Sexual Assault Evidence Kit
Institutionalising a Model for Addressing Care and Evidence-Linked Issues

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There is sufficient evidence to show that early and good quality documentation of evidence is associated with positive legal outcome and hence this area of reform in medico-legal services need to be actively pursued. Needless to add, good quality training and motivation building will be the mainstay of success and sustainability for any such efforts. Involving the medical professional in this fashion and trying to work at the interface of law enforcement, medical profession and prosecution could be one strategy to address barriers faced by survivors of sexual assault

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CEHAT[1] works with the perspective that health and health care are a basic human right. The last a decade or so when CEHAT has been active as a voluntary organization has also marked a period of collective research and action in India for recognising violence against women as a major health and human rights issue. Talking about gender-based violence as a public health issue has been a fairly recent phenomenon. CEHAT's contribution along with that of other organizations also has been the discourse on the role of the health care provider in the context of violence and the ensuing ethical dilemmas.

There have been three distinct problems that have engaged our concern. The first has been the problem of the constantly lowering sex ratio in India which points to the active connivance of the medical professional in a society with a strong 'son preference'.[2] Modern technology has just helped bolster the old beliefs and find 'convenient' methods of eliminating 'unwanted girl children'.[3] The second has been the high prevalence of domestic violence in society, which goes 'unnoticed' even when women do visit health care providers, or 'unrecorded' as it is considered a personal problem. Often such cases of violence end up at the same health care facility with fatal consequences of violence. Unfortunately medical professionals do not seem to feel any responsibility towards prevention of these deaths. The third problem came up specifically when a voluntary group investigated the role of medical professionals in the Gujarat carnage two years back.[4] Often it has been noticed, though difficult to prove that health care professionals are themselves polarized during riots and do not perform the role of unbiased care providers. Even when there is no active connivance with riot mongers, there is no systematic component of importance of unbiased care to all especially in these circumstances in their trainings. Besides these their role in police torture, in administering the 'truth' serum and in capital punishment to pronounce the person dead has invited much criticism from bio-ethics activists. Attempts to encourage medical associations and professionals to self-regulate have failed miserably. Merely directing reforms at the medical professionals will not help either. This initiated the

challenge to involve medical professionals themselves more thoroughly in the process of reform.

Violence against women in India cuts across geographical areas, age groups as well as caste, class, ethnicity, religion and other community differentials. Indirect evidence points to its high prevalence and yet it is one of the most under-reported events. Violence is the number one cause of death for women of the reproductive age group in India, and most of these deaths occur within the home setting. These deaths include dowry deaths, as well as those resulting from other forms of domestic violence. Besides these there is a wide spectrum of violence prevalent in society affecting women such as 'sex-selective abortions', 'acid attacks by spurned lovers', sexual violence and others. Needless to say it is a gross violation of human rights as well as an important health concern. While gender based violence, as violence against women is better recognized as, follows women from the 'womb to the tomb', getting recognition for it either as a human rights issue or a health issue has been an uphill task for those concerned in India. An important reason for this has been the presence of a strong patriarchy in society as well as state machinery and consequently the non-recognition of women' rights as human rights. She has been traditionally considered a commodity owned by the men in the family and society so much so that even health concerns resulting from violence are seen to fall within the realm of her 'private' life, and the cause is not open to enquiry by any outsider including a health professional. Thus any proactive screening for violence or addressing it within the health sector has been a neglected area in India.

Recently much work has been done to show the high prevalence of violence and how its pervasive nature, harmful health effects for women, deprivation of healthy years of life as well as their rightful stake in the economic and political arena effectively makes it a public health problem. The health sector is increasingly being seen as an effective and accessible yet non-threatening medium of addressing consequences of violence, while also giving the woman space to build her confidence and get appropriate referrals for any legal action she may want to pursue. While this is a welcome initiation in as yet uncharted areas, we would like to draw attention to a further neglected area, viz., health and human rights concerns of those facing sexual violence.

