault survivor to seek medical examination and care. The doctor should examine such cases even if the survivor reports to the hospital first without FIR.

- Requisition: Once the case is booked in a particular police station/court, the investigating officer (minimum rank of sub-inspector of police) of the case forwards a requisition for medical examination of survivor of sexual assault. The police constable may accompany the survivor as escort along with the requisition from the investigating officer.

## **IX. General Information:**

- Start by recording the name, age, sex (male/female/transgender), address and contact number of the survivor.
- Information about the police case registered, such as Medico Legal Case (MLC) number, Crime Register (CR) number, U/S should also be recorded.
- Who the survivor was brought by and relationship to accompanying persons must be recorded.
- Date, time and place of examination should be specifically written.
- Marks of identification (two in number), in the form of moles, scars, tattoos, preferably from the exposed parts of the body to be documented. While describing identification mark emphasis should be on size, site, surface, shape, colour, fixity to underlying structures.

## **X. Medical History**

- Conventionally, obstetric history including past history of pregnancy, abortions etc is recorded. However, this may be considered an invasion of privacy as it forces survivors to reveal past sexual history/practice, which is irrelevant to the case of sexual assault. (Section 146 of the Indian Evidence Act) Hence such history should not be routinely sought. It must only be sought for the purpose of treatment.
- Relevant medical history in relation to sexually transmitted infections (gonorrhoea, HIV, HBV etc). This has a bearing on what gets transferred between survivor and accused of sexual assault. Such a history can be elicited by asking about discharge per-urethra/per-anus, warts, ulcers, burning micturition, lower abdominal pain etc. Based on this information reexamination including investigations can be done after incubation period of that disease.
- Relevant surgical history in relation to treatment of fissures/injuries/scars of ano-genital area should be noted.
- Information related to past abuse (physical/sexual/emotional) should be recorded. This is important in order to understand whether there are any health

consequences related to the assault, which would also inform referral for further care. This information should also be kept in mind during examination & interpretation of findings.

## **XI. Sexual Assault History**

- Keep in mind that narration of the history of sexual assault might be a traumatizing experience for the survivor. It is very difficult for most survivors to talk about this and s/he might not want to tell you all the details.
  - Be very sensitive of this and explain to the survivor that the process of history taking is important for further treatment and for filing a case if needed.
  - Talk to the survivor in a non-threatening environment.
  - Do not pass judgmental remarks or comments that might appear unsympathetic and disbelieving. An accurate history can be obtained only by gaining the trust of the survivor and not by accusing him/her of lying.
  - Police officers must not be present while history is being recorded. If the survivor is comfortable with a relative being around while recording the history then the relative could be present with the consent of the survivor.
- 
- History of the incident, documented specifically in the survivor's own words has evidentiary value in the court of law as this is being recorded by neutral and unbiased doctor. The doctor should record it completely as it may be the first opportunity for the survivor to narrate her history.
  - Details of the place of the assault, time, nature of force used, areas of contact are recorded here. If the assailants are known, please ask and mention the names of the assailants.
  - If any sensitive information is revealed (such as identity of assailants) it is better to have the identity (name) and signature of the informant (survivor or her parent/guardian in case of minor).
  - Information collected on activities like bathing, washing genitals (in all cases) rinsing mouth, drinking, eating (in oral sexual assault) has bearing on the evidentiary outcome of trace evidence collected from these sites.
  - Please specifically note history of injury marks that the survivor may state to have left on the assailant's body as it can be matched eventually with the findings of the assailant's examination.
  - Pertinent data of the assault with regard to injuries, threats and weapons used must be recorded. While recording such data, please note the following:

- Physical violence: mention weapons or objects used. Pushing, banging, slaps, kicks, blows with sticks, acid burns, gun shots, knife attacks etc. are examples of physical violence. Survivor may have had blunt trauma which should be looked for during examination.
- Verbal threats should be recorded in survivor's words, eg. harming her or her near and dear ones. Threats to divulge information regarding occurrence of the assault to others will also amount to a threat.
- Information regarding attempted penetration or completed penetration by penis/finger/object in vagina/anus/mouth should be properly recorded along with information about emission of semen. Indicating that penetration was complete precludes the need to indicate that it was attempted.
- It is important to bear in mind that, there is a wide range of acts that amount to 'sexual assault'. These could be penetration of the vagina/mouth/anus by the penis/finger/object, or other acts such as masturbation of the assailant by the survivor, masturbation of the survivor by the assailant, oral sex by the assailant on the survivor or sucking, licking, kissing of body parts. While recording a history of sexual assault, it is important to probe whether these acts occurred or not.
- It is observed that generally doctors are awkward in asking for history of the sexual act. If details are not entered it may weaken the survivors' testimony. History of oral sex, anal sex and masturbation should be asked in simple language, using terms that the survivor understands.
- In case of children, illustrative books, body charts or a doll can be used if available, to elicit the history of the assault. When it is difficult to elicit history from a child, please call an expert.
- Information about emission of semen outside the orifices should be elicited as swabs taken from such sites can have evidentiary value.
- Information regarding use and status of condom during the assault is relevant because in such cases, vaginal swabs and smears would be negative for sperm/ semen.
- If there is a history of last consensual sexual intercourse in the week preceding the assault, it should be recorded because detection of that sperm/semen has to be ruled out. While seeking such history, explain to the survivor why this information is being sought, because the survivor may not want to disclose such history as it may seem invasive.
- If the survivor is menstruating at the time of examination then a second examination is required on a later date in order to record the injuries clearly.

- Some amount of evidence is lost because of menstruation. Hence it is important to record whether the survivor was menstruating at the time of assault/examination.
- The same applies to bathing, douching, defecating, urinating and use of spermicide after the assault.
- If there is vaginal discharge, record its type, i.e., texture, colour, odour, etc.
- In case there are any cancellations while recording anything on the proforma, it is important for the doctor to countersign next to the correction.

## **XII. Forensic Evidence Collection**

- Based on Locard's principle of exchange there may be a possibility of exchange of bodily evidence between accused and survivor.
- Before you begin, make an assessment of the case and determine what evidence needs to be collected. This procedure cannot be done mechanically and will require some analysis. This assessment will have to be made on a case-to-case basis.
- The nature of forensic evidence collected will be determined by three main factors - nature of assault, time lapsed between assault and examination and whether the person has bathed/washed herself since the assault.
- If a woman reports within 96 hours (4 days) of the assault, all evidence including swabs must be collected without fail, in keeping with the history of assault. The likelihood of finding evidence after 72 hours (3 days) is greatly reduced (WHO, 2003), however it is better to collect evidence upto 96 hours in case the survivor may be unsure of the number of hours lapsed since the assault.
- Please keep in mind that spermatozoa can be identified only for 72 hours after assault. So if a survivor has suffered the assault more than three days ago, please refrain from taking swabs for spermatozoa. In such cases swabs should only be sent to FSL for tests for identifying semen.
- Evidence on the outside of the body and on materials such as clothing can be collected even after 96 hours.
- The nature of swabs taken is determined to a large extent by the nature of assault and the history that the survivor provides. The kinds of swabs taken should be consistent with the history. For example, if the survivor is certain that there is no analintercourse, anal swabs need not be taken.
- Request the survivor to stand on a large sheet of paper, so as to collect any specimens of foreign material e.g. grass, mud, pubic hairs or scalp hairs etc.

which may have been left on her person from the site of assault or from the accused. This sheet of paper is carefully folded and preserved in a bag to be sent to the FSL for trace evidence detection.

- Clothes that the survivor was wearing at the time of the assault are of evidentiary value if there are any stains/tears/trace evidence on them. Hence they must be preserved. Please describe each piece of clothing in the table provided. Presence of stains - semen, blood, foreign material etc - should be properly noted. Also note if there are any tears or other marks on the clothes. If clothes are already changed then the survivor must be asked if s/he has the clothes that were worn at the time of assault and these must be preserved.
- Always ensure that the clothes and samples are air dried before storing them in their respective packets.
- Ensure that clothing is folded in such a manner that the stained parts are not in contact with unstained parts of the clothing.
- Pack each piece of clothing in a separate bag, seal and label it duly.
- If a woman reports with a pregnancy resulting from an assault, she is to be given the option of undergoing an abortion, and protocols for MTP are to be followed. The products of conception (PoC) may be sent as evidence to the forensic lab (FSL) for establishing paternity / identifying the accused.
- The examining doctor/AMO/CMO is to contact the respective police station, ask them to collect the DNA Kit from the FSL and bring it to the hospital to coincide with the time of MTP. The DNA Kit is used to collect the blood sample of the survivor. The accompanying DNA Kit forms are to be filled by the examining doctor. A photograph of the survivor is required for this form, and should be arranged for prior to the MTP.
- The products of conception (PoC) are to be rinsed with normal saline (NOT completely soaked in saline) and collected in a wide-mouthed container with a lid. This sample is to be handed over immediately to the police along with the DNA Kit, or preserved at -4 degree Celsius. It is to be transported by the police in an ice-box, maintain the temperature at sub-zero at all times.

### ***Body Evidence:***

- Collect oral swab for detection of semen and spermatozoa. Oral swabs should be taken from the posterior parts of the buccal cavity, behind the last molars where the chances of finding any evidence are highest.
- Swabs are used to collect bloodstains on the body, foreign material on the body surfaces seminal stains on the skin surfaces and other stains.

- Detection of scalp hair and pubic hair of the accused on the survivor's body (and vice-versa) has evidentiary value. Collect loose scalp and pubic hair by combing. Intact scalp and pubic hair is also collected from the survivor so that it can be matched with loose hair collected from the accused. All hair must be collected in the catchment paper which is then folded and sealed.
- If there is struggle during the sexual assault, with accused and survivor scratching each other, then epithelial cells of one may be present under the nails of the other. Examine nail scrapings and nail clippings for epithelial cells (this can also be used for DNA detection). Clippings and scrapings must be taken for both hands and packed separately.
- Ensure that there is no underlying tissue contamination while clipping nails.
- Blood is collected for grouping and also helps in comparing and matching blood stains at the scene of crime.
- Collect blood and urine for detection of drugs/alcohol as the influence of drugs/alcohol has a bearing on the outcome of the entire investigation. If such substances are found in the blood, the validity of consent is called into question. In a given case, for instance, there may not be any physical or genital injuries. In such a situation, ascertaining the presence of drug/alcohol in the blood or urine is important since this may have affected the survivor's ability to offer resistance.
- Venous blood is collected with the sterile syringe and needle provided and transferred to 3 colour coded vacutainers for the following purposes:

<b>Colour Code</b>	<b>Contents</b>	<b>Purpose</b>
Red	Plain Vacutainer	Blood grouping and drug estimation
Grey	Sodium Fluoride	Alcohol estimation
Purple	EDTA	DNA Analysis

- Blood group and HIV, VDRL should be sent to the hospital laboratory.
- Urine sample may be collected in a container to test for drugs and alcohol levels as required.
- Note the time drugs/metabolites remain in the body.
  1. Alcohol - Found up to 10 hours.
  2. Rohypnol (Flunitrazepam) - Found up to 36-72 hours.
  3. GHB (Gamma Hydroxybutyric Acid) - Found up to 10-12 hours.
  4. GLB (Gamma Butyrolactone) - Found in urine up to 6 hours and in the blood up to 24.

