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SOUTH AFRICA
VIOLENCE AGAINST WOMEN AND THE MEDICO-LEGAL SYSTEM

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INTRODUCTION

> The Special Rapporteur is absolutely convinced that without a complete overhauling of the criminal justice apparatus, the retraining of its members and the creation of a more representative service, violence in general, and violence against women in particular, will never be contained.[1]

South Africa's criminal justice system is, as recently noted by the United Nations Special Rapporteur on violence against women, a product of the system of racial and political oppression operated by the previous government. It is also a reflection of a sexist society which has historically disregarded or placed a low priority on the need to address discrimination and violence against women. While the government elected in 1994 has taken significant steps to improve the response of the state to violence against women, women in South Africa who have been the targets of rape or sexual or other assault continue to face a system that is often hostile to their efforts to seek redress.

The police, usually the first point of contact with the criminal justice system for a woman who has been assaulted, are often uninformed and unsympathetic. Despite recent efforts to improve the system, a woman complaining of rape may have no choice but to give a statement to an untrained and unsympathetic male officer, within the hearing of others waiting for attention. Once the case is opened, the police may carry out the investigation with a minimum of enthusiasm and allow known perpetrators to walk free. Women who have been seriously assaulted, to the extent of needing medical attention, may find their cases dismissed as unimportant given the levels of "real" crime needing police attention. Police officers are often unaware of the legal or other remedies available to women.

The court system is little better. Prosecutors may also refuse to handle domestic violence cases, and in rape cases often subscribe to the usual stereotypes, dropping cases where the woman involved is not a "good" victim. Magistrates and judges often have discriminatory and sexist assumptions about women that can prejudice those cases that do reach court. A high percentage of rape and sexual assault cases are dropped before they reach trial or result in acquittals. For a woman seeking to obtain redress, the experience of attempting to use the criminal justice system is often more likely to compound the trauma of the original assault than to provide the satisfaction of seeing a perpetrator punished.

This report focuses mainly on one aspect of the criminal justice system and its handling of violence against women: the performance of those involved in the provision of medical expertise to the courts when it is alleged that women have been abused. Medical evidence is often a crucial element in the investigation and prosecution of a case of rape or sexual assault. Many rape cases result in acquittals simply because, if the only evidence before the court consists of the differing accounts given by the woman and man, the man will be given the benefit of the doubt; medical evidence, where it is available, may provide the only corroboration of the woman's allegations. While the absence of medical evidence does not indicate that no assault occurred, it is essential that medico-legal examinations be carried out promptly, expertly and objectively, to ensure that crucial evidence to support the case is not passed over. Police and court officials must be equipped to evaluate that evidence and to ensure that it is properly used.

The report concludes that the medico-legal system in South Africa is deeply flawed, with problems of inaccessibility, prejudice and lack of training at all levels. Some of the doctors employed by the state to carry out medico-legal work are dedicated and expert practitioners, providing an excellent service to women and others who need them. But this expertise and dedication is acquired through their own efforts: it is possible for a student to graduate from medical school without a clear idea of the normal anatomy of a woman's genitalia, still less of the complex physical and psychological consequences that may result from sexual assault, and no further training is absolutely required before a doctor can begin to practice as a district surgeon. Meanwhile, district surgeons, historically largely male and white, often reflect the prejudices and preconceptions of the wider South African society.

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[1] "Report of the Special Rapporteur on violence against women, its causes and consequences, Ms. Radhika Coomaraswamy, Addendum, Report on the mission of the Special Rapporteur to South Africa on the issues of rape in the community," U.N. Document E/CN.4/1997/47/Add.3.

The police who are responsible for investigating offenses of violence against women are for the most part ignorant of the interpretation of medico-legal evidence and as a consequence may not pursue good cases where the only other evidence is the account of the woman herself. In other cases, lack of transport or differing police priorities may mean that women have to make their own way to the district surgeon; or even that the complainant and the suspect are placed together in a police van for transportation to the doctor for examination and the collection of biological samples. In addition, courts are ill-equipped to evaluate medical evidence, and prosecutors, interpreters and magistrates need training in the technical medical detail of rape and sexual assault as well as sensitization to the wider issues.

The report briefly examines recent policy initiatives and the proposals for reform that have been made by the new government in its review of health services. The reform proposals aim to rectify some of the most glaring problems with the current medico-legal system, including problems of access, but they also risk placing too heavy an emphasis on accessibility at the expense of providing a high-quality service in this very technical area. Within the constraints placed by the many demands on the government's budget for reconstruction and development, the aim must be to raise the standards of the services currently offered, as well as to extend that service to all parts of the population.

South Africa is obliged under international law to ensure that women are guaranteed respect for their human rights and fundamental freedoms on the same basis as men. This obligation extends to the provision of an effective remedy if those rights are violated. In many cases, the state does not provide an effective remedy to South African women who are subjected to violence. The current condition of medico-legal services is one part of this failure. However, the improvement of the response of South Africa's medico-legal services in cases of violence against women cannot focus only on district surgeons or their replacements. Proposals for reform must take into account the experiences of the women themselves from the time they first report an assault through the time they appear in court.

RECOMMENDATIONS

In addition to the general recommendations in its 1995 report, *Violence Against Women in South Africa: The State Response to Domestic Violence and Rape*, Human Rights Watch makes the following recommendations to the South African government specifically relating to the medico-legal system and its response to violence against women. Some of these recommendations are already being implemented in some provinces, others have received less attention. We believe that all are necessary.

General:

- Women who have been sexually assaulted and report to a police station should be taken by the police to be examined by a specialist medico-legal practitioner as soon as possible, to ensure that forensic evidence is not lost and to allow the complainant to wash herself and change as soon as possible. There is no need for a full statement to be taken by the police at the time of initial reporting.

- Women who have been sexually assaulted and report to a public health facility should wherever possible be examined for medico-legal purposes at that facility, if necessary after calling a specialist from elsewhere to carry out the examination. The woman should be informed of her right to lay a charge and, with her consent, police should be called to the facility for the crime to be reported.

- Following medico-legal examination, government policy should pay greater attention to the need for women to receive appropriate treatment for injuries, infections, or other related trauma. Women should be informed in writing and orally in their own language (if possible), or in a language they understand, about governmental and nongovernmental support services available and referred for counseling. Special care should be taken to ensure that a woman who decides to lay a charge against her assailant and who therefore requires a medico-legal examination (a purely diagnostic procedure) is not effectively deterred or prevented from also obtaining treatment for her injuries.

- Private practitioners who treat women who have been sexually assaulted should have sufficient training and information at their disposal to be able to advise their patients of the desirability of a medico-legal examination by a specialist and refer them to the nearest facility where that is possible.

- Government departments should ensure through training and distribution of information that all those who have contact with victims of sexual assault in an official capacity, whether in the health or criminal justice system, are able to refer them to appropriate governmental and nongovernmental support services and to inform them of their rights.

- Efforts should be made to increase the number of women practicing in the medico-legal field and to ensure that a woman who has been assaulted is examined by other women where possible, or that another woman health worker is present while the examination is conducted.

- In developing policy initiatives, the problems faced by women and children and the solutions suggested should be disaggregated and addressed as separate issues.

District surgeons/medico-legal practitioners:

- In reforming district surgeon services, attention should be paid to the urgent need to ensure adequate expertise in medico-legal matters among those doctors providing medico-legal services. Although the integration of medico-legal services with general primary health care responsibilities would be a welcome step toward making those services more accessible, an examination carried out by an inexperienced and untrained doctor may be useless. As accessibility improves, every effort must be made to ensure that quality is maintained by requiring thorough and appropriate training for all medico-legal practitioners.

- Training programs should be developed for those appointed to carry out medico-legal work, both as a requirement before appointment and as annual in-service training. These programs should include information on the technical aspects of medico-legal practice and education on the psychological impact of sexual assault on the victim.

- Manuals should be developed for newly appointed district surgeons (or district medical officers, as they are now to be known) which outline the relevant laws for their work, review the necessary specialized medical information (for example, ways of determining the time of injury), and provide detailed descriptions of injuries specific to sexual assault in both adult and child victims.

- Standardized protocols for the examination and treatment of survivors of rape and sexual assault and the collection of biological samples should be developed and distributed to all those engaged in medico-legal work.

- Specialized curricula in clinical forensic medicine for medical students should be developed by the universities offering medical training and made compulsory for all medical students, with practical expertise in a medico-legal clinic a requirement of such courses; a qualification in clinical forensic medicine, similar to that for forensic pathologists, should also be developed and made available to those doctors who wish to specialize in this area of work.

- Specialized curricula in clinical forensic medicine for nurses should be developed, and a qualification in clinical forensic practice made available to nurses who wish to specialize in this area. The possibility of specialized nurses carrying out medico-legal examinations should be investigated.

- The Medical Association of South Africa, which publishes a journal of continuing medical education, should arrange for a special edition of this publication dealing with medico-legal aspects of violence against women.

Police:

- Police investigating officers handling sexual assault and rape cases should specialize in such investigations and be trained in the issues surrounding gender violence and the use of medical and other forensic evidence.

The courts:

- Specialized curricula in clinical forensic medicine for law students should be developed and successful completion of such a course made compulsory for lawyers applying to become prosecutors or magistrates.

- Justice College, in Pretoria, where prosecutors and magistrates are trained, should include courses on the use of medical evidence within its syllabi.

- As is already the trend, each regional magistrates court should identify specialized prosecutors to handle cases of sexual abuse and rape, who should receive additional training in the issues surrounding such violence.

- Where appropriate, the use of doctors as lay assessors to sit with magistrates to judge sexual assault cases should be encouraged.

- The Department of Justice should make available specialized training in medico-legal vocabulary to court interpreters.

- Legislation should be introduced to abolish the use of the "cautionary rule" in rape cases, which requires courts to exercise additional care in assessing the credibility of a rape survivor. The cautionary rule in rape cases places a particular premium on corroborative evidence if a woman is to win her case.

The collection and analysis of medico-legal evidence:

- The J88 form, used to record the findings of a medico-legal examination, should be redesigned along the lines set out in the body of this report.

- The Pretoria forensic biology laboratory, and forensic services in general, should be taken out of control of the police and placed under the Department of Health, with an independent status, similar for example to that of the attorneys general.

Collection and dissemination of information on violence against women:

- All health facilities should have information on display and available to be taken away on the medico-legal and other services available to women who have been subjected to sexual assault or domestic violence.

- A national directory of governmental and nongovernmental services available to women should be developed, and information should be distributed to police stations and magistrates courts, as well as to district surgeons, hospitals and other health care facilities about locally available referral services for women who have been assaulted.

- In designing data collection models, the specific issues of violence against women should be addressed (for example, the means of collecting statistics from the health services on both rape and domestic violence, or the possibility of making rape a reportable occurrence as child abuse already is).

BACKGROUND: THE STATE RESPONSE TO VIOLENCE AGAINST WOMEN

In a 1995 report, *Violence Against Women in South Africa: The State Response to Domestic Violence and Rape,* Human Rights Watch concluded that — although statistics are suspect and assaults on women are often unrecorded — "South African women, living in one of the most violent countries in the world, are disproportionately likely to be victims of that violence."[2] The report looked at the facts of domestic violence and sexual assault of women, considered the legal and economic background to their subordination, and examined the response of the state, in particular the criminal justice system, to the issue of violence against women. Despite the changes brought by the ending of the apartheid era, with the election on the basis of universal suffrage of a government led by the African National Congress (ANC), Human Rights Watch found that the state response to violence against women was inadequate.

In particular, Human Rights Watch found that the police were often hostile or unsympathetic to women who had been battered by their partners or sexually assaulted, that they might be ignorant of the legal remedies open to women, and that incompetence or indifference meant that many perpetrators were not arrested, or that charges laid against them were dropped. Prosecutors were likely to treat cases of violence against women with less seriousness than other assault cases and were poorly trained and paid; judges and magistrates shared the prejudices of police and prosecutors; and the system for the examination by state doctors of women who complained of rape was also problematic. As a consequence of these problems, women who had been assaulted or raped could not hope for much defense from the state, and perpetrators were going unpunished. Moreover, the whole experience of attempting to use the criminal justice system to obtain redress was such an unpleasant ordeal that many if not most women preferred to seek assistance elsewhere, if at all.

Since our report was published at the end of 1995, the government of South Africa has made significant policy statements and taken initiatives to improve the state response to violence against women. Some of these developments, ranging from new laws to new victim support centers are described below.

Recent Developments in Government Policy

[2] Human Rights Watch/Africa and Human Rights Watch Women's Rights Project, *Violence Against Women in South Africa: The State Response to Domestic Violence and Rape* (New York: Human Rights Watch, November 1995), p. 44.

On December 15, 1995 South Africa ratified the United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW),[3] thus committing itself to a wide range of obligations under international law. One year later, on December 10, 1996, international human rights day, President Nelson Mandela signed into law a final constitution for South Africa. Like the interim constitution[4] that was negotiated before the elections and governed the period until the final constitution came into effect on February 4, 1997, the final constitution prohibits discrimination on a number of grounds, and it has added pregnancy and marital status to a list already including sex, gender, and sexual orientation.[5] Meanwhile, the Constitutional Court appointed to adjudicate cases under the constitution (whether interim or final), has decided a handful of cases that touched on the non-discrimination provisions of the interim constitution, including one case in which the court ruled that insurance legislation was unconstitutional for discriminating against married women in certain circumstances.[6]

[3] Adopted and opened for signature, ratification, and accession by General Assembly resolution 34/180 of December 18, 1979; entry into force September 3, 1981. South Africa had signed the convention on January 29, 1993.

[4] Constitution of the Republic of South Africa Act, Act No. 200 of 1993. The interim constitution was drafted in multilateral negotiations between a number of political parties during the four-year period between February 1990, when the ANC was unbanned, and December 1993, when it was finally adopted by the racially based parliament of the old regime. The representatives elected in the 1994 elections sat in Cape Town both as members of a new nonracial parliament and as a constitutional assembly charged with drafting a final constitution in compliance with "constitutional principles" agreed in the pre-election negotiations and enshrined as a schedule to the interim constitution.

[5] Constitution of the Republic of South Africa 1996, section 9(3). See Human Rights Watch Women's Rights Project , "No Guarantees: Sex Discrimination in Mexico's Maquiladora Sector," *A Human Rights Watch Short Report* (New York: Human Rights Watch, August 1996), for a discussion of the issues surrounding discrimination on the basis of pregnancy.

[6] *Brink v. Kitshoff NO* Case No. CCT 15/95, Judgment dated May 15, 1996 available on the University of the Witwatersrand School of Law Constitutional Law web site, at http://www.law.wits.ac.za/judgements/.

During the course of 1996, the South African government also began to establish the elements of a "national machinery for the advancement of women." An Office on the Status of Women was created within the office of the deputy president, Thabo Mbeki, and in November a Commission on Gender Equality was appointed, constitutionally mandated to "promote respect for gender equality and the protection, development and attainment of gender equality,"[7] following the adoption of legislation providing a framework for the commission in July.[8] Other government departments also adopted machinery to promote gender equality or undertook specific commitments to implement the Platform of Action adopted at the 1995 U.N. Fourth World Conference on Women held in Beijing, China.[9]

Following a November 1995 conference in Cape Town, the government entered a nationwide partnership with both the private and public sectors to combat violence against women. The National Network on Violence against Women, set up under this initiative, which has provincial networks affiliated to it in each province, aims to bring together different government departments and the nongovernmental sector. Different provinces have had different experiences of the effectiveness of these networks, with poor attendance or few meetings in some cases. Nonetheless, they have been useful at least at an information-sharing level and are an attempt to address the crippling lack of coordination between service providers. At the same time, there is an ever-increasing number of local initiatives, such as the creation of specialist rape reporting centers, linked to a greater or lesser extent with national initiatives and policy changes.