Reform in Rape Laws in 1980s

The injustice faced by women suffering sexual assault was first brought to light by the women's movement in India in the 1980s. This was triggered by the Mathura rape case of 1972 that became a landmark case and judgement in the women's struggle. Mathura, a tribal girl ran away with her fiancé and Mathura's family registered a complaint against them. The police for purposes of interrogation detained the fleeing couple. In the police custody a drunken constable sexually assaulted Mathura. When a police complaint was made her character was tarnished with references to her earlier sexual life. The chief support to this was given by the medical evidence which stressed

'habituation to sex' and findings of 'old tear of hymen'. Mathura lost the case at the district level. A favourable decision was given in the high court on appeal, but this was again overturned by the Supreme Court. This created an uproar in the progressive women's groups and they staged a massive struggle against the court decision. Although Mathura lost the case, the achievement of this struggle was that custodial rape came to be recognized as an aggravated form of rape, for which the onus of proving the crime would be on the suspect and not the victim, as is the usual case.

This struggle also led to the Criminal Law Amendment Act 1983. It amended section 376 of the Indian Penal Code and stipulated that the penalty for rape should not be less than 7 years. It also provided for trial in camera and inserted a clause, making the disclosure of the victim's identity a punishable offence. On January 3, 2003, one other landmark change notified the enforcement of a legal amendment stipulating that in a rape case the victim cannot be questioned or cross-examined about her ''general immoral character''. Even so the deeply entrenched erroneous beliefs and biases of the judiciary continue to keep justice a dream for women. In the more recent rape case of Bhanwari Devi, a village volunteer, in Rajasthan, the courts released the rapists presuming that they being of upper castes would not rape a dalit such as her.

Medical, Law Enforcement and Judicial Systems

Adequate management of sexual assault and securing justice is a complex process necessitating a good coordination between the medical, law enforcement and judicial machinery. Unfortunately in India we see problems in each of these systems, as well as lack of effective coordination between the three systems. It is the survivor who bears the brunt of this.

The role of health care providers in management of 'Sexual Assault Cases' is still an inadequately dealt with problem in India. The medical professional in India today is totally at a disadvantage in giving effective care and medico-legal services to cases of sexual assault. Several problems co-exist which effectively deny important services to women, one of the primary problem being unwarranted bias against the victims themselves again arising out of long held, prejudiced beliefs of gender roles, various myths and no contact with facts about prevalence of violence in society. Most medical professionals we interacted with and also their textbooks are preoccupied with false charges often made by women[5]. *'.... it is not possible for single man to hold sexual intercourse with a healthy adult female in full possession of her senses against her will'- t*his is a statement from a very widely used textbook of Forensic Medicine in India[6]. In a personal interaction, one professional went to the extent of persuading us that even when children are brought by parents it is often their way to get even with neighbours, using child abuse as the ruse. Under-reporting rather than false reporting is the main problem. For every reported rape case, 68 cases went unreported, notes Pramod Kumar and Rainuka Dagar in their study from Punjab[7]. With such strong beliefs and disconnected from the reality that hardly any of the already few cases reported are false, the medical professional is often not in a position to empathise with survivors.

The conviction rate of all cases standing trial for sexual assault are less than 30 per cent and considering ever-reported cases the conviction rate is as low as 4 per cent[8]. Here we would like to present specifically the problems regarding the role of the health care provider, whom the proposed use of the 'Sexual Assault Evidence Kit' is most likely to benefit.

Inadequacy of training and motivation

Inadequacy of training and motivation is an important cause of the lack of care and ineffective documentation of evidence in India and other developing countries.

Most basic graduate doctors have no idea of how to examine cases of sexual assault and the range of services required. "I had an excellent medical education, but formal education never taught me to handle cases of raped women and to look for signs of violence and abuse against women and children in the emergency rooms," says Sylvia Estrada-Claudio, a medical doctor who works with NGOs struggling for social justice in the Philippines.[9]

Most doctors do not pay heed to the minimum training that is received in this regard in the second year of medical training on the premise that they would not need to use it in future. On the contrary many doctors end up in government service and have to undertake this duty. Even when they are in private practice the state holds the authority to invite doctors for examination if a public servant cannot be accessible. It was the doctor on call at the Umerkhadi Observation Home who was called to examine the case of Billa No. 31, a case of sexual assault by an employee on the premises. He recorded his findings in 4 lines and did not collect any samples for evidence. No attempt was made to get the suspect examined, although he was on the premises all the time[10].

