



“SEXUAL ASSAULT”

“Rape: Is a Lifestyle or Behavioural Problem?”

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Sexual assault is a crime of violence, often motivated by aggression and rage, with the assailant using sexual contact as a weapon for power and control. Sexual assault can include a range of coercive behaviors ranging from kissing, fondling, and molestation, to rape or attempted rape. For this review, sexual assault is defined as “an event that occurred without the victim’s consent, involved the use of force, or the threat of the use of force, and involved actual or attempted penetration of the victim’s vagina, mouth, or rectum.”¹⁸ According to recent statistics, one out of eight women will be raped during her lifetime, and 39% will be sexually assaulted more than once.¹⁸ Many rapes are unreported, either because of feelings of shame and guilt, or because the victim does not define the event as rape (e.g., spousal and date rape). Well-known sequelae of rape, whether reported or not, include isolation, depression, anxiety, somatic symptoms, suicide attempts, and post-traumatic stress disorder (PTSD). The experience of rape has a strong effect on the subsequent health of victims/survivors and has thus become a major public health issue. Sexual assault victims often present to the emergency department (ED) for initial evaluation, evidence collection, treatment, and crisis intervention. Although some cities have model sexual assault centers or use specially trained sexual assault nurse examiners (SANE), the emergency physician (EP) is responsible for the initial evaluation and management in most EDs. It is, therefore, imperative that the EP be familiar with a complex array of reactions (emotional and physical), common injuries, and elements of proper evaluation and treatment of sexual assault victims.

STATISTICS

According to recent national telephone surveys, 13% to 18% of women, and 3% of men have experienced an attempted or completed rape in their lifetime. ¹⁸ Only 16% of rapes are ever reported to the police, therefore FBI, and law enforcement statistics grossly underestimate the incidence of rape. Annually, approximately 300,000 to 700,000 adult women are victims of sexual assault in the United States, and 40,000 victims are treated in emergency

departments. 18 Contrary to popular myth, most sexual assaults are committed by acquaintances and significant others. According to the National Women's Study, 29% of women were raped by acquaintances, 9% by ex-husbands, 11% by stepfathers, 10% by boyfriends, and 16% by other relatives; only 22% of the women were raped by strangers. Assault by a known perpetrator is often more emotionally devastating than is stranger assault because it involves the violation of trust and often includes repeated victimization.

HISTORICAL PERSPECTIVE

Traditional definitions, derived from British Common Law, defined rape as “carnal knowledge of a woman by force and against her will.” This definition was gender-specific (excluding males or children), and required penile penetration of the vagina (carnal knowledge), by a stranger (therefore, it excluded marital rape), through the use of force (requiring proof of “resistance to the utmost”). Traditionally, marital rape was not considered a crime because a woman was the property of her husband, and he could not commit a crime against himself. The legal definition of rape was reformed in the 1960s, with influence from the women's movement to include gender-neutral language, and the concept of rape as a violent crime, rather than a fulfillment of sexual desire. In the 1980s, the reform of rape laws included the recognition of marital rape (which has since been adopted by all 50 states, although some states require proof of force in marital rape), and shield laws, which prohibit the introduction of the victim's previous history into court.²⁰ The term nonconsensual has replaced the concept of the use of force, recognizing that even the threat of bodily harm can be intimidating, in the absence of actual force or injuries inflicted. The use of drugs in date and acquaintance rape is an increasingly common problem. Drugs incapacitate the victim and decrease the ability to give consent. Furthermore, drugs impair the recollection of events surrounding the sexual assault, making identification and prosecution of the assailant difficult.

