International Journal of Health Sciences and Research
www.ijhsr.org ISSN: 2249-9571

Review Article

Psychological & Medico Legal Aspects of Management of Sexual Assault: Indian Perspective

Kukreti Prerna[1], Kishore Jugal[2], Tanwar Renu[3]

[1]Assistant Professor, Department of Psychiatry, Hamdard Institute of medical sciences and research (HIMSR), Jamia Hamdard University, Delhi.
[2]Professor & Head, Dept of community medicine, Vardhaman Mahavir medical college (VMMC), Indraprastha University, Delhi.
[3]Professor, Department of Obstetrics & Gynecology, Maulana Azad Medical College (MAMC), Delhi University, Delhi.

Corresponding Author: Kukreti Prerna

Received: 10/03/2016 *Revised: 23/03/2016* *Accepted: 30/03/2016*

ABSTRACT

Sexual assaults are increasing at an alarming rate. It leaves a deep impact on physical and psychological health of victim. There is high prevalence of associated physical and psychological health problems. Despite this, the health seeking ratio of persons from this segment is very meager. Disrespectful societal attitude and at times improper handling at hands of healthcare providers also becomes an important cause of secondary victimization, further reducing health care seeking. Here we present an overview of psychological and medico legal aspects for health care providers for better handling of such cases and providing holistic care.

Keywords: Sexual assault, psychological health, medico legal aspect, secondary victimization.

INTRODUCTION

The World Health Organization (WHO) defines sexual violence as ‘’any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality using coercion, by any reason regardless of their relationship to the victim, in any setting, including but not limited to home and work.’’ [1] The circumstances of sexual violence may range from rape by strangers to rape within any established relationships, sex trafficking, child marriage and violent sexual acts.

Magnitude of the problem is alarmingly disturbing, nearly 24 percent of women experience rape or attempted rape in their lifetime, [2] while 7 to 36 percent of female and 5 to 10 percent of male children suffer from some form of sexual violence. [3] Despite huge magnitude of problem, rates of health services utilization are dynamic; utilization is more limited only to emergency services in post assault period then follow up in subsequent routine health services. [4-7] Reasons behind are twofold, first, individual-level explanations focuses on how the trauma of the assault causes severe anxiety, depression and self-blame, which interferes with proactive attempts to seek therapeutic services. [4,8-10] Secondly, societal attitude and secondary victimization at the hand of family, legal agencies and health care providers discourages victims from disclosure and help seeking. [11-13]

Health care providers play an important role in providing immediate treatment as well as helping legal agencies in collecting evidences. They may also play the key role of referral for comprehensive

care involving liaison with social, welfare and legal agencies, which client may need at later stage. But, in resource constrained settings of developing countries, there is wide gap between needs of clients with sexual assault and existing provision of services. For example, a victim being subjected to multiple examinations, absence of adequate number of specially trained medico-legal examiner or health care providers, absence of sexual assault resource centres equipped with team of concerned medical, social, legal personnel. Most of the available services are more inclined towards medico-legal angle for collecting evidence for punishing perpetrator than being victim friendly. Sexual assault victims are often handled in an insensitive manner by health professionals due to clinical overload or inexperience or lack of training for handling such situations. So, there is need for developing training modules for sensitization of health professionals and imparting them skills to handle such situations. [2]

HEALTH CONSEQUENCES OF SEXUAL ASSAULT [14]

Sexual assault is violation of one s human right and is a crime against humanity. It is associated with detrimental consequences to victim s physical and mental health and undesirable devastating social consequences to victim and family.

- **Physical consequences**

❖ Individuals who have experienced sexual assault may suffer from:
❖ Unwanted pregnancy
❖ Unsafe abortion
❖ Sexually transmitted infections (STIs), HIV/ AIDS
❖ Pelvic pain / pelvic inflammatory disease
❖ Urinary tract infections
❖ Genital injuries
❖ Sexual dysfunction

- **Psychological consequences**

Psychological effects vary from individual to individual. It also depends on the age of victim; time elapsed since the assault, relationship with perpetrator, circumstances surrounding assault, victim's life situation, and reaction of supporting people, one's own coping skills and self appraisal of assault. It may present as:

❖ acute stress reaction;
❖ adjustment disorder;
❖ post-traumatic stress disorder;
❖ depression;
❖ social phobias (especially in marital or date rape victims);
❖ anxiety;
❖ increased substance use or abuse;
❖ suicidal behaviour.