In April 1996, the South African Law Commission published an "issue paper" in which it raised various questions for debate surrounding the Prevention of Family Violence Act (Act No. 133 of 1993), extensively analyzed in Human Rights Watch's 1995 report, which provides for an expedited and low-cost interdict procedure for women (or men) abused by their partners. Public submissions were invited, and in February 1997 the Law Commission published its final recommendations and a draft bill, which took on board many of the criticisms of the act made by the women's rights movement in South Africa.[10] Meanwhile, the application of the Prevention of Family Violence Act (together with other legislation dating to the apartheid era) has finally been extended to all parts of the country, including the former homelands.[11]

Campaign of the Department of Justice on Preventing Violence Against Women

Among its commitments under the Beijing Platform of Action, the Department of Justice undertook to amend laws that discriminate against women on a gender basis, to improve women's access to justice, and "to take integrated

[7] Constitution of the Republic of South Africa 1996, section 187. The Commission on Gender Equality is one of several government-funded but autonomous "state institutions supporting constitutional democracy" established by Chapter 9 of the final constitution, signed by President Mandela on December 10, 1996, which entered into force February 4, 1997. The others are the Human Rights Commission, the Electoral Commission, the Public Protector, the Commission for the Promotion and Protection of the Rights of Cultural, Religious and Linguistic Communities and the Auditor-General.

[8] Commission on Gender Equality Act, Act No. 39 of 1996. The chair of the commission is Thenjiwe Mtintso; full-time commissioners are Elize Delport, Faried Essack, Nomboniso Gasa, Pinkie Mbowane, Beatrice Ngcobo, and Harriet Ngubane; part-time commissioners are Cathi Albertyn, Zubeida Barmania, Derrick Cooper, Phumelele Ntombela-Nzimande and Vivienne Taylor.

[9] "Report on the National Conference of Commitments, held at the World Trade Centre, Kempton Park, 22 and 23 February 1996," (Pretoria: Ministry of Welfare and Population, 1996).

[10] Human Rights Watch made a submission to the Law Commission in October 1996 in which it highlighted some of the issues already raised in its 1995 report, including the need to expand the applicability of the act to cover more relationships, and questions surrounding costs, service of an interdict, bail, and legal representation.

[11] Justice Laws Rationalisation Act, Act No. 18 of 1996. The extension of application of the law took effect as of April 1, 1997.

measures to prevent and eliminate violence against women and to facilitate the prosecution of perpetrators of violence."[12]

[12] "Report on the National Conference of Commitments," pp. 19-20.

In line with these commitments, the national Department of Justice, under the leadership of Deputy Minister of Justice Dr. Manto Tshabalala, ran a campaign on the prevention of violence against women from November 1996 to March 21, 1997. Within the department, the campaign involved a series of workshops with staff employed in the justice system in order to sensitize personnel to the issues and to engage them in seeking solutions. In addition, the department conducted a public education campaign, distributing leaflets and posters on themes related to violence against women.[13] As a result of consultations during the campaign, the department recommended in January 1997 that a "high level task team" be formed to develop "standard practical guidelines for use throughout the country by all role-players in the chain of handling sexual violence against women."[14] Other recommendations included the establishment of "gender desks" at magistrates courts,[15] gender sensitivity training, and the reform of laws relating to sexual offenses.

On June 20, 1997, the Department of Justice released, for public discussion, a draft document on gender policy considerations to give effect to the commitments of the Beijing Platform of Action, including both an internal departmental policy on the promotion of gender equality and an outward looking strategy aimed at improving women's experience of the justice system.[16] An interdepartmental task team for the development of guidelines on the handling of sexual offenses has been formed as envisaged in January 1997, involving the departments of justice (including magistrates, prosecutor,s and an appellate court judge), health, welfare, and correctional services, the police, and a representative of nongovernmental organizations (NGOs) from the National Network on Violence Against Women, and it is anticipated that the guidelines will be launched by the minister on August 9, 1997, women's day in South Africa. The guidelines, which include detailed protocols for all departments, will eventually be published as a manual for wide distribution to all role players.[17]

Police Initiatives

In most cases, a woman's first contact with the criminal justice system in a rape case will be with the police, when she reports that she has been attacked. It is crucial both for the eventual success of her case, and to ensure that women feel comfortable reporting rape in the first place, that the police treat women sympathetically and know the correct procedures for statement-taking and referral. Several initiatives have been introduced over the last year in an attempt to improve the response of the police service in cases of violence against women. Although there have been problems with some of these initiatives, as described below, they all indicate a welcome commitment to improving services for women who have been the object of sexual assault, rape, or battery.

Victim Support Services

[13] "Campaign on Prevention of Violence Against Women," notes for a speech given by the deputy minister of justice, June 1997 (document supplied by the Department of Justice).

[14] Office of the Deputy Minister of Justice "Prevention of Violence Against Women: Department of Justice Interim Report," (Pretoria: Department of Justice, January 1997).

[15] In the South African court system, the magistrates court is the lowest judicial division of the formal court system.

[16] "Presentation by Dr. M.E. Tshabalala-Msimang MP Deputy Minister of Justice: Launch of Gender Policy Considerations Discussion Paper," Cape Town, June 20, 1997 (document supplied by the Department of Justice).

[17] "Presentation to the Justice Portfolio Committee by Dr. M.E. Tshabalala-Msimang MP Deputy Minister of Justice," June 6, 1997 (document supplied by the Department of Justice); telephone interview, Zoe Rathus, Department of Justice, June 24, 1997.

In 1996, the Department for Safety and Security published a National Crime Prevention Strategy (NCPS), prepared by an inter-departmental team consisting of representatives of the Departments of Correctional Services, Defense, Intelligence, Justice, Safety and Security, and Welfare. The NCPS recognized "gender violence and crimes against children" as one of the "crime categories of particular concern." Among the national programs proposed by the document was a "Victim Empowerment Programme," consisting of three "key actions": to "extend training to police and justice officials which introduces greater victim sensitivity;" to "implement a victim support programme;" and to "provide basic information to complainants and victims regarding the progress of all cases, as well as key information which enables victims to lay complaints more easily."[18] It identifies the Department of Welfare as the lead agency with regard to the program, although the Department for Safety and Security has been tasked with ensuring the overall success of the NCPS. In November 1996 an Interdepartmental Guardian Committee was formed, consisting of representatives of the Departments for Safety and Security, Health, Welfare, Justice, and Correctional Services, as well as NGOs and academics, to oversee the development of a training curriculum for all criminal justice personnel involved in victim support.[19]

In addition, the South African Police Service (SAPS) has taken steps to develop its own victim support program, with the aim of training police officers to provide support to victims of crime, coordinating support services with other government departments and NGOs, establishing "comfort rooms" at police stations or victim support centers, and setting up a referral system and resource directory. A national "core management team" has been appointed for victim support services throughout the SAPS. In January 1996, the first support center for victims of domestic and sexual violence, the Ncedo Care Centre, was opened close to one of the African townships near Port Elizabeth in the Eastern Cape. The Ncedo Care Centre is a "one stop" center attached to a hospital but run by the police, where medical staff and trained police are available on a twenty-four-hour basis to assist women who have been raped and are brought there after reporting to one of the local police stations. Although the Ncedo Care Centre does not meet the needs of everyone in the area, and lacks support from other government agencies, it has improved service for those who have been referred there. Plans to establish at least one victim support center per province, in under-resourced areas, are being developed.[20] In January 1997, a task team was established to develop guidelines for SAPS personnel on the treatment of victims of crime, especially survivors of rape and sexual assault or domestic violence. A pilot training program to sensitize SAPS members to victims' needs began in April 1997, and it is intended to integrate this program into the national training curriculum.[21]

Nevertheless, it remains the case that in general the "present support services for victims of crime and violence in South Africa are limited, fragmented, uncoordinated, reactive in nature and therefore also ineffective."[22] While individuals in the police and in the Department for Safety and Security are clearly committed to the new ideals of policing exemplified by the victim support program, equally clearly it does not enjoy full institutional support. The SAPS victim support program is under-resourced — at the time he was interviewed by Human Rights Watch, the coordinator's own office was in a virtually abandoned building, away from the rest of the police administration, with no

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[18] "National Crime Prevention Strategy: Summary,"(Pretoria: Department for Safety and Security, May 22, 1996), pp. 6 & 14.

[19] Letter dated May 13, 1997 from J.H. Benadé, deputy head, In-Service and Specialized Training, South African Police Service, to Human Rights Watch.

[20] Snr. Supt. Juan A. Nel, national coordinator, SAPS Victim Support Program, "The South African Police Service Victim Support Programme Initiative: The Way Forward," paper presented to the 1996 International Conference on Crime and Justice in the 1990s, Pretoria, July 1996.

[21] Letter dated May 13, 1997 from the SAPS to Human Rights Watch.

[22] Nel, "The SAPS Victim Support Programme Initiative," p. 19.

telephone and no computer — and poorly linked to other initiatives both within the SAPS and managed by other government departments.[23]

Gender Sensitivity Training

The Gauteng province Department for Safety and Security initiated a "gender sensitivity training program" during 1996, aimed at informing police officers of the particular factors influencing gender-based crimes such as domestic violence and rape. The program consists of a three-day course, during which police officers are encouraged to confront their own prejudices and to learn from women's rights activists, district surgeons, prosecutors, and other police officers about issues such as the evidence needed to prosecute a sexual offense successfully, the procedures of the Prevention of Family Violence Act, the reasons why a woman who is battered may not persist with a charge against her partner, and other relevant questions. Police officers sent on the course are selected by SAPS "training officers" or station commissioners (formerly known as station commanders, but renamed with the "demilitarization" of SAPS ranks).

[23] "Progress Report: SAPS RDP Victim Support Programme," October 24, 1996; interview with Snr. Supt. Juan Nel, October 29, 1996.

While the training initiative is a very welcome attempt to address insensitivity and ignorance among the police about gender-based crimes, it has met with serious problems in practice, mostly related to an apparent lack of enthusiasm for the course from the police middle management. Its impact is clearly limited by the fact that many of those sent on the training course are not volunteers. Some of them appear to have been selected to attend as some form of punishment; others hold positions to which the course is not relevant (including members of the dog unit). Moreover, actual attendance at the course has varied between 60 and 80 percent of those booked to participate, the shortfall being unexplained but possibly due to station commissioners' reluctance to release staff for such "inessential" training.[24] Meanwhile, police officers who would have been keen to attend are unaware of the course's existence.[25]

Specialized "FCS" Units

One of the recent initiatives of the SAPS has been the introduction of specialized units handling crimes related to family violence, child abuse, or sexual assault. The intention is to transform the existing police Child Protection Units (CPUs), themselves an initiative of recent years, into "FCS" units of this type. There were thirty-five CPUs as of May 1997, spread across different regions of the country.[26]

One of the first FCS units to be established is based in Braamfontein, in Johannesburg, and is responsible for covering crimes of this type committed in the entire Johannesburg metropolitan area. In theory, when a complainant falling into one of these categories reports to a local police station, the Braamfontein FCS unit is contacted, and an officer from the unit is despatched to the police station to handle the case. Alternatively, a complainant can report directly to the Braamfontein offices of the unit.

The Johannesburg city-center Hillbrow medico-legal clinic, a publicly owned facility which handles a large number of rape cases, reports that there has been a great improvement in police relations with the clinic since the special unit was founded. The waiting period before women are taken to the clinic is now shorter, and more cases are reaching court. The FCS unit is substantially more professional than other police units, which, for example, may still on occasion bring the suspect and the complainant in the same car to the clinic for examination, then leave them together without any protection for the complainant.[27]

Nevertheless, the record of the new unit is not unproblematic. Doctors at the Alexandra Clinic, which provides primary and some secondary health care services to the population of the Alexandra township in the northern suburbs of Johannesburg (population approximately 250,000), complain that it is very difficult to get through to the FCS unit, so that women end up going to Alexandra police station to report a rape or assault in any event; meanwhile the police at the Alexandra police station complain that they are only allowed to refer a case and receive no feedback as to its progress, so that they have nothing to say to community members who ask them for information about a case. Both the clinic and officers at the Alexandra police station report substantial delays in getting a response from the unit even if they are successfully contacted. Community leaders in the township complain that officers from the FCS unit do not know the township and are hampered in their search for suspects by this lack of local knowledge; they and many others recommend that the unit should be decentralized so that trained officers are accessible to each community. Moreover, in some cases the unit is reportedly biased in its approach. For example, it has been known to refuse to assist in rape cases against prostitutes — an attitude it reportedly shares with most other police units. Also of concern is the fact that most domestic violence cases handled by the unit concern white women. Part of the explanation for this discrepancy may be that local police stations often do not refer domestic violence cases to the FCS unit, apparently seeing such matters as not worth reporting, so that the unit therefore generally assists women who come directly to it. These women may be predominantly white for reasons, for example, of access to transport and information. Nevertheless, the lack of

[24] Interview, Marietjie Fourie, Gauteng Department for Safety and Security, November 22, 1996.

[25] Interview, Boksburg CID, November 22, 1996.

[26] Letter dated May 13, 1997, from the SAPS to Human Rights Watch.

[27] Interview, Dr. Audrey Gule, Hillbrow Medico-Legal Clinic, October 31, 1996.

attention given to black women abused by their partners also raises concerns about the effectiveness and attitudes of the unit.

Some other police stations, including Pietermaritzburg in the KwaZulu-Natal midlands, also have specialized rape units (although most have not integrated domestic violence specialists into the same structures), which have improved service in some cases. However, in Pietermaritzburg, for example, if a woman does not go straight to the unit but reports to a police station in a rural area that she has been raped, the effect of having a special unit has been simply that she must tell her story one more time (both to the rural police station and to the rape unit) and that she must travel into Pietermaritzburg, waiting for transport, perhaps for hours, at the local police station.[28] Women's rights organizations report that the quality of investigation has not noticeably improved. In other places, Criminal Investigation Divisions may simply have investigators who specialize in rape cases — at Boksburg police station to the east of Johannesburg, for example, this is the case, where three of eighteen detectives are women handling rape cases. But such specialization may not solve all problems: although rape cases at Boksburg are investigated by women police officers, none speaks an African language. African male police officers from the charge office (the first point of access for the public at a police station) are therefore used as interpreters if necessary, undoing the effect of having a female investigator; only one African woman works in the charge office at Boksburg.[29]

While the advantage of centralized units such as the Braamfontein FCS unit is that generally sympathetic police officers who have volunteered for their positions and been trained in the particular issues surrounding gender violence will handle complainants after the first report of an offense, there are costs attached to such concentration of expertise. A balance needs to be struck so that — even if it is not possible in the short term to ensure that every police station has a specialist investigative unit — the area covered by a specialized team is not so far removed from affected communities that it is perceived to be inaccessible and irrelevant.

The Continuing Failure of the System to Respond to Violence against Women

Despite these initiatives, in most cases the treatment that a woman victim of violence receives from the criminal justice system remains poor. Police are often hostile or unsympathetic to women who report to a police station that they have been assaulted. Once the case is opened, the police may carry out the investigation with a minimum of enthusiasm and allow known perpetrators to walk free. Prosecutors may also refuse to handle domestic violence cases, and in rape cases often subscribe to the usual stereotypes, dropping cases where the woman involved is not a "good" victim. Magistrates and judges often have discriminatory and sexist assumptions about women that can prejudice those cases that do reach court. Poor black women in the rural areas are worst off, with the least access to services, particularly to advice and assistance from nongovernmental organizations specializing in these issues, which may be able not only to provide support services in their own right but also to provoke an effective response from the system.

In particular, Human Rights Watch is concerned about the interface between the police and criminal justice system and the medical profession: the medico-legal system. Often overlooked, the maintenance of an efficient and responsive medico-legal system is a crucial part of the state's responsibility to ensure that survivors of assault have an effective remedy and that perpetrators of crimes are brought to justice. The current procedures for obtaining medical evidence in assault cases, and in particular in cases of sexual assault of women or children, are woefully inadequate, neither ensuring that perpetrators are convicted nor providing women with appropriate treatment. Moreover, while the deficiencies of the current system have been recognized and proposals made for its improvement, the reform proposals themselves are problematic in some respects and do not adequately address the issues surrounding rape and sexual violence.