### ***Genital and Anal Evidence:***

- In the case of any suspected seminal deposits on the pubic hair of the woman, clip that portion of the pubic hair, allow to dry in the shade and place in an envelope.
- Pubic hair of the survivor is then combed for specimens of the offender's pubic hair. A comb must be used for this purpose and a catchment paper must be used to collect and preserve the specimens. Cuttings of the pubic hair are also taken for the purpose of comparison or to serve as control samples. If pubic hair has been shaved, do not fail to make a mention of it in the records.
- Take two swabs from the vulva, vagina, anal opening for ano-genital evidence. Swabs must be collected depending on the history and examination. Swabs from orifices must be collected only if there is a history of penetration. One vaginal smear is to be prepared on a glass slide provided, air-dried in the shade and placed in an envelope. Wherever the expertise exists, an additional 'wet smear can be made and examined for spermatozoa under the microscope. This will aid the doctor in writing the provisional opinion with more certainty.
- Often lubricants are used in penetration with finger or object, so relevant swabs must be taken for detection of lubricant.
- Other pieces of evidence such as tampons (may be available as well), which should be preserved.
- Swabs for microbiological tests for infections may be sent as per institutional policy and availability.
- Swabs must be air dried, not dried in direct sunlight. Drying of swabs is absolutely mandatory as there may be decomposition of evidence which can render it un-usable.
- Always ensure that all the envelopes containing the samples are labeled

### **XIII. General Examination**

- Make an assessment of the general mental condition of the survivor. Observations on the general mental condition of the survivor should include whether she was agitated, restless, numb, anxious, whether she was able to respond to all the questions asked by the doctor. A doctor can also record her feelings in her words for ensuring accuracy.

Note: Due to the stigma related to sexual assault, it is under reported. It is therefore pertinent that such reporting be interpreted as an act of courage.



Survivors may respond in different ways to such traumatic events. Please note that "the patient is indifferent, detached or controlled" may be used against her by the defense hence such reference may be avoided.

- Any signs of intoxication by ingestion or injection of drug/alcohol must be noted.
- A general examination begins with the inspection of the body surface for bruises, scratches, bites and other injuries. Specifically look for marks on the face, neck, shoulders, breast, upper arms, buttocks and thighs.
- Note and describe all injuries. Describe the type of injury - abrasion, laceration, incised etc.
- Mention possible weapon of infliction in the words such as - hard, blunt, rough, sharp, etc.
- It is important to keep in mind that injuries might not always be seen. There may be circumstances in which the survivor may have been threatened with bodily harm, physically restrained, or afraid to resist for other reasons, thus explaining absence of injuries. In fact, only one-third of cases of sexual assault have visible injuries. (Bowyer and Dalton, 1997) Moreover, mucosal injuries heal rapidly. They may not be visible during examination and may not leave any scars either. (McCann et. al, 2007) Even so, cases of assault have been proved even in the absence of injuries. As per the Cr Law Amm Act 2013, physical resistance on the part of the survivor is not required to demonstrate lack of consent (Section 375, Explanation 2), and so even if injuries are not present it does not mean that sexual assault did not occur.
- Injuries are best represented when marked on body charts. They must be numbered on the body charts and each injury must be described in detail. Photographic evidence is even better than body charts, provided the survivor consents to it.
- Actual measurements, site, shape, with time since injury should be described. Time since injury calculation is as follows:

***Abrasion:***

Fresh	Bright Red
12 to 24 hours	Reddish scab
2 to 3 days	Reddish brown scab
4 to 7 days	Brownish black scab
After 7 days	Scab dries, shrinks and falls of from periphery

*Contusion:*

Fresh	Red
Few hours to 3 days	Blue
4th day	Bluish-black to brown (haemosiderin)
5 to 6 days	Greenish (haematoidin)
7 to 12 days	Yellow (bilirubin)
2 weeks	Normal

*Note: This is a reference chart only, as many external and internal factors contribute in the healing of injuries*

If there is deep bruise or contusion, signs of injury will usually show after 48 hours. In case you see signs of injury on the follow-up, please record them and attach the documentation to MLC papers.

*Laceration:* It becomes difficult to estimate exactly the time since injury based on the size and contamination. However a rough estimate can be done based on signs of healing.

*Incised injury:*

Fresh	Haematoma formation
12 hours	Edges - red, swollen
24 hours	Scab of dried clot covering the entire area
After this rough estimate can be based on signs of healing.	

Please do not mention old scars as they are identification marks rather than new injuries due to assault. If mentioning those seems pertinent, add a note on when they were acquired.

*Stains on the body:*

- Describe the type of stain - blood, semen, lubricant, etc.
- Describe the actual site and size and colour.
- Mention the number of swabs collected and their sites.

**XIV. Genital Examination**

- A careful observation of the perineum is made for evidence of injury, seminal stains and stray pubic hair.
- In case of female survivors, the vulva, labia, fourchette, hymen and introitus are inspected likewise. A note is made of any swelling, bleeding and tearing, these being signs of recent injury.

- Bleeding/swelling/tears/discharge/stains/warts around the anus and anal orifice must be documented. Examine the anal sphincter tonicity and document findings. Per-rectal examination to detect tears/stains/fissures/hemorrhoids in the anal canal must be carried out and relevant swabs from these sites should be collected.
- Examination of the vagina of an adult female is done with the help of a sterilised speculum. Gentle retraction allows for inspection of the vaginal canal. Look for bruises, redness, bleeding and tears, which may even extend into the perineum, especially in the case of very young girls. In case injuries are not visible but suspected; 1% Toluidine blue is sprayed and excess is wiped out. Micro injuries will stand out in blue.
- The examination and treatment as needed may have to be performed under general anaesthesia in case of minors and when injuries inflicted are severe.
- Micro injuries are better appreciated under a colposcope. Per vaginal and per speculum examination is not a must in the case of children when there is no history of penetration and no visible injuries. Per speculum examination should be done with a sterile water/ saline (preferably warm) lubricated speculum.
- Please note that the size of the vaginal introitus has no bearing on a case of sexual assault, and therefore the two-finger test of admissibility must not be conducted. It is often used against survivors in court to prove that they are 'habituated to sexual intercourse', even though such information about past sexual conduct has been considered irrelevant to the case. (Section 146 of the Indian Evidence Act).
- Routinely, there is a lot of attention given to the status of hymen. However it is largely irrelevant because the hymen can be torn due to several reasons such as cycling, riding or masturbation among other things. Research shows that an intact hymen does not rule out sexual assault, and a torn hymen does not prove previous sexual intercourse. Hymen should therefore be treated like any other part of the genitals while documenting examination findings in cases of sexual assault. Only those that are relevant to the episode of assault (findings such as fresh tears, bleeding, edema etc.) are to be documented.
- If there is vaginal discharge, comment on the characteristics ie. texture, colour, odour, etc.
- As with general examination, genital findings must also be marked on body charts and numbered accordingly.

## XV. Opinion:

- Opinion has to be given on following issues
  1. Any clinical evidence that the survivor is mentally incapable of giving consent, or under the influence of ethyl alcohol/narcotic drug/ psychotropic substance.
  2. Any means by which the assailants can be identified.
  3. Evidence of penetrative or non-penetrative sexual assault:
    - A. Non-penetrative sexual assault

Non-penetrative sexual assault like fondling, sucking, forced masturbation, etc. Properly eliciting history in this regard is vital. Examination for any injuries caused by these acts must be documented and marked on body charts. Relevant swabs must be collected.
    - B. Penetrative sexual assault
      - ❖ Evidence of vaginal, anal or oral intercourse.
        - Evidence of vaginal intercourse is in the detection of spermatozoa, semen in the vaginal swabs/smears detected by FSL.
        - Evidence of anal intercourse is in the detection of spermatozoa, semen in the anal swabs/smears detected by FSL.
        - Evidence of oral intercourse is in the detection of spermatozoa, semen in the oral swabs/smears detected by FSL.
      - ❖ Whether there is evidence of vaginal, anal penetration by finger or object.
        - Vaginal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
        - Anal penetration: presence of injuries and lubricant - detection of lubricant in the swabs by FSL.
      - ❖ Whether there are signs of use of force.
        - based on both physical and genital injuries;
        - based on physical injuries over body like abrasions, contusions, lacerations, incised injuries, fractures, nail scratches, bite marks, etc;
        - based on genital injuries like tear on fourchette, introitus, in the vagina, fresh hymen tears or lacerations, urethral lacerations, anal lacerations, abrasions.

- ❖ Whether intercourse was a recent act or not.
  - o based on time since injuries.
- 4. Actual age of the survivor in case of minor (< 18 yrs).
  - o medical age is mean of physical age, dental age and radiological age.
- Drafting of provisional opinion should be done immediately after examination of survivor and wet smear examination.(if carried out).
- The opinion must state the number of days after which examination and evidence collection was carried out, after the incident.
- The following section gives the reader some scenarios about ways to draft a provisional and final opinion. However, this list is not exhaustive and readers are advised to form provisional opinions based on the examples given below.
- It should be always kept in mind that normal examination findings neither refute nor confirm forceful sexual intercourse. Hence circumstantial/other evidence may please taken into consideration.
- Absence of injuries or negative laboratory results may be due to:
  - a. Inability of victim to offer resistance to the assailant because of intoxication or threats
  - b. Delay in reporting for examination
  - c. Healing of injuries with passage of time
  - d. Activities such as urinating, washing, bathing, changing clothes or douching which may lead to loss of evidence
  - e. Use of condom/vasectomy or diseases of vas

This reasoning must be mentioned while formulating the final opinion.

## Provisional opinion PENETRATIVE Assault by PENIS

Genital injuries/ diseases	Physical injuries/ diseases	Opinion
present	present	There are signs suggestive of recent use of force/ forceful penetration of vagina/anus. Sexual intercourse cannot be ruled out.
present	absent	There are signs suggestive of recent forceful penetration of vagina/anus. Sexual intercourse cannot be ruled out.
absent	present	"There are signs of use of force, however Sexual intercourse cannot be ruled out.
absent	absent	There are no signs of use of force; however final opinion is reserved pending availability of FSL reports. Sexual intercourse cannot be ruled out.

