SEXUALIZED VIOLENCE IN THE NATIONAL DEBATE

Cross-border observations on India and South Africa

Edited by Melanie Verwoerd & Claudia Lopes

HEINRICH BÖLL STIFTUNG

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This publication pays tribute to Anene and Jyoti, and to the many other women whose voices may not have been heard as clearly as theirs. We salute you.

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PREFACE

In 2013 two young women, Anene Booysen and Jyoti Singh Pandey, became household names around the globe. The two women had never met and lived thousands of kilometers apart – Anene, in a tiny town at the southern point of Africa, Joyti, in the massive city of New Delhi, India. On the face of it they shared little in common, except the way they died. Both were gang raped and mutilated to the extent that they died from their injuries.

In a world where reports of rape and other forms of gender-based violence have become so commonplace, the horrific deaths of these two young women, shocked people and mobilised many into action. In India, protests, on a scale rarely seen before, broke out all over the country. In South Africa protests were smaller, yet politicians, civil society and other interests groups all stood together in condemnation of this crime.

Although there was some degree of understanding of why the levels of gender-based violence were extremely high in both India and South Africa, questions around what needed to be done about it and why certain cases received so much more attention than others, still needed answering. The Heinrich Böll Foundation took a commendable step in doing two studies on these specific cases in 2013 – one in India and one in South Africa. Following the completion of the reports the foundation engaged in intensive dialogues with various interest groups in both countries on sexual violence issues and related media, public and political responses. Some of the results of these dialogues are discussed in the introduction written by Claudia Lopes.

However, two years after the deaths of Anene and Joyti, the question arose to what extent the measures that had been implemented following their murders have made any difference in the fight against gender-based violence. In search of answers the Heinrich Böll Foundation approached lawyers, social activists, academics and journalists in both countries. They also asked the participants to indicate what further changes they regarded as necessary in both countries.

This publication contains these experts' responses to the questions. The participants consistently indicate that some positive changes have been made, yet that a lot remains to be done in order to create a world where women can live free from the threat of gender-based violence.

This publication will be insightful to those who want to understand what happened after Anene and Joyti's deaths and what changes are still required. It is a powerful tool for advocacy and also something every politician and policy maker should read.

We owe it to Anene and Joyti as well as all the thousands of rape and abuse victims, to not let their suffering be in vain. With this report, the Heinrich Böll Foundation is not only keeping the memories of these victims alive, but also trying to make a positive change to the achievement of justice and women's rights to be free of gender-based violence.

Melanie Verwoerd

CHAPTER 10

IMPLICATIONS OF THE CHANGES IN RAPE LAW ON HEALTH SECTOR

A Case for paradigm shift

Padma Bhate-Deosthali and Sangeeta Rege

INTRODUCTION

The outrage and protests following the brutal assault of a young health student compelled the Government of India to take cognisance of sexual violence. One of the immediate responses by the state was to set up the Justice Verma Committee (JVC) which produced a report within a month with clear recommendations about what needs to change within various institutions in order to respond sensitively to survivors of sexual violence and guarantee justice and care for them. The JVC report included an entire chapter that addressed institutional bias to rape within the health system. Amongst the recommendations pertaining to the health sector, one was for developing uniform protocols and guidelines in responding to sexual violence. This included strong recommendations for the removal of insensitive and unscientific procedures that traumatize survivors. The report further recommended the setting up of services for the provision of psycho-social care and rehabilitation of survivors of sexual violence. The Criminal Law Amendment Act (CLA) 2013 expanded the definition of rape to include all forms of sexual violence-penetrative (oral, anal, vaginal) including by objects/weapons/fingers and non-penetrative (touching, fondling, stalking, disrobing etc) – and recognised the right to treatment for all survivors of sexual violence by public and private health care facilities. Failure to treat is now an offence under the law. The law further disallows any reference to past sexual practices of the survivor.