INTERNATIONAL AND NATIONAL LAW ON VIOLENCE AGAINST WOMEN

International Law

[28] Interview, Futhi Zikalala, Centre for Criminal Justice, Pietermaritzburg, November 7, 1996.

[29] Interviews, Boksburg police station, November 22, 1996.

International law requires states to show due diligence in preventing and responding to human rights violations. With respect to violations of bodily integrity in particular, governments have a duty to prevent, investigate, and prosecute such abuse, including cases in which the perpetrator is a private citizen. Where states do not prohibit such abuse or routinely fail to respond to evidence of rape or assault of women, they send the message that such attacks can be committed with impunity. In doing so, states fail take the minimum steps necessary to protect women's rights to physical integrity or even life. To the extent that this failure reflects discrimination on the basis of gender and/or race, it also constitutes a violation of the state's international obligation to guarantee equal protection of the law.[30]

South Africa has ratified the U.N. Convention on the Elimination of All Forms of Discrimination against Women (CEDAW).[31] Under CEDAW, the government is committed to a wide range of measures to end formal inequality between women and men and to take "all appropriate measures, including legislation, to ensure the full development and advancement of women, for the purpose of guaranteeing them the exercise and enjoyment of human rights and fundamental freedoms on a basis of equality with men."[32] In 1992, the Committee on the Elimination of Discrimination Against Women, established under CEDAW, adopted a general recommendation and comments on violence against women and states' obligations under the convention. The committee noted that states are obliged under CEDAW to take steps to provide:

> (a) Effective legal measures, including penal sanctions, civil remedies and compensatory provisions to protect women against all kinds of violence, including *inter alia* violence and abuse in the family, sexual assault and sexual harassment in the workplace;
> (b) Preventive measures, including public information and education programmes to change attitudes concerning the roles and status of men and women;
> (c) Protective measures, including refuges, counseling, rehabilitation and support services for women who are the victims of violence or who are at risk of violence.[33]

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[30] For a more detailed discussion of South Africa's obligations under international law, see Human Rights Watch, *Violence Against Women in South Africa*, pp. 39-43.

[31] Adopted and opened for signature, ratification, and accession by General Assembly resolution 34/180 of December 18, 1979; entry into force September 3, 1981.

[32] Ibid., article 4.

[33] Committee on the Elimination of Discrimination Against Women, "Violence Against Women," General Recommendation No. 19 (Eleventh session, 1992), U.N. Document CEDAW/C/1992/L.1/Add.15.

These recommendations are based on the international law obligation of states to ensure that those whose rights are violated shall have an "effective remedy."[34] Without a remedy in case of violation, paper guarantees of rights are meaningless. In the case of violence against women, as for any other assault, one of the primary elements of an effective remedy is prosecution of the perpetrator in the criminal courts. In this report, because of its significance to the state response to violence against women, Human Rights Watch focuses on one particular and often neglected aspect of the criminal justice system, the collection of medical evidence and the ability of the police, prosecutor and judge to use and evaluate that evidence. An effective investigation is central to the successful implementation of penal sanctions against those who violate women's human rights.

The obligations enumerated by the CEDAW Committee extend beyond the criminal justice system; they include preventive and protective measures, including "rehabilitation and support services." The U.N. Declaration of Basic Principles of Justice for Victims of Crime and Abuse of Power[35] also state that: "Victims should receive the necessary material, medical, psychological and social assistance through governmental, voluntary, community-based and indigenous means."[36] Human Rights Watch believes that the protective measures provided by the state must at minimum, in the case of the medico-legal system, include the effective collection of medical evidence for use in the court system. The state should also ensure that women who require a medico-legal examination for court purposes are not prejudiced as regards treatment for their injuries by the fact they have been examined by a state doctor specializing in such examinations and not in general practice. The state should take steps to promote women's access to health care services, whether state-provided or otherwise.

South African Law

[34] The International Covenant on Civil and Political Rights (Adopted and opened for ratification, signature, and accession by General Assembly resolution 2200A(XXI) of December 16, 1966; entry into force March 23, 1976), provides in Article 2 that "any person whose rights and freedoms . . . are violated shall have an effective remedy." South Africa signed the ICCPR in 1994, although it has not yet ratified the covenant. The language of the ICCPR in this respect is echoed in a number of other international instruments, including CEDAW, which obligates states "to establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination" (Article 2).

[35] Adopted by U.N. General Assembly resolution 40/34 of November 29, 1985.

[36] Principle 14.

In South Africa, rape is defined as intentional unlawful sexual intercourse with a woman without her consent. The law only applies between men and women and there must be penetration of a vagina by a penis; other assaults of a sexual nature are criminalized under different names, such as indecent assault or sodomy. Women's organizations have criticized this narrow definition of rape for a number of reasons: because other types of sexual assault than penetration by a penis may be as serious if not more serious for the victim; because only a woman or girl may be raped; and because lack of consent, not coercion, is the standard used to criminalize the act committed.[37] In proving the offense of rape in court, all the elements of the offense must be shown to exist. According to those working in the South African criminal justice system, consent is the most usual element of the offense in dispute. As in the case of all other criminal offenses, witnesses of fact may be called by the prosecution, such as those who saw what occurred or the first person to whom the victim reported what happened to her.[38] In general, the opinion of witnesses that the complainant's allegations are or are not credible is not admissible evidence; however, the court may also call expert witnesses who can give their opinion on the credibility of the allegations. The Criminal Procedure Act (Act 51 of 1977) sets out the different persons who can be "experts;" in the case of medical evidence doctors but not nurses are automatically qualified to give expert evidence.

THE MEDICO-LEGAL SYSTEM

Medical evidence is central to the successful prosecution of a sexual assault case. Often, the medical evidence will be the only corroboration of the complainant's case, confirming not only the fact that sexual contact or intercourse took place, and with a particular individual, but also that such contact took place without the complainant's consent. Medical evidence cannot prove that there was no consent — states of mind leave no physical record — but it can be strongly suggestive that intercourse was the result of assault and not agreement. Prejudice and lack of expertise among the doctors carrying out medical examinations for legal purposes are just as detrimental to a woman's case as prejudice and lack of expertise among the police or court officials.

A thorough and well-recorded medical examination can provide much circumstantial evidence to support a rape survivor's story, by noting injuries ranging from obvious scratches and tears, to small and easily missed abrasions indicating that sexual intercourse took place without lubrication. If survivors of sexual assault are examined by specially trained doctors, who have experience in the field and are aware of what would assist the judiciary in reaching a decision, the chances of a conviction are substantially improved.[39] If, on the other hand, a medical examination is carried out by a doctor who is untrained, inexperienced, or biased against the patient — or if there is no examination at all because there are no medico-legal services accessible to the assault survivor — the consequence may be that the prosecution drops the case or, where the stories of perpetrator and complainant are simply compared in court, that a perpetrator is wrongfully acquitted for lack of corroboration of the victim's story. In either case the cycle of impunity in cases of sexual violence will continue.

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[37] The South African law relating to violence against women is described in the Human Rights Watch report *Violence Against Women in South Africa*. See also, for example, Managay Reddi, "A feminist perspective of the substantive law of rape," in S. Jagwanth, P-J. Schwikkard, B. Grant (eds), *Women and the Law* (Pretoria: Human Sciences Research Council, 1994).

[38] There is a general rule of evidence that "previous consistent statements" by a witness are not admissible as evidence, essentially because they are irrelevant and would be easily manufactured. There is an exception to this rule in sexual offenses cases, relating to evidence that the complainant reported the offense at the first reasonable opportunity; such evidence is admitted to show consistency of conduct and to support absence of consent. Pamela-Jane Schwikkard, "A critical overview of the rules of evidence relevant to rape trials in South African law," in Jagwanth et al, *Women and the Law.*

[39] Lorna J. Martin, *Rape in Johannesburg* (Johannesburg: Centre for the Study of Violence and Reconciliation, 1993), p. 7.

Because medico-legal examination is a specialized task and because the whole experience of reporting to the police and being examined by a medico-legal practitioner can be an intimidating experience, it is essential that those who carry out this work have specialized training. In particular, doctors conducting medico-legal examinations need to be fully conversant with the technical aspects of examination of assault victims. Furthermore, because the requirement for "hard evidence" of sexual assault means that women must report promptly to a police station or medico-legal practitioner, at a time when they are most likely to want to avoid any such stressful contact with the authorities, the procedures for reporting and examination must be arranged to encourage women to report and to eliminate the cycle of "secondary victimization" by biased and abusive treatment from police, courts, or doctors. Without both of these elements, perpetrators of sexual assault will continue to enjoy impunity for their actions.

Currently in South Africa, if a woman has been raped, sexually assaulted, or battered and chooses to report that assault at a police station, the police will open a file or "docket" on the case and take a statement from the woman. In cases of rape or sexual assault, yet in only the most severe cases of battery, the woman will then be provided with two forms (the "J88" form and the "308" form), one of a series of "crime kits," and either taken to a state medical practitioner known as a district surgeon or told to get her own doctor to fill out the forms and conduct an examination. (In most cases, however, doctors in private practice do not wish to get involved in medico-legal issues, as discussed below.) The purpose of the 308 form is to establish the complainant's informed consent to disclosure of otherwise confidential medical evidence by the doctor to the police for the purpose of criminal proceedings.[40] The J88 form is used by the district surgeon or other doctor to record medical evidence; the crime kits contain test tubes, slides and other equipment for taking such biological samples as may be necessary. A police officer is supposed under internal police departmental standing orders to escort the woman to the district surgeon, wait while she is being examined, and then take her to where she wishes to go.

The crime kit and J88 form are returned to the police station, where the J88 form will be added to the docket, while the crime kit is sent to the Police Forensic Science Laboratory in Pretoria for analysis. The results of the analysis will be returned to the police station and added to the docket. Investigation of the case is in the hands of the Criminal Investigation Division (CID), and in general the uniformed branch of the police will have no further involvement. If the case reaches court, the prosecutor will call the district surgeon (or other doctor) to present the medical evidence and indicate whether it is consistent with the account put forward by the complainant.

The following sections address three issues: first, how this system fits into the South African health care system generally and the provisions for medico-legal practice more particularly; second, the problems that surround the system from the point of view of women who have been sexually assaulted or raped, including the use of medical evidence by the police and courts; and finally, the proposals that have been made for reform by the new government and some of the problems they raise.

The South African Health Care System

Not surprisingly, given the history of apartheid, the provision of health care in South Africa is heavily biased in favor of the white population and in favor of the urban over the rural areas. Two parallel systems exist: a private and a public sector. In 1992/93, expenditure on health care in South Africa was R.30 billion (US$9.825 billion[41]), or 8.5 percent of GDP: the major sources of this expenditure were private medical insurance, whether or not part of an employment package (40 percent), general tax and local government revenue (38 percent), and cash payments (14 percent). Of the total health care expenditure, 58.2 percent was spent in the private sector, 38.6 percent on public

[40] If the person to be examined has been arrested in connection with an offense, the form used is SAP 308(a), and the person arrested cannot refuse to be examined or have samples collected: under section 37 of the Criminal Procedure Act 1977 (No. 51 of 1977) a suspect out on bail who refuses to give samples can be taken to court for an order to provide samples. If he still refuses to present himself to the district surgeon, he can be arrested and taken there.

[41] On January 1, 1993, the exchange rate was 1 South African Rand = .3275 U.S. Dollar.

health services, 1.3 percent on public and donor-funded capital projects, and 1.8 percent on research and training. Seventeen percent of the population has private health insurance, and another 4 percent pays cash in order to access private health care services on a regular basis; 79 percent of the population is dependent on state health care services, provided on a low- or no-fee basis.[42]

[42] *South African Health Review 1996* (Durban, South Africa and California, USA: Health Systems Trust and the Henry J. Kaiser Family Foundation, October 1996), p. 73.

Reflecting this distribution of resources between public and private, a majority of all health professionals, apart from nurses, work in the private sector, including 57 percent of doctors. South Africa's overall doctor-to-patient ratio compares favorably with the internationally recommended figures, but the overall ratio disguises sharp disparities between public and private sector, urban and rural areas, and in particular former "white" South Africa and the former homelands.[43] Furthermore, within the public sector, resources are disproportionately concentrated in hospitals: in 1992/93, for example, academic and other tertiary hospitals accounted for 44 percent of total public sector expenditure; by contrast, only 11 percent was spent on non-hospital primary health care.[44] As a consequence of these disparities, South Africa's health statistics compare poorly with those of countries with a similar per capita income: according to the United Nations Children's Fund (UNICEF), South Africa's infant mortality rate (deaths of children under five years old per 1,000 live births) in 1991 was twice as high as might be predicted from its level of income.[45]

[43] There is a national average of 4.2 doctors per 10,000 people, against an international recommended average of 4.9; but within South Africa Gauteng province has a ratio of 9.1 to 10,000, while Northern Province, at the other extreme, has a ratio of 0.9 per 10,000. When only doctors in the public sector are taken into account, the national ratio decreases to 1.8 per 10,000. Similarly, in 1993, South African had a total of four public and private hospital beds per 1,000 population, comparable to countries with a similar per capita income; however, the distribution of beds varied greatly between provinces, ranging from 2.1 beds per 1,000 population in Mpumalanga to 6.0 in Gauteng. *South African Health Review 1996*, pp. 89-90 & p. 65.

[44] *South African Health Review 1996*, p. 74.

[45] South Africa's infant mortality rate in 1991 was reported by UNICEF to be seventy-two, against an expected rate of thirty-four for a GNP per capita of US$2,530; by comparison, Mexico's rate was thirty-six, against an expected rate of thirty-two for a GNP per capita of US$2,800. South African Institute of Race Relations, *Race Relations Survey 1994/95* (Johannesburg: South African Institute of Race Relations, 1995) p. 295. Infant mortality rates quoted by the Department of Health for 1994 indicated an overall rate of 48.9 per 1,000 population, with whites at 7.3 per 1,000, Indians 9.9, coloreds 36.3 and Africans 54.3. *South African Health Review 1996*, p. 228. (In this report, Human Rights Watch will use the racial categories established by the previous South African government for ease of reference. While we realize that to some these categories are objectionable, they remain relevant to all South Africans, and monitoring of attitudes on racial lines remains relevant and essential to policy initiatives to be taken to overcome the racist legacy of the past. "Colored" describes South Africans of mixed-race descent, "African" those of African descent, "white" those of European descent, and "Indian" those whose ancestors came from the Indian subcontinent. "Black" will be used here to describe all South Africans who are not of European ancestry.)

With the election of the ANC-led government of national unity in 1994, the government initiated a major debate over the future of health services. Although policy discussions are still underway, restructuring of health services is already in full swing; in particular, the reallocation of responsibilities for service delivery to the nine new provinces that have replaced the four provinces of "white" South Africa and ten African "homelands" of the previous dispensation, and in turn the attempt to devolve control over health service provision to the district level.[46] The health care budget has also been adjusted to reallocate funds from the historically relatively "overfunded" sectors to the most impoverished, in particular toward primary health care in the rural areas. On May 24, 1994, in one of his first presidential initiatives, President Nelson Mandela announced that starting June 1, all health care for children under the age of six years and for pregnant women would be free.[47] The policy resulted in an immediate rise in number of patients attending public health care facilities: although indigent patients were already accessing state health care on a no-fee basis (theoretically means-tested), the announcement gave women the confidence to access health services in much greater numbers than before.[48] Nevertheless, there are still many barriers to accessing health care, even of the most basic type and even to those eligible for free services: in many rural parts of South Africa, the costs of travel to a health care facility are likely to be far more than the medical fees.