In the longer-term, victims may develop eating disorders, sleep disturbances (i.e. nightmares, flashbacks), sexual dysfunctions, fear and anxiety, irritability, social phobia, chronic headaches, multiple unexplained somatic symptoms, occupational decline, school refusal, poor academic performance, low self esteem and suicidal behavior.

ROLE OF HEALTH PROFESSIONALS

Health and welfare of the victim is of primary importance. Medicolegal services are important but should be of secondary importance. Regardless of the setting (i.e. hospital or community-based) and location (i.e. urban or rural area), care should be ethical, compassionate, objective and above all patient-centered. Safety, security and privacy are also important aspects of service provision.

- **General principles and ethical considerations**

When providing services to victims of sexual violence, following ethical principles to be considered:

❖ ***Autonomy*:** The right of patients to take decision, it includes giving or refusing consent for any examination or filling a legal suit.
❖ ***Beneficence:*** The duty of therapist to act in best interest of the patient.
❖ ***Non-maleficence*:** The duty of therapist is to avoid harm to the patient.
❖ ***Justice or fairness*:** Doing and giving what is rightfully due. Therapists should display sensitivity and compassion.

Sexual assault is a crime against humanity. State has duty to protect women from sexual violence and providing survivors complete care. Some of the rights and services that should be offered to victims of sexual violence are:

- ***Right to Health*:** Every survivor has the right to quality reproductive healthcare services including prevention and management of sexually transmitted infections (STIs), HIV/AIDS and pregnancy.
- ***Right to Human Dignity*:** Victims of sexual violence deserve to be treated with respect and dignity. This means they should be provided equitable access to medical care, privacy, confidentiality, clear information in their native tongue about possible interventions and a safe clinical environment.
- ***Right to Non-Discrimination*:** Laws, policies or practices should not discriminate against a victim of sexual violence on any grounds (including sex, ethnic group and the like).
- ***Right to Self-Determination*:** Survivors of sexual violence should be able to make their own decisions about whether to receive treatment or an examination. It is important that a victim receive clear information about her options in order to make an informed decision.
- ***Right to Information*:** Information about all possible medical, social and legal options should be provided to each victim.
- ***Right to Privacy*:** Victims of sexual violence should be offered complete privacy while giving their statements and undergoing a medical or forensic examination.
- ***Right to Confidentiality*:** All information related to a victim's health status should remain completely confidential. [15]

- **How health professionals should conduct themselves**

Following strategies and techniques are helpful when dealing with victims of sexual violence:

- Introduce yourself to the patient and explain your role.
- Greet the patient by name. Use her preferred name.
- Be respectful, professional and maintain a calm demeanour.
- Be unhurried. Give time.
- Maintain eye contact as much as is culturally appropriate.
- Be empathetic and non-judgmental as your patient recounts her experiences
- Validation of patient's feeling. Body language, gestures and facial expressions all contribute to conveying an atmosphere of believing the patient's account.

- **How health professionals should deal with the client**

A victim may be in a heightened state of awareness and emotional turmoil after the assault; they may have a range of emotional reactions. Never be judgmental, use words judiciously. Appreciate survivor's strength in help seeking; it can help build therapeutic relationship. Help the client deal with their emotions:

EMOTIONS	WAYS TO RESPOND
Guilt, self blame	'' You are not to be blamed, it was not your fault''
Numbness	''this is a common reaction to severe trauma. You will feel again all good in time''
Hopelessness	''you are a valuable person''
Helplessness	''we are here to help you''
Shame	''there is no loss of honour, you are a honourable person
Anger	This is a legitimate feeling and avenues can be found for its safe expression
Fear	''you are safe now''

WHO/UNHCR 2004 [15]

- **Legal responsibilities of health professionals**

Section 164 (A) of the Criminal Procedure Code lays out following legal

obligations of the health worker in cases of sexual violence: [16]

- 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 (preferably but not necessarily a gynecologist).
- Examination to be conducted without delay and a reasoned report to be prepared by the RMP.
- Record consent obtained specifically for this examination.
- Exact time of start and close of examination to be recorded.
- RMP to forward report without delay to Investigating Officer (IO) and in turn IO to Magistrate.