## Provisional opinion PENETRATIVE Assault by FINGER/OBJECT

only genital injuries present	absent	There are signs of use of force/forceful penetration of vagina/anus by finger / object.
no genital injuries	absent	There are no signs of use of force/forceful penetration of injuries vagina/anus, however sexual assault cannot be ruled out. The opinion regarding lubrication is reserved pending availability of FSL reports

Rationale why forced penetrative sex cannot be ruled out

What can FSL detect

Evidence for semen and spermatozoa are to be yet tested by laboratory examinations

Evidence of semen except when condom was used

Evidence for semen and spermatozoa are to be yet tested. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened.

Evidence of semen except when condom was used

The lack of injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened or use of lubricant.

Evidence of semen or lubricant

The lack of genital injuries could be because of use of lubricant. The lack of physical injuries could be because of the survivor being unconscious, under the effect of alcohol/drugs, overpowered or threatened.

Evidence of semen, lubricant and drug/alcohol

This could be because, there was fingering or penetration by object with or without use of lubricant – which is an offence under Sec 375 IPC

Evidence of lubricant

This could be because, there was fingering or penetration by object with use of lubricant– which is an offence under Sec 375 IPC

Evidence of lubricant

## FINAL OPINION AFTER RECEIPT OF FSL REPORT

Genital injuries/ diseases	Physical injuries/ diseases	FSL report
present	present	positive for presence of semen
present	absent	positive for presence of semen
absent	present	positive for presence of semen
absent	absent	positive for presence of semen
absent	absent	positive for drugs/alcohol and semen
present	present	negative for presence of semen/ alcohol/ drugs/ lubricant
genital injuries present	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
absent	only physical injuries	negative for presence of semen/ alcohol/ drugs/ lubricant
absent	absent	negative for presence of semen/ alcohol/ drugs/ lubricant
Presence or Absence of genital injuries	absent	positive for presence of lubricant only



## FINAL OPINION AFTER RECEIPT OF FSL REPORT

### Final opinion

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There are signs suggestive of forceful vaginal/anal intercourse.

There are signs suggestive of forceful vaginal/anal intercourse.

There are signs suggestive of forceful vagina/anal intercourse.

There are signs suggestive of vagina/anal intercourse.

There are signs suggestive of vagina/anal intercourse under the influence of drugs/alcohol.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of assault.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of genital assault.

There are no signs suggestive of vagina/anal intercourse, but there is evidence of assault.

There are no signs suggestive of vagina/anal intercourse.

There is a possibility of vaginal/anal penetration by lubricated object.

## OPINION FOR NON-PENETRATIVE ASSAULT

- |   |   |   |
|---|---|---|
| 1 | Bite marks present and /or FSL detects salivary stains  | There are signs suggestive of evidence of bite mark/s on _____ site (time the injury)                                   |
| 2 | sucking marks (discoid, subcutaneous extra-vasation of blood, with or without bite marks) present and /or FSL detects salivary stains                         | There are signs suggestive of sucking mark/s on _____ site (time the injury).   |
| 3 | forceful fondling, with presence of bruises or contusions with or without fingernail marks  | There are signs suggestive of forceful physical injuries on _____ site (time the injury) (which may be due to fondling) |
| 4 | only forceful kissing and FSL detects salivary stains   | There are signs suggestive of salivary contact (which may be due to kissing)  |
| 5 | if the history suggests forced masturbation of the assailant by the survivor and if there is evidence of seminal stains detected on the hands of the survivor | There are signs suggestive of seminal fluid contact (which may be due to masturbation)                                  |
| 6 | In case there are no signs of sucking, licking..... detected, but the history suggests some such form of assault  | It is still important to document a good history because the survivor may have had a bath or washed him/herself.        |

## XVI. Signature and seal

- After the examination the medical practitioner should draft the report, formulate the opinion, sign the report and handover report and sealed samples to police under due acknowledgement.
- On the last sheet, please mention how many pages are attached. It is imperative that the doctor signs each page of the report so as to avoid tampering.
- It is important that one copy of all documents be given to the survivor as it is his/her right to have this information. Copies must also be given to the police and FSL and one copy must be kept for hospital records. It is hence preferable that all documentation be filled out in quadruplicate.
- All evidence needs to be dried, packed and sealed in separate envelopes. The responsibility for this lies with the examining doctor.
- Each envelope must be labeled as follows

Packet number .....	
Name of the hospital & Place .....	
Hospital Number & Date .....	
Police station with Crime number & Sections ( if any) .....	
Name of the person with age & Sex .....	
Sample collected .....	
Examination required.....	
Date & Time	Signature of doctor with seal

## XVII. Requisitions for Forensic Science Laboratory/Pathology/ Microbiology

- Once samples are collected, they must be sent to the Forensic Science Laboratory for testing. Pack all samples separately, seal and label them before handing over to the appropriate authority. While handing over, a requisition letter addressed to the FSL, stating what all samples are being sent and what each sample needs to be tested for should be stated. For example, "Vaginal swab to be tested for semen". This form must be signed by the examining doctor as well as the officer to whom the evidence is handed over.

- Please ensure that the numbering of individual packets is in consonance with the numbering on the requisition form.
- Specimens sent to the Forensic Science laboratory will not be received unless they are packed separately, sealed, labeled and handed over.
- Wet smears for spermatozoa evidence and smears for detecting bacteria or parasites causing STI's and histo-pathological evidence of such tissue smears for evidence of STI's - send samples to Pathology / Microbiology departments under due acknowledgements.
- All blood samples must ideally be refrigerated until handed over to next in chain of custody.
- Chain of custody: The hospital must designate certain staff responsible for handling evidence and no one other than these persons must have access to the samples. This is done to prevent mishandling and tampering. If a fool-proof chain of custody is not maintained, the evidence can be rendered inadmissible in the court of law. A log of handing over of evidence from one 'custodian' to the other must be maintained.

## **XVIII. Treatment Guidelines and Psychosocial Support**

- Health care providers, both public and private, are obligated as per section 357C to provide prompt care to survivors of sexual assault. Not doing so is liable to punishment under section 166 B.
  - Urgent medical needs must be prioritized.
  - At the end of the first examination the survivor is assessed and treated, advised or referred for conditions like injury, sexually transmitted diseases and pregnancy that may result from the assault. Counselling and psychosocial support should be offered. In the absence of such expertise kindly refer the survivor to the nearest competent personnel.
- 1. Sexually Transmitted Infections:** If clinical signs are suggestive of STD, collect relevant swabs and start PEP. If there are no clinical signs, wait for lab results.
- For non-pregnant women, the preferred choice is Azithromycin 1gm stat or Doxycycline 100mg bd for 7days, with Metronidazole 200mg (7days) with antacid.
  - For pregnant women, the preferred choice is Amoxicillin/  
Azithromycin with Metronidazole (NO METRONIDAZOLE TO BE GIVEN IN THE 1ST TRIMESTER OF PREGNANCY)

- Hepatitis B. Draw a sample of blood for HBsAg and administer 0.06 ml/kg HB immune globulin immediately (anytime upto 72 hours after sexual act).

## 2. Pregnancy Prophylaxis (Emergency Contraception)

- The preferred choice of treatment is 2 tablets of Levonorgestrel 750 µg (Norlevo), within 72 hours. If vomiting occurs, repeat within 3 hours.  
Or  
2 tablets COCs Mala/ Ovral  
Mala/Ovral G => 2 tablets stat repeated 12 hours within 72 hours  
Novelon/Femilon/Ovral L => 4 tablets stat repeated after 12 hours within 72 hours.
- Although emergency contraception is most efficacious if given within the first 72 hours, it can be given for up to 5 days after the assault.
- Pregnancy assessment must be done on follow up and the survivor must be advised to get tested for pregnancy in case she misses her next period.

**3. Lacerations:** Clean with antiseptic (Savlon/Dettol) or soap and water. If survivor is already immunised with Tetanus Toxoid or if no injuries, TT not required. If there are injuries and survivor is not immunised administer ½ cc TT IV. If lacerations require repair and suturing, which is often the case in minor girls, refer to the nearest centre offering surgical treatment.

**4. Post Exposure Prophylaxis (PEP) for HIV** should be given if a survivor reports within 72 hours of the assault. Before PEP s prescribed, an assessment of HIV risk must be done.\*

**5. Follow-up:** Because sexual assault survivors have multiple needs (medical as well as psychosocial), follow-up is essential at 3 and 6 weeks. Please emphasize the importance of follow up to the survivor. It is ideal to call the survivor for re-examination 2 days after the assault to note the development of bruises and other injuries. All follow ups should be documented.

- Within 72 hours after initial assessment to record developing bruises
- Repeat test for gonorrhoea if possible.
- Test for pregnancy.
- Repeat after six weeks for VDRL.
- Assess for psychological sequelae. Re-iterate need for psychological support.

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\* For further details on HIV risk assessment, please refer to *Post-Exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO guidelines*, WHO 2007.

## 6. Psycho-social Support

- **Establishing rapport** with the survivor is an extremely crucial part of providing services. This is particularly important because s/he has come after a traumatic episode and has crossed several hurdles in order to report the crime. It must be emphasized that coming to the hospital is an act of courage, given the stigma attached to the crime of sexual assault. Appreciating the survivors' strength in this regard can serve to build a bond of trust. Gaining the trust of the survivor will make it easier for them to talk about the episode which is essential to recording a good history.
- **Facilitating and demystifying procedures:** All the procedures, reasons/rationale needs to be explained to the survivor in a language that s/he understands. Ensure confidentiality and explain to the survivor that s/he must reveal the entire history to you without fear and not hide anything. The fact that this process requires internal examination must also be explained. Genital examination may be uncomfortable, but that it is for his/her benefit needs to be stressed. Often survivors are shuttled from one department to the other for carrying out various tests and procedures such as x-rays etc. The need for these also needs to be explained as survivors are often confounded by the number of procedures being performed.
- **Conveying messages of validation and addressing feelings of self-blame:** The most important message that needs to reach the survivor is that rape or sexual assault is an act of violence. This drives home the point that the survivor is not responsible for precipitating the act of rape by any of her actions or inactions. It is a tool used to exert power over women/girls to establish control. It needs to be emphasized that this is a crime/violence and not a sexual act. It is not a loss of honour but a violation of his/her rights and it is the perpetrator who should be ashamed.
- **Addressing suicidal thoughts:** Feelings of shame and guilt often lead to thoughts of wanting to end one's life. It should be conveyed to the survivor that such thoughts are common and that there are ways to overcome them. You must encourage him/her to engage in activities that help to deal with negative feelings. In case s/he has too many intrusive negative feelings, encourage her to seek help.
- **Involving the family/friends:** Friends and families may be equally traumatised with the episode and may feel completely lost so it is important for you to explain the procedures to them as well. At the same time they may have common perceptions/myths about rape that could lead to victim blaming, isolation or even desertion of the survivor. Explain to them that rape is an act of violence and not an act that the survivor has precipitated; that she is not to be

blamed for what has happened. Dealing with the aftermath of sexual assault requires a great deal of support from the family and society. It is important to involve the family so as to create an enabling environment for the survivor once she goes back home.