EMERGENCY DEPARTMENT EVALUATION

Initial Approach-

Evaluation and treatment of sexual assault survivors in the ED must include the following:

1. Treatment of physical injuries
2. Creation of a safe, secure environment for the victim
3. A thorough history of medical problems and the events surrounding the assault
4. A thorough but compassionate physical examination, with evidence collection (if the patient consents)
5. Treatment and prophylaxis of pregnancy and sexually transmitted diseases
6. Emotional support and crisis intervention, with a plan for follow-up care

Physicians should remember the following tenets when evaluating the patient, to prevent secondary victimization from negative or judgmental attitudes: No one ever deserves to be raped. Many survivors harbor intense

feelings of guilt and shame that they might have somehow prevented the assault. It should be stressed that no matter what the circumstances, the survivor did not deserve to be raped. The perpetrator, not the survivor, is responsible for the assault-always. Societal attitudes often support the notion that the victim is somehow partially responsible for the assault; this differs from society's attitude toward other victims of violent crimes. The survivor made the best choices possible for survival under the circumstances. These choices allowed the victim to survive the assault. Survivors should be congratulated for their courage in seeking help. With these thoughts kept in mind, the initial evaluation of the sexual assault victim/survivor in the ED should concentrate on detecting life- and limb-threatening injuries. Although 70% of rape victims sustain no obvious physical injuries, 24% sustain minor injuries, and up to 5% sustain major nongenital injuries. Although death is rare (0.1% sustain fatal injuries), the fear of death during the assault is one of the most intense reactions. The commonest causes of death in fatal sexual assaults are asphyxiation, blunt trauma, and laceration. The commonest nongenital injuries in survivors of rape include bruises, cuts, scratches, and swelling (81%); internal injuries and unconsciousness (11%); broken bones or teeth (4%); and knife or gunshot wounds (2%).²⁵ Once life- and limb-threatening injuries have been ruled out, and lacerations and other physical injuries are treated, the patient should be moved to a quiet, private setting for further evaluation. A systematic, thorough, but compassionate approach to obtaining the history and collecting evidence is essential for the appropriate treatment of the victim.

Taking a History

The practitioner should elicit the sexual assault history in a calm, nonjudgmental, and objective, yet compassionate and supportive, manner. If possible, an advocate or rape crisis counsellor should be present during the examination. Most states have standardized evidence collection kits that help to guide history taking. Direct patient quotes should be used whenever possible. Excessive historical detail should be avoided because this can lead to inconsistencies compared to the police report.

Initial questions should be aimed at obtaining pertinent medical history while establishing trust and rapport. Important medical history includes a history of major medical illness, a history of thrombosis (deep venous thrombosis or pulmonary embolus), liver disease or hypertension (theoretical contraindications to pregnancy prophylaxis with estrogens), tetanus status, last menstrual period, and a history of previous sexual assaults. The history of previous sexual assaults is important to elicit because there is evidence to suggest that previous victimization can predispose to revictimization and can also influence response to current victimization

Important historical points surrounding the rape include the time and setting at which the sexual assault occurred; the number, relationship, appearance, and physical build of the assailant(s); and the use of weapons or threat of bodily harm. Information regarding the event should include types of actual or attempted penetration (e.g., vaginal, oral, and rectal), any objects used, ejaculation, and condom use. The physician should ask about the patient's activities since the attack occurred (including changing clothes, bathing, vomiting, urinating, defecating,

douching, teeth brushing, or showering) because these activities can decrease the chances of collecting evidence. The patient should be asked about the last consensual intercourse.

Information regarding the use of contraceptives and the last menstrual period helps to estimate the risk of pregnancy from the rape. If the victim has a poor recollection of the incident, with only minimal alcohol or drug intake, the physician should consider the use of sedative-hypnotics (e.g., flunitrazepam [Rohypnol] or gamma-hydroxybutyrate [GHB]) by the assailant. Most common drug assays do not test for these drugs. Specimens can be sent to Hoffman LaRoche laboratories (1-800-608-6540); the company offers testing for flunitrazepam free of charge to medical and legal professionals.' Important historical points of the history are presented here:

- Date and time
- Physical surroundings Number, relationship, brief description of assailant(s)
- Threats
- Use of force/trauma
- Suggestion or evidence of weapons
- Sexual acts demanded/performed
- Penetration (by body part or object)
- Ejaculation, condoms
- Last consensual intercourse
- Last menstrual period
- Use of birth control
- Activities since sexual assault (e.g., did the victim urinate, douche, bathe, change clothes, etc.)