The Criminal Law Amendment Act 2013, in Section 357C Cr. PC says that both private and public health professionals are obligated to provide treatment. [17] Denial of treatment of rape survivors is punishable under Section 166 B IPC with imprisonment for a term which may extend to one year or with fine or with both. [18]

MEDICAL EXAMINATION AND REPORTING OF SEXUAL ASSAULT

A client may reach to the health professionals in one of the following ways:

i. As voluntary patient for evaluation and or treatment
ii. Brought by family, victim may or may not be in a state to give consent, for evaluation and or treatment
iii. Brought by police
iv. Brought via court directives

In all case, hospital is bound to provide treatment and police requisition is not essential for same. If client comes without FIR, he/she can be offered for the same. But, if client refuses to lodge FIR and just wants treatment. As per the law, the hospital/ examining doctor is required/duty bound to inform the police about the sexual offence. However, if the victim does not wish to participate in the police investigation, it should not result in denial of treatment for sexual violence. In such cases, a medico legal case (MLC) must be made and client should be informed about her right to refuse to lodge FIR and informed refusal should be documented. At the time of MLC, intimation should be sent to the police with a clear note stating "informed refusal for police intimation". [19]

In all circumstances, it is mandatory to seek an Informed Consent/refusal for examination, evidence collection, treatment and police intimation. Doctors shall inform the victim/ parent/ guardian about the nature and purpose of examination. The consent form must be signed by the victim (>12 years age) or guardian/ parent (if victim's age <12 years). The consent form must be signed by the survivor, a witness and the examining doctor. Only in situations, where it is life threatening the doctor may initiate treatment without consent as per section 92 of IPC. [19]

Overview of assessment and examination

Individuals who have suffered sexual violence, irrespective of the point at which they present within the health sector, should be offered a full medical-forensic examination, the main components of which are as follows:

i. an initial assessment, including obtaining informed consent
ii. a medical history, including an account of the alleged incidence
iii. mental state assessment
iv. a "top-to-toe" physical examination
v. a detailed genito-anal examination;
vi. recording and classifying injuries;
vii. collection of indicated medical specimens for diagnostic purposes;
viii. collection of forensic specimens;
ix. labeling, packaging and transporting of forensic specimens to maintain the chain of custody of the evidence;
x. therapeutic opportunities;
xi. arranging follow-up care;
xii. storage of documentation;
xiii. provision of a medico-legal report

Preferably same sex examiner should do the examination. If the victim is female and examiner is male, a female attendant for the patient should always be present. All parts of the examination should

be explained well in advance; during the examination, patients should be informed when and where touching will occur and should be given ample opportunity to ask questions. The patient's wishes must be upheld at all times. Patients may refuse all or parts of the physical examination and one must respect the patient's decision. Allowing the patient a degree of control over the physical examination is important for her recovery. [19-21]

- **Documentation**

Document all pertinent information accurately and legibly during the consultation. Notes should not be altered unless this is clearly identified as a later addition or alteration. Deletions should be scored through once and signed and not erased completely. Record the extent of the physical examination conducted and all "normal" or relevant negative findings. Record verbatim any statements made by the victim regarding the assault. This is preferable to writing down your own interpretation of the statements made. In sexual assault cases, documentation should include the following:

i. demographic information (i.e. name, age, sex);
ii. consents obtained;
iii. history (i.e. general medical and gynaecological history);
iv. an account of the assault;
v. results of the physical examination;
vi. tests and their results;
vii. treatment plan;
viii. medications given or prescribed;
ix. patient education;
x. referrals given.

Patient records and information are strictly confidential. All health care providers have a professional, legal and ethical duty to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by local, state and national statutes. [19]

TREATMENT GUIDELINES AND PSYCHOSOCIAL SUPPORT [19,20]

- **Sexually transmitted infections (STI):**

i. If clinical signs are suggestive of STI, collect relevant swabs and start treatment. If there are no clinical signs, wait for lab results. For non-pregnant women, the preferred choice is Azithromycin 1gm stat or Doxycycline 100mg twice a day for 7days, with Metronidazole 400 mg for 7days with antacid. For pregnant women, Amoxicillin/Azithromycin with Metronidazole is preferred. {Metronidazole should NOT to be given in the 1st trimester of pregnancy}.
ii. For Hepatitis B. Draw a sample of blood for HBsAg and administer 0.06 ml/kg HB immunoglobulin immediately (anytime upto 72 hours after sexual act).