- **Dealing with Children:** In cases of child sexual abuse, it might be difficult to talk to the survivor about the incident. At such times, it is best to speak to the mother. Often it is the mother who is the immediate carer for a child; but also invariably faces the brunt for not taking adequate care of the child. It is pertinent to talk to the mother and deal with her feelings too. At the same time you must also educate the mother about ways to deal with the child and explain the meaning of good and bad touch. It should also be stressed that the child should be allowed to go about his/her daily activities and should not be subject to restraint (such as preventing him/her from going to school, to play etc) as a result of the assault.
- **Refer** to the hospital social worker if available in the hospital or a counseling centre. While making such a referral convey to the survivor that such incidents cause long term psychological trauma and may re-surface over a period of time. It is hence important to address the psychological impact through counselling.

## **XIX. Age estimation**

- Age estimation is required when examining survivors. in the borderline age group of 10-20 years. Assaults on minors are punishable with more severe sentences and therefore age assessment is critical.
- Please bear in mind that age estimation is not required in every case. If there is enough documentary proof, age determination is not required. If the age is at the borderline, the doctor can make a judgment regarding need for age determination test. (*Ashwani Kumar Saxena v State of MP, 2013(1) OLR(SC)-214*)
- Medical age is the mean of physical age, dental age and radiological age of the person.
- Physical age is estimated based on physical growth like height, weight, chest circumference etc and also based on secondary sexual characteristics.
- Tanner staging of breast and pubic hair should be used to determine stage of growth

Breast Development using Tanner's Index:		
Stage 1	Pre-adolescent: Elevation of papilla only	Less than 9 years
Stage 2	Breast bud stage: Elevation of breast and papilla as a small mound. Enlargement of areola diameter	10-11 years
Stage 3	Further enlargement and elevation of breast and areola with no separation of their contours	12 years
Stage 4	Projection of areola and papilla to form a secondary mound above level of breast	13-14 years
Stage 5	Mature stage: projection of papilla only due to recession of the areola to general contour of breast	15-16 years

Pubic Hair Staging		
Stage 1	Preadolescent: Vellus over pubes is not further developed than that over the abdominal wall (ie. No pubic hair)	Less than 12 years
Stage 2	Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly along the labia	12-13 years
Stage 3	Considerably darker hair, coarser, more curled. Hair spreading sparsely over the junction of the pubes	13-14 years
Stage 4	Hair now adult in type, but area covered is still considerably smaller than in adult. No spread over medial surface of thighs.	14-15 years
Stage 5	Adult in quantity and type with distribution to horizontal pattern. Spread to medial surface of thighs.	More than 15 years

- Dental age is estimated by identifying the total number of teeth, how many and which among them are temporary and which are permanent. It is also essential to identify which is the last tooth erupted and based on charts we can estimate the dental age by noting the age corresponding to the tooth last erupted.
- Count the total number of teeth and also differentiate which of them are temporary or permanent. Accordingly, mark them in the chart provided.
  1. P - for permanent
  2. T - for temporary
  3. ✓ - for erupted
  4. X - not erupted



## Eruption of teeth

- Temporary teeth (Rule of halves)
  - Lower central incisors - 5 to 6 months
  - Upper central incisors - 6 to 7 months
  - Upper lateral incisors - 7 to 8 months
  - Lower lateral incisors - 8 to 9 months
  - First molars - 1 year
  - Canines - 1 ½ years
  - Second molars - 2 to 2 ½ years
- Permanent teeth
  - First molars - 6 to 7 years
  - Central incisors - 7 to 8 years
  - Lateral incisors - 8 to 9 years
  - First premolars - 9 to 10 years
  - Second premolars - 10 to 11 years
  - Canines - 11 to 12 years
  - Second molars - 12 to 14 years
  - Third molars - 17 to 25 years

## Differences between temporary & permanent teeth

Temporary teeth	Permanent teeth
Smaller	Larger
Shiny	Lusterless
Vertical upper incisors	Forward & downward upper incisors
Smooth incisor edge	Serrated incisor edge
Worn out cusps in molars	Prominent cusps in molars
Twenty - 2102 (Incisor, Canine, premolar, molar)	Thirty two - 2123 (Incisor, Canine, premolar, molar)

*Note: This a reference chart only, as many external and internal factors contribute in the eruption of teeth.*

- Radiological Age:

Radiological age is estimated by looking for appearance of ossification centers, fusion of those with the shaft, fusion of sutures etc. for this we have to take radiographs of various joints to look for these findings of ossification centers.

- Important changes at various ages in joints visible radiologically

12 years	Hip joint (center for lesser trochanter appears 10 to 12 yrs) Elbow joint (center for lateral epicondyle appears 11 to 12 yrs) Wrist joint (center for pisiform appears 10 to 12 years)
14 years	Hip joint (center for iliac crest appears 14 yrs) Elbow joint (center for radial tuberosity appears 14yrs)
16 years	Hip joint (center for ischial tuberosity appears 16 yrs)
18 years	Shoulder joint (all centers of upper end of humerus fuse with shaft) Wrist joint (all centers of lower end of radius and ulna fuse with shaft) Hip joint (center for iliac crest fuses with ilium)
21 years	Hip joint (center for ischial tuberosity fuses with the ischial body)

*Note: This is a reference chart only, as many external and internal factors contribute in the fusion of ossification centers.*

## References

- Agnes, F. (2005). To whom do experts testify? Ideological challenges of feminist jurisprudence, *Economic and Political Weekly*, 40(18), 1859-1866.
- Bowyer, L. and Dalton, M. E. (1997). Female victims of rape and their genital injuries. *Br J Obstet Gynaecol*, 104, 617-620.
- Burgess and Holmstrom (1974). Rape trauma syndrome. *Am J Psychiatry*, 131, 981-986.
- Dobbin S. A. and Gatowski, S. I. (1998). The social production of rape trauma syndrome as science and as evidence. In Michael Freeman and Helen Reece (Eds.). '*Science in court*' (pp. 125 - 145). New Delhi: Sage Publications.
- Jagadeesh, N; Deosthali, P; Contractor, S; Rege, S and Malik, S. (2010). A Comprehensive health sector response to sexual assault: Does the Delhi high court judgment pave the way?, Working Paper No. 1. Mumbai: CEHAT.
- Kacker, L; Varadan, S and Kumar, P (2007). *Study on child sexual abuse in India*. New Delhi: Ministry of Women and Child Development, Government of India 192 p.
- Mc.Cann J.; Miyamoto, S; Boyle, C. and Rogers, K. (2007). Healing of hymenal injuries in prepubertal and adolescent girls: A descriptive study. *Pediatrics*, 119(5), 1094 - 1106.
- World Health Organization (2003). *Guidelines for medico-legal care for victims of sexual assault*, 6 p.



## ANNEXURE 1: RELEVANT LAWS & RESEARCH

<b>IPC</b>	
Section 375	<ul style="list-style-type: none"><li>● A man is said to commit "rape" if he (a) penetrates his penis, to any extent, into the vagina, mouth, urethra or anus of a woman or makes her to do so with him or any other person; or (b) inserts, to any extent, any object or a part of the body, not being the penis, into the vagina, the urethra or anus of a woman or makes her to do so with him or any other person; or (c) manipulates any part of the body of a woman so as to cause penetration into the vagina, urethra, anus or any part of body of such woman or makes her to do so with him or any other person; or (d) applies his mouth to the vagina, anus, urethra of a woman or makes her to do so with him or any other person, under the circumstances falling under any of the following seven descriptions:—<ol style="list-style-type: none"><li>1. Against her will.</li><li>2. Without her consent.</li><li>3. With her consent, when her consent has been obtained by putting her or any person in whom she is interested, in fear of death or of hurt.</li><li>4. With her consent, when the man knows that he is not her husband and that her consent is given because she believes that he is another man to whom she is or believes herself to be lawfully married.</li><li>5. With her consent when, at the time of giving such consent, by reason of unsoundness of mind or intoxication or the administration by him personally or through another of any stupefying or unwholesome substance, she is unable to understand the nature and consequences of that to which she gives consent.</li></ol></li></ul>

	<p>6. With or without her consent, when she is under eighteen years of age.</p> <p>7. When she is unable to communicate consent.</p> <p>Explanation 1.—For the purposes of this section, “vagina” shall also include labia majora.</p> <p>Explanation 2.—Consent means an unequivocal voluntary agreement when the woman by words, gestures or any form of verbal or non-verbal communication, communicates willingness to participate in the specific sexual act:</p> <p>Provided that a woman who does not physically resist to the act of penetration shall not by the reason only of that fact, be regarded as consenting to the sexual activity.</p> <p>Exception 1.—A medical procedure or intervention shall not constitute rape.</p> <p>Exception 2.—Sexual intercourse or sexual acts by a man with his own wife, the wife not being under fifteen years of age, is not rape.</p>
<p>Protection of Children from Sexual Offences Act 2012</p>	<p>Child is considered to be anyone under the age of 18 years</p> <p><b>Penetrative sexual assault.-</b></p> <p>(i) Penetration of penis/object/other body part to any extent, into the vagina, mouth, urethra or anus of a child or makes the child to do so with him or any other person; or</p> <p>(ii) Manipulation of any part of the body of the child so as to cause penetration into the vagina, urethra, anus or any part of body of the child</p> <p>(iii) Applying his mouth to the penis, vagina, anus, urethra of the child</p> <p><b>Sexual assault -</b></p> <p>(i) Touching the vagina, penis, anus or breast of the child with sexual intent or makes the child</p>