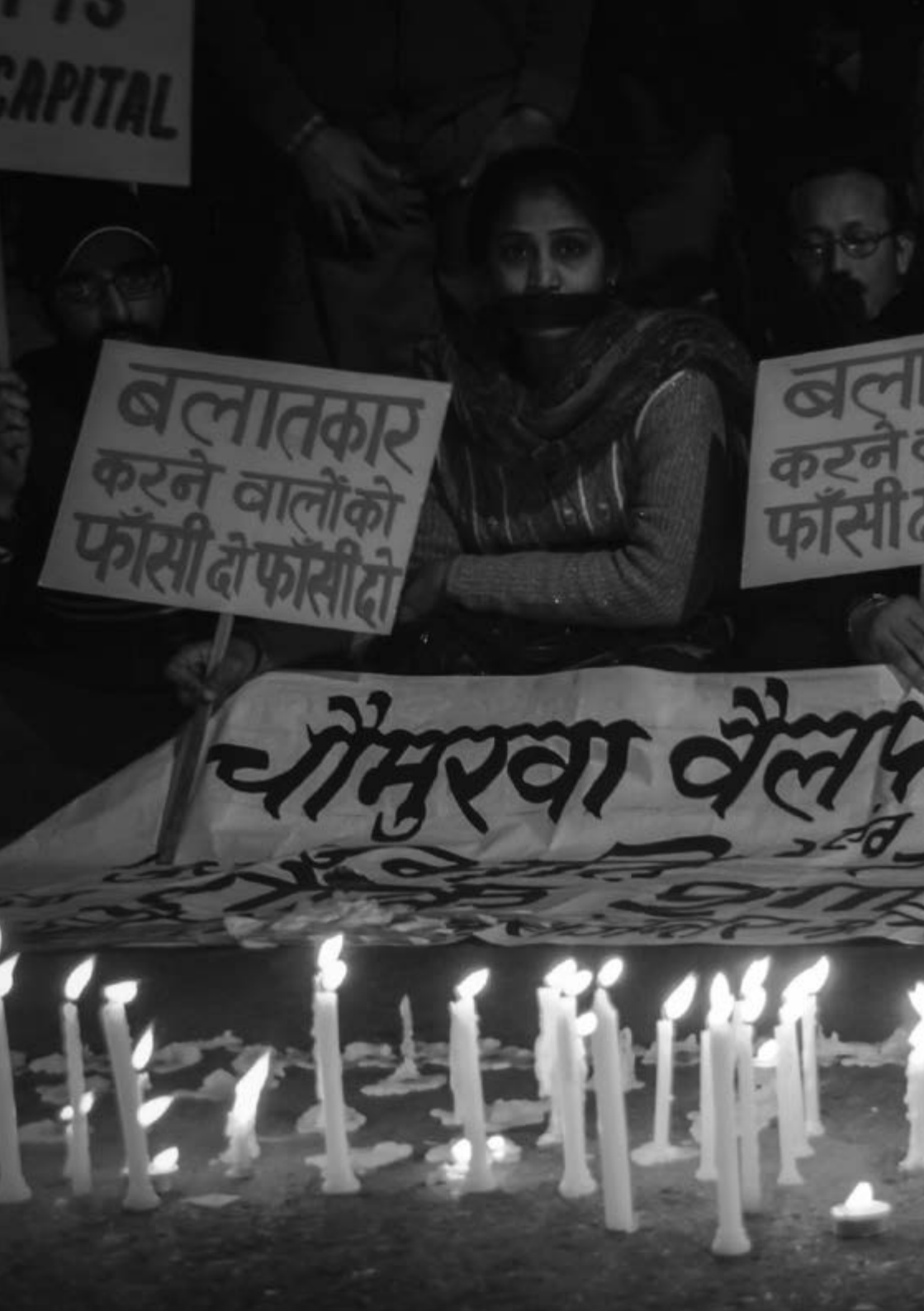
The CLA 2013 has made a strong case for transforming the response of the health sector to sexual violence. In India, the health sector does not recognise violence against women as a public health issue. India lacks a national health policy to address violence against women. It is absent from health policy and programme. Although all victims/survivors of violence (of any form) are either brought to the doctor or come on their own, the medical profession may not recognise violence and its consequences or provide comprehensive care and treatment. One of the issues that women and health activists raised was the insensitivity of the health sector and the

use of unscientific and anti-women practices of forensic medicine such as making comments on virginity and past sexual history through the use of the two-finger test. At the same time, there was also focus on good practice. An evidence based model[1] set up by CEHAT and the Municipal Corporation of Greater Mumbai that had provided comprehensive care and treatment to a large number of rape survivors was discussed in various fora (Rege et al, 2014). CEHAT made a written submission along with the Lawyers Collective to the JVC and consistently worked with the media and others to focus on the need to upscale this model.