- **Pregnancy Prophylaxis (Emergency contraception)**

i. The preferred choice of treatment is 2 tablets of Levonorgestrel 750 µg, within 72 hours. If vomiting occurs, repeat within 3 hours. OR 2 tablets (COCs) Mala D stat and repeat after 12 hours within 72 hours of assault.
ii. 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.
iii. 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.

Lacerations

Clean with antiseptic or soap and water. If the survivor is already immunized with Tetanus Toxoid (TT) or if no injuries, TT not required. If there are injuries and survivor is not immunized, administer 0.5ml TT intramuscular (IM). If lacerations require repair and suturing, which is often the case in minor girls, refer to the nearest centre offering surgical treatment.

Post Exposure Prophylaxis (PEP)

PEP for HIV should be given if a survivor reports within 72 hours of the assault. Before PEP is prescribed, HIV risk should be assessed.

Follow-up

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; thereafter at 3 and 6 weeks. All follow ups should be documented.

- ❖ Repeat test for gonorrhoea if possible.
- ❖ Test for pregnancy.
- ❖ Repeat after six weeks test for syphilis (VDRL).
- ❖ Assess for psychological sequelae and re-iterate need for psychological support

Psychosocial care

All survivors should be provided the first line of psychosocial support. The health professional must provide this support himself/herself or ensure that patient is referred to some trained counselor or social workers of the hospital. In acute stage, client needs crisis counseling/ intervention, which should include the following:

- ❖ Restoring patient's psychological safety: Ventilatory support with non judgmental, non directive, facilitatory attitude & continuous reassurance along with environmental manipulation, if required.
- ❖ Providing information related to current medical status, addressing fears related to misattributions.
- ❖ Restoring and supporting effective coping: assistance in preparing for ways in which they can deal with the practical & emotional needs in future using cognitive & problem solving techniques.

In appropriate cases, referral to concerned mental health unit should be made. Red flag signs warranting need for urgent referral to specialized mental health team are:

i. Suicidal behavior
ii. Stuporous state
iii. Severe depressive disorder
iv. Presence of psychotic symptoms
v. Prolonged adjustment disorder
vi. Post traumatic stress disorder (PTSD)
vii. Co-morbid substance dependence/ withdrawal
viii. Client with psychosocial disability

SAFETY ASSESSMENT OF THE CLIENT

- If assessment reveals that she is unsafe and fears reoccurrence of sexual violence, health professional must offer her alternate arrangements for stay such as temporary admission in the hospital or referral to shelter services in collaboration with hospital social worker. A safety plan must be made which may include suggestions such as making a police complaint about threats received, building support strategy with family.
- **In situations, where a parent is the perpetrator of sexual abuse:**

Survivors under 18 years are likely to be accompanied by parents / guardians. If a health professional finds out that the perpetrator is the parent, it is critical to involve social worker /counselor from the hospital to discuss safety of the child. As per protection of children from sexual offences (POCSO) Act, 2012, social worker would have to speak with the child to assess whom the child trusts and can be called upon in the hospital itself. Simultaneously social worker would also have to contact police, who in communication with social worker should assess whether the child is in need of protection and care. Likewise the child may be admitted to the hospital for a period of 24 hours till a long term strategy for shelter or child welfare home is made. [22,23]

PATIENT INFORMATION

On completion of the assessment and medical examination, it is important to discuss any findings, and what the findings may mean, with the patient. In particular:

- ❖ Give the patient ample opportunity to voice questions and concerns.
- ❖ Reassure the patient that he/she did not deserve to be sexually assaulted

and that the assault was not their fault.