The Organization of Specialist Medico-Legal Services

Specialist medico-legal services in South Africa are currently organized according to a structure established under the 1977 Health Act (Act No. 63 of 1977), which provided for medico-legal services to be rendered to the public (and the Department of Justice) by the Department of National Health and Population Development (now the Department of Health). Forensic post mortem and laboratory services were designated a national function, organizationally centralized in Pretoria; "clinical" forensic services, relating to the examination of (still living) assault victims, the testing of blood alcohol levels and so forth, were delegated to the four provincial administrations (Transvaal, Natal, Cape, and Orange Free State), which employed full- and part-time "district surgeons" to carry out this work.[49] In practice, however, the two aspects of medico-legal work were and are usually carried out by the same people. Only in towns with a university medical school are post mortems carried out by full-time state pathologists (employed by the Department of Health); in smaller towns and rural areas, district surgeons carry out both post mortems and medical examinations of the living for legal purposes. The structure of these services varies significantly among the four old provincial administrations and in particular among the former homelands, both "independent" and "self-governing," where services are particularly poor.

Also involved in the system are the police and court system. The police are usually responsible for referring women for medico-legal examination and for providing transport to the place where they will be examined. The police also control the laboratories where medical samples are analyzed for legal purposes. In the court system, prosecutors play a key role, since their ability to use and evaluate medico-legal evidence may determine not only their decision to take a case to court but also their success in presenting the case to the magistrate or judge. Where prosecution skills are

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[46] Under the system of apartheid as originally conceived, it was intended that all Africans would be deprived of South African citizenship and become instead citizens of "independent" homelands. Although this goal was never achieved, ten homelands were created, of which four (Transkei, Bophuthatswana, Venda, and Ciskei) became nominally independent. The remaining six (KwaZulu, Gazankulu, KaNgwane, Lebowa, QwaQwa, and KwaNdebele) had a lesser degree of autonomy and were designated "self-governing." The homelands were integrated into nine provinces which were formed with the coming into force of the interim constitution in April 1994.

[47] *Government Gazette* Notice 657 (1994), as quoted in *South African Health Review 1996*, p. 158.

[48] Following the introduction of the policy, revenue from user fees dropped by about 30 percent, equivalent to a decrease of about 1.5 percent of the total public sector health budget. *South African Health Review 1996*, p. 161.

[49] It is proposed to change the name of district surgeon to "district medical officer," and in some provinces this is already the case, but in this report the title district surgeon will still be used for ease of reference.

deficient, the magistrate's or judge's knowledge of medical evidence and ability to question an expert medical witness for clarification of the case becomes all the more important.

Medico-legal services are provided free to the public at the point of use. Although they are thus accessible in terms of cost to those who need them, other barriers exist, in particular the distances that many women must travel to reach a district surgeon or other medico-legal facility, the length of time that they may have to wait, and the experience that many have of hostile and unprofessional treatment. Because of the uncoordinated nature of the system, which is split between national and provincial health departments and the police service, it is at present virtually impossible to calculate the cost to the government of providing medico-legal services.

District Surgeons

The heart of the medico-legal system is the national network of district surgeons, who have provided clinical forensic medical services for the state for most of the century. District surgeons have three main areas of responsibility: primary health care functions; medico-legal functions; and *ex officio* functions, of which the most important is probably prison health care.[50] Medico-legal functions form a small part of the practice of district surgeons: according to a survey carried out by the directorate of medico-legal services in Gauteng province, clinical medico-legal services accounted for 9 percent of cases seen by district surgeons in the province during 1995.[51] Only 2 percent of the medico-legal cases (either clinical or forensic) led to court appearances.

As the practice of district surgeons relates to violence against women, it is largely restricted to cases of rape and sexual assault, including sexual assault of children. District surgeons are rarely involved in cases of domestic violence: since women who have been battered seldom lay charges or, if they do, frequently withdraw them (for reasons examined in the Human Rights Watch report, *Violence Against Women*), they are not often referred by the police to district surgeons for examination.

Until the Choice on Termination of Pregnancy Act (Act No. 92 of 1996) came into force in February 1997, district surgeons' duties also included the examination of all those applying for legal abortions, under the exemption for rape victims from a general ban on abortions. The new law has removed this obligation in many cases. Overturning the restrictive law on abortion established by the Abortion and Sterilization Act (Act No. 2 of 1975), it provides (in section 2) for abortion on request during the first twelve weeks of pregnancy; for abortion from the thirteenth to twentieth weeks if a medical practitioner, after consultation with the pregnant women, is of the opinion that the continued pregnancy would pose a risk of injury to the woman's physical or mental health, that there exists a substantial risk that the fetus would suffer from a severe physical or mental abnormality, that the pregnancy resulted from rape or incest, or that the continued pregnancy would significantly affect the social or economic circumstances of the woman; and for abortion after the twentieth week if a medical practitioner, after consultation with another medical practitioner or with a registered midwife, is of the opinion that the continued pregnancy would endanger the woman's life, would result in a severe malformation of the fetus, or would pose a risk of injury to the fetus.

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[50] Other *ex officio* responsibilities include, for example, examination of persons applying for public employment or for early retirement and assessment of those applying for state disability grants and of juveniles being admitted to "places of safety" (centers for the accommodation of juvenile offenders and of children placed in care). Primary health care duties include treatment of indigent persons, social pensioners, children in "places of safety," and some others. In addition to post mortems and examination of living victims of assault, medico-legal duties include the examination of those accused of driving under the influence of alcohol, of those whose mental competence to appear in court is in doubt, and some other cases. "Medicolegal Services in South Africa," Report of the Working Group appointed by the Director-General of Health (Pretoria: National Ministry of Health, January 1996), p. 2-3.

[51] "District Medical Officer Statistics 1995," Gauteng Directorate: Medico-Legal Services, 1996. Personal health care and ex officio services accounted for 49 percent of cases; prison medical services for 34 percent of cases; and post mortems for 3 percent. Twenty-six district surgeons were included in the survey.

Most district surgeons in the rural areas are part-time, combining their official duties with private practice; in some cases, district surgeon work is shared within a joint practice, with partners of the doctor who is officially district surgeon covering for him should he be off duty or away. In urban areas, some district surgeons are full-time, operating from their own practice rooms or from specialist medico-legal clinics (see below).

Obtaining accurate information about the distribution of district surgeon provision country-wide is difficult. The nine different provinces appear to keep statistics relating to their employment of district surgeons on a different basis, making comparisons across provinces difficult. However, the figures obtained by Human Rights Watch from the national Department of Health indicate that there are 165 full-time district surgeons employed across the country: fifty-nine in the Eastern Cape, sixty-four in KwaZulu-Natal, twenty-two in the Northern Province, twelve in the Northern Cape and eight in the Western Cape. The Eastern Cape also employs sixty-three part-time district surgeons, KwaZulu-Natal fifty-two, and the Northern Province sixteen. The Free State, Gauteng, and North West Province calculate their use of district surgeons according to the total number of hours for which they have paid, so that the Free State paid doctors for 585 hours of service as district surgeons during 1996, Gauteng paid for 222 hours, and North West Province for 319 hours. In addition to the full-time district surgeons employed by the Western Cape, 364 hours of service were paid for separately. The statistics for Mpumalanga are included in those for Gauteng.[52]

[52] Telephone interview, Hannes van Rooyen, Department of Health, April 8, 1997. However, new appointments of "district medical officers" by Gauteng province among others mean that these statistics are probably already out of date.

Many district surgeons are dedicated and skilled practitioners who have acquired expertise and understanding of violence against women through years of experience of medico-legal work and court appearances. Nevertheless, the reputation of district surgeons among organizations providing services for abused women is, in the words of one counselor, "horrendous."[53] Part of the problem is lack of incentive to do a good job: district surgeons are poorly remunerated compared to doctors in private practice; working conditions are likely to be bad, whether the district surgeon is employed in a state hospital, medico-legal clinic or his or her own offices; and medico-legal work is often stressful. As a consequence, especially in the urban areas, many district surgeons are junior doctors or recent immigrants to South Africa who are taking a comparatively low-status position in order to get on the ladder of promotion. The long-established district surgeons in smaller towns are often more elderly white men, using part-time state employment as a useful and undemanding supplement to their private practice. District surgeons receive little in the way of supervision or feedback on the quality of their work from their employers, the provincial departments of health. As a consequence, the quality of service provided varies enormously, and with it the likelihood that women who have been sexually assaulted will receive a thorough medico-legal examination that will assist in the conviction of her assailant.

Medico-Legal Clinics and Hospitals

In several of the major cities in South Africa, specialist medico-legal clinics are affiliated with large government hospitals and employ a number of full-time district surgeons at the same location: at the Hillbrow medico-legal clinic in Johannesburg, for example, there are five full-time district surgeons, three part-time, and five full-time nurses. In Gauteng, similar medico-legal clinics exist in Pretoria and Soweto (at Baragwanath Hospital), although the type of work and the level of staffing vary from case to case. In some other state hospitals, medico-legal services are supposedly integrated into the general work of the institution and carried out by the regular doctors working there, with no provision made to ensure a specialized service. In these cases, access is on the same cost basis as for other patients.

Problems with the Medico-Legal System

The Uniformed Police

The point of entry to the medico-legal system for a woman who has been sexually assaulted is usually the police station where she reports the crime. In most cases, the experience of a woman reporting to a police station remains highly problematic, despite the national and local initiatives to improve this situation. Uninformed and prejudiced officers in the charge offices (the reception area) are the norm. Whatever the instructions coming from police headquarters, and even though some police stations have separate rooms where a woman can be interviewed, many women complaining of rape may have no choice but to give a statement to an untrained and unsympathetic male officer within the hearing of others waiting for attention. Women who have been seriously assaulted, to the extent of needing medical attention, may find their cases dismissed because they do not fit the stereotype of a rape victim, or because their cases are seen as unimportant given the levels of "real" crime needing police attention. Police officers are often unaware of the legal or other services available to women who wish to obtain assistance elsewhere.[54]

[53] Interview, Diane Washkansky, counselor with Rape Crisis, Cape Town, February 10, 1995.

[54] The Human Rights Watch report, *Violence Against Women in South Africa,* describes the problems of the police response to violence against women in detail.

Under departmental standing order, police are supposed to provide transport for women to the district surgeon's office. Failure to do so is a disciplinary offense. Yet a woman may be told she has to find her own way to the district surgeon's office and get home from there. In addition, problems with the availability of police vehicles are notorious. In one case, a fourteen-year-old who had been raped told Human Rights Watch that she was unable to reach the district surgeon for a medical examination. The police did not have any vehicles to transport her, and so she finally went home.[55] Human Rights Watch received reports in late November 1996 that in some cases the police continue to place a suspect and complainant in a van together for transportation to the district surgeon's office, without consideration of the psychological or even physical consequences for the woman involved.

The inadequacy of the police response to rape cases is exemplified by the treatment received by Nomboniso Gasa, a member of the Gender Commission, when she reported in January 1997 that she had been raped by a prison officer during a recent visit to the former apartheid prison of Robben Island. Gasa complained of the failure to respond properly to her allegation and of the lack of sensitivity shown by the police appointed to investigate the case. This led Minister for Safety and Security Sydney Mufamadi to refer the case to the newly established Independent Complaints Directorate (ICD), appointed to look into complaints against the police. The ICD published a report of its investigation in April 1997, finding that there was "*prima facie* evidence" of negligence, improper conduct, dereliction of duty, and insensitivity in the handling of the investigation by the initial investigating team. The ICD recommended that the provincial commissioner of the Western Cape publicly acknowledge the findings of the report and apologize unreservedly to Ms. Gasa, that two police officers be "strongly reprimanded," that the SAPS "should embark on an intensive education and training programme," and that a number of steps should be taken in respect of the handling of rape cases by the police.[56] The report was accepted by the provincial commissioner and an "unreserved apology" issued;[57] however, the commissioner refused to act on the recommendation to reprimand the two officers and later retracted his unreserved apology, saying that he had "only apologized to Gasa for the perception on her part that insensitivity was displayed to her."[58]

Inaccessibility: Distance and Time

Every part of the country is allocated to fall within the practice of at least one district surgeon. In urban areas, district surgeons or clinics providing medico-legal services are usually centrally located and thus accessible by public transport. Specialist medico-legal clinics are often open twenty-four hours a day. But in most cases they are still some distance from the townships where most black people live. There are exceptions to this rule: in Gauteng, for example, Baragwanath hospital in Soweto has a medico-legal clinic; the Alexandra Clinic serving the Alexandra township in northern Johannesburg also provides medico-legal services; the townships of Vosloorus, Daveyton, Tembisa, Katlehong and Lenasia near Johannesburg also have district surgeons; and district surgeons have recently begun to practice in Soshanguve and Mamelodi townships outside Pretoria. In Port Elizabeth, the newly established Ncedo Care Centre is located in a hospital close to the African township of KwaZakhele, although it is far from the colored areas. But in the Cape Town metropolitan area, for example, residents of Guguletu, itself closer to the town center than most townships, have to travel to Wynberg or to the Red Cross Children's Hospital in Rondebosch, perhaps twenty kilometers away. Mitchell's Plain, a colored township near Cape Town, had no district surgeon for several months in 1996.

In rural areas, the situation is much more acute. District surgeons, the vast majority of them still white (and male), live in the formerly white areas, which may be several hours travel from parts of the former homelands. In some

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[55] Interview, Johannesburg, February 17, 1995.

[56] "Report by the Independent Complaints Directorate into Police Conduct During the Investigation into the Robben Island Rape Case: Executive Summary" (Pretoria: Ministry for Safety and Security, April 2, 1997).

[57] South African Press Association, April 2, 1997.

[58] Gustav Thiel, "Gasa case: We're not THAT sorry, say police," *Mail & Guardian* (Johannesburg), May 2-8, 1997.

cases, local facilities are available to remedy this problem: in KaNgwane, for example, a former homeland on the Swaziland and Mozambique borders, the district surgeon is based at Komatipoort, several hours away by shared taxi. Women are therefore usually referred by police and examined by doctors at a local mission hospital. In other cases, no alternatives are available.

In addition, women's NGOs and others continually report that women wait long periods once they have reached the district surgeon's office. At almost every session of the Gauteng gender sensitivity training course described above, the police attending noted that waiting periods to see a district surgeon could be very long, as long as eight hours.[59] One women's organization told Human Rights Watch of a case in which a woman who had been gang-raped at around 4:00 or 5:00 p.m. and immediately reported to the police station was told that the district surgeon could only see her the next day. She had to remain in the same clothes without washing until she was seen.[60] Police at Boksburg CID complained of the (white) district surgeon responsible for their area, who was consistently difficult to see at any time outside his morning consulting hours. In one rape case, the investigating officer had phoned the district surgeon at about 9:00 p.m. He had stated he was not on call, so the officer contacted the nearest hospital, which did not want to become involved in a medico-legal case. After trying other district surgeons from outside the area, the woman was eventually told to come back at 8:00 a.m., without washing or changing in the meantime, and she was then taken to be examined.[61]

The implications of these delays are particularly serious in cases of sexual assault and rape. Physical evidence of major injuries will be apparent for some time, and in some cases, such as external bruising, may in fact be more difficult to evaluate immediately after inflicted than several hours later. Similarly, with modern laboratory techniques, traces of semen or other foreign matter in the vagina can be detected and analyzed up to two or three days later. However, in cases in which no physical struggle took place, where the woman is sexually active, and especially if she has had several children, the types of physical injury suffered during rape may be relatively minor and will disappear after several hours. The Pretoria medico-legal clinic stated to Human Rights Watch that a woman who has been raped should be seen within four hours to ensure that minor physical abrasions — which may be crucial to the woman's case that sexual intercourse took place without consent — can be detected.