Taking cognizance of the lack of uniform protocols and gaps in provision of medico legal care to survivors of sexual violence, recommendations of the JVC, the CLA 2013 and Protection of Children from Sexual Offences (POCSO) 2012, the Ministry of Health and Family Welfare (MoHFW) set up a national committee comprising of experts to formulate uniform protocol and guidelines for health professionals to respond to sexual violence. While doing so, international standards especially the World Health Organisation (WHO) Guidelines on medico legal care (2003) and Clinical and Policy Guidelines for responding to IPV and sexual assault (2013) were referred to. The committee has drawn from the available evidence from health sector interventions, legal and other expert opinions and voices of survivors. This is the most significant achievement as it is the first national directive for the health sector on responding to violence.

THE IMPLICATIONS OF THE LEGAL AMENDMENTS

The right to health care: The amendment to CLA 2013 recognises the right to health care for survivors of sexual violence thus compelling health professionals and health systems to make the shift from preoccupation with evidence collection to that of provision of comprehensive care and treatment. It further makes it binding on the health sector to respond to sexual violence without making any demand for a police complaint thus recognising rape a medico-legal emergency. Although the Supreme Court had observed in State of Karnataka V Manjanna (in the year 2000) that the medical examination of sexual violence victims should be done immediately and no hospital/doctor should delay examination for want of police requisition it was not seen in practice. Several instances where a victim/survivor was refused treatment as there was no police complaint made have been reported across the country. Even health professionals interviewed have said that rape survivors are always accompanied by the police thus making it clear that they do not recognise voluntary reporting. Section 357 C CrPC3 (Criminal Procedure Code) 2013 states that the hospital must immediately provide treatment[2] and care. This guarantees the right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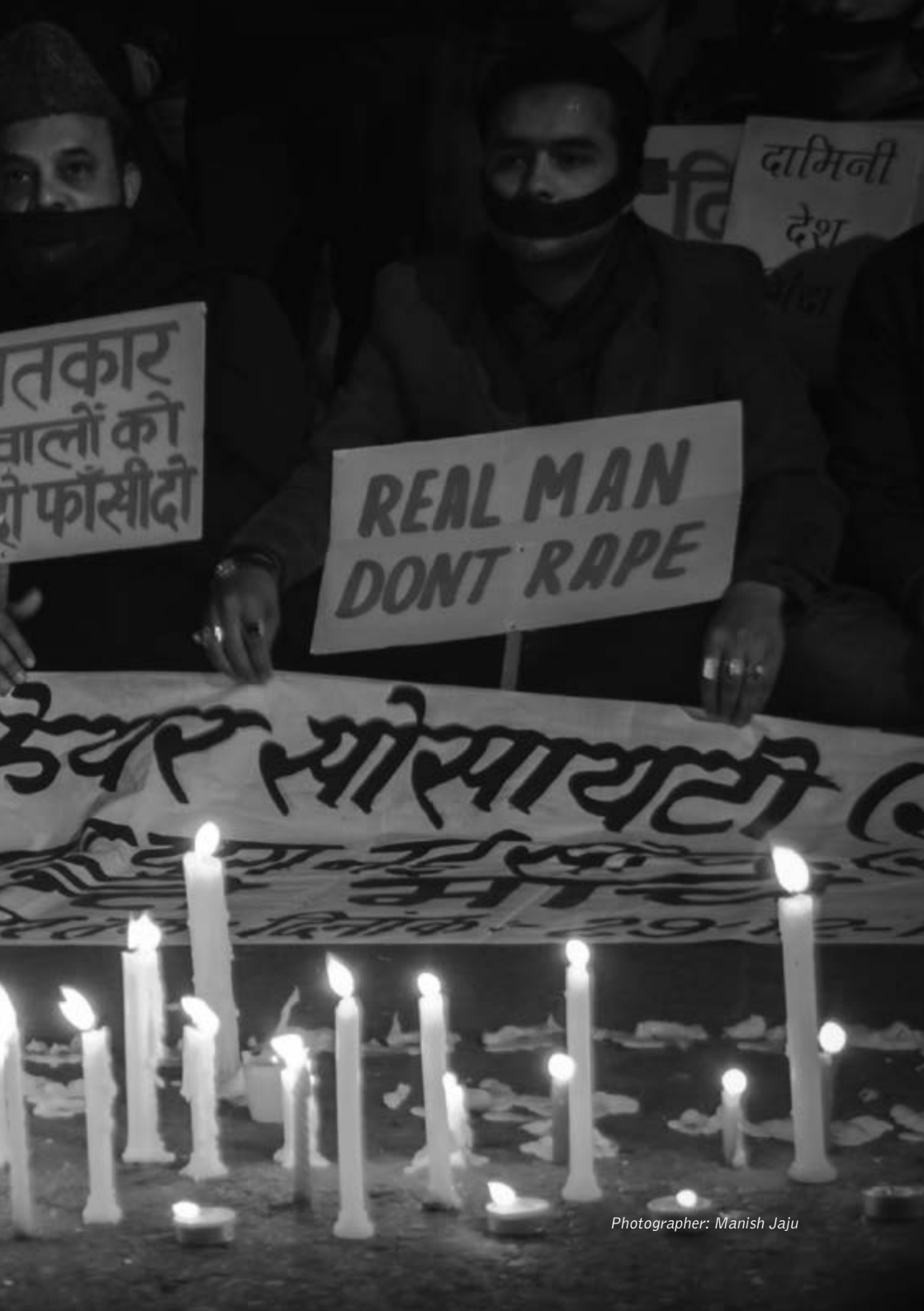