Evidence Collection and Documentation

Valid evidence may be collected up to 5 days after a sexual assault. Consent should be obtained before examination and evidence collection. This helps to reestablish the victim's sense of control and is essential for the use of evidence in a court of law. The physician should make an effort to persuade the victim to consent to evidence collection. The physician should emphasize that vital information can be lost if evidence is not collected early, and that evidence collection does not commit the victim to pressing charges. The patient should be told that the examination will be terminated if it becomes too painful or uncomfortable for her. Most states have standardized kits for evidence collection and storage. Essential evidence includes documentation of a full physical examination (including the back and buttocks) for cuts, bruises, tenderness, and swelling. Documentation of physical injuries is essential for successful prosecution, and objective evidence of trauma (even minor) is associated with increased chances of successful prosecution. Clothing is collected as the patient undresses on a white sheet and placed in properly labelled paper bags. Any debris should be collected also. Evidence collection includes a sample of the patient's saliva (on filter paper), and swabs of all involved orifices (oral, rectal, and vaginal swabs and smears). A thorough pelvic examination with evidence collection is essential, even if there are no complaints of genital pain

because up to one-third of victims can have traumatic genital injuries without ~symptoms. Common patterns of genital injury include tears of the posterior fourchette and fossa, abrasions on the labia, and ecchymosis on the hymen.³⁶ Significant genital injuries are more common in postmenopausal victims. Colposcopy should be used if available because this technique increases the detection of more subtle injuries of the cervix and vagina. One study reported that the use of colposcopy in the ED increased recognition of genital trauma from 6% to 53% of victims. A Wood's lamp facilitates the identification of semen on the skin, which then should be collected with moistened cotton swabs. Evaluation for sperm should not be performed by the clinician because identification by forensic specialists is more accurate. A blood sample is collected for typing, to differentiate the blood type of the victim from that of the assailant. After evidence is collected, it is signed and sealed. Evidence should be either held in person or locked in a secure place to maintain a chain of evidence.

Treatment and Prophylaxis for Pregnancy and STDs

Treatment includes medication prophylaxis for pregnancy and common sexually transmitted diseases (STDs). This author believes that testing for common STDs such as Chlamydia and gonorrhea should not be performed at the time of examination if the patient is going to be treated with prophylactic medication. Although many states have shield laws that prohibit the victim's sexual history from being admitted into a court of law, proof of previous STDs is not helpful for the patient's medical care if prophylactic treatment is given. These tests should be performed at follow-up. The following are recommendations for testing and treatment for pregnancy and sexually transmitted infectious diseases.

Pregnancy

The risk of rape-related pregnancy is estimated at approximately 5% per rape among victims of reproductive age.¹³ Most pregnancies, unfortunately, occur in adolescents, often the victims of incest, who never report the incident or receive medical attention. An estimate of the risk of pregnancy can be evaluated based on the report of penetration, ejaculation, and the victim's menstrual cycle. The risk of pregnancy is greatest when intercourse occurs during the six days preceding ~ovulation. Women's menstrual cycles vary, and thus a definite estimate of pregnancy is unreliable; if the possibility is in question, pregnancy prophylaxis should be offered. Prophylaxis can be administered for up to 72 hours after the rape and consists of 2 doses of 100 µg of estrogen, given 12 hours apart. Some examples of estrogen/progestin regimens are: 50 µg ethinyl estradiol and 0.5 mg norgestrel (2 Ovral), or 30 µg ethinyl estradiol and 0.3 mg norgestrel (3 Lo/Ovral), at the time of initial visit and 12 hours later. After 72 hours but within 5 to 7 days, IUD implantation remains an option (but patients should be given an antibiotic prior to insertion, to avoid ascending infection). A negative pregnancy test to exclude a preexisting pregnancy should be confirmed before administering medications (although the regimen is unlikely to have teratogenic effects, it is not useful if the patient is already pregnant). Side effects of estrogen/progestin combinations include nausea (in up to