	<p>touch the vagina, penis, anus or breast of such person or any other person,</p> <p>(ii) Any other act with sexual intent which involves physical contact without penetration is said to commit sexual assault.</p> <p><b>Sexual harassment.-</b></p> <p>(i) utters any word or makes any sound, or makes any gesture or exhibits any object or part of body with the intention that such word or sound shall be heard, or such gesture or object or part of body shall be seen by the child; or</p> <p>(ii) makes a child exhibit his body or any part of his body so as it is seen by such person or any other person; or</p> <p>(iii) shows any object to a child in any form or media for pornographic purposes; or</p> <p>(iv) repeatedly or constantly follows or watches or contacts a child either directly or through electronic, digital or any other means; or</p> <p>(v) threatens to use, in any form of media, a real or fabricated depiction through electronic, film or digital or any other mode, of any part of the body of the child or the involvement of the child in a sexual act; or</p> <p>(vi) entices a child for pornographic purposes or gives gratification therefor.</p> <p><b>Aggravated Offences:</b> Each offence is regarded as 'aggravated' in circumstances when</p> <ul style="list-style-type: none"> <li>• The child is under 12 years, pregnant, mentally or physically disabled.</li> <li>• by a police officer, member of the armed forces or security forces, public servant, management or the staff of a jail, remand home, protection home, observation home, or of any institution providing services to the child, management or staff of a hospital, management or staff of an educational institution or religious Institution.</li> <li>• physical or mental disability is caused due to the assault or if HIV is transmitted</li> </ul>
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	<ul style="list-style-type: none"> <li>• if corrosive substances and deadly weapons are used, the offence is considered aggravated.</li> <li>• there is an attempt to murder the child; or</li> <li>• sexual assault occurs in the course of communal or sectarian violence</li> <li>• Assault is committed by more than one person</li> <li>• Assault is committed more than once or repeatedly</li> <li>• Assailant is relative or person in authority</li> <li>• Assailant is a repeat offender</li> <li>• The child is made to strip or parade naked in public, is said to commit aggravated penetrative sexual assault.</li> </ul>
Section 354	<p>A. A man committing any of the following acts:</p> <ol style="list-style-type: none"> <li>1. Physical contact or advances which include unwanted sexual overtures</li> <li>2. Request for sexual favours</li> <li>3. Showing pornography against will</li> <li>4. Making sexually coloured remarks</li> </ol> <p>B. Assaults or uses criminal force to the woman with intent to disrobe</p> <p>C. Voyeurism</p> <p>D. Stalking (including online )</p>
Section 377	<ul style="list-style-type: none"> <li>• 'Unnatural sexual intercourse against the order of nature' which includes anal/oral penetration.</li> </ul>
Section 166B	<p>Whoever, being in charge of a hospital, public or private, whether run by the Central Government, the State Government, local bodies or any other person, contravenes the provisions of section 357C of the Code of Criminal Procedure, 1973, shall be punished with imprisonment for a term which may extend to one year or with fine or with both.”.</p>



Section 89	<ul style="list-style-type: none"> <li>● Consent of parent/guardian is necessary for anyone under the age of 12 years</li> </ul>
<b>CrPC</b>	
Section 164 A	<ul style="list-style-type: none"> <li>● Examination of a case of rape shall be conducted by a registered medical practitioner (RMP) employed in a hospital run by the government or a local authority and in the absence of such a practitioner, by any other RMP</li> <li>● Examination to be conducted without delay and a reasoned report to be prepared by the RMP.</li> <li>● Record specifically consent obtained for examination. Record General Mental Condition Record Injuries</li> <li>● Exact time of start and close of examination to be recorded.</li> <li>● RMP to forward report without delay to IO, and in turn IO to Magistrate</li> </ul>
Section 53 A	<ul style="list-style-type: none"> <li>● Elaborates on medical examination of a person accused of rape. It clearly states what includes medical examination. It also states that medical examination of accused must be carried out without any delay and can be conducted by any RMP.</li> </ul>
Section 157	<ul style="list-style-type: none"> <li>● Deals with procedure of investigation in relation to the offence of rape. The 2008 amendment of the Act says that the recording of the statement of the survivor shall be conducted at her residence or a place of her choice as far as possible by a woman police officer.</li> </ul>
Section 327	<ul style="list-style-type: none"> <li>● Mandates an in-camera inquiry and trial of rape and that as far as practicable, the trial would be conducted by a woman judge or magistrate.</li> </ul>

Section 173	<ul style="list-style-type: none"> <li>• Mandates that investigation in relation to rape of a child may be completed within three months from the date on which the information was recorded by the officer in charge of the police station. When the report is forwarded to the magistrate, it must also contain the report of medical examination.</li> </ul>
Section 176 (1 A)	<ul style="list-style-type: none"> <li>• Mandates Judicial Magistrate to investigate all custodial rape and deaths.</li> </ul>
Section 357 (A)	<ul style="list-style-type: none"> <li>• Victim Compensation Scheme - all state governments in consultation with the central government are required to prepare a scheme for victim compensation.</li> </ul>
Section 357 (C)	All hospitals, private or public, run by central or state government need to provide first aid or medical treatment, free cost to the victims and immediately inform the police
<b>Indian Evidence Act</b>	
Section 114 (A)  Ashwani Kumar Saxena v State of MP, 2013(I) OLR(SC)-214	<ul style="list-style-type: none"> <li>• If sexual intercourse by the accused is proved and the question is whether it was with or without out the consent of the woman and if she testifies before the court that she did not consent, the court shall presume that she did not consent.</li> </ul>
Section 146	<ul style="list-style-type: none"> <li>• Not permissible to put questions in cross examination of the prosecutrix as to her general immoral character.</li> </ul>
<b>Case Laws</b>	
State of Karnataka v Manjamna (2000 SC (CrI) 1031/CriLJ 3471/2006(6) SCC 188	<ul style="list-style-type: none"> <li>• Police requisition not necessary for forensic examination by hospital or doctor.</li> </ul>
BharwadaBogibhaiHirjibhai vs State of Gujarat (1983)	<ul style="list-style-type: none"> <li>• Corroboration with medical evidence not required to prove a charge of rape. Circumstantial evidence and the survivor's own statement are crucial pieces of evidence notwithstanding the results of medical evidence.</li> </ul>

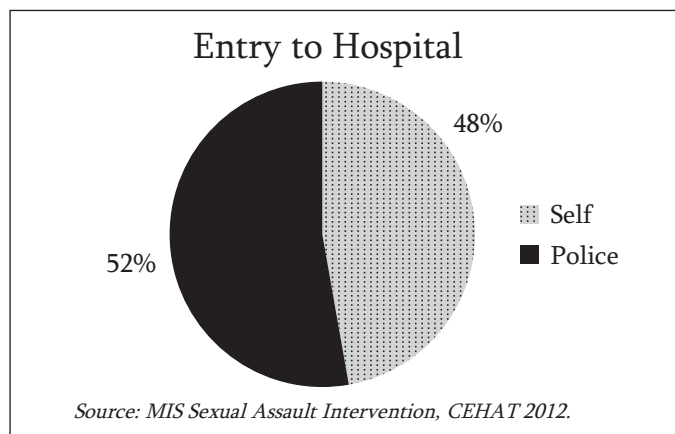
<p>State of H.P. v. Tara Chand And Anr 2008 (3) Shim LC1</p>	<ul style="list-style-type: none"> <li>• Past sexual conduct is irrelevant to a case of sexual assault. The Himachal Pradesh High Court while overruling the decision of the trial court stated: <i>"Thus in our considered opinion the learned trial Court unnecessarily attached too much importance to the subsequent statement of KantiKumari and wrongly gave the benefit to the respondents on the observation of the doctor that the prosecutrix was habituated to the sexual intercourse, the absence of spermatozoa on the vaginal swab and the absence of injuries on genital organs of the prosecutrix and the respondents. Whereas, we have found the testimony of the prosecutrix worth inspiring confidence and it also finds corroboration in its material particulars as a stated above. There is no material defect in the investigation of the case, which makes the testimony of the prosecutrix unbelievable."</i></li> </ul>
<p>Delhi Commission for Women V Delhi Police, Delhi HD W.P. (CRL) 696/2008, Order 23rd April, 2009.</p>	<ul style="list-style-type: none"> <li>• Hospitals must have special rooms for examination of survivors of sexual assault</li> <li>• A uniform method of documentation and evidence collection to be adopted in all Delhi Hospitals - SAFE kit to be used</li> <li>• Requisite infrastructure for such an examination has been described that must be available at all facilities</li> <li>• Proper &amp; safe storage of evidence is the responsibility of the hospital</li> </ul>
<p>St. Vs. Munna, FIR No. 513/07, PSShalimarBagh</p>	<p>The 'two-finger test' is often routinely performed by doctors, to make a comment on 'habituation to sexual intercourse' based on the size of the vaginal introitus. However, this information is irrelevant in a case of sexual assault and can be misleading. Therefore the courts have ruled that this 'test' should not be carried out. A sessions court in Delhi, for instance, ruled that <i>"This court has come across a number of MLCs of victims of rape where [...] the information "PV: two fingers admissible or</i></p>

	<p><i>inadmissible" as the case may be is also mentioned. In this information it is also transcribed as "habituated to sex" or "used to sex". The category of habituated is used against raped women to suggest they lie about rape and this extends to child sexual abuse cases too. It is this test which is the cause of concern. It is being routinely conducted by the doctors on the victims of sexual abuse and rape be it a minor (as in the present case), unmarried girl or married woman, without having any regards to the fact that the opinion of the doctors rendered after conducting such a test has no bearing with regard to the guilt or otherwise of the accused."</i></p>
<p>Ashwani Kumar Saxena v State of MP, 2013(I) OLR(SC)-214</p>	<p>Age estimation not required in every case:  <i>"Age determination inquiry" contemplated under section 7A of the Juvenile Justice Act, read with Rule 12 of the 2007 JJ Rules enables the court to seek evidence and in that process, the court can obtain the matriculation or equivalent certificates, if available. Only in the absence of any matriculation or equivalent certificates, the court need obtain the date of birth certificate from the school first attended other than a play school. Only in the absence of matriculation or equivalent certificate or the date of birth certificate from the school first attended, the court need obtain the birth certificate given by a corporation or a municipal authority or a Panchayat (not an affidavit but certificates or documents). The question of obtaining medical opinion from a duly constituted Medical Board arises only if the above mentioned documents are unavailable."</i></p>
<p><b>Research Evidence</b></p>	
<p>Rape may not leave obvious signs of injury</p>	<ul style="list-style-type: none"> <li>• A retrospective study of case records of women who reported rape showed that less than 30% of them had genital injuries (Bowyer L, Dalton ME. Female victims of rape and their genital injuries. Br J Obstet Gynaecol. 1997;104:617-620)</li> </ul>

	<ul style="list-style-type: none"> <li>• Genital injury is absent in more than 50% of cases of sexual assault, even among victims presenting to a hospital based service. (McGregor MJ, Du Mont J, Myhr TL. Sexual assault forensic medical examination: is evidence related to successful prosecution? Ann Emerg Med. June 2002; 39:639-647)</li> </ul>
<p>The survivor need not show extreme emotional reactions to the incident when s/he presents at the hospital</p>	<ul style="list-style-type: none"> <li>• Emotional responses to sexual assault are varied ranging from emotive to controlled. McGregor in her study found even distribution of victims who presented as emotive (44.4%) versus controlled (47.6%).</li> </ul>
<p>Hymen need not always provide evidence of sexual assault</p>	<ul style="list-style-type: none"> <li>• In a 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 mis-diagnosed 'virgins' in 50% of the cases, suggesting that integrity of the hymen does not necessarily provide information about sexual history. (Underhill RA, Dewhurst J. "The doctor cannot always tell. Medical examination of the "intact" hymen."Lancet. 1978 Feb 18;1(8060):375-376.)</li> </ul>