Photographer: Manish Jaju

to health care for all survivors of sexual violence as they can voluntarily report to a hospital instead of reporting to the police. This is a crucial shift from the past model of mere evidence collection in such instances to recognising the role of treatment and care by doctors. The CrPC further insists that such treatment should be free of cost. Not following this is an offence and a doctor could face imprisonment for a year and/or receive a fine.

Notwithstanding the guarantee of treatment in law, there have been several reports of rape survivors who were not provided with treatment on reporting to a hospital. These survivors then had to revisit a health facility for an abortion as emergency contraception was not given or had to seek treatment for burning micturition or infections (CEHAT 2013). Doctors mindlessly collect vaginal, oral and anal swabs during their examinations – often their foremost concern is to collect evidence of intercourse (Bhate-Deosthali, 2013) not to provide care and treatment to the survivor. *In 2010 CEHAT* filed an *intervention petition* in a Public interest litigation demanding gender sensitive protocols for medico-legal examination and the right to treatment and care for all survivors of sexual violence. But there was strong resistance from the health system. So deep-rooted are these biases that the experts on the committee were not able to appreciate scientific evidence and WHO guidelines that make a demand on the medical profession to move from evidence to care in their response to sexual assault.

Making redundant the pre-occupation with injuries: Explanation 2 to Section 375 on consent in the CLA 2013[3], is critical for the medical profession as it notes that lack of resistance does not mean that a survivor of rape consented to the act of rape. The forensic medical textbooks as well as the medico-legal practice in India, is hinged on 'finding injuries" as signs of struggle/resistance. The preoccupation is so much that absence of injuries is often construed as "no signs of rape". Many, mucosal injuries heal within hours but this is not understood. This is despite global evidence that only 33% of cases of sexual violence may show any injury. The absence of injuries could be due to various reasons – the victim being unconscious either due to trauma or being drugged/intoxicated, overpowered, and/or silenced with fear. Even the use of lubricant may decrease the risk of injury in sexual violence cases.

However even the latest editions of forensic science textbooks continue to propagate that rape cases must have signs of resistance. They further state that resistance offered depends upon the type of woman she is – her stage of development, whether she is a virgin or not and on the class of society to which she belongs. It emphasizes that doctors note the height, weight, general build and configuration of a victim as it

denotes capacity to resist the offender, e.g. in the 2010 Principles of Forensic Medicine Including Toxicology textbook, Nandy states that "[a] smart working and educated woman will be able to offer resistance while a timid, weak and shy woman is not expected to offer much resistance"[4].

