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16. Who Benefits From the Sexual Assault Evidence Kit?

Jane Doe

The first section of Part II examines the practices of evidence production, proof, and adjudication that determine whether responsibility for sexual assault will be allocated to alleged perpetrators. Jane Doe's research investigates the utility and harms caused by the Sexual Assault Evidence Kit from the perspective of women who have experienced this form of evidence gathering as well as the perspective of community-based workers who support them and those who administer the kit. This chapter bridges from Part I, which explored aspects of women's lived experience of sexual assault and the very real perils of entering the legal system, as well as the professionalization and institutionalization of rape crisis services. Here Jane Doe demands that we ask who benefits from the kit when women so consistently report it as a further assault and its legal value is so tenuous. Her persistent question, "who benefits?" from the medicalization of sexual assault upon which the kit is premised, also fuels her important challenges to feminists to make linguistic choices that do not further disempower women who have been raped and to interrogate the role of racism in sexual assault.

Examining Canadian laws and policies as they apply to women who experience sexual assault feels like a natural progression for me. It is the next step in the body of work I began when, over twenty years ago, I became the woman in the lawsuit, *Jane Doe v the Metropolitan Toronto (Municipality) Commissioners of Police*.¹

I am interested in addressing the ways in which certain protectionist Canadian public policies in the areas of sexual assault exert control over women by limiting their choices, agency, and activities.² The degree to

1 *Jane Doe v Metropolitan Toronto (Municipality) Commissioners of Police* (1998), 39 OR (3d) 487 (Ont Ct (Gen Div)).

2 Jane Doe, "What's in a Name? Who Benefits From the Publication Ban in Sexual Assault Trials?" in Ian Kerr, ed, *Lessons From the Identity Trail* (New York: Oxford University Press, 2009) 265, similarly reflects on the protectionist nature of Canadian sexual assault legislation.

which the distinctively gendered and sexual nature of the violence of sexual assault elicits an exceptionally paternalistic and protectionist response on the part of the state and policy-makers cannot be dismissed.

The stigma and lack of agency afforded to women who have experienced sexual assault are powerful in constructing them/us as “victims” who are disordered or otherwise unstable, and in need of paternalistic state protections.³ Certainly, women who have experienced sexual assault are not alone in being subjected to these myths and formulations. State policies enshrined in sexist and discriminatory stereotypes of female gender/sexuality work especially to disenfranchise women who are Aboriginal, racialized, sex workers, disabled, or women who live with poverty.⁴

In addressing the Sexual Assault Evidence Kit [SAEK] in this paper, I attempt to trace government initiatives that have relocated feminist, community-based, sexual assault, and other Violence Against Women [VAW] services into medical/hospital institutions. The negative effects of the corporatization of women’s anti-violence services through the implementation of “one stop” medical and social work models of practice are observed. I identify the resultant pathologizing of rape as illness, and the loss of funding and advocacy functions within feminist, community-based rape crisis and sexual assault centres.

Questions of informed consent, and the problems regarding the gathering, efficacy, and purpose of the [SAEK] and its medico-legal functions were exposed by women I interviewed. They identify the kit and its process as unnecessary, invasive, and terrorizing.

- 3 In addition to many of the articles in this text, a sampling of writing on this subject includes the following: Jane Doe, *The Story of Jane Doe: A Book About Rape* (Toronto: Random House, 2003); Lise Gotell, “Rethinking Affirmative Consent in Canadian Sexual Assault Law” (2008) 41 *Akron L. Rev.* 865; Elizabeth Sheehy, “Causation, Common Sense and the Common Law: Replacing Unexamined Assumptions With What We Know About Male Violence Against Women or From Jane Doe to Bonnie Mooney” (2005) 17 *CJWL* 97; and Carol Smart, *Feminism and the Power of Law* (London: Routledge, 1989).
- 4 Rosemary Basson, “Sexual Health of Women with Disabilities” (2005) 17 *CJWL* 97 (1998) 159 *Can Med Ass J* 359; Janet Mosher, *No Cherries Grow on Our Trees: A Social Policy Research Paper for the Take Action Project to Address Women’s Poverty and Violence Against Women* (Toronto: Metropolitan Action Committee on Violence Against Women and Children, 2008); Mariana Valverde, *The Age of Light, Soap, and Water: Moral Reform in English Canada, 1885–1925* (Toronto: McClelland & Stewart, 1991); Yasmin Jiwani, *Discourses of Denial: Meditations of Race, Gender and Violence* (Vancouver: UBC Press, 2006).

The legal, corroborative purpose of the kit and women's experiences of it reveal the improbability that they have given informed consent for its collection. I further observe the lack of a standard of practice in kit content and collection within and across regions, controversy amongst medical and legal institutions that administer and utilize the kit, and its insignificant effect on the legal process.⁵

THE LANGUAGE OF RAPE

Feminist activists, researchers, and scholars have been examining rape and its significance on women's equality, agency, and choice for decades.⁶ Critiques of the legislation and policies that govern the crime are certainly not original to this chapter. There also exists an impressive body of Canadian research specific to the use and efficacy of the [SAEK].⁷

To my knowledge, however, there is little that situates women who have experienced the crime of sexual assault/rape as experts and analysts of their own experience. It is impossible to find research that privileges or even equates their narratives with those of other experts. There is also little that identifies sexually assaulted women's acumen, joy, or intelligence. I attempt to do some of that here.⁸ In doing so, I wish to

- 5 This research was originally conducted through a grant received by myself and Kara Gillies from Status of Women Canada in 2006. Titled "Bound by Law: How Canada's Protectionist Public Policies in