50% of patients), and vomiting (in up to 20%)- breast tenderness, and heavier menstrual period. An antiemetic can be prescribed one half hour prior to administration to decrease nausea. Theoretical but unproven risks of this regimen (extrapolated from long-term oral contraceptive users) include thrombosis and thromboembolism (including stroke). In reality, they occur extremely rarely with the two-dose regimen." Patients should be informed that their next menstrual period may be late. Although current regimens are approximately 74% to 84% effective, patients should be told to return if their next menstrual period is more than 1 to 2 weeks late.

STDs

The risk of acquiring STDs after rape has been estimated: the risk of acquiring trichomonas is approximately 12%, bacterial vaginosis 12%, gonorrhoea 4% to 12%, chlamydia 2% to 14%, syphilis 5%, and HIV <0.1%.^{14, 16, 33} In reality, these risks are difficult to predict and vary by geographic location, type of assault, an assailant. Preexisting infections are also common in sexually assaulted patients. The general recommendation is to provide prophylaxis for hepatitis, gonorrhea, and chlamydia (MMWR). Current recommendations include ceftriaxone 125 mg IM, plus azithromycin 1 g (single dose) or doxycycline 100 mg twice a day for 7 days. This regimen does not treat incubating syphilis (which requires an IM benzathine penicillin, or doxycycline 100 mg b.i.d. for 10 days). A single dose of 1 g of azithromycin is probably adequate to treat both chlamydia and gonorrhea,³¹ and 2 g will also treat resistant forms of gonorrhea (which are currently rare in the United States).[^] The treatment for bacterial vaginosis (BV) includes a 2-g oral dose of metronidazole. Prophylaxis for BV is controversial; BV rarely causes ascending pelvic infection, and the regimen can cause significant nausea, which can interfere with pregnancy prophylaxis compliance.

Hepatitis

Prophylaxis for hepatitis B should be administered in high-risk victims (e.g., penetration, blood or body fluid contact). Recommendations include the first dose of Heptavax in the ED, with boosters at 1 to 2 months and 4 to 6 months. Current recommendations do not include administration of the immune globulin.

HIV

Although the fear of contracting HIV after a sexual assault is common in survivors and is often the primary concern after a rape: prophylaxis for HIV remains a topic of heated debate, with little direct evidence to guide decision-making. ^{12, 15, 16, 22, 32} Cases of HIV transmission from rape have been reported.³ Although the heterosexual transmission from male HIV-positive partner to female victim has been estimated to be at 18% in transfusion-related HIV, transmission most often occurs after multiple sexual encounters.²⁸ The risk of HIV transmission in a single sexual assault is estimated at less than 0.1%, similar to that reported in parenteral exposure in health care workers.^{12, 15, 16, 32} The risk of transmission may be related to many factors, including the type of penetration, number of sexual contacts, and viral load of the assailant.^{10, 22, 32} The theory behind prophylaxis in

HIV exposure is based on antiretroviral inhibition of local HIV replication, allowing host immune defences to destroy the virus before it infects cells. Data supporting early administration of antiretrovirals include results of studies with maternal-fetal and healthcare worker HIV exposures. Studies demonstrate a decrease in maternal transmission of HIV by two-thirds after administration of zidovudine.⁷ The effect of newer regimens, including double therapy (with zidovudine and lamivudine) and triple therapy (addition of a protease inhibitor), is unknown. A recent case-control study evaluating healthcare worker prophylaxis with zidovudine found an 81% odds reduction of HIV transmission in healthcare workers given postexposure prophylaxis (PEP). Although the CDC has made no formal recommendations for HIV prophylaxis in victims of sexual assault, many experts recommend offering prophylaxis to candidates who are willing to take the full course of medications and comply with follow-up testing.^{15, 16} The risks and side effects of the medications should be discussed with patients, as well as the need for close monitoring. The financial cost of a 1-month trial of PEP is significant (up to \$300-\$500, and an additional \$200 for laboratory testing and office visits); it also may not be covered by insurance. Although laboratory tests should be sent from the ED (CBC, LFTs, and amylase if indinavir is added), treatment should not await test results because it is most effective when administered early. Currently, trials for HIV prophylaxis in homosexual men with high-risk sexual encounters are underway (HIVNET) in five major cities for testing and treatment.