- ❖ Teach patients how to properly care for any injuries they have sustained.
- ❖ Explain how injuries heal and describe the signs and symptoms of wound infection.
- ❖ Teach proper hygiene techniques and explain the importance of good hygiene.
- ❖ Discuss the signs and symptoms of STIs, including HIV, and the need to return for treatment if any signs and symptoms should occur. Stress the need to use a condom during sexual intercourse until STI/HIV status has been determined.
- ❖ Explain the importance of completing the course of any medications given.
- ❖ Discuss the side effects of any medications given.
- ❖ Explain the need to refrain from sexual intercourse until all treatments or prophylaxis for STIs have been completed and until their sexual partner has been treated for STIs, if necessary.
- ❖ Explain rape trauma syndrome (RTS) and the range of normal physical, psychological and behavioural responses that the patient can expect to experience to both the patient and (with the patient's permission) family members and/or significant others. Encourage the patient to confide in and seek emotional support from a trusted friend or family member.
- ❖ Inform patients of their legal rights and how can they exercise those rights. Also inform the client about free legal aid from state legal service authority.
- ❖ Give patients written documentation regarding:

i. any treatments received;
ii. tests performed;
iii. date and time to call for test results;
iv. meaning of test results;
v. date and time of follow-up appointments;
vi. information regarding the legal process.

- ❖ Stress the importance of follow-up examinations at two weeks, three and six months.
- ❖ Tell the patient that she can come to the health care facility at any time if she has any query, complications related to the assault, or other medical problems.

ROLE OF FAMILY, FRIENDS AND COMMUNITY

Recovery from sexual violence is dependent on the extent of support received from family, friends and community. Health professionals are best suited to engage with family and discuss ways of promoting survivors' well-being. It must be discussed with all care givers that survivor should not be held responsible for the assault. Judgments such as; "she should have been careful", "she should have resisted" make the survivors journey to recovery more difficult.

INTERFACE WITH LEGAL AGENCIES

Health professionals have to interface with other agencies such as the police, public prosecutors, judiciary and child welfare committees to ensure comprehensive care to survivors of sexual violence.

- **Interface of health systems and the police**

i. Whenever a survivor reports to the police, the police must take her/him to the nearest health facility for medical examination, treatment and care. Delays related to the medical examination and treatment can jeopardize the health of the survivor.
ii. Health professionals should also ask survivors whether they were examined elsewhere before reaching the current health set up and if survivors are carrying documentation of the same .If this is the case, health professionals must

refrain from carrying out an examination just because the police have brought a requisition and also explain the same to them

iii. The health sector has a therapeutic role and confidentiality of information must be ensured. The police should not be allowed to be present while details of the incident of sexual violence, examination, evidence collection and treatment are being sought from the survivor.

iv. The police cannot interfere with the duties of a health professional. They cannot take away the survivor immediately after evidence collection but must wait until treatment and care is provided.

v. In the case of unaccompanied survivors brought by the police for sexual violence examination, police should not be asked to sign as witness in the medico legal form. In such situations, a senior medical officer or any health professional should sign as witness in the best interest of the survivor.

vi. Doctors may also be asked to opine regarding client's fitness for statement under 164 A, Cr. P.C. [17]

- **Interface of health systems and the judiciary**

Doctors are termed as "expert witness" by Law. As per 164 A, Cr. P.C., an examining doctor has to prepare a reasoned medical opinion without delay. A medical opinion has to be provided on the following aspects-

i. was victim administered drugs/psychotropic substance/alcohol/etc.,

ii. Evidence that the victim has an intellectual, or mental disability;

iii. Evidence of physical health consequences such as bruises, contusions, lacerated wounds, tenderness, swelling, pain in micturition, pain in defecation, pregnancy, etc.

iv. Age of the victim if in doubt;

v. Client's fitness for giving statement or fitness to stand trial or fitness to testify as witness.

The examining doctor should clarify in the court that normal examination findings neither refute nor confirm whether the sexual offence occurred or not. They must ensure that a medical opinion cannot be given on whether 'rape' occurred because 'rape' is a legal term. [17,24]

INTERFACE WITH SOCIAL WELFARE AGENCIES

Clients in need can also be referred to self help groups/ non-governmental organizations (NGOs)/ rape crisis cells. They should be informed regarding women in distress helpline (1099), provisions of contacting protection officers in case of domestic violence and various social welfare schemes under department of women and child welfare. Help from a social worker should be taken for formulating a comprehensive rehabilitation plan for the client.

CONCLUSION

Sexual assault is a crime against humanity. Victims are facing the pain of trauma, societal discrimination and associated medical morbidities. A comprehensive medical care can be instrumental in recovery. Health professionals should provide an impartial, non judgemental, empathetic care and help in collecting evidence neutrally. Client should not only receive medical care, but a complete package of access to legal and social welfare aids and as health professionals, it should be duty of all to provide this holistic care with dignity & compassion.