Racist and Sexist Attitudes among District Surgeons

In March 1996, the *South African Medical Journal* (SAMJ) published an article by Dr. S.A. Craven, district surgeon in the Western Cape, in which he evaluated the use of medical evidence in the courts and stated, "The impression I gained after 4½ years of performing after-hours rape examinations for the Wynberg and Athlone magisterial districts of South Africa was that few women had any evidence to support their allegation of rape, and that I was unable to help them in the courts." From this assertion, which itself was based on his own conclusion that because he had been able to find no medical evidence, there was no evidence at all, Dr. Craven went on to conclude that the allegations of rape were therefore unfounded: "There is no law against wasting the time of a police officer in South Africa. The passing of such legislation, with a few well-publicized prosecutions, might well reduce the number of unfounded allegations."[62]

[59] "Gender Sensitivity Programme: Progress Report," Gauteng Department for Safety and Security, 1996; interviews with police officers attending one course, November 21, 1996.

[60] Interview, People Opposing Women Abuse (POWA), October 31, 1996.

[61] Interviews, Boksburg police station, November 22, 1996.

[62] References in this paragraph from S.A. Craven, "Assessment of alleged rape victims — an unrewarding exercise," *SAMJ* Vol.86, No. 3 March 1996, pp. 237-238; several reactions to the article were published in a later edition of the journal (*SAMJ* Vol.86, No. 7, July 1996, pp. 842-845).

While it is certainly a matter of concern that, according to the article, "only about 10% of women examined have any medical evidence to support their allegation of rape,"[63] many other conclusions are possible than that women are fabricating rape stories — including that women are not examined by district surgeons soon enough after the rape for medical evidence to be present or, indeed, that the prejudices and lack of specialized training of district surgeons are preventing them from conducting proper examinations to ensure that all relevant medical evidence is noted and properly used to secure a conviction. District surgeons with a particular interest in the field noted to Human Rights Watch that, if a woman is seen soon enough, there is in the majority of cases — even if the woman has had several children — physical evidence suggestive of forced penetration.[64] One study found that 37.7 percent of women alleging they had been raped who reported to a medico-legal clinic had evidence of genital injuries, and 37.3 percent had evidence of non-genital injuries.[65]

Examination for medico-legal purposes is an invasive experience, especially following the trauma of a sexual assault. Doctors need to be aware of the psychological context in which they are working and to take this into account as they conduct the examination, but this is often not the case. Women's NGOs report that district surgeons are often unsympathetic to women who report abuse, particularly in cases where black women are examined by white district surgeons. One woman interviewed by Human Rights Watch complained that she had been made to feel as though she was the guilty party and that she was simply wasting the time of the police and the doctor by asking to be examined.[66] Police at Boksburg police station Criminal Investigation Division complained about the attitude of the (white) local district surgeon, who was frequently unavailable to examine rape survivors and, when he did see them, treated both police and complainant "like children." Another (colored) district surgeon in the area, however, treated the women "very nicely."[67] Even district surgeons who are critical of the system and sympathetic to women who have been raped may be judgmental in their approach: one district surgeon interviewed by Human Rights Watch alluded to "frustrations" with women who were drunk when they came to be examined or alleged rape "because a guy hasn't paid," saying that "if it's not a 'genuine' rape case you feel disturbed that you are being used"; another referred to "two types of victims," those who are "really" victims, and those who "happen to be where they should not be," out late at night drinking at bars.[68]

In the current context, in which most district surgeons are white and do not speak an African language and an interpreter is often needed to take a medical history, linguistic misunderstandings may explain part of the impression of lack of sympathy and poor treatment. District surgeons based at hospitals or in specialist clinics will usually have African nurses or lay health workers available to interpret for them if necessary; white district surgeons in part-time private practice, however, will usually employ white nurses, meaning that no interpretation may be available. This situation clearly has serious implications both for the details of an examination and for the woman's comfort, especially where technical vocabulary is used.[69]

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[63] Ibid.

[64] Interviews, November 1996.

[65] Lorna J. Martin, *Rape in Johannesburg* (Johannesburg: Centre for the Study of Violence and Reconciliation, 1993).

[66] Interview, Johannesburg, November 1, 1996.

[67] Interview, Boksburg, November 22, 1996.

[68] Interviews, November 8 and 28, 1996.

[69] It is of course not the case that a black district surgeon necessarily speaks the same language as a black patient, even if both are South African, given the linguistic diversity of the country (in which there are eleven official languages). Indian and colored doctors are no more likely than white doctors to speak an African language, though not all white, Indian, or colored district surgeons are restricted to English and Afrikaans. However, lack of a common language in which both doctor and patient are comfortable is currently most likely to occur when the doctor is white and the patient African.

Lack of Informed Consent

Linguistic problems also have serious implications with respect to obtaining informed consent for a medico-legal examination. According to medical ethics, a doctor should obtain the informed consent of his or her patient before carrying out any medical procedure. Special rules relate to situations where this is not possible. Yet women's NGOs report that some of their clients have no idea of the purpose of the examination by a district surgeon after they have reported a rape. Women reporting to a police station that they have been raped may find themselves taken to the district surgeon without any explanation as to why this is necessary. In many cases neither the police nor the district surgeon bother to explain why the J88 must be filled in or samples taken; in others, there may have been an explanation of sorts, but language difficulties prevented the woman from understanding the implications.[70]

Lack of Privacy

During the examination of a rape complainant by the district surgeon, the only people who should be present are medical personnel. Although in most cases district surgeons do ensure that police, for example, are not present, Human Rights Watch also received reports of cases in which policemen have wandered in and out of the room where the woman is being examined, even making comments on what they see.[71] Even if the police officer is female, this is not acceptable. Such intrusions into the privacy of the woman being examined create an extremely intimidating and hostile environment for women who have already been traumatized and had their privacy brutally violated.

Incompetent Examination Technique

For medical evidence to be useful, it is important that the initial examination be properly conducted, all specimens for forensic analysis collected, and the findings fully recorded. The examination of a rape survivor for legal purposes is a specialized task, especially if the person is a child.

Doctors need to be aware of the varying signs that may be visible to suggest that forcible sexual intercourse took place: these signs vary not only according to whether a woman has ever had full intercourse, but according to her age, whether she is sexually active, or whether she has had children. There is likely to be some evidence visible to the trained eye in every case if the woman is seen soon enough after the incident took place. Many doctors (including many interviewed by Human Rights Watch) will say, for example, that in the case of a sexually active woman who has given birth to several children, there may be no physical signs of forced sex (absent external bruising or other indications of a struggle). Yet even in that case, an expert doctor who sees the woman soon enough after the incident occurred will know to look for small abrasions indicating the use of physical force in penetration. Since medical evidence may be decisive as corroboration not only of the fact that sexual intercourse took place but also of a woman's allegation that she did not consent, it is therefore crucial that district surgeons are fully trained in the detailed procedures of a full examination.

[70] Interviews with women's organizations, November 1996.

[71] Interview, People Opposing Women Abuse (POWA), October 31, 1996.

The consequences of the lack of proper examination or an improper record of that examination can be serious. A prosecutor in the magistrates court (the lowest judicial division of the formal court system) in Johannesburg cited one case in which a woman who had been raped appeared in court eight months after the incident took place, with wounds still visible resulting from the struggle with her attacker. Nothing was noted on the J88 form relating to these scars, and it was only the fortunate presence of another eyewitness that meant that her story could be confirmed.[72] Police reported that the district surgeon in Boksburg did not even always ask and fill out all the questions on the form, even questions which could have a crucial bearing on the medical examination, such as the number of children to whom a woman had given birth. In one case, he had refused to take hair samples from a man accused of rape because he said it was not necessary.[73]

The Hillbrow medico-legal clinic in Johannesburg has a detailed set of protocols for doctors working there to follow when they carry out examinations of assault victims generally, and rape victims in particular.[74] They were developed by Dr. Lorna Martin, the former senior district surgeon at the clinic, and include procedures for the medical examination and treatment of the complainant (and of the perpetrator) and standard letters for referral to relevant organizations, such as HIV counseling centers and women's NGOs, to request that the patient be given time off work to recover, or to complain to a police station commissioner of a delay in bringing a woman to the clinic for examination. The doctor will also fill out a form indicating brief details of the alleged incident, including the relationship of the perpetrator to the victim, the place of the rape, the level of violence that took place, and the sexual act(s) performed. The purpose of taking a history of the incident is to prompt the doctor to look for evidence that might corroborate each element of the story. The Pretoria medico-legal clinic also has detailed protocols for different types of examination, in addition to a formal training program for new district surgeons operating in the Pretoria area that covers all aspects of medico-legal examination in cases of sexual assault. Other big hospitals with clinics seeing rape victims, such as Groote Schuur hospital in Cape Town or Baragwanath in Soweto, also have protocols for examination of sexual assault victims. Protocols of this type are, however, neither standardized nor available to most district surgeons; nor would most district surgeons have the time, knowledge, or inclination to develop similar standard procedures for themselves.

While in general it is important that a rape survivor be seen by a doctor as soon as possible for examination and collection of medical evidence, some injuries (bruising for example) may only be detected some time later. No standard procedures exist to ensure that, in such cases, women are brought back to the district surgeon for re-examination. While some district surgeons will tell women to come back, this is rare; and it is even rarer for the women actually to report back, given the problems of transportation and the waiting periods that may be expected.

Lack of Training

In order to conduct a proper examination of someone who alleges that she has been raped, detailed and expert training is needed beyond general medical training. Thorough training of medico-legal officers is badly needed. It is entirely possible that a woman who reports to a police station that she has been raped and is taken to a district surgeon for examination will be examined not by an expert but by a doctor who has little idea of the physical signs of coercive sex. If the complainant is a child, it is even more likely that the district surgeon will not have the skills to conduct a full examination. As one doctor involved in discussions for the restructuring of the system commented, "There are good district surgeons, but only by accident — the training is sadly lacking."[75]

[72] Presentation by Corina Coetzee, prosecutor, to police gender sensitivity training course, November 21, 1996.

[73] Interview, Boksburg police station, November 22, 1996.

[74] The Hillbrow protocol for examination of a rape victim is attached as Appendix I.

[75] Interview, Dr Marietjie de Villiers, Tygerberg Hospital, November 18, 1996.

No national requirement exists for the training of district surgeons contracted to do work for the state. The scope of any available training depends on the arrangements of each provincial health department and on the chief district surgeon for a particular area within the province: in some cases, new district surgeons may receive lectures from experienced colleagues before beginning to practice and/or periodic "refresher courses" in aspects of their practice; in others, they are simply told their duties and given no further instruction. District surgeons interviewed by Human Rights Watch indicated that they had learnt what they knew about examination of a rape victim, how to prepare for court, or how to fill out a J88 form "on the job" by trial and error. The government had shown absolutely no interest in their qualifications for the job at the time of appointment, nor was any recognition in financial terms given to experience. If they were lucky, they had received ad hoc advice from more senior colleagues on taking up a position. But in some cases, advice from more senior district surgeons may be counter-productive: one district surgeon reported that she had been told by a colleague not to put too much detail on the J88, because it would only "cause trouble," making it more likely that she would have to go to court.[76] Compounding this lack of training is the fact that district surgeons are at liberty to subcontract their state work to other doctors, who may have even less expertise and experience and over whom the state has even less control.

While specialized training and qualifications exist for forensic pathologists in South Africa, the state provides no dedicated training for doctors wishing to obtain a specialist qualification in clinical medico-legal practice, relating to the medico-legal examination and assistance of victims of assault or other crimes. Some district surgeons obtain a diploma in forensic medicine, which includes both clinical and forensic pathology elements, but no financial recognition is given to this qualification, and as a consequence there is no incentive to undertake the one year of full-time study to obtain it.[77] Most district surgeons therefore rely essentially on the training they received in medical school and whatever other experience they have gained.

During the course of their general training, medical students will usually (although there is no standard curriculum shared among the different universities and teaching hospitals) take a compulsory course in forensic medicine. The University of the Witwatersrand, for example, offers this course for one year during the fourth year of medical studies (before the students have any medical experience); it includes only two lectures on sexual offenses. The University of Cape Town offers a course lasting over two years for third- and fourth-year students; just one lecture covers sexual offenses.[78] The course involves attendance at a minimum of two autopsy demonstrations (required by the South African Medical and Dental Council, which approves medical training programs), but no similar attendance at a medico-legal clinic. In any event, in most cases students take the course before they have any clinical experience, and there is a long period within which to forget it before they need to examine a woman who has been raped. One doctor commented that it is possible to leave medical school without, for example, a clear idea of what the normal anatomy of a woman's genitalia should be, making a useful assessment of a rape victim virtually impossible.[79]

[76] Interview, October 30, 1996.

[77] The Diploma in Forensic Medicine is a qualification offered through the College of Medicine (an independent body run by the medical profession). The requirements for the diploma are both an examination and practical experience (that is to say, it is only available *after* a doctor has already been practicing in the medico-legal field). It is taught by various university medical departments in South Africa. Specialist degrees in forensic pathology are offered both by the College of Medicine (a Fellowship in Forensic Pathology) and by some of the universities (a Masters degree in forensic pathology). Both are at least four-year courses. The South African Medical and Dental Council (SAMDC) approves all training courses both at universities and at the College of Medicine.

[78] Interview, Dr. Lorna Martin and Prof. G.J. Knobel, University of Cape Town, November 18, 1996.

[79] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 22, 1996.

Some government facilities have taken initiatives to improve this situation. The Hillbrow medico-legal clinic in Johannesburg has developed a training system for all new district surgeons, including both those at the clinic and those practicing part-time in outlying areas, including some of the local townships. At the Pretoria medico-legal clinic, a training program exists for newly appointed district surgeons who spend some time each week examining patients under supervision before returning to their practices. The chief district surgeon, Dr. K. Muller, has taken the initiative to obtain a donation from Polaroid South Africa of a special high-resolution camera, which will be used to photograph the injuries sustained by complainants examined at the clinic. The photographs will be used both to add to the information included in the J88 form, providing visual evidence to the court, and in the preparation of a comprehensive training manual for future medico-legal practitioners, who will therefore be able to gain information about injuries sustained in sexual assault without the "secondary victimization" that could occur if a woman who has reported a rape is examined not only by the doctor who will fill in the J88 form, but also by student doctors learning medico-legal skills.[80]

In addition to the medical skills and knowledge needed to conduct a proper examination in cases of sexual assault, doctors involved in medico-legal functions also need the skills to ensure that they can give useful evidence in court. Yet district surgeons do not receive training in court procedure, the law relating to assault or other relevant crimes, how to prepare to give evidence in court, or other forensic skills. Several district surgeons commented to Human Rights Watch that they had probably given very poor evidence in their first cases, before learning by experience what was needed. One said that in her first couple of court appearances she could not remember the details of the case because she had not taken enough notes on the J88 at the time; as a consequence she had learnt the need to record cases in great detail and to keep copies of all notes taken at the time of the examination.[81] Moreover, district surgeons are not officially given information about the referral services or legal remedies available to women, including the Prevention of Family Violence Act (although some may seek out such information independently).

Lack of Treatment

District surgeons are charged only with examining women who have been assaulted or raped and indicating their findings. They are not required to provide any treatment to the women they have examined. In practice, however, the conduct of district surgeons varies, and in some cases treatment will be provided. The specialized medico-legal centers in the major cities will usually provide treatment. At the Hillbrow medico-legal clinic in Johannesburg, for example, women are offered prophylactic treatment with antibiotics against a range of sexually transmitted diseases and a "morning after" pill. At the Alexandra Clinic in Johannesburg, women are treated for STDs, given contraceptive drugs, and also referred for counseling to social workers based at the clinic. In Pretoria, however, women are not offered prophylactic medication against STDs, on the basis that treatment without diagnosis or proper follow up is problematic. However, the practice at the city center medico-legal clinic is to provide women with a gynecological douche, which is effective against some STDs and has the important psychological benefit of allowing the woman to take steps to "clean" herself after a sexual assault. In addition, women are told and given written information about symptoms of STDs and referred to places where they can obtain a full check-up and treatment.