Emotional Reactions and Crisis Intervention

Although serious physical injury rarely occurs, victims sustain long-lasting serious psychological injury, which can affect emotional and physical well-being. The predominant initial reaction during a sexual assault is an intense horror and fear of being killed by the rapist.²⁷ Survivors of sexual assault who present to the ED can display an array of reactions to their feelings of anger and fear, varying from anxiety, agitation, and sobbing and crying or smiling (expressed style), to a quiet, calm, and removed affect (controlled style). Burgess and Holstrom, in their early work with rape victims presenting to Boston City Hospital, first characterized rape trauma syndrome, which was described as a “syndrome of behavioural, somatic and psychological reactions [in response] to a life-threatening situation.” Burgess and Holstrom described two phases of response to the trauma of sexual assault: the acute disorganization phase, lasting several weeks, and the recognition phase, lasting from several weeks to years. During the acute phase, common initial emotional reactions include shock and disbelief, fear, shame, self-blame, humiliation, anger, isolation, grief, and loss of control. Somatic reactions include skeletal muscle tension, gastrointestinal (GI) irritability, and genitourinary (GU) disturbances (e.g., vaginal itching, burning, and bleeding). Patients often fear that family and friends will find out about the assault.

During the reorganization phase, feelings of vulnerability, despair, guilt, and shame continue. Symptoms include nonspecific anxiety; somatic complaints such as headaches, insomnia, and sleep disturbances; or depression and anger. The reorganization phase occasionally is characterized by frequent relocations and telephone number changes. Phobias include the fear of being indoors (if the assault happened indoors), agoraphobia, fear of open spaces (if the attack occurred outdoors), fear of being alone, and sexual fears. The victim finally becomes a survivor when

she can recognize the rape, express appropriate anger, feel sorrow, and resume her life. Long-term sequelae of sexual assault can include depression, suicide attempts, use of drugs and alcohol, sexual dysfunction, and problems in relationships. Up to one-third of rape victims subsequently develop PTSD, and one-third experience at least one major depressive episode in the year after a rape, compared with 10% of the general female population.¹⁸ In one follow-up study, 33% contemplated suicide, compared with 8% of the general female population. Rape victims were 13 times more likely to have made a suicide attempt.¹⁸ Women who have suffered criminal victimization (rape is one of the severest forms of victimization) demonstrated increased physician visits in the year following victimization, and up to 3 years after the incident.¹⁹ "Silent" rape victims (those who do not report the rape) can exhibit increasing anxiety, phobias, loss of self-esteem, self-blame, and nightmares and can present with multiple visits to the ED for somatic symptoms without an obvious aetiology.

FOLLOW-UP CARE

All sexual assault victims should receive medical follow-up at 1 to 2 weeks, and 2 to 4 months. During follow-up, examination for STDs, and blood testing for HIV and syphilis (RPR) should be performed, and the remaining hepatitis vaccinations should be administered. Survivors should be immediately referred to local rape crisis centers within 1 to 2 days. The goal of rape crisis centers is to decrease the long-term effects of the assault on the health and well-being of survivors. This is accomplished by building self-esteem, alleviating guilt, and encouraging the expression of anger. The victim truly becomes a survivor when she has mastered the assault, without intrusive flashbacks and memories. This mastery results in decreased symptoms of anxiety and depression.