REFERENCES

1. Violence against women – Intimate partner and sexual violence against women. Geneva, World Health Organization, 2011.
2. Sarah B, Guedes A, Claramunt MC, Guezmes A. Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries.

International Planned Parenthood, Western Hemisphere Region 2004:3-4.
3. Sarah B, Morrison A, Ellsberg M. Preventing and responding to gender-based violence in middle and low-income countries: a global review and analysis. World Bank Policy Research Working Paper no. 3618, 2005: 27.
4. Chartier MJ, Walker JR, Naimark B. Childhood abuse, adult health and health care utilization: results from a representative community sample. Am J Epidemiol. 2007; 165:1031–8.
5. Henning KR, Klesges LM. Utilization of counseling and supportive services by female victims of domestic abuse. Violence Vict. 2002; 17:623–36.
6. Paranjape A, Heron S, Kaslow NJ. Utilization of services by abused, low-income African-American women. J Gen Intern Med. 2006; 21:189–92.
7. Kapur N, Windish D. Health care utilization and unhealthy behaviors among victims of sexual assault in Connecticut: results from a population-based sample. Gen Intern Med. 2011; 26(5):524–30.
8. Hathaway JE, Mucci LA, Silverman JG, Brooks DR, Mathews R, Pavlos CA. Health status and health care use of Massachusetts women reporting partner abuse. Am J Prev Med. 2000; 19:302–7.
9. Foa EB, Rothbaum BO. Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: The Guilford Press; 1998.
10. Angelo FN, Miller HE, Zoellner LA, Feeny NC. I need to talk about it: a qualitative analysis of trauma-exposed women's reasons for treatment choice. Behav Ther. 2008; 39(1):13–21.
11. Maier SL. I have heard horrible stories: Rape victim advocates' perceptions of the revictimization of rape victims by the police and medical system. Violence Against Women, 2008; 14(7):786–808.
12. Martin P, Powell R. Accounting for the "second assault": legal organizations' framing of rape victims. Law & Social Inquiry.1994; 19(4), 853–90.
13. Campbell R, Raja S. Secondary victimization of rape victims: insights from mental health professionals who treat survivors of violence and victims. Vol. 14 (3), 1999. [Cited 2016 Feb 13]. Available at https://mainweb-v.musc.edu/vawprevention/research/victimrape.shtml.
14. Ledray L. Sexual Assault Nurse Examiner (SANE) development and operation guide. U.S. Department of Justice: Office for Victims of Crime: Sexual Assault Resource Service 1999: 5.
15. Clinical Management of Rape Survivors. WHO /UNHCR, 2004: 3-4.
16. The Code of Criminal Procedure, 1973. *Current Publications, 2015.*
17. The criminal law (amendment) Act 2013, No.13 of 2013. Gazette of Govt. of India Extraordinary. Ministry of Law & Justice (Legislative Division) 2013.
18. *B.M. Gandhi. Indian Penal Code, EBC, 1–796. Current Publications, 2015.*
19. Guidelines & protocols for medico-legal care for survivors/victims of sexual violence. Ministry of Health and Family Welfare, Government of India. [Cited 2016 Feb 13]. Available at http://www.mohfw.nic.in/showfile.php?lid=2737.
20. Guidelines for medicolegal care for victims of sexual violence, WHO, 2003
21. Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, 2013. [Cited 2016 Feb 13]. Available at http://www.who.int/ reproductive health/ publications/ violence/9789241548595/en.
22. Protection of Children from Sexual Offences Act 2012, No.32 of 2012.Gazette of Gov of India Extraordinary. Ministry of Law & Justice (Legislative Division) 2013. [Cited 2016 Feb 13]. Available at: A*wcd.nic.in/sites/default/files/childprotection31072012.pdf.*
23. Guidelines for the use of professionals and experts under the POCSO Act, 2012. Ministry of Women and Child Development, September 2013.
24. *The Indian Evidence Act 1872,* Act No. 1 of 1872. [Cited 2015 Feb 13]. [Cited 2016 Feb 13]. Available at: *ncw.nic.in/Acts/The Indian Evidence Act 1872.pdf.*

How to cite this article: Prerna K, Jugal K, Renu T. Psychological & medico legal aspects of management of sexual assault: Indian perspective. Int J Health Sci Res. 2016; 6(4):507-515.

****