In other cases, district surgeons will refuse to provide treatment even if asked by the woman, although they may refer her to a hospital that will treat her.[82] This is usual for part-time district surgeons who receive a fixed budget for their state work and do not wish to take money from that budget for drugs; full-time district surgeons have their drugs supplied by provincial health authorities and so are not financially penalized if they treat women prophylactically. Some district surgeons may even not refer a woman to a hospital or other location where she may obtain treatment, or warn her of symptoms that indicate, for example, infection with a sexually transmitted disease or that are normal after a sexual assault, such as depression or feelings of guilt.

[80] Interview, Dr. K. Muller, Pretoria, November 28, 1996.

[81] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 22, 1996.

[82] This was the case, for example, for the district surgeon in Port Shepstone interviewed by Human Rights Watch, November 8, 1996.

The implications of the lack of treatment by district surgeons of the actual or potential medical consequences of rape and sexual assault may be serious for the women concerned. Those women who know that district surgeons do not usually provide treatment may be deterred from visiting a doctor who is qualified to carry out a medico-legal examination because they know that they will also have to wait again for treatment for any medical problems that are a result of being raped or sexually assaulted. As a result, medical evidence of the assault may be lost. Women who are examined by a district surgeon, on the other hand, may believe that having seen a doctor, they need not seek further medical assistance and may be ignorant of the sorts of symptoms that may result from a rape. Although free or low-cost outpatient clinics are fairly widely available, the demands placed on these facilities mean that it can be difficult to access such treatment except in emergency situations. In effect, women who are examined by a district surgeon may therefore be deterred in their effort to seek treatment given the double burden of seeking assistance from both the medico-legal and general health care services.

General Medical Practice and Medico-Legal Services

The great majority of rapes are not reported to the police; in even fewer cases do women report incidents of domestic violence.[83] The reasons for the low rate of reporting, set out in the Human Rights Watch report, *Violence Against Women in South Africa*, relate both to the hostile and unsympathetic treatment women in many cases receive from the criminal justice system and to the low rate of conviction for the cases that are reported.[84] Many women choose to use what other avenues of support and justice are available to them rather than risking the trauma of interaction with the police, district surgeons, and courts at a time when they feel most vulnerable. In most cases a woman who is abused or sexually assaulted and seeks medical attention will therefore see a general practitioner in private practice or a doctor in a state hospital rather than a district surgeon.

Although private practitioners are free in law to become involved in medico-legal matters and to appear in court as expert witnesses, they are generally both ignorant of and reluctant to become involved with the criminal justice system. The reasons for this reluctance vary from nervousness about the court process and fear of cross-examination by hostile defense counsel, to the loss of income associated with waiting at court for a case to be heard.[85] The effect of this reluctance is to discourage women from taking their cases forward. In one case reported by People Opposing Women Abuse (POWA), an NGO in Johannesburg offering counseling and other assistance to women, for example, a woman who had come to them the week before had gone to her own doctor with injuries inflicted by her partner including an open wound on her head, and said she wanted to lay a charge. Her doctor had treated her, but had referred her to the district surgeon for completion of the J88 form, saying he did not want to be involved in any court proceedings. The woman had then decided that she would not go ahead.[86] In Cape Town, even those doctors who have been trained by and are helpful to the local rape crisis center usually refuse to go to court on behalf of the women they have seen, and as a consequence, if a woman wishes to lay a charge, she must be referred for examination at Groote Schuur hospital.[87]

[83] Estimates of the ratio of reported rapes to the actual number of rapes in South Africa range from one in 2.5 to one in thirty-five. Human Rights Watch, *Violence Against Women in South Africa*, p. 51. In cases of domestic violence, separate statistics are not kept by the police.

[84] Less than 15 percent of reported rapes end in convictions. Ibid., p. 90.

[85] Part-time district surgeons who also have private practices may be reluctant to go to court for similar reasons. However, district surgeons who appear regularly in court usually have arrangements with the prosecutors to schedule cases involving their evidence on the same day or to be called just in time to arrive in court without waiting too long.

[86] Interview, POWA, Johannesburg, October 31, 1996.

[87] Interviews, Rape Crisis, Cape Town, November 18, 1996.

If alternatively a woman seeks attention from a state hospital, again without going to the police, the hospital is legally obliged to provide medico-legal services, although in practice the standard of service offered is highly variable. At the Alexandra Clinic, for example, women who report to the clinic after being raped are seen by doctors who care for the female patients generally. The system is currently arranged under the supervision of an experienced doctor; those under her supervision conduct a medico-legal examination and fill out a J88 form as a matter of course (even if the patient has at that time no intention of laying a charge), in addition to giving the woman medical treatment and referring her to a social worker if necessary. In other cases, doctors may effectively be unable to conduct a medico-legal examination: one district surgeon reported to Human Rights Watch that he had been called to a large state hospital to conduct an examination of a girl who had been raped because the gynecological registrar on duty was unable to do so.[88]

If women choose to go directly to a hospital for treatment, they may face long waits for attention. As in the case of district surgeons, delays have serious implications for the usefulness of the examination when it is finally carried out, given that some medical evidence may be transient. Delays of several hours before a doctor is available are not uncommon, although at the Alexandra Clinic, for example, an attempt is made to give preferential treatment to women who have been sexually assaulted by allowing them to move to the front of the line.

In a hospital where doctors trained in medico-legal issues are available, women should be referred immediately to the correct part of the hospital for a medico-legal examination to be carried out and for treatment to be given. Yet even at those hospitals with specialized medico-legal clinics, which generally provide some of the best services to women who have been abused, problems of coordination exist. At Baragwanath hospital in Soweto (the largest in the world), where there is a medico-legal clinic, medico-legal services are not available in other parts of the hospital, nor are the services coordinated. Often it depends on the woman to know that she should report to the medico-legal center if she wishes to lay a charge, since the accident and emergency department (for example) does not refer patients to the medico-legal center for information about the legal remedies available and for the correct forms to be completed.[89] If a woman returns to the main section of the hospital having later decided to lay a charge, it may be impossible to trace the doctor who treated her, or to find her file, in order to have a J88 form completed retrospectively. Without a J88, the police may refuse to open a docket.[90] At the Alexandra Clinic, while services are well-organized during the week and integrated into the general medical work of the clinic, women who report to the accident and emergency department on the weekend will not see one of the trained members on staff or receive a proper examination, no J88 will be completed, and there may simply be a two-line report in the intake records.[91]

Examination of patients for medico-legal purposes is a specialist task; appearing in court also requires special skills. It is not desirable that doctors without training be generally expected to become involved in medico-legal functions. Yet, even if a woman does not initially intend to lay a charge and sees a general practitioner rather than a district surgeon or other trained person, she may later change her mind, and this avenue should not be closed by the lack of medical evidence to support her case. It is therefore important that general practitioners have some understanding of the issues surrounding violence against women and the possible legal remedies that may exist, even though they neither can nor should attempt to carry out a full medico-legal examination. In particular, where a woman seeks treatment from a general practitioner, her doctor should know enough to explain to her the desirability of examination by a specialist should she wish to lay a charge at some later stage, especially in cases of sexual assault and especially if she reports soon enough after the assault occurred for the medical evidence to be compelling. Doctors should also be able to refer women to both state and nongovernmental support services available to survivors of violence. At the same time,

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[88] Telephone interview, March 7, 1997.

[89] Interview, Sister Alferia Mqaba, Baragwanath Medico-Legal Clinic, November 21, 1996.

[90] Interview with domestic violence survivor to whom this had happened, POWA, Johannesburg, October 31, 1996.

[91] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 22, 1996.

general practitioners should remain compellable as witnesses if in fact a court case results and no examination was carried out by a specialist.

Private Practitioners and Domestic Violence

Lack of knowledge of the legal system by general practitioners is particularly widespread in cases of domestic violence; the possibility of laying a charge of sexual assault is more likely to be known and suggested in rape cases. Medical students do not generally receive any training in the particular health and other problems faced by women who are abused by their partners nor any information about the legal remedies available; most doctors are probably unaware of the provisions of the Prevention of Family Violence Act.[92] If a woman has seen only her own doctor, she may as a consequence never learn of any legal remedies available to her.[93] At the FCS unit in Braamfontein, only one or two of over a hundred cases being handled by the officer responsible for domestic violence cases had been referred by doctors.[94]

THE USE OF MEDICAL EVIDENCE BY THE CRIMINAL JUSTICE SYSTEM

The Collection, Recording and Handling of Medical Evidence

The J88 Form

The key document recording medical evidence that may be needed in order to obtain a conviction in an assault case is the J88 form.[95] In court, the J88 is the most important written evidence of the medical indications that a rape may have taken place. Moreover, since the hearing will be several months at least after the original examination, the doctor's memory of the examination may well be hazy at that point, and his or her oral evidence will depend heavily on the J88's contemporaneous record.

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[92] This statement is supported by interviews with a number of doctors currently or formerly in private practice who stated either that they were not aware of the legislation or that they had only become aware for some reason unrelated to their training or continuing medical education, such as (in one case), being themselves subjected to abuse and finding out about the interdict procedure after consulting a lawyer. Similarly, interviews of forty family practitioners from different racial groups carried out by the authors of three undergraduate dissertations from the Faculty of Social Work at the University of the Witwatersrand, revealed that not one doctor, when questioned as to other resources available to abused women, suggested going to a lawyer or attempting to obtain an interdict under the Prevention of Family Violence Act. Deborah Khourie, "Attitudes, Knowledge and Responses of 'Coloured' General Practitioners to Women Abuse;" Tessa Hochfeld, "Jewish Family Doctors as a Support System for Abused Women: Can They Be Relied On?;" Shahana Rasool, "Women Abuse: Knowledge, Attitudes and Practices of Indian Medical General Practitioners in the Lenasia Area," dissertations submitted to the Faculty of Arts, University of the Witwatersrand for the degree of Bachelor of Arts in Social Work, 1995.

[93] There are exceptions to these rules: one doctor in Durban who has close links with a local NGO, the Advice Desk for Abused Women, takes many referrals from the Advice Desk to the extent that battered women form about 10 or 15 percent of her practice; equally, she refers women who come directly to her to the Advice Desk for help. She fills out J88 forms in 20 or 30 percent of the cases of women abuse that come to her; although, since most cases are not proceeded with, she has never been called to court to give evidence. Interview, Dr. P. Naicker, Durban, November 6, 1996.

[94] Interview, Inspector Elsa Kriel, November 15, 1996.

[95] A copy of a J88 form is attached as Appendix II.

The J88 form is defective in several respects. In particular, the form neither asks all the relevant questions, allowing doctors to omit important details in their record of the examination, nor does it provide sufficient space for a doctor to record other relevant information, including a record of the woman's description of what had happened to her.[96] In the case of sexual abuse of children, it is particularly inadequate. District surgeons spoken to by Human Rights Watch who took a particular interest in questions of violence against women stated that they usually had to attach a separate sheet or write on the back of the form to ensure that all details were recorded so that they could refresh their memories at any trial. They noted that it was not until they had been to several trials and been embarrassed by the fact that they could not clearly remember the examination that they had realized how necessary this was. In the meantime, of course, those women who had been examined while the district surgeon was still inexperienced may have suffered as a result. At Pretoria's medico-legal clinic, a separate form has been designed to provide a record of information in cases of suspected child sexual abuse, which is much more detailed than the J88 form.[97]

Amendments and additions to the J88 form suggested to Human Rights Watch by doctors working in the field[98] include the following:

- The form should provide for the doctor to record not only the date of the examination, but also the time. In some cases, it may be crucial to know how long after the alleged assault took place an examination was carried out.

- The ethnic group of the complainant should be recorded, for statistical purposes. While there is a natural resistance in South Africa to the idea of continuing to categorize people by race and ethnicity, public policy interventions can only be properly designed if sufficient information is available to evaluate various possible initiatives. If women of a particular ethnic group report the most cases of assault, then that should be taken into account in devising government responses to the question of violence against women.

- The form currently provides for the doctor to record the "[s]tate of the person as regards physical powers, general state of health and mental state." This section should be expanded to include an assessment as to whether the complainant is under the influence of alcohol or other drugs, which (provided the examination takes place soon enough after the alleged incident) may be relevant to the issue of whether she was capable of giving consent to sexual intercourse.

- The section providing for the doctor to record his or her clinical findings should be substantially enlarged and should in addition be broken into specific questions so that crucial information cannot be omitted by an inexperienced district surgeon unaware of all the relevant details to be recorded.

  Firstly, the doctor should record a brief history of the alleged assault. While it may be asserted that it is the job of the police to take a statement from the victim, the doctor's examination is designed to discover whether there is any physical evidence to provide corroboration of the complainant's story. If the doctor has not found out and recorded that story, then he or she will not necessarily think to carry out all relevant examinations. The

[96] A British forensic pathologist has commented on the J88 form: "First it must be said that any kind of form which encourages systematic collection of information needs to be encouraged. . . . The compact nature of the J88 form and what appears to be a lack of the option of adding continuation sheets will encourage a minimalist approach to the recording of information, whereas it is desirable to encourage the exact opposite. The absence of any section to record the history as stated by the complainant is also fundamentally wrong since it is an essential part of the examination and necessarily informs and directs a medical examination. Clearly, the form should be redesigned to encourage the doctor to record as much information as possible." Quoted in *Breaking with the Past? Reports of Alleged Human Rights Violations by South African Police 1990-1995* (Johannesburg: Network of Independent Monitors, Trauma Centre for Victims of Violence and Torture and Independent Board of Inquiry, May 1995).

[97] A copy of the form is attached as Appendix III.

[98] In particular by Dr. Lorna Martin, former district surgeon.

doctor should be prompted to record the alleged date, time, and place of the assault; the nature of the assault (including a check list of possible acts, such as vaginal or anal intercourse, fellatio, cunnilingus, penetration by a finger or by another object, vomiting, defecation, or urination by the victim or the perpetrator, etc.); whether a condom was used by the perpetrator; the number of perpetrators and their identity and relationship to the complainant, if known by her; whether any weapons were used or the complainant was threatened; and any other relevant details. In each case the form should prompt the doctor to confirm whether the result of the medical examination is consistent with the complainant's history of the incident.

In addition, the doctor should be asked a separate list of questions relating to the physical exam, including both genital and nongenital injuries. At present, he or she is left free to decide which details are relevant, the only prompt to carry out particular examinations being a set of pictures of the human body, including both male and female genitalia.

- The pictures on which the doctor may record the position of an injury should be improved, and space should be provided for the doctor to annotate the picture with details of the type of injury as well as simply indicating its position. Presently, there is no picture of an anus nor of the left side view of a penis, and both should be added.

- Given the different physical signs that may be relevant in children of various ages, consideration should be given to designing a specialized J88 form for children. The Pretoria medico-legal clinic, for example, has found it necessary to develop its own form for use in examination of children, which provides a detailed set of questions relating to the vulva and anus, in both cases providing a list of approximately twenty-five different physical signs to consider. While there are pictures of children on the current J88, there are no pictures of children's genitalia, which again should be provided.

- The doctor should be required to note the language in which the examination was conducted, the home language of the complainant, whether an interpreter was used, and who the interpreter was (currently there is a record of interpretation, but in small print, with not enough detail).

- The form should include a space for the doctor to note the type of "crime kit" used and the seal number of the kit, so that the form can be matched with the laboratory results when they are returned; since each kit includes spare labels for additional samples, the best solution might be for a space to be marked for one of these labels to be attached.[99]

Crime Kits and the Collection of Biological Samples

Since 1993, the police have provided a series of "crime kits" for the collection of medical evidence. When a woman reports a rape to the police and is then taken, or (as may unfortunately be the case) is told to go by herself, to a district surgeon for medical examination, she should be supplied with one of these crime kits. The kits contain slides, swabs, test-tubes, and other equipment for the collection of biological samples, including blood, vaginal fluid, or foreign matter such as semen or hair. Five types of kits exist; the one used depends on the crime that is reported, whether the collection is to be from the complainant or suspect, and the tests that are requested by the police or prosecutor.

[99] Currently, it depends on the initiative of the doctor to do this, meaning that there is every likelihood that medical evidence could simply be lost: if there were any confusion in the delivery system there is no way of rematching the crime kit results with the appropriate J88 form.