Col P.R. Pathak, Professor and Head, Department of Forensic Medicine, A.F.M.C, Pune, writes – "As per the MCI Regulations on Graduate Medical Education, 1997, only 100 hrs have been allotted for teaching forensic medicine and toxicology during the second year of the course…It is evident that 100 hrs of teaching will be inadequate…Health Care Delivery system prevalent in our country expects that the subject be practised efficiently at the PHC level."[11] He goes on to note, "The discipline of forensic medicine is still a back seater as it used to be in the past".

Especially as these cases of sexual assault are medico-legal in nature, the medical professional is often called to the court to testify as an expert. Examination and documentation of such cases thus becomes the most avoidable of all tasks. Often the doctor is asked to testify many years after she has examined and would be lucky to receive her documentation at least half an hour prior to her testimony. Sometimes doctors have been transferred in the interim and are made to travel back to the place of examination that makes them feel as though it is a punitive work. High motivation regarding the work, and keeping the doctor posted about its outcome will give her a sense of how important her travel or extra work has meant to the survivor- literally a matter of getting justice.

In South India, only women doctors are allowed to handle these cases.[12] Often trainee doctors do not even attend these classes, as they would never need to examine a case of sexual assault. Besides even where training is given and taken seriously, the

component of mental health care and counselling are totally absent. The medical textbooks used to educate doctors themselves exhibit considerable bias against women.[13]

Current System of Handling Cases of Sexual Assault

Good quality training should be coupled with training in the use of uniform protocols and guidelines regarding care and examination of such cases. There is high turnover of resident doctors in city and town hospitals, and the rural doctors see few cases with a huge time gap in between. These are the doctors who most often need to manage cases of sexual assault. Without uniform guidelines they are left to fend for themselves. The Survey Committee Report on Medico-legal Practices in India, has noted way back in 1964:

> Committee notes with regret the lack of uniformity in the practice and procedures followed in different parts of the country. There are no adequate arrangements for the investigation of the majority of medico-legal cases.

This unfortunately holds true to date.

Care for ailments is another area where often the woman suffers. It is seen that she seldom gets both good care and good collection of evidence. Berit Schei, notes:

> In the past, victims of sexual assault reporting directly to the police may not have received total medical care. Victims often face a no win situation. On one hand, those reporting directly to the police presumably have forensic documentation and evidence collection performed, but they might not receive appropriate medical treatment and psychological follow-up. On the other hand, victims who do not contact the police in the acute phase and seek direct medical care might not receive appropriate evidentiary documentation.[14]

We also find gross insensitivity towards survivors, such as multiple referrals, where the survivor needs to tell her story to multiple care providers. Sometimes more than one doctor is involved in the examination but only one of them completes the 'Opinion based on examination' section and testifies in the court. A gynaecologist from Sangli district of Maharashtra narrated this incident: He was called to examine a woman who had complained of sexual assault. On P/V examination he wrote one of his findings as 'Fornices are free' meaning no adnexal mass. The casualty medical officer who was writing his opinion inferred that this meant that no sexual intercourse had taken place.

Need for the SAFE kit

One effective way in countering at least some of the above problems is to use a 'Sexual Assault Evidence Kit, Uniform Protocol and Manual', along with good quality training and motivation building. The kit can be useful in itself as well as an advocacy tool to build linkages between the law enforcement and prosecution. Such kits have long been in use in developed countries, but we are still struggling to make a strong case for its use in India. The *World Report on Violence and Health* has acknowledged that use of uniform protocols could enhance quality of care as well as evidence

documentation, at the same time citing that most under-developed and developing countries do not use standard procedures and are unable to provide comprehensive services to survivors. We would also like to site here the experiences in developed countries regarding the linkages between meticulous evidence collection and legal outcome, to answer any scepticism.