Stopping insensitive and unscientific practices: Although section 146 (3) of the Indian Evidence Act prohibits any mention or reference to previous sexual experience/past sexual practices in the witness box, medical professionals continue to document these through comments on the size of the vaginal opening, old tears to the hymen, hymenal status and past obstetric history. In fact forensic medical textbooks are so biased that they provide information on how to differentiate between women who are and who are not habituated to sexual intercourse on mere examination of their breasts, vaginal opening, labia major and minora. The MoHFW has issued a directive to remove these practices from the medico-legal practice by issuing a protocol that is gender sensitive. The protocol disallows any mention of past sexual practices through comments on the size of vaginal introitus, elasticity of vagina or anus. Further, it bars comments of build/height-weight/nutrition or gait that perpetuate stereotypes about 'victims'.

Roping in the private health sector: Both public and private health service providers are now obliged to provide prompt care to survivors of sexual assault. Not doing so is liable to a punishment of imprisonment or a fine or both. This makes it mandatory for all public and private hospitals to provide health care free of charge. This is really significant as the private health sector is a dominant provider of health care in India but unregulated. Until this amendment, cases of sexual violence were not treated in private hospitals but referred to public hospitals to avoid medico-legal procedures. The private health sector therefore will have to gear up and train themselves on how to use the national protocol and guidelines of 2014. This is indeed an important achievement as it provides choice to the survivor and increases access to health care services.

Recognising all forms of sexual violence: The amended definition of rape as it stands includes all forms of sexual violence thus recognising non peno-vaginal sexual assaults. For years the health sector has limited its medico-legal practice in rape examination to the legal definition of 'peno-vaginal penetration". The CEHAT intervention model found that only 45% of sexual violence cases have involved peno-vaginal penetration. The amended definition makes it absolutely essential for the dismantling of old

medico-legal practice as doctors will now have to listen to what the survivor is saying before they begin the examination and collection of evidence. They cannot treat the survivor's body merely as a site for the mindless collection of swabs.

Demystifying medical evidence: In cases of rape the courts and police have given a lot of credit to medical evidence without recognising the dynamics of sexual violence, in terms of the nature and circumstances in which it occurs. Globally, it is known that medico-legal evidence is rarely found in sexual violence. The fact that the definition of rape has been broadened will no doubt increase the number of cases where no medical evidence is present at all. This has to be clearly understood by doctors, the police, lawyers, the courts and all other relevant stakeholders.

OTHER IMPORTANT IMPACTS

Focus on history and relevant evidence collection: The dynamics of sexual abuse, e.g. the nature of the assault, the activities undertaken following the incident and the use of verbal threats/intimidation, are important factors that need to be considered. The national protocol focuses on recording the history of the incident instead of the old practice of the "History of (H/o) alleged rape" thus recognising various forms and dynamics of sexual violence, including activities that may lead to a loss of evidence.

The national protocol also provides guidance on evidence collection based on science and history. Swabs taken for evidence will test positive only if there has been intercourse with ejaculation. If the woman has bathed, urinated, used a douche or washed herself – which is often an immediate response following a sexual assault of this nature – such evidence is not likely to be found. If a condom has been used or ejaculation has taken place outside the body, then body swabs may not provide evidence. There could be a delay in reporting the crime, and a further delay in reaching a health facility. If these important facts are not accurately noted in the medico-legal form, negative findings may go against the survivor. Mere non-detection in a medical examination does not mean that sexual violence/crime did not occur.

Provision of psychological care: The MoHFW has issued standard treatment guidelines that are not limited to treatment of physical symptoms but also for addressing trauma. Health providers are therefore instructed to provide such services in privacy, to ensure confidentiality, be non-judgmental and supportive, and validate what the survivor is saying. They are expected to provide practical care and support, including legal, social and other services. If the health provider does not have the time then they

should ensure that someone at the health facility is available to do so. This is an important step for creating good quality services for survivors of violence within health settings.