SEXUAL ASSAULT IN SPECIAL POPULATIONS

Male Victims

Although many male sexual assaults occur in institutionalized persons (prisons), 5% to 10% of noninstitutional assault victims are male.¹⁷ Most male victims are assaulted by other men, who often describe their sexuality as heterosexual. Male victims often sustain more injuries, are more likely to be the victim of multiple assaults, and are more likely to present to the ED for treatment of nongenital injuries. They are more likely to demonstrate initial reactions of control and denial. They are less likely to report the genital component of their injuries to emergency providers.¹⁷ The healthcare provider must therefore have a high index of suspicion for such injuries in assaulted male victims and show extreme sensitivity during evaluation.

Older Victims

Postmenopausal women represent approximately 2% to 3% of sexually assaulted women, are more likely to be assaulted in their homes, and are more likely to sustain nongenital and genital injuries. Major genital injuries are commoner, including vaginal lacerations, some often severe enough to require surgical repair.³⁰ Elderly women

may be perceived as more vulnerable because of disabilities. They may be less likely to report sexual assaults, based on long-held biases and beliefs about sexual assault victims. The elder victim may depend on the assailant for basic needs, such as food and housing. Many states mandate reporting of elder abuse. Practitioners should be aware of reporting requirements in their states.

PREVENTION

Efforts by the public and healthcare community must also concentrate on sexual assault prevention. An important part of the mission of rape crisis centers includes focus groups and educational sessions with adolescents about issues of intimate partner and acquaintance rape. Prevention efforts should be aimed at changing the knowledge and attitudes of male and female students about relationships as well as changing societal attitudes. Because sexual assault is common in young women, interventions must begin early. Studies in high school and college-aged students reveal that 15% to 30% of female students had been forced to have and 8% to 30% of male students reported attempts at forced sexual contact without consent.^{8, 26} To be most effective, interventions therefore must be aimed at high school and college-aged students.

Scheme of WCD Ministry under Nirbhaya Fund for Critical Care and Support to POCSO victims

Under Nirbhaya Fund, a scheme of the Ministry of Women & Child Development namely Scheme for critical care and support for accessing justice to rape gang rape survivors and minor girls who get pregnant was appraised at the total cost of Rs.74.10 cr. The scheme aims at providing shelter, food & daily needs, safe transportation for attending court hearings and legal aid to the minor girls who have been abandoned by the family due to forced pregnancy, either due to rape/ gang rape or due to any other reason, and have no other means to support themselves.

In the year 2021, the National Crime Records Bureau reported 51,863 cases under the POCSO Act. Out of these, 64% (33,348) cases were reported under sections 3 and 5 (penetrative sexual assault and aggravated penetrative sexual assault respectively).

Further analysis of this data shows that out of a total 33,348 cases reported under section 3 and 5 of the Act 99% (33,036) cases were committed against girls. In many of these cases, girls become pregnant and bear several physical and mental health concerns, which are further aggravated when they are disowned or abandoned by their own families or are orphan.

Objectives of the Scheme are :

1. To provide integrated support and assistance to girl child victims under one roof and
2. To facilitate immediate, emergency, and non-emergency access to a range of services including access to education, police assistance, medical (also comprising maternity, neo-natal and infant care), psychological and mental counselling legal support and insurance cover for the girl child victim and her new-born under one roof to enable access to justice and rehabilitation of such girl child victims.

The eligibility criteria are :

- Any girl below the age of 18 years, who is a victim of:
 - Penetrative Sexual Assault - Section 3 of the POCSO Act,
 - Aggravated Penetrative Sexual Assault - Section 5 of the POCSO Act,
 - Section 376, 376A-E of Indian Penal Code, 1860 (IPC)
- And has become pregnant due to such assault or rape is covered under the Scheme. Such girl child victim should be:
 - An orphan or
 - Abandoned by the family or
 - Does not wish to live with the family

It is not mandatory for the girl child victim to have a copy of the FIR for availing the benefits under the Scheme. However, it shall be the responsibility of the persons responsible for the implementation of the Scheme to ensure that information is provided to the police and that FIR is registered.