When a woman is taken to the district surgeon he or she will open the crime kit and use the equipment to take samples from the complainant. The crime kits come with clear instructions on how to use them. Nevertheless, the collection of biological samples, like other aspects of medico-legal work, requires training to be done correctly. For example, the police forensic laboratory in Pretoria reports that in some cases where sexual intercourse is beyond doubt, forensic analysis of vaginal swabs has failed to detect the presence of semen, because doctors have failed to take representative samples.[100] In other cases, doctors have failed to collect potentially crucial samples such as foreign skin cells under the complainant's finger nails, which might indicate that a struggle had taken place. In principle, if there is no suspect at the time the woman is examined, the only samples that need to be collected at that time are those that will disappear over time — such as vaginal swabs for traces of semen or fingernail scrapings — and the woman can be asked to report again for the collection of different samples, such as blood for DNA matching. However, it is better if all samples are taken at once, to avoid the trauma for the woman of going through the same procedure again and the likelihood of important evidence being missed if discretion is involved in deciding which samples to take.

Several reports were made to Human Rights Watch of problems with the availability of the correct crime kits. At Boksburg police station, for example, an investigating officer took a woman to see the district surgeon, but did not have the correct crime kit with her because the police station had run out. The district surgeon refused to examine the woman, although he had the necessary slides and other equipment available in his office for use in his private practice.[101] At the Alexandra Clinic crime kits are supplied by the district surgeon to the clinic (women who report to the clinic and allege that they have been raped are automatically examined for medico-legal purposes whether or not they have been to the police), but they frequently run out.[102]

For the last few years, standard form affidavits have existed to prove the "chain of control" over medical evidence, in order to link the laboratory results to the particular complainant if she appears in court. However, these forms are often filled in retrospectively by police officers, so that in fact no effective system exists to ensure that there is a chain of control. Although the envelope in which the results are returned will usually be correctly labeled with a name as well as seal number, enabling them to be matched to the J88, it would be easy for the results of forensic testing to become separated from the form and thus rendered useless, since the J88 form does not currently provide for the seal number of the crime kit to be recorded.

Police Control of Laboratory Services

[100] Telephone interview, forensic analyst, forensic science laboratory, Pretoria, March 6, 1997.

[101] Interview, Boksburg police station, November 22, 1996.

[102] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 20, 1996.

Up until the 1960s, what is now the Department of Health had at least three forensic biology laboratories, which supported both clinical forensic medical services and forensic post mortem services. During the late 1960s and 1970s, these services were progressively taken over by the South African Police Forensic Science Laboratory, which was able to offer better pay and conditions to technical staff. This police laboratory, in Pretoria, is currently the only forensic biology laboratory in South Africa, and the police thus have a monopoly on forensic biological analysis.[103] The laboratory is equipped to carry out tests, including DNA analysis, on a variety of biological samples and offers a sophisticated service comparable to that available in Europe or the U.S.

The police monopoly on forensic biological laboratory services, like police control over mortuaries, has been much criticized by human rights groups and pathologists, especially those involved in investigating cases of death in police custody, where post mortem evidence has been crucial. Even if the laboratory operates independently in practice, the possibility of police pressure on forensic laboratory services to produce the "right" result could be avoided by taking laboratory services out of police control; moreover, the creation of regional forensic biology laboratories would allow for results to be double-checked in controversial cases.

Since the advent of DNA analysis and the introduction of crime kits, it is of less importance that biological samples be refrigerated during storage and transportation or analyzed within a certain time: DNA analysis requires only cell matter, and samples can be preserved by drying rather than refrigeration. Slides and swabs therefore have a long shelf life; liquid blood samples are more perishable, although it is less urgent that they reach the laboratory quickly than when the only test possible was blood-group matching. In any event, the kits are insulated in polystyrene containers which give them some protection. Nevertheless, the police forensic science laboratory in Pretoria continues to recommend that crime kits should reach the laboratory within fourteen days. Contamination by fungal or bacterial growths if evidence is stored in moist conditions is of more concern, especially of samples that are not included in the crime kit: for example, if a woman's underwear is taken in order for traces of semen to be analyzed, but is stored in a plastic bag (rather than in a container that allows air-drying to take place) and not sent to the laboratory in good time, DNA analysis may become difficult.[104] Clear guidelines should be developed and made known to all police responsible for handling medical evidence, setting out acceptable time limits, storage requirements, and other technical considerations to ensure that evidence is not contaminated.

The Police Use of Medical Evidence

Like other crimes, rape, sexual assault, and child abuse cases are investigated by the Criminal Investigation Division (CID) of the SAPS. In many CID units, investigating officers who specialize in sexual assault cases or child abuse have been identified, or alternatively specialized units have been set up to handle such matters (such as the FCS unit in Braamfontein). While national training schemes have been established for officers investigating such cases, there often appears to be insufficient attention paid to the use of forensic medical and other scientific evidence, including the information contained in J88 forms and the results from the analysis of crime kits.

[103] The forensic biology laboratories in Cape Town and Johannesburg closed in the 1970s. The laboratory in Durban continued functioning in conjunction with the Natal Blood Transfusion Service until the early 1990s, when, upon the request of the SAP laboratory, it was also closed. The Department of Health has three forensic chemistry laboratories, in Pretoria, Johannesburg, and Cape Town. Other laboratories which are capable of rendering some but not all of the services of a full forensic biology laboratory are South African Institute of Medical Research, the Natal Blood Transfusion Service, the Western Province Blood Transfusion Service and Tissue Laboratory, the South African Blood Transfusion Service, Onderstepoort Veterinary Laboratory, the National Institute for Virology, and university or private laboratories. *Proposed National Policy on Medicolegal Services in South Africa* (Pretoria: Department of Health, September 1996), p. ii; "Medico Legal Services in South Africa," pp. 9-11.

[104] Telephone interview, Johann van Niekerk, forensic analyst, Pretoria forensic science laboratory, March 6, 1997.

At its most basic level, this lack of concern is indicated by failure even to ensure that medical evidence is included in the docket. If police officers do not wait while a woman or child is examined, it may be the case that the J88 and crime kit are collected only late or not at all. The Alexandra clinic, for example, informed Human Rights Watch that it could be many days before police collected crime kits and J88 forms, even though they phoned the Alexandra police station regularly to remind them. Theoretically, the Braamfontein FCS unit, responsible for investigating rapes, should collect the kits, but it was difficult to contact them to do so.[105] The Pretoria medico-legal clinic similarly had a "stack" of crime kits waiting for collection and complained that it was "amazing" how police investigators appeared unable to care about or make good use of medical evidence.[106]

The police also need training in the handling of biological samples and the possibility of contamination since it is the police who are responsible for the crime kits and other material before it is sent to the forensic laboratory for analysis. Human Rights Watch received frequent reports of lost crime kits or items of clothing that had not been properly stored. Similarly, prosecutors, doctors, and women's organizations complain that police investigators are often unable to appreciate the importance of medical evidence, and hence keep women waiting rather than taking them promptly to the district surgeon for examination.[107]

The Courts and Medical Evidence

Prosecutors

In addition to their law degree, prosecutors receive a six-week training at Justice College, the state legal training center in Pretoria, before they begin to practice. The course includes a section on the law of rape, but it deals only with the legal issues and not with the use of medical evidence. Degree courses are unlikely to have made up for this lack: the University of Cape Town law school, for example, offers only an optional course on forensic medicine in the final year; during 1996 only twelve students took this course.[108] In most cases, forensic medicine is only available as an elective course during the LLB degree, which is a postgraduate degree not compulsory for prosecutors (who need only the undergraduate BJuris).

Rape cases are handled by regional rather than district magistrates' courts (a slightly higher position in the court hierarchy), where prosecutors should theoretically be more experienced. Nevertheless, many prosecutors are not familiar with the details of the possible medical evidence. While ignorance of the medico-legal evidence could be rectified by consulting with the medical expert before the case, prosecutors rarely have the time to do so. As a consequence, when leading evidence (presenting their case with the assistance of witnesses) prosecutors often do not ask the district surgeons questions that can help to advance the case but simply make them confirm their signature and the contents of the J88 form, not adding anything to the written evidence already before the court.

By contrast, where the suspect has legal representation (in a small minority of cases), the defense lawyer will usually conduct a vigorous cross-examination of the expert witness, who may therefore be made to appear weak even if the case is good. Because prosecutors are poorly paid for their work, many move quickly on to private practice, where they can make more money and enjoy better working conditions. As soon as they have gained the experience that might allow them to conduct a more effective case, they leave their jobs.

[105] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 22, 1996.

[106] Interviews, November 28, 1996.

[107] Interviews, November 1996.

[108] Interview, Dr. Lorna Martin, November 18, 1996.

Attempts have been made to address the problem of inexperienced and untrained prosecutors. The office of the Attorney General for the Transvaal, for example, has issued guidelines to prosecutors in sexual assault cases. The guidelines state that in offices where there is more than one prosecutor, one person should be identified to specialize in handling sexual assault cases and in any event, one prosecutor should always handle a case from start to finish. The prosecutor is instructed to consult thoroughly with the complainant before the trial commences and with the district surgeon where medical evidence is available. A list of medical terms and their meanings is attached to the guidelines in an attempt to ensure that prosecutors are familiar with the terminology of medical examinations and the J88 form. Special treatment is mandated for complainants who will be witnesses, and prosecutors are encouraged to apply for proceedings to be held *in camera* where appropriate, especially when the complainant is a child. Prosecutors are told to seek expert evidence where possible with regard to sentencing of sexual offenders and the possibility of treatment, and to address the court on the question of sentencing to avoid a situation in which the offender might once again have access to the victim. If the prosecutor regards a sentence as inadequate, he or she is instructed to contact the attorney general's office immediately with a view to appeal.[109]

At Johannesburg regional magistrates court (the chief court in a magisterial district), negotiations between women's groups and the court have resulted in the allocation of rape cases to specialized prosecutors, who receive one training session a year on medical evidence from a district surgeon at the Hillbrow medico-legal clinic. Notes are handed out with the lecture. A training course on medical evidence was organized in late 1996 for all prosecutors at the court; yet of 150 prosecutors, only twenty-five attended, of whom fifteen left early. Such courses are usually regarded as compulsory.[110]

Magistrates and Judges

Rape cases are heard either by a magistrate in a regional magistrates court or by a judge in a division of the Supreme Court (a higher level of courts that hear some of the more serious cases at first instance, and in other cases are the first level of appeal from the magistrates courts). Historically, magistrates in South Africa have been ordinary civil servants, while judges had greater independence guaranteed by statute. Since 1994, the Department of Justice has taken steps to increase the independence of magistrates by amending the procedures for appointment and removal. A complete review of the justice system, under the title "Justice Vision 2000" is in progress.

Magistrates and judges also receive training at Justice College in Pretoria, where all court officials are trained, before they begin adjudicating cases. As with prosecutors, this training does not include any specific medico-legal content. An LLB or post-graduate legal diploma is compulsory for magistrates in the regional courts where rape cases are heard, but again forensic medicine is an elective subject. In recent years, the Law, Race and Gender Unit at the University of Cape Town has also held training sessions for practicing magistrates and given lectures at Justice College; it is intended to make gender awareness training a regular part of the curriculum at Justice College. In late 1996, a training session for magistrates was held in KwaZulu-Natal, in association with the School of Law at the University of Natal, Pietermaritzburg. The main aim of the workshops is to provide gender sensitivity training and to encourage gender awareness in the legal profession; so far they have not included a specific discussion of medico-legal evidence.

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[109] *Attorney-General Guidelines: Victims of Rape and Sexual Offences Against Children*, General Minute No. 3 of 1995 to all prosecutors within the jurisdiction of the Attorney General, Transvaal. Each of the old administrative provinces of South Africa, and the Witwatersrand, has an attorney general who is responsible for the conduct of prosecutions within that province. There is no national attorney general. Section 310A of the Criminal Procedure Act (Act No. 51 of 1977) provides for appeal against a sentence by an attorney general, provided that a judge in chambers has granted an application for leave to appeal.

[110] Interview, prosecutor, Johannesburg magistrates court, November 21, 1996.

While those attending the sessions have given positive feedback, magistrates have rejected some other initiatives. Magistrates at the Johannesburg magistrates court, for example, refused to accept training in medical evidence for sexual offense cases: their reasoning was that they did not wish to appear unobjective and biased against defendants in rape cases.[111] Yet reports suggest that in practice magistrates and judges are not equipped to evaluate medical evidence. In one case, for example, a defendant convicted in the magistrates court applied for leave to appeal, which was granted by the Witwatersrand Supreme Court. In assessing the case, the Supreme Court judge stated that "the absence of medical evidence indicating penetration is disturbing; the evidence rather indicates assault." The case concerned a woman of forty-two who had three children, in which circumstances it would be quite possible that no evidence of forcible penetration would be found if examination had not occurred very shortly after the incident.[112]

A doctor who has often given evidence in court commented to Human Rights Watch that both magistrates and prosecutors have trouble understanding medical evidence, especially in child cases, where there is such variation in what is "normal." One magistrate found it difficult to understand, for example, that a child could have become infected with an STD through sexual abuse, even though her hymen was still intact because her vagina was simply still too small to allow full penetration.[113] Although Rape Trauma Syndrome has been recognized by the South African courts,[114] many magistrates are unaware of the psychological aspects of a rape case and the reasons why a woman may not, for example, report a rape at the first opportunity.[115]

Lack of medical knowledge by the courts may also prejudice a defendant: one district surgeon interviewed by Human Rights Watch referred to a case he had learnt of where a seventy-two-year-old man had been sentenced to five years' imprisonment for rape, although he was diabetic and taking medication for hypertension that is well known to increase the chances of impotence. This medical evidence, clearly relevant to the case, had not been raised at the man's trial.[116]

Interpreters

While efforts are being made to improve the representativeness of court staff in South Africa, magistrates and prosecutors, like district surgeons, are mostly white and Afrikaans-speaking. The languages of record in the courts are English and Afrikaans. A large percentage of those appearing before the criminal courts, however, including both defendants and witnesses, are African and may or may not be comfortable speaking to the court in one of the recognized languages. Interpreters therefore play a crucial part in the process. Yet court interpreters do not have special training in legal terminology, nor — particularly relevant here — in medical terminology. While some interpreters have acquired skills through years of experience, others are new and "virtually incompetent."[117] Even where technical vocabulary is not needed, interpreters must, especially in sexual assault cases where euphemisms are common, be skilled to translate the nuances of the language used by the different witnesses and the defendant and ensure that the meaning is clear. In one case reported to Human Rights Watch, for example, a fourteen-year-old Zulu

[111] Interview, Dr. Lorna Martin, Cape Town, November 18, 1996.

[112] Interview, prosecutor, Johannesburg regional magistrates court, November 21, 1996.

[113] Interview, Dr. Linda Cartwright, Alexandra Clinic, November 22, 1996.

[114] See Human Rights Watch, *Violence Against Women in South Africa*, pp. 109-110.

[115] Interview, prosecutor, Johannesburg regional magistrates court, November 21, 1996.

[116] Telephone interview, Dr. S.A. Craven, November 20, 1996.

[117] Interview, prosecutor, Johannesburg regional magistrates court, November 21, 1996.

girl was asked if she had "slept with" the man whom she alleged had raped her. She denied it, apparently not understanding that "slept with," which had been translated literally into Zulu, also meant "had sex with."[118]

GOVERNMENT PROPOSALS FOR REFORM

Medico-legal services are necessarily linked to the state provision of health care services generally. Health care in South Africa, like all other aspects of life, was historically arranged to benefit the white population the most, with South Africans of purely African descent at the bottom of the heap. This legacy is a difficult one to overcome: services currently enjoyed by a small section of the population cannot, for financial reasons, be extended to all; yet the government is committed to ending the extreme inequality of access to health (and education, welfare, legal, and other) services that characterized the apartheid state. The policy debates over medico-legal services reflect this dilemma.