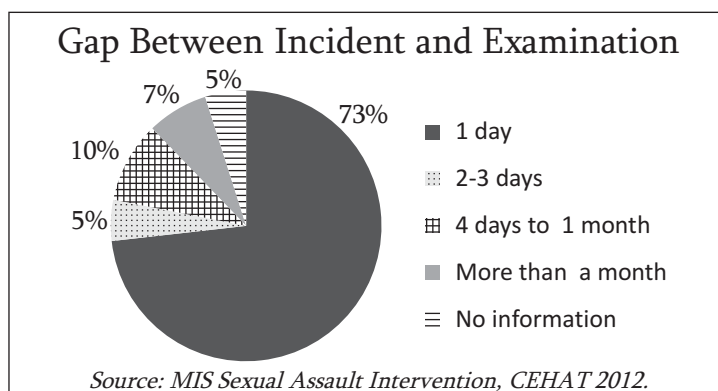
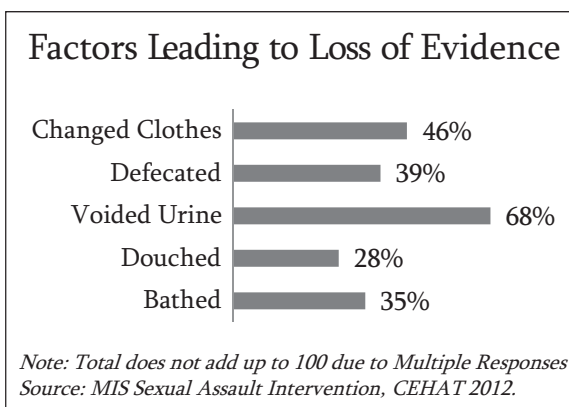
## ANNEXURE 2: EVIDENCE FROM HOSPITAL-BASED RESEARCH IN INDIA

Data from 82 cases of sexual assault that CEHAT has responded to in three public hospitals in Mumbai between August 2008 and January 2012, shows that:

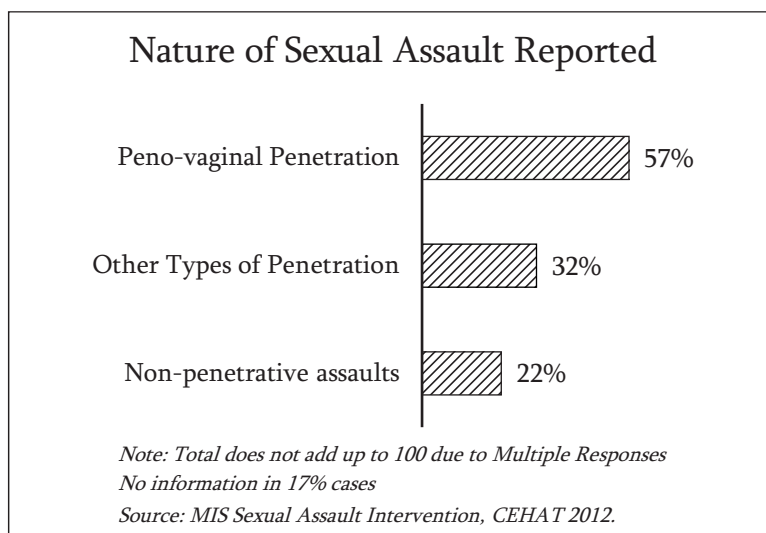


About half of the survivors of sexual assault reported to the hospital on their own - ie, without a police requisition. This underscores the need for voluntary reporting to the hospital to be recognized by both the health system as well as the law enforcement system.

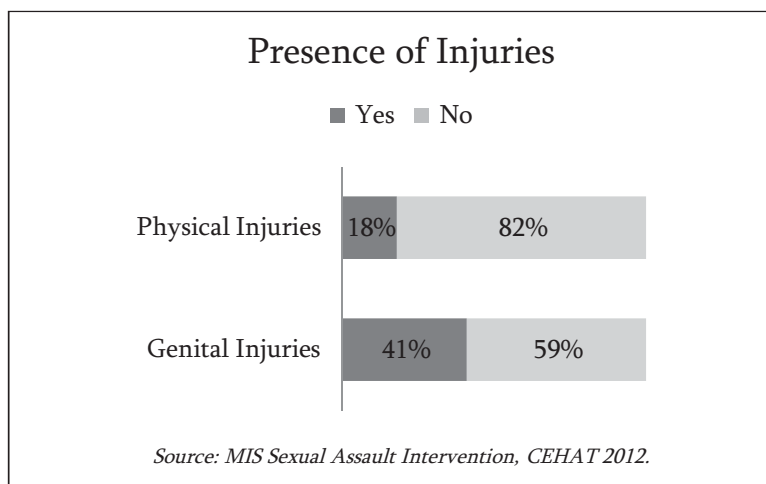
Of the 82 cases, 73% reported within one day of the assault, 5% in 2-3 days, 10% in 4 days to a month and the rest reported after a month. 35% had had a bath, 28% had douched, 68% had voided urine, 39% had defecated and 46% had changed their clothes. All of these activities result in loss of evidence. These factors therefore need to be recorded in the history and taken into account while providing an opinion in sexual assault cases.

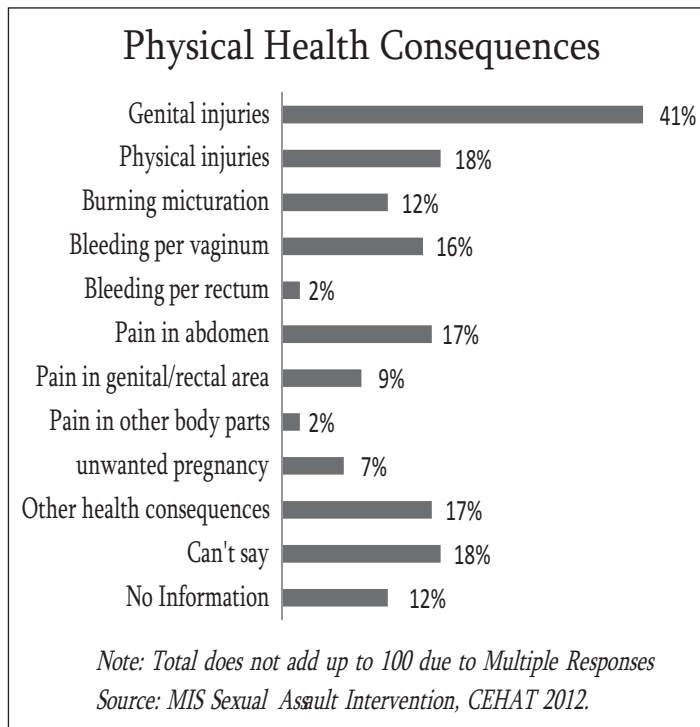


While the largest proportion of women reported completed or attempted penovaginal penetration, it is pertinent to note that in a large number of cases other forms of sexual assault such as peno-anal/ oral penetration or fingering (32%) and non-penetrative assaults such as fondling, touching of genitals, masturbation (22%) were reported. In 27% of the cases, more than one type of assault was reported.



More than half of the survivors showed no genital injuries and over 80 % showed no physical injuries. In 9 % of the cases the victim was intoxicated or rendered unconscious. In 26% the survivor had been threatened that she or her loved ones would be harmed if she resisted or informed anyone about the assault. In 24% cases, physical force had been used against the survivor. These point to the circumstances in which an assault occurs, which prevents women from resisting it.





72% of the survivors reported some sort of health consequences when they came to the hospital. Out of them at least 4 reported to the hospital only for treatment of health complaints. These 4 survivors were denied treatment in other hospitals, though they had been examined and forensic evidence was collected. This points to the inadequacy of the prevailing response of health systems to survivors of sexual assault; while medico-legal examination and evidence collection receives attention, provision of treatment is absent.

Survivors reporting sexual assault demonstrated feelings of anxiety, fear, sadness and self blame in the process of providing emotional support. Though these feelings were verbalized in the process of counselling, almost all survivors were composed throughout the examination, evidence collection and treatment process. None of the survivors presented as disoriented or disheveled or crying uncontrollably. In case of child survivors, it was observed that most of the children demonstrated signs of irritability and anxiety, which were related to being in the hospital. Carers of child survivors, especially mothers expressed feelings of self blame and also feared that they would be labeled as 'irresponsible parents'.

Coping with sexual assault is a difficult process. Survivors reported being anxious about their future. This anxiety was related to community perceptions about them as rape survivors, prospects of getting married, prospects of siblings getting married and potential pressure from the accused. Survivors were also threatened with another assault and faced pressures to withdraw the legal case. In order to deal with these issues, families have relocated to a new place and some have gone back to the native. In some instances, child survivors were also removed from schools for ensuring their protection.

*Source: MIS Sexual Assault Intervention, CEHAT 2012.*

**Acknowledgement :** Thank you to Prachi Avalaskar for research assistance.





Location of assault ..... Date and time of assault .....

Number of assailants and name/s .....

Whether known to survivor Yes/ No ..... if yes- Relationship to survivor .....

Is there any history of drug or alcohol being given to the survivor before or during the assault? .....

Since assault has the survivor changed clothes?- Yes/ No .....

If yes, are they available?..... Were they washed / repaired? .....

Since assault has the survivor, (*tick*) 1. Eaten food 2. Ingested fluids 3. Smoked 4. Brushed 5. Gargled

Has the survivor left any marks of injury on the body of the assailant during the assault? If yes, enter details .....

Describe pertinent data of the assault with regard to :

Verbal threats .....

Body areas touched .....

Physical violence .....

Weapons or objects used (or threatened with) .....

Details regarding penetration: Was penetration attempted by penis, fingers or other object? ( Write (Y), No (N), or Don't know (DK) )									
	Attempted Penetration			Completed Penetration			Emission of Semen		
	By Penis	By Finger	By Object	By Penis	By Finger	By Object	Yes	No	Don't know
Orifice									
Vagina									
Anus									
Mouth									

Was oral sex performed by assailant on survivor?	Y	N	DK
Masturbation of survivor by assailant	Y	N	DK
Masturbation of assailant by survivor	Y	N	DK
Did ejaculation occur outside body orifice?	Y	N	DK
Describe Location			
Kissing, licking or sucking of breasts or parts of survivor's body?	Y	N	If Yes, describe-

Was condom used? ..... Y / N / DK .....

If yes - Status of the condom ..... Untorn / Torn / DK .....

Was lubricant used? ..... Yes / No / DK .....

If penetration was attempted by object, describe object: .....

Was last previous intercourse within one week prior to the assault? ..... Yes / No / Do not remember .....

Was survivor menstruating at the time of the assault? .....

Was survivor menstruating at the time of the examination? .....

Between the assault and the time of the examination did the survivor:			
	Yes	No	Don't know
Bathe			
Douche			
Void Urine			
Defecate			
Use Spermicide			
Since the assault has there been any vaginal/anal/oral bleeding/discharge?			
Prior to the assault has there been any vaginal/anal/oral bleeding/discharge?			

**IV) FORENSIC EVIDENCE**

- Debris Collection Paper (on which survivor is undressed) to be placed in envelope .....
- Is the clothing worn now the same as worn during the assault? ..... Yes / No .....  
(If not, request clothes worn during the assault to be submitted)
- Clothing evidence to be air dried and placed in the bag provided.....