Providing a reasoned medical opinion: Section 164 A of the CrPC (specific law for medical examination of the victim of rape) insists that doctors provide a reasoned opinion. The national guidelines give direction on how doctors can frame such an opinion based on the history, the clinical findings and the results of forensic evidence. The absence or presence of medical evidence (e.g. absence of semen due to use of a condom) needs to be explained.

CHALLENGES

Mandatory Reporting: Section 19 POCSO Act and Section 357 C CrPC instruct the doctor/hospital to mandatorily inform the police when they see a case of sexual violence. Section 21 POCSO Act and Section 166 B IPC3 (Indian Penal Code) prescribes punishment for not doing so. This provision in law is problematic for survivors who may want treatment but who may not be ready to report the offence to the police. It contradicts existing laws in the country:

Section 164A of CrPC asserts that an examination can only be carried out if there is informed consent by the victim/survivor. This applies to the consent of medico-legal examination, treatment, evidence collection and informing the police. But now, should a survivor not want the doctor to inform the police, the doctor faces a significant dilemma – caught between ethics and legal requirements. Section 357 Cr PC and rule 5 POCSO further specify that treatment must be provided and that no hospital can deny it. As the 'right to treatment' and 'mandatory reporting' (even without the informed consent of the survivor) are enshrined in the same section of the law, this jeopardises the right to health care for survivors who do not want to report to the police immediately or ever for that matter.

Further, the Medical Termination of Pregnancy Act 1971 recognizes the right of the woman to terminate a pregnancy when it is as a result of sexual violence and also guarantees that this information is kept private and confidential. The current mandatory reporting of sexual violence laws violates the right of the survivor as all pregnancies resulting out of rape have to be mandatorily reported to the police even if the survivor does not want to report the case.

The National Guidelines by the MoHFW do clarify that medical professionals can document informed refusal in cases where the victim/survivor requires treatment but refuses to report the case to the police. The documentation noting informed

refusal may be kept at the medical institution but the police still need to be informed of this.

DNA: The Criminal Procedure Code insists on the collection of DNA evidence in all cases of sexual violence. This requires some discussion as DNA has to be compared and profiled properly. If a perpetrator of sexual violence is not found, then there is nothing to compare the collected evidence to. Forensic Science laboratories are few and are overburdened with cases. Most facilities across the country have limited infrastructure to adequately preserve evidence and as a result collected evidence is often contaminated by the time it is tested. There are no defined standards or process of accreditation of forensic science laboratories. The relevance and insistence on DNA testing therefore needs more discussion.

RECOMMENDATIONS

The national guidelines issued by the MoHFW that lay down standard operating procedures for the care, treatment and rehabilitation of survivors of sexual violence must be made applicable to all public and private health facilities across the country. These guidelines address all issues including medical examination, psychosocial care, treatment, issues when dealing with children, disabled, transgender and intersex persons, persons with alternate sexual orientation, sex workers, and people facing caste, class or religion based discrimination. It is imperative that civil society activists, law practitioners etc demand that these be implemented across the country.

It is important that health professionals are trained on how to use these guidelines as academic medical education does not currently equip them on how to do so. To fulfill their obligations, health facilities need to set up the necessary infrastructure including the provision of free medicine. Last but not least, current forensic medical textbooks must delete medieval biases and be rewritten as a matter of priority.

We must recognise that the sensitive handling of survivors/victims can reduce self-blame and enhance their coping and rehabilitation. The health sector needs to foster effective multi- sectoral collaboration with the police, Child Welfare Committees, prosecution and the judiciary to provide essential services to survivors and deliver justice.

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Endnotes

1 The model is survivor centric and seeks informed consent for medico legal purposes, provides medical care and psychological first aid, and uses gender sensitive protocol for describing medico legal findings.
2 Rule 5 of the Protection of Children from Sexual Offences Act (POCSO) specifies that treatment should include care for Injuries, STD, HIV, Pregnancy testing, Emergency contraception, and psychological counselling.
3 It states: "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".
4 What do the forensic medicine textbooks say about sexual assault?: An analysis by CEHAT, available at http://www.cehat.org/go/uploads/ResearchAreas/Roundtable%20at%20NLUD.pdf