Rape Laws in India- A Brief Review

India is one of the prominent nations that is taking the lead in crime. Rape is the fourth major crime in our country which leaves the victim in physical as well as mental agony and torture. The cases of violence against women is not a new concept in India. Such loss can't be replaced by doing anything. So, it is the need of the hour to make our laws more stringent and strict with their implementation. There is a need to enhance the declaration of judgments of punishments as well as penalties to punish the offenders as soon as possible. Such laws should be stricter in cases of child rape and child pornography. Not only rapes but other offenses relating to women need to be treated seriously like sexual assault, voyeurism, stalking cruelty, dowry deaths, acid attacks etc.

Introduction Many offences comes within the ambit of “violence against women” that are Rape, Sexual Assault, Voyeurism, Stalking, Dowry Deaths, Eve Teasing, Marital Rape, Child Sex Abuse, Domestic Violence, etc. Many cases remain unreported due to the pressure of the society and fear of stigma for the victim. It can be considered

as a kind of theft, but not of any movable property but it is a serious theft of the victim's body and soul which leaves her helpless and traumatized. Besides the strict laws and regulations, India is still taking a lead in such crimes. The fourth most common crime in India is the Rape which is a big question mark on the safety of a women. It is very serious as well as heinous crime which is very shameful for our society. Such pain and torture lasts long in cases of gang rapes. As per the Report of National Crime Report Bureau, the total number of rape cases that has been reported are 221724 in 2010, 24206 in 2011, 24923 in 2012, 33707 in 2013, 36735 in 2014, 34651 in 2015, 38947 in 2016. So in the present data, the continuous increase in the number of rapes is being observed.¹ Prior to amendment, the term "Sexual Intercourse" was interpreted as the penetration of the male genital organ into the female genital organ only. The courts interpreted the term sexual intercourse as "mere slightest or partial penetration of the male organ within the labia majora or the vulva or pudenda is sufficient to constitute 'sexual intercourse'.² Other facts were also being held such as the depth of penetration is immaterial and the presence of injuries on private parts is also immaterial to constitute rape.

To constitute the offence of rape it is not at all necessary that there should be complete penetration of the male organ with the emission of semen and rupture of hymen. Even Partial or slightest penetration of the male organ within the labia majora or the vulva or pudenda with or without any emission of semen or even an attempt at penetration into the private part of the victim would be quite enough for the purposes of section 375 and 376 of the Indian Penal Code. That being so it is quite possible to commit legally the offence of rape even without causing any injury to the genitals or leaving any seminal stain.

Under section 376 of the Indian Penal Code, The minimum punishment is of seven years and it can also be given with a fine and extend to life imprisonment. However, section 376(2) provides the situations where the quantum of punishment will be very high and it will include rigorous imprisonment which will not be less than a term of 10 years. The punishment for gang rape is provided under sub-section 2 of section 376 IPC which postulates that when a woman is raped by more than one person then each of person will be convicted of the crime of gang rape and the punishment would not be less than ten years of rigorous imprisonment in such cases.

After the amendment of 2013, the scenario is totally changed. The punishments and penalties have been enhanced due to the worst case in Indian history of the Nirbhaya Rape and Murder Case which took place in December 2012, a twenty-three-year-old college student, was fatally gang-raped on a private bus in Delhi. This case gave new strength and safety to the women of our nation. The definition of rape is widened after the amendment which include any kind of penetration and also in any body part of the woman or girl. The new recommendations added that any penetration would be considered as rape. Moreover 'voyeurism' was also inserted as a new crime in the Criminal Law (Amendment) Act, which means the recording or viewing of images, movies or any such media material without the permission of the person portrayed or screened in them would result in penal punishment. Under section 354 of IPC Any man who watches, or captures the image of a woman engaging in a private act in

circumstances where she would usually have the expectation of not being observed either by the perpetrator or by any other person at the behest of the perpetrator or disseminates such images shall be punished on first conviction with imprisonment of either description for a term which shall not be less than one year, but which may extend to three years, and shall also be liable to fine, and be punished on a second or subsequent conviction, with imprisonment of either description for a term which may not be less than three years but which may extend to seven years, and shall also be liable to fine.