Clothing Evidence	Description

Body evidence samples duly labeled to be placed in the bag provided. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination. (Use Distilled water provided for moistening swab sticks)

BODY EVIDENCE	List sites where applicable. If not collected, give reason.
Oral Swab	
Blood Stains on body	
Foreign material on body	
Seminal Stains on body	
Other stains (specify site and suspected nature of material)	
Head Hair Combing	
Scalp Hairs (5-10 strands)	
Take nail scrapings of both hands separately	
Nail clippings of both hands separately (Write if deeply cut already)	
Blood for grouping (Plain Vacutainer)	
Blood for drug estimation (Plain Vacutainer)	
Blood for alcohol levels (Sodium Fluoride Vacutainer)	
Blood for DNA analysis (EDTA Vacutainer)	
Any other sample (collect in sterile container)	

Genital and Anal evidence samples to be placed in the bag provided. Each sample to be packed, sealed, labeled separately & sent to FSL for further examination (Use Distilled water provided for moistening swab sticks)

GENITAL AND ANAL EVIDENCE	List sites where applicable. If not collected, give reason.
Matted Pubic Hair	
Combing of Pubic Hair (mention if shaved)	
Cutting of Pubic Hair of survivor (5-10, mention if shaved)	
Vulval Swabs (2)	
Vaginal Swabs (2)	
Anal Swab (2)	
Vaginal Smear (1 for detecting spermatozoa)	
Vaginal Smear(for evidence of STD - to be sent to hospital laboratory)	

**V) GENERAL EXAMINATION**

General mental condition .....

Physical Examination: Examine the following areas for assault related findings:

- Scalp examination for areas of tenderness (if hair pulled out/dragged by hair) .....
- Facial bone injury: orbital blackening, tenderness .....

- Petechial haemorrhage in eyes and other places .....
- Lips and Buccal Mucosa / Gums .....
- Behind the ears .....
- Ear drum .....
- Neck, Shoulders and Breast .....
- Wrists and forearms .....
- Medial aspect of upper arms .....
- Inner aspect of thighs .....
- Buttocks .....
- Other, please specify .....

**VI) Genital examination** - Examine the following areas for assault related findings

(Note- PV & PS examination not to be performed in children unless required to detect injuries)

State of the sphincters : .....

Labia Majora : .....

Labia Minora : .....

Fourchette and introitus : .....

External urethral meatus: .....

Hymen (only if relevant): .....

Anus and Rectum: .....

Per Speculum examination: YES / NO .....

If yes, findings: .....

Per Vaginum Examination : YES / NO .....

If yes, findings: .....

Any other findings to be noted: .....

**VII) Opinion**

After examining ..... bearing identification marks as described above, ..... day/s after the incident.

I am of the opinion that .....

.....  
 .....  
 .....

Date

Time

Place

Signature of Examining Doctor

Name of Examining Doctor with Seal

This report contains \_\_\_\_\_ (number of) Sheets.

## SURVIVOR CONSENT FORM

I, ..... (*Name of the person giving consent*) hereby give voluntary consent to:

1. Examine and treat ..... (*Survivor's name*)  
(myself / my ..... / specify other relationship .....) for the effects of sexual assault.
2. Conduct a medico-legal examination for the purpose of assisting the police in apprehending and/or prosecuting the persons who committed the assault. This investigation will include a physical examination which may involve an examination of the mouth, breasts, vagina, anus and rectum; in addition it may include the removal and isolation of articles of clothing, scalp hair, foreign substances from the body surface, saliva, pubic hair, samples taken from the vagina, anus, rectum, and the collection of a blood specimen.

I give my consent to the above fully and freely. I also understand that I have the right to refuse either a medico-legal examination or collection of evidence or both, but that my refusal will in no way result in denial of treatment for the effects of the assault. I have also been informed that as per law the hospital/ examining doctor is duty bound to inform the police about the offence. In such instances, I have the final decision related to seeking/ not seeking legal recourse on my case.

I also understand that I am free to revoke all or any part of this consent at any time during the examination.

The content of above is explained to me in ..... language which I understand and hence I sign.

.....  
.....

(Name & Signature of Witness)

.....

(Date, Place and Time)

.....  
.....

(Name & Signature of Doctor)

.....

(Date, Place and Time)

.....  
.....

(Name & Signature of Survivor)

.....

(Name & Signature of Guardian or Relative of the Survivor when s/he is unable give her consent due to mental disability, or if s/he is under the age of 12 years.)

## ESTIMATION OF AGE IN CASE OF MINORS

Kindly fill in a request for X-rays and attach a copy to this form.

Height

Weight

Breast Staging (Please refer manual)

Axillary Hair

Pubic hair (Please refer manual)

Dentition:

8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8
8 7 6 5 4 3 2 1	1 2 3 4 5 6 7 8

Teeth: Permanent / Deciduous / Mixed

Whether space formed behind second molar

Yes

No

Ossification test -

1. X-rays advised .....

2. Observations .....

Opinion on Age .....

Date

Signature of Examining Doctor

Time

Place

Name of Examining Doctor with Seal

**REQUISITION FOR LABORATORY EXAMINATION BY  
FORENSIC SCIENCE LABORATORY**

From :  
Name and Address of Hospital

\_\_\_\_\_  
\_\_\_\_\_

To,  
The Director Forensic Science Laboratory

\_\_\_\_\_

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from.....

age..... sex.....

Concerning OPD/IPD No..... MLC No .....

Cr. No. .... U/S ..... of Police Station .....

Please examine the following sealed packets and opine on

- |         |                       |
|---------|-----------------------|
| 1. .... | For Evidence of ..... |
| 2. .... | For Evidence of ..... |
| 3. .... | For Evidence of ..... |
| 4. .... | For Evidence of ..... |
| 5. .... | For Evidence of ..... |
| 6. .... | For Evidence of ..... |
| 7. .... | For Evidence of ..... |
| 8. .... | For Evidence of ..... |

Yours sincerely

Dr..... Hospital name .....

Signature

Seal

Received intact, sealed, labelled samples by

..... (Signature)

PC No: ..... Police Station: .....

Date:

**REQUISITION FOR LABORATORY EXAMINATION BY  
PATHOLOGY/ MICROBIOLOGY DEPT**

(To be used if a pathology/microbiology laboratory is not available in the hospital)

From

To,

The HOD

Dept of \_\_\_\_\_

Sir/ Madam,

Sub: Requisition for laboratory examination of material evidence collected

Submitting herewith material evidence collected from.....  
age....., sex.....

Concerning OPD/IPD No..... MLC No .....

Cr. No. .... U/S ..... of Police Station .....

Please examine the following sealed packets and opine on

1. .... For Evidence of .....
2. .... For Evidence of .....
3. .... For Evidence of .....
4. .... For Evidence of .....
5. .... For Evidence of .....

Yours sincerely

Dr..... Hospital name .....

Signature

Seal

Received intact, sealed, labelled samples by

.....(Signature)

PC No: ..... Police Station: .....

Date:



### DISCHARGE / SUMMARY SLIP

Survivor's name : .....

Date of examination : .....

Doctor's name : .....

Sexually transmitted diseases	Test done	Treatment given /	Follow up on .....
Gonorrhoea			
Chlamydia			
Syphilis			
HIV testing (after counselling and if consent given)			At 3 mths & 6 mths
Routine prophylaxis for HIV			
Hepatitis B			At 1 mth & 6 mths

	Tests done	Post-coital contraception given	Follow up on .....
Pregnancy			

Injuries	Surgery	Follow up on .....
1.		
2.		
3.		
4.		
5.		

Injection Tetanus Toxoid (T.T.)      Yes       No

Psychological assessment and counselling .....

Immediate referral to .....

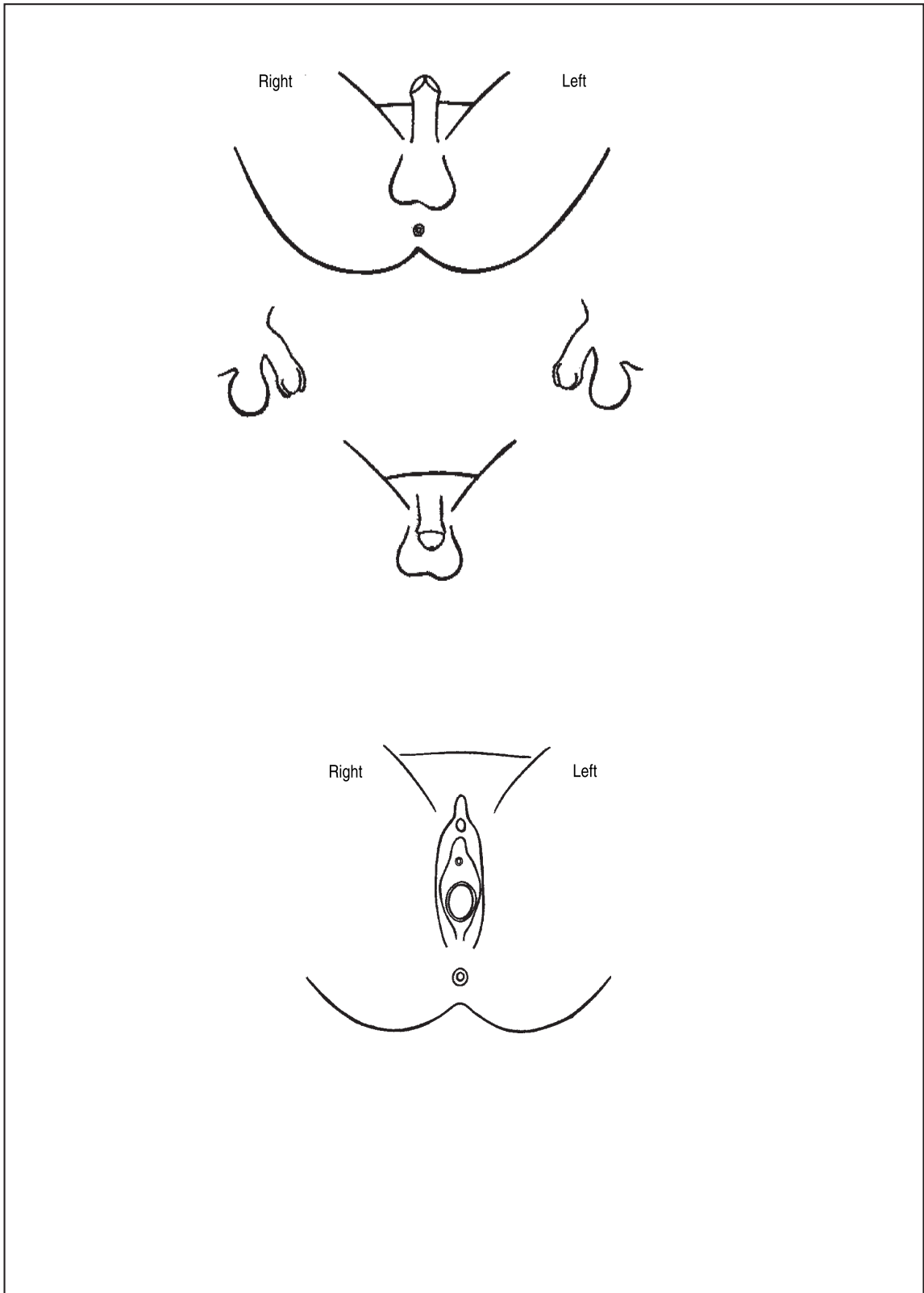
Advise on discharge (including follow up dates) .....