Linkages between good quality evidence and legal outcome

"In all cases of medico-legal importance, the report of the medical experts is of primary importance." [15] [Bakshi, 1994]. The study done by McGregor in Canada shows that the very presence of a record on the case-file (70 per cent) by the police officer that forensic samples were received and sent for examination, was significantly associated with charges being filed (OR 3.45, 95 pr cent CI).[16] It also shows that effective documentation of moderate to severe injuries increases the possibility of a legal outcome. That doctors need to be trained and to have basic equipments for examination is also brought out by Rambow, Adkinson et al where they document genital injuries in 9 per cent women. This finding is significant in view of the fact that only 29 per cent of these had complaints of genital pain or bleeding. The genital injuries could have been missed if a systematic examination were not carried out[17]. In the Cleveland study (Riggs et al 2000), sperm was found in the Emergency Department wet mount only in 13 per cent of cases, but putting together with crime laboratory findings, it was noted in 48 per cent of cases. Special efforts need to be made in this direction as many survivors in developed as well as less developed countries report not having received essential services. In one study, only 1 in 10 adult sexual assault victims was found to address themselves to post-rape services.[18] In another study, 1 in 5 adult female victims received post-rape treatment.[19] Other studies too find that less than one third of incidents are reported to law enforcement.[20].There is a significant delay in getting care for many and this seriously damages forensic evidence collection. Examination of survivor within 24 to 36 hrs and documentation of evidence, especially injuries are positively associated with legal outcome, i.e. 'charge-sheeting' or conviction. Only $1/10^{th}$ of the most serious violent incidents in an intimate partner relationship came to the attention of the police according to a Finnish study.[21] In a population-based study women assaulted by a stranger were more likely to report having received medical care compared to those assaulted by an intimate partner.[22]

Suffice to say that delay in getting medico legal care for survivors of sexual assault is common and all efforts must be made to reach comprehensive services to them. There is sufficient evidence to show that early and good quality documentation of evidence is associated with positive legal outcome and hence this area of reform in medico-legal services need to be actively pursued. Needless to add, good quality training and motivation building will be the mainstay of success and sustainability for any such efforts. Involving the medical professional in this fashion and trying to work at the interface of law enforcement, medical profession and prosecution could be one strategy to address barriers faced by survivors of sexual assault.

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Notes

[1] Centre for Enquiry into Health and Allied Themes is a health research, action and advocacy organisation based in Mumbai, India.
[2] Census 2000, India shows sex ratio in India has gone down to 933 females per 1000 males
[3] Sex Selection, Issues and Concerns, CEHAT, Mumbai, 2002.
[4] Carnage in Gujarat, A Public Health Crisis, A report by the Medico Friend Circle.
[5] Agnes, Flavia, Gender Review of Medical Textbooks.
[6] Modi's Medical Jurisprudence & Toxicology, 21st Edition, 1988, p 510.
[7] Pramod Kumar and Dagar, Rainuka, 1995, Chandigarh, 'Atrocities against Women' in Punjab, Institute for Development and Communication.
[8] Laxmi Murthy, April 2003, Infochange News and Features, Legislating for change: Articulating Women's Rights.
[9] Arrows for change, December 1995, Violence Against Women: A Silent Pandemic, Women's and Gender Perspectives in Health Policies and Programmes, ISSN 1394-4444.
[10] D'Souza, Lalita, October to December 2000 , *Issues in Medical Ethics*.
[11] Paper written for the X Annual Conference of Medicolegal Association of Maharashtra, 2000.
[12] Narrated by Dr. Jagadeesh Reddy, at the Medical Consultation on 18th December 2004, at KEM hospital, Mumbai to update and finalise the SAFE Kit. Based on Supreme Court Judgement to the effect that only women doctors may examine female survivors of sexual assault.
[13] 'To whom do the experts testify', Flavia Agnes.
[14] Berit Schei, 2003, Rigshospitalet, Copenhagen, Denmark.
[15] The Offence Of Rape and Certain Medico-legal Aspects, A Study by P.M. Bakshi, National Commission for Women, New Delhi, 1994.
[16] *Margaret J. McGregor, Janice Du Mont, Terri Myhr, January 2002University of British Columbia, Canada.*
[17] Female sexual assault: Medical and legal implications, Ann Emer Med, 1992, 21, 737-1.
[18] Schei B, Sidenius K, Lundvall L, Ottesen GL, Adult victims of sexual assault: acute medical response and police reporting among women consulting a center for victims of sexual assault, Center for Victims of Sexual Assault, Rigshospitalet, Copenhagen, Denmark.
[19] Ibid
[20] Diana Beebe, *Sexual Assault*.
[21] Diane Beebe, *Sexual Assault*.
[22] Schei B, Sidenius K, Lundvall L, Ottesen GL, *Adult victims of sexual assault: acute medical response and police reporting among women:Consulting a center for victims of sexual assault*, Center for Victims of Sexual Assault, Rigshospitalet, Copenhagen, Denmark