Now the punishment for rape has been increased to ten years which may extend to imprisonment of life, and shall also be liable to fine. Also, section 376A is also being inserted in the new criminal law that states that punishment for causing death or resulting in a persistent vegetative state of the victim is to say that Whoever commits an offence punishable under sub-section (1) or sub-section (2) of section 376 and in the course of such commission inflicts an injury which causes the death¹ of the woman or causes the woman to be in a persistent vegetative state, shall be punished with rigorous imprisonment for a term which shall not be less than twenty years, but which may extend to imprisonment for life, which shall mean imprisonment for the remainder of that person's natural life, or with death.

Under section 376B- Sexual Intercourse by Husband upon his wife during separation meaning thereby Whoever has sexual intercourse with his own wife, who is living separately, whether under a decree of separation or otherwise, without her consent, shall be punished with imprisonment of either description for a term which shall not be less than two years but which may extend to seven years, and shall also be liable to fine.

Under section 376C- Sexual Intercourse by person in authority- whoever, being— in a position of authority or in a fiduciary relationship; or a public servant; or superintendent or manager of a jail, remand home or other place of custody established by or under any law for the time being in force, or a women's or children's institution; or on the management of a hospital or being on the staff of a hospital, abuses such position or fiduciary relationship to induce or seduce any woman either in his custody or under his charge or present in the premises to have sexual intercourse with him, such sexual intercourse not amounting to the offense of rape, shall be punished with rigorous imprisonment of either description for a term which shall not be less than 5 years, but which may extend to ten years, and shall also be liable to fine.

Under section 376 D- Gang Rape- Where a woman is raped by one or more persons constituting a group or acting in furtherance of a common intention, each of those persons shall be deemed to have committed the offence of rape and shall be punished with rigorous imprisonment for a term which shall not be less than twenty years, but which may extend to life which shall mean imprisonment for the remainder of that person's natural life, and with fine; Under section 376E-Punishment for repeated offenders- Whoever has been previously convicted of an offence punishable under section 376 or section 376A or section 376AB or section 376D or section 376DA or section 376DB and is subsequently convicted of an offence punishable under any of the said sections shall be punished with imprisonment for life which shall mean imprisonment for the remainder of that person's natural life, or with death

Under section 376AB- Punishment for rape on woman under twelve year of age- Whoever, commits rape on a woman under twelve years of age shall be punished with rigorous imprisonment for a term which shall not be less than twenty years, but which may extend to imprisonment for life, which shall mean imprisonment for the remainder of that person's natural life, and with fine or with death:-

Under section 376DB- Punishment for gang rape on woman under twelve years of age- Where a woman under twelve years of age is raped by one or more persons constituting a group or acting in furtherance of a common intention, each of those persons shall be deemed to have committed the offense of rape and shall be punished with imprisonment for life, which shall mean imprisonment for the remainder of that person's natural life, and with fine, or with death.

CONCLUSION

Sexual assault is a pervasive form of violence that has a significant impact on the future health and well-being of victims. EPs are often first-line care providers in the initial evaluation and treatment of sexual assault victims. The EP can facilitate the transition from victim to survivor by being aware of avoiding common preconceptions and harmful attitudes toward victims of sexual assault. El should be aware of reporting requirements in their state and be familiar with the elements of history taking and evidence collection necessary for proper evaluation. The El' must also be aware of medications that are available for the treatment and prevention of STDs, including HN, and for pregnancy prophylaxis following rape. It is crucial that the El' be aware of the common initial reactions and the community resources available to the survivor. Linkages to long-term follow-up care with local rape crisis centers, counsellors, and the survivor's primary care physician (after the survivor's permission is obtained) should be initiated whenever possible in the ED.

References :

1. Geneva :- World Health organization 2002, World Report on violence & Health.
2. Rozee PD. Forbidden or Forgiven? [google scholar]
3. Wikipedia
4. Rajlakshmi Tk. Worrisome [google scholar]
5. Dipa Dube, Rape Laws In India (2008)