

## COMMENTARY

# Sexual violence in India: addressing gaps between policy and implementation

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The savage Delhi rape of 16 December 2012 was instrumental in generating the Verma Report that framed policies for amending the Criminal Laws related to sexual violence, professionalizing forensic/medical examination of victims, and sensitizing the police, electorate and the educational sectors. Unfortunately, even after a year, the Indian Home Ministry has abysmally failed to implement most recommendations, even underutilizing budgetary allocations. This article addresses gaps in governance systems and offers solutions to the problem of sexual violence in India.

**Keywords** Rape, violence against women, gender, policy implementation, health sector reform, Millennium Development Goals

## KEY MESSAGES

- The Delhi Rape of 2012 precipitated a nation-wide outrage which prompted the Government of India (GOI) to produce the Verma Report (VR) for reforming judicial policy on gender violence and improving victim care.
- Even after a year, the GOI has not implemented most recommendations in the VR.
- While focusing merely on legislative reforms for punishing sex crimes, the GOI falls abysmally short of addressing the humanitarian goal to help victims resume a meaningful life.
- GOI must mandate the deployment of forensic nurses/examiners, invest in forensic and rape-crisis facilities and sensitize professionals to facilitate evidence collection and victim counselling.
- GOI needs to bridge the policy–programme gaps and learn from Western models to effectively implement the Verma recommendations.

## Introduction

The savage Delhi rape of 16 December 2012 brought up the long-ignored problem of sex crimes in India (EPW 2012). As the news of the bestial sexual assault on a student in a moving bus went viral, the outraged community came out on the streets protesting against the apathy of law enforcement agencies towards women's safety (Shakil 2013). Given the statistics of sex crimes, the outrage seems completely justified. Alarming, rape cases registered in India went up from 2919 in

1973 to 24 206 in 2011; but convictions dropped by 18%. In 2012, Delhi registered 706 rapes (23.4% higher than 2011) with only one conviction (NCRB 2011, 2012; Timmons and Gottipati 2012).

Responding to the nationwide protests, the Government of India (GOI) constituted a committee, headed by the former Chief Justice of India Late J.S. Verma, 'to recommend amendments to the Criminal Law... for quicker trial and enhanced punishment for... sexual assault against women' (PRS 2012). The committee

reviewed more than 70 000 suggestions by experts and the general public, and compiled the Verma Report (VR) within 29 days. This white paper, released on 23 January 2013, was comprised of comprehensive recommendations on laws related to sexual violence, child sexual abuse, trafficking, medical examination of victims, in addition to sensitizing the police, electorate and the educational sectors (Verma *et al.* 2013). The public welcomed the VR as a 'moment of triumph for women' (Kannabiran 2013), offering them protection from all forms of gender violence.

As sexual crimes cannot be eliminated overnight, policies for victim care and rehabilitation should be the priority (Yee 2013). The VR rightly emphasized the need to establish a more effective response care system for rape and sexual assaults, and the United Nations (2013a,b) urged the GOI to act upon these recommendations. Unfortunately, even after a year, the Indian Home Ministry has abysmally failed to implement most of the Verma recommendations (FirstPost 2013a,b; HRW 2013). The Criminal Law (Amendment) Ordinance 2013, passed by GOI on 23 February 2013, was criticized by the public and women's groups for bypassing vital recommendations regarding 'reforms in Constitution, governance, policing and education' and for not recognizing rehabilitation of rape survivors as a state responsibility (Naqvi 2013; Shakil 2013; The Hindu 2013). Subsequently, an anti-rape bill tabled in the parliament sought detailed discussions on VR. Although the important bill (Criminal Law Amendment Act 2013) managed approval, the patriarchal parliamentary debate (EPW 2013) ignored rape victims care and focused on defining rape and punishing sex crimes (GOI 2013; United Nations 2013b). In addition, the INR 10 billion Nirbhaya funds, approved by the parliament in the last year's budget, to ensure women's safety and security 'have not been used so far [as of 1<sup>st</sup> January 2014], as the relevant schemes are yet to be finalized' (Shaji 2014). This article discusses the shortcomings which the GOI must address to effectively implement the VR recommendations.

## Forensic investigations: inadequate infrastructure and human resources

Although the Supreme Court decrees that the victim's testimony alone is enough to arrest the accused (The Hindu 2006), forensic evidence is critical for convicting rapists. Sub-optimal forensic investigations (HRW 2010) have diminished the conviction rate; in 2011, courts delivered verdicts to only 21 489 of the 127 000 accused. Pending cases have increased from 78% to 83% during the past 20 years (NCRB 2011).

The VR highlights 'The Model Police Act 2006', which mandates both state level and regional forensic science laboratories along with mobile units for every district, necessary to collect the evidence quickly because evaluation and treatment are time sensitive (Linden 2011). Nevertheless, India lacks forensic laboratories for gathering, documenting and analysing biological samples such as DNA and physical evidence. Just 4 central and 25 state forensic laboratories cater to the whole of India. Only 5% of medical institutes can entertain rape forensic investigations (Tondon 2013). Of 30 000 pending files in Maharashtra's six forensic laboratories, more than 3840 relate to sexual assault. Rape cases constitute more

than 16% of 9000 pending files in the central forensic science laboratory (CFSL), Kolkata (TOI 2013).

India has only 25 DNA experts, 300 medico-legal experts and 5000 forensic experts (Tondon 2013). The CFSLs have 42% vacant posts against the projected requirement of 106% above the sanctioned strength. In other words, these laboratories require almost twice the currently sanctioned jobs and 2.5 times the presently available employees (Mishra and Damodaran 2010). Most laboratories receive samples late, and many are contaminated because of untrained professionals and poor storage facilities.

## Multi-faceted 'community-based' approach

India needs to constitute and mobilize task forces and crisis centres to support medical examination of victims, provide legal counsel during trials and thereby improve reporting of sexual offences which might increase conviction of perpetrators. The VR recommends implementation of the World Health Organization's (2004, 2009) guidelines on how trained health-care professionals can collect and document evidence, treat injuries, prevent transmitted diseases and pregnancy, provide psychiatric counselling and follow up. Although VR proposes a 'sexual assault crisis center (SACC)', 'public emergency response system (PERS)' and 'medical examiner', the GOI seems unaware of specific procedures for implementation and professional competencies required of such centres. As in United States of America (USA) and Europe, the SACC should be the emergency department at hospitals or rape crisis centres where victims can report the crime. The importance of PERS, a professional helpline network for victims, becomes evident from the experience with the women's helpline in Delhi, which has received an average of 1800 calls per day since its reactivation on 31 December 2012 (Kumar 2013). Nonetheless, India lacks a network of professionally trained personnel (women's rights lawyers, social workers, sexual assault nurses, psychoanalysts, medico-legal experts, trained policemen, etc.) for establishing an effective nationwide PERS. To realize the VR recommendations such as SACC and PERS, the GOI should adopt Western models that successfully address sexual violence.

## Recommendations

### Learning from the West

Rape, Abuse and Incest National Network (RAINN 2009), the largest anti-sexual violence organization in the USA, has 1100 local rape treatment hotlines helping ~1.5 million victims with around-the-clock free confidential victim-care supports. RAINN also provides statistics to policy makers, public health centres and educational institutions. The USA has 650 sexual assault response teams with representatives from health care, forensic, local rape crisis centres, law enforcement and prosecution units (Linden 2011). With such measures, the USA has reduced rapes by 60% since 1993, preventing around 2 546 420 rapes in 10 years (NCVS 2012). Similarly, the Rape Crisis Network (RCNE), a European organization, operates in 30 member countries by collecting data, conducting research, offering

counselling, legal advice and assisting policy makers for educational and legal reform. RCNE's English and Welsh chapters also assist their respective governments similarly.

It is vital that India implements similar schemes, beginning with training and recruitment of professionals. VR will not translate into action unless professional practices replace the outdated ones, bridging the gap between policy and programme implementation.

### Empowering victim-care professionals

Surprisingly, India disregards the concept of forensic nursing, which forms the first line of victim care in the West (Pitre 2005) with sexual assault nurse examiner (SANE) and sexual assault forensic examiner (SAFE) offering comprehensive health care to victims. SAFE performs physical assessment, provides first aid/medications and helps in psycho-social counselling, forensic sample collection, preparation of medico-legal reports and work with victim-care centres, police, hospitals and forensic laboratories (Ort 2002; Lynch 2006; Markowitz 2007). However, such medical examiners will see only a small fraction of victims in India, because for every reported case, 50 go unreported (Bhalla and Vishnu 2012). Unless specific roles are assigned to all categories of health professions, and not just medical practitioners, the outcome will remain sub-optimal.

Furthermore, Ledray (1996) reported that rape victims prefer and must be seen by a female examiner and professionals with humanistic training. However, rape victims in India have to face a patriarchal investigation system wherein examiners, police and lawyers are mostly insensitive men (Gupta 2013; Shakil 2013). As highlighted by the VR, Indian police and health professionals need to eliminate their callous attitude towards victims. Unfortunately, India continues to practice archaic post-rape procedures, such as the two-finger test to determine 'habituation to sexual intercourse' (Pitre and Lingam 2013). Stories by rape survivors (HRW 2010) suggest that this test undermines the survivor's dignity by raping them twice and is exploited often so as to be named as full-fist test. An eminent sexual assault prosecutor said, 'The brutal examination by... police and doctors is unacceptable... There must be an attitudinal change... to ensure the dignity of the victim' (Ali and Perappadan 2012). In addition, the police need to be more accountable by working with other institutions and advocacy groups, and must be educated about the 'dynamics of rape and how they differ from other crimes' (PERF 2012; Bhalla 2013). Victim-care professionals should be sensitized about rational procedures for supporting rape survivors, and confidential reporting for mitigating the stigma that discourages self-reporting.

### Conclusion

The Delhi rape case has opened a Pandora's Box, and the ensuing brouhaha has revealed the atrocious gender attitudes of Indian lawmakers and health systems. The GOI needs to understand that 'law can never be the entire answer... framing laws and making them perfect should not take up all our time' (Bhabha 2013). Even maximum punishment, i.e. death penalty, for the Delhi rapists does not begin to address the needs of rape survivors. With each day's delay, we are risking the lives of hundreds of women.

While focusing merely on legislative reforms for punishing sex crimes, the GOI falls short of addressing the more humanitarian issue of helping victims resume a meaningful life. Assuaging the trauma of rape is as important as punishing the guilty. The GOI must mandate the deployment of forensic nurses/examiners, invest in forensic and rape-crisis facilities and sensitize professionals to facilitate evidence collection and victim counselling. In view of extreme under-reporting (85% in 2011) and acute shortage of physicians (Jain 2013; Sharma *et al.* 2013), every healthcare professional must be included in victim-care surveillance teams.

Without augmenting professional competence in victim care and modernizing post-rape protocols/procedures, India cannot empathize with and provide dignified treatment to the rape survivors, two things they deserve the most. India must take a 'systems approach' to assuage sexual violence, and contribute to the 2015 Millennium Development Goal of gender equality and women empowerment.

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