Date :

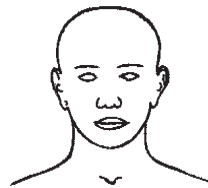
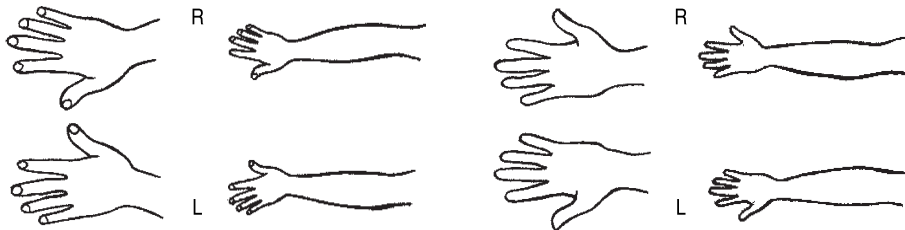
Signature of Examining Doctor

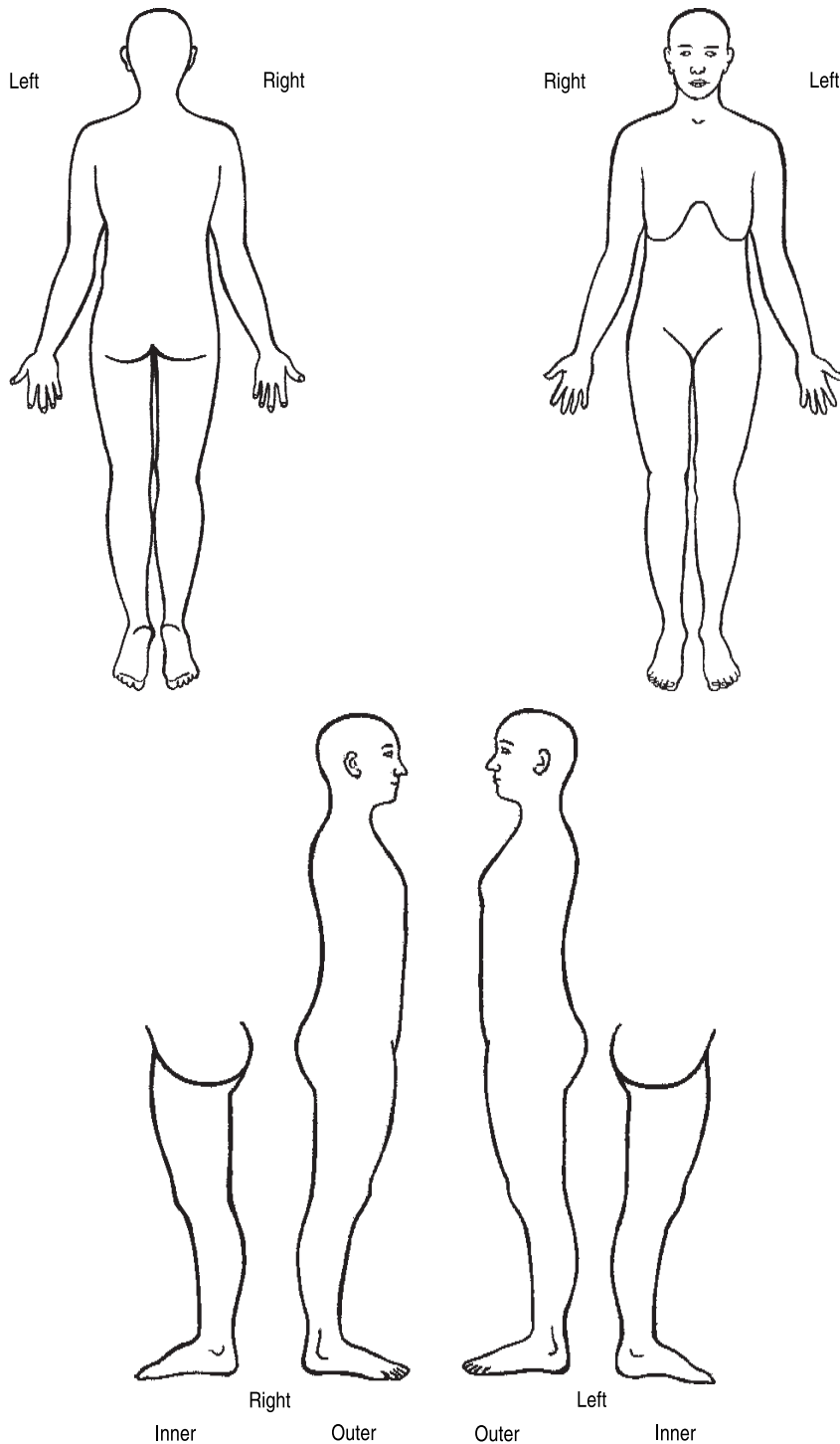
Time :

Name of Examining Doctor with Seal



Mark all injuries on the diagram provided on next page, indicating type of injury, size (length, breadth and depth as relevant), shape, colour, borders, age and content. Opinion regarding cause of injury for each injury - - - e.g; sharp object, cloth, rope, cigarette butt, metal/wood, nails/ fingers to be recorded. Nature of force used - - - very aggressive, violent, restraint, etc. to be recorded.





Figures courtesy WHO document 'Guidelines for Medico-Legal Care for Victims of Sexual Assault'

## ANNEXURE 4: SAMPLE STANDARD OPERATING PROCEDURES

*This is a proposed SOP developed at mid-sized public hospitals in Mumbai.*

1. Any survivor 12 years of age or above may give consent for sexual assault examination (as per Section 89 of the IPC). If the survivor is younger than 12 years, the parent/guardian's consent must be taken.
2. It is not mandatory to admit the survivor in case of sexual assault, if her medical condition does not warrant admission. Every effort should be made to ensure that all evidence collection and examination is completed within a few hours and the survivor is allowed to leave immediately, without admission. In case some investigations (such as radiographs) are pending, the survivor must be informed of their importance, and explained that it would be preferable if she stayed admitted in the hospital so that these investigations may be completed. If she still refuses admission after being informed, then she must be asked to come the next day for the relevant investigations and this must be taken in writing from the woman. The responsibility thereafter, rests on the woman herself. In case the woman doesn't come the next day, the examining doctor must make a note of the investigations that were not completed and then dispatch the sealed SAFE kit to the MRO.
3. The responsibility of preserving and sealing the collected evidence lies with the examining doctor. Assistance can be sought from the nurse who is the witness in the course of examination / or any other nurse on duty for air drying evidence and sealing the evidence. Each piece of evidence must be sealed and signed individually by the examining doctor.
4. Each sealed evidence requires the hospital stamp which should be taken from the MR department.
5. Once evidence is sealed, it should be handed over to the MRO.
6. In case the evidence needs to be preserved in a refrigerator, it must be kept in the labor ward.
7. The evidence will be handed over to the police by the MRO.
8. Once the evidence is handed over by the examining doctor to the MRO, it is the responsibility of the MRO to ensure that it is collected by the police. This might require following up with the police station. In case follow up is required, the CMO may be called upon to contact the relevant police station through the police constable on duty.
9. It is the responsibility of the MRO to make sure that the evidence is preserved until collected by the police.
10. In case the evidence remains uncollected by the police, the MR department has to preserve the evidence for 15 years or till the time that it is collected by the police.

## ANNEXURE 5: PAMPHLET FOR PROVISION OF PSYCHO - SOCIAL SUPPORT TO SURVIVORS

As a health care provider, you play a crucial role in the recovery of the survivor. Section XVIII of this manual provides you with components of psycho-social support. This pamphlet details out the various ways in which sexual assault may affect the survivor's well being and what you can do to address these effects. Survivors require immediate and long term psychosocial support. She may feel overwhelmed with all that is happening at the hospital/health centre, the police station, within her family and the community at large. Explain to her that some friends and family members may be more supportive, while others may blame her or may distance themselves from her. She may also receive threats from the abuser or may be pressurised to withdraw the case.

It is important to explain to her that such an assault can have both physical and psychological health consequences. The following are some examples of possible psychological responses to the sexual assault:

1. Fear that she is not safe and that sexual assault could happen again.
2. Disorientation, lack of concentration
3. Feeling guilty or responsible for what has happened (e.g. "I should not have gone there, or "I should have never trusted him")
4. Feelings of shame and embarrassment
5. Fear of social contact with people due to shame
6. Not feeling like eating
7. Not able to sleep
8. Nightmares and flashbacks
9. Fear of any physical contact even with those known to her
10. Fear of sexual contact with her partner
11. Desire to get away from the location where the incident occurred to erase the memory of the incident.
12. Feelings of ending her life or that life is not worth living

These feelings may be experienced immediately after the episode or a few weeks later. Encourage her to speak to a close and trusted person about these feelings or seek support from a health provider or counsellor. Emphasize that disclosing these feelings would enable her to deal with the trauma and take steps towards the healing process. Convey to her that sexual assault is not an act of passion but an abuse of power. She has not done anything wrong so there is no need to feel ashamed or embarrassed. Sexual assault in

fact must be understood as a severe form of physical assault causing physical and emotional trauma.

Emphasize the need to seek counseling and support from friends and family. Provide her with information about women's organizations and women's rights lawyers who she could contact for legal and other support. It is crucial that she remain in contact with her health care provider and seek both medical and psychological support when required.

CEHAT is the research centre of Anusandhan Trust, conducting research, action, service and advocacy on a variety of public health issues. Socially relevant and rigorous academic health research and action at CEHAT is for the well-being of the disadvantaged masses, for strengthening people's health movements and for realizing the right to health care. CEHAT's objectives are to undertake socially relevant research and advocacy projects on various socio-political aspects of health; establish direct services and programmes to demonstrate how health services can be made accessible equitably and ethically; disseminate information through databases and relevant publications, supported by a well-stocked and specialised library and a documentation centre.

CEHAT's projects are based on its ideological commitments and priorities, and are focused on four broad themes, (1) Health Services and Financing (2) Health Legislation, and Patients' Rights, (3) Women and Health, (4) Investigation and Treatment of Psycho-Social Trauma.