[118] Interview, Futhi Zikalala, Centre for Criminal Justice, Pietermaritzburg, November 7, 1996.

With the coming of a new, democratically elected government in April 1994, South Africa's four provinces and ten homelands were rearranged into nine, geographically logical regions.[119] The allocation of responsibilities between provincial and national government is set out in the constitution, which provides that health services are designated one of the "Functional Areas of Concurrent National and Provincial Legislative Competence."[120] In practice, the division of responsibilities is that health care policy is set at national level, but service delivery is organized at provincial level. The different provincial administrations are at very different points in their efforts to reorganize medico-legal services (and health services in general).

National Level

At the national level, a "proposed" national policy on medico-legal services was published by the Department of Health in September 1996.[121] The "draft document" concentrates very heavily on the medico-legal investigation of death, at the expense of clinical medico-legal services related to the living — of eleven pages dealing with the proposed organization of a new medico-legal service for South Africa, for example, just over one refers to the examination of live rather than dead patients. While not wishing to deny the importance of the arrangements for control of mortuaries and carrying out of post mortems, clinical medico-legal services deserve the same attention and should not be regarded as less important.

With respect to clinical forensic medical services, the document proposes that district surgeons — discredited over many years because of their failure, for example, to speak out in cases of police torture of political activists — be renamed, probably to become district medical officers. Its recommendations for the reorganization of these services state (in their entirety) that:

> Clinical forensic medical services and *ex officio* duties should be rendered on a *provincially* organized basis by the same doctors who render primary health care services. All the functions are of a clinical nature and should be easily accessible and available to patients at the nearest primary health care centre or hospital. This includes *clinical forensic medical services* such as the examination of victims of rape, child abuse, assault and so forth, as well as *clinical ex officio duties* such as assessing a person's fitness to stand trial, clinical care of persons in detention, and so on. The examination of victims and the accused should take place in appropriate premises, preferably in a primary health care facility.
>
> *There is no question* that these medical practitioners must have special training in assessing and caring for the above cases. The clinical evaluations of cases and inevitably the subsequent involvement in judicial proceedings, require particular skills and experience. *Shortcomings in the physician will be ruthlessly exposed by the judicial process, to the detriment of the physician and justice in society. Possibly worse, it can even cause a miscarriage of justice and implicating innocent persons in crimes they did not commit.* Physicians will be under great pressure in this regard, since these cases are usually time-consuming and require utmost diligence in examination procedures and note-keeping. Furthermore, a high percentage of these cases result in complaints being lodged with the Interim National Medical and Dental Council of South Africa. It is therefore not surprising that there is a reluctance in clinicians to render these services, which may in itself present very real problems at this interface.
>
> Teams consisting of doctors, nurses, social workers, rape crisis workers, psychologists, and so forth, should be involved in the management of the above cases. As this is such an important topic, all

[119] Schedule 1, Act 200 of 1993.

[120] Schedule 4, Constitution of South Africa Act 1996.

[121] *Proposed National Policy on Medicolegal Services in South Africa* (Pretoria: Department of Health, September 1996).

students in the mentioned fields should be exposed to district medical practitioners as they currently lack the latter inputs in their training.

In the United States of America the shortage of suitably qualified and interested medical practitioners has resulted in authorities using Forensic Nurses to examine cases of rape, assault and child battering, and even persons suspected of driving under the influence of alcohol. In addition to bringing the service closer to the community, in some of the cases, especially child abuse cases, nurses have more success with the children than the doctors. It must be emphasized, however, that this is a *specially trained* group of forensic nurses.

A *warning* must be sounded that the implementation of the *clinical* forensic medical service as set out above, i.e. being rendered by *all* medical practitioners involved in primary health care services on a sessional and full-time basis, and even nurses, will most probably lower the current standard of work acquired over many years of rendering the service by designated medical practitioners (district surgeons). When this (new) system is implemented, all available doctors will participate and it will take years for them to develop the expertise most district surgeons already have. This view is supported by the Public Service Commission, the Attorney-General of the Eastern Cape and the Head of Forensic Medicine at Medunsa. The new incumbents of clinical forensic medical services will have to be trained as a matter of dire urgency.[122]

Although the document recognizes, briefly, many of the problems with the existing system and proposes alternatives (acknowledging some disadvantages associated with them), it has not (possibly because of the composition of the committee that drafted it, which was dominated by forensic pathologists rather than district surgeons) fully engaged with the demands of a successful clinical medico-legal service. Even though the basic framework proposed for the reorganization of medico-legal services — that is, that they should be rendered at all primary health care facilities — is highly desirable, the danger is, as the document acknowledges, that the effect may be a deterioration rather than an improvement of services to those who have been assaulted and need medico-legal examination to pursue their case in the courts, unless safeguards are built in to prevent this from happening. Yet, while the document makes detailed proposals for specialist structures for the medico-legal investigation of death (admittedly not a function for which accessibility to communities is such an issue), it has not made equally detailed recommendations to address the problems facing clinical medico-legal services, and in particular clinical medico-legal services in a transition period before adequate numbers of trained practitioners are available to provide services at primary health care level.

The state must improve accessibility to medico-legal services if it is to fulfill its responsibilities to ensure that the criminal justice system responds effectively to violence against women. Primary health care facilities, the most accessible part of the health care system, are logical places to locate these services. But a simple decision to move medico-legal responsibilities to primary health practitioners cannot be the whole answer. Medico-legal services are specialized, and the skills and knowledge needed are different from those needed by general primary health care practitioners. Moreover, because of the lag time between examination of a complainant and the appearance of a case in court, there is a strong need for stability of staffing; a stability which will not necessarily be available in primary health care facilities likely to be staffed by junior medical practitioners. The training of specialist forensic nurses might address the question of staff stability, but time would be needed to investigate the possibilities for such training, and then for qualified nurses to be trained. There is a need to revisit this issue, with wider consultation among current service providers and users, to ensure that the proposed reforms do *not* "lower the current standard of work." As this report has argued, there is rather an urgent need to *improve* the current standards of service as well as to make the service more widely available.

The proposed policy also fails to consider the issues surrounding the medico-legal treatment of violence against women, or indeed other gender- or race-specific questions such as the predominance of white male doctors practicing as district surgeons. Violence against women (indeed violence generally) is a public health issue as well as a legal one.

[122] Ibid., pp. 31-32. All emphases in the original.

Specific knowledge and skills are necessary for doctors who examine or treat women who have been abused by their partners or sexually assaulted. In particular, doctors need training in the types of injuries that may result from rape, including the most subtle injuries that may disappear after a few hours, and the appropriate treatment; they need training to be aware of the psychological consequences of sexual assault and to ensure that the examination does not cause further trauma; and they need information on referral services, such as women's organizations offering counseling. The national policy document should consider some of these issues in order to devise the best ways of ensuring that such training and information are given to doctors engaged in medico-legal practice. Additionally, recruitment practices and conditions of service should be examined in order to consider ways of increasing the number of women doctors, black doctors, and doctors speaking African languages in medico-legal practice.

In April 1997, the government published a "White Paper for the Transformation of the Health System in South Africa."[123] The white paper does not include a section on medico-legal services, nor does it mention violence against women — or violence generally — as a health issue. The section on "Maternal, child and women's health" concentrates on the provision of health services to children and mothers, rather than to adult women (apart from reproductive health).

Provincial Level

Even as the national policy debate is continuing, individual provinces, responsible for service provision on the ground, are proceeding at different speeds to introduce reforms in practice. Since reforms are urgently needed, it is difficult to insist that their implementation wait for the national consultation process to be completed, but the effect may be to introduce conflicting policies at the provincial and national levels. In most provinces, the individuals in charge of medico-legal services within each department of health do not have specific medico-legal experience and are therefore not aware of the particular problems and difficulties that have faced medico-legal examination of death and assault under the previous policies.

[123] Notice 667 of 1997; published in *Government Gazette* No. 17910, April 16, 1997.

There are exceptions to this rule. In KwaZulu-Natal, the director of forensic services is herself a forensic pathologist, who is also committed to reform of clinical medico-legal services. The provincial Department of Health is aiming to create "one-stop" centers throughout the province attached to hospitals and community health centers, where clinical medico-legal services will be offered. These centers would have an independent registration process, be open twenty-four hours, and have a range of professional staff permanently available, including a district medical officer and a police officer, with gynecological and pediatric services on call. There would be bathing facilities and a room which could be used for an overnight stay if necessary. Both examination for legal purposes and treatment for any medical condition would be offered. The province will be divided into six districts for medico-legal purposes (corresponding with the police and justice districts), each to have the services of a forensic pathologist (ideally)[124] and a clinical forensic medical officer, who should form a committee with representatives of the police, justice department, and NGOs in order to coordinate services in each district. In urban areas, trained forensic medical officers will deal with rapes, assaults, and some post mortems, although in general post mortems will be assigned to specialist forensic pathologists. In rural areas, it will not be possible for all health facilities to have medico-legal services, but the aim is to make such services more accessible than at present. The exact number of "one-stop" centers will be determined once plans are further advanced. Curricula for training both nurses and doctors in clinical medico-legal practice are in development at the University of Natal, as well as courses in forensic medicine for law students. A provincial forensic biology laboratory is also being developed at the University of Natal, to take over from the police laboratory beginning in 1999.[125]

In Gauteng, the province including the major urban areas of Johannesburg, Soweto, and Pretoria, 1997 has seen rapid advances in planning and implementation of an improved medico-legal service. In order to improve accessibility of medico-legal services, the number of district surgeons, now under new contracts as district medical officers, has been increased greatly, and all district medical officers provide services at designated clinics, which are open on a twenty-four hour basis, rather than at private doctors' surgeries as was usually the case before. Detailed protocols have been developed for distribution to district medical officers to assist them in conducting medico-legal examinations and referring patients for assistance elsewhere. Training of the new district medical officers, whether or not they were previously district surgeons, has also commenced, including lectures by expert medico-legal practitioners brought to the clinics where the doctors and nurses involved in medico-legal practice are working.

One of the problems faced by the government in the process of reform is the status of the existing contracts held by district surgeons. The current incumbents have strongly resisted the idea of restructuring, especially district surgeons in rural areas whose income depends largely on the state work. While resignations have been negotiated in many cases, with the commitment to rehiring under a new system although not necessarily on the same terms, in other cases contracts have been unilaterally terminated by the provincial government, and court cases have resulted.

LACK OF ATTENTION TO OLDER CHILDREN AND ADULT WOMEN

[124] There are fewer than twenty forensic pathologists in South Africa altogether.

[125] Interview, Shireen Akoojee, Director, Forensic Services, KwaZulu-Natal Department of Health, November 7, 1996.

South African government initiatives have tended to conflate the problems faced by women and children and hence to run together the solutions proposed to those problems. The summary of the National Crime Prevention Strategy, for example, lists one "priority crime" as "gender violence and crimes against children;" the specific initiatives described relate largely to children. Similarly, as noted above, the recent white paper on the health system does not separate women from mothers and children. Even those initiatives that appear to focus on women generally in practice are usually directed largely at young children: the Wynberg sexual offenses court, for example, has increasingly focused on cases of child sexual abuse; girls over fourteen and women are usually referred to the regular courts if they wish to pursue a case.[126] Baragwanath medico-legal clinic similarly concentrates on cases of child abuse. There is a much stronger public consciousness of the problem of child abuse, reflected in the creation of specialized Child Protection Units within the police (of which there were thirty-five in May 1997, although their transformation into "FCS" units with a wider mandate is intended, as discussed above) and in legislation such as the Prevention of Family Violence Act, which provides for compulsory notification of the police if child abuse (but not rape of adult women) is suspected.[127] As a consequence, pediatric cases are usually given much more attention than cases of rape or sexual assault of adults by medical, judicial, and police personnel; by the media; and by women themselves.

Without in any way wishing to deny the seriousness of child abuse cases or diminish the level of attention paid to them, Human Rights Watch believes the government should disaggregate the policy initiatives directed to gender violence generally and to violence against children. The problems faced by adult women and by children are different, and different approaches are needed to address them. Similarly, the problems faced by women because they are women are different from the problems faced by women if they are mothers. In the case of rape, the reported figures (while unreliable) indicate that teenagers and women under the age of twenty-five are most at risk; anecdotal evidence suggests that this group is also least likely to be focused on by special services and the most likely to be blamed for the violence to which they have been subjected (for wearing the wrong clothes, for example, or for being in the wrong places). A special initiative to assist these women and older children would be appropriate.

CONCLUSION

As is already recognized by the authorities in South Africa, the current system for provision of medico-legal services is deficient in many respects — not only as it relates to violence against women — and urgently in need of reform. The reform proposals that have been made, however, have for the most part not considered the system as a whole, nor have the individual initiatives that have been taken to improve the system been well coordinated between government departments or between government and the nongovernmental sector. Although this is changing at the national level, at the provincial level — responsible for delivery of health care, including medico-legal services — the different departments still often act at odds from each other and without consultation with nongovernmental organizations.

The improvement of the response of South Africa's medico-legal services in cases of violence against women must consider the experience of women from the time they first report an assault to the time they appear in court. It depends not only on improving the district surgeon system, but also on improving the manner in which the police and

[126] The Wynberg sexual offenses court, described in the Human Rights Watch report, *Violence Against Women in South Africa* (pp. 118-121), is the most high-profile attempt to improve court handling of rape cases. The Wynberg court has achieved a much higher conviction rate than other magistrates' courts, although there are questions as to the extent to which this is achieved by selecting those cases for the court that are most likely to be successful. The provincial department of justice has not carried out any official assessment of the court's performance, despite the fact that it is a most unusual commitment of state resources that deserves official assessment to determine whether it is worth replicating. Rape Crisis in Cape Town, a local NGO, is itself undertaking such a review. Interviews, Cape Town, November 18-19, 1996.

[127] Section 4 of the Act reads: "Any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances—(a) to a police official; or (b) to a commissioner of child welfare or a social worker referred to in section Child Care Act, 1983 (Act No. 74 of 1983)."

courts use that system and ensuring proper cooperation between the different branches of the criminal justice system. Attention must be paid to the better training of police, prosecutors and magistrates with respect to issues of gender violence in general, and to the understanding and use of medical evidence in particular. This training must be acquired before police, prosecutors, and magistrates begin work in the field. In the case of district surgeons, the existing system is inaccessible to many women. The service provided varies hugely in quality and at its worst may compound the trauma already experienced by a woman who has been raped. Lack of training in the field of violence against women manifests itself in failures to collect and record all the necessary medical evidence, reluctance to take a full history from the woman who is being examined, and racist or sexist attitudes more generally.

Human Rights Watch believes that the current proposals for reform go some way toward addressing the deficiencies of the existing system, in particular the effort to develop standardized guidelines for the handling of sexual offenses by all within the criminal justice system. Yet the proposals at the national level relating to the medico-legal system have concentrated on the examination of the dead rather than the living, and they fail to address adequately the specific issues of violence against women. While some provinces have independently moved forward to improve the service for women who have been sexually assaulted, others are still failing to grapple effectively with the changes needed. Most importantly, the reforms should address the need of the district surgeon — or district medical officer responsible for medico-legal work, if that is the new terminology — for training before appointment and for back-up from the state health sector more generally; for example, by the development of protocols, provision of referral information or a requirement for regular in-service training. If medico-legal services are to be provided at primary health care facilities, specialized training is equally needed for those responsible. Furthermore, if the results of medico-legal examinations are to be useful in obtaining convictions of the perpetrators of sexual assault, police, magistrates and especially prosecutors also need to be thoroughly trained in the interpretation and presentation of medical evidence.

In the area of violence against women, as with other violations of bodily integrity, the government has responsibilities in international and national law to prevent, investigate and prosecute such abuse. A key part of the criminal investigation of cases of sexual violence is the collection and use of medical evidence. An effective medico-legal system is needed if South Africa is to fulfil its responsibilities under international law to protect the human rights of women in South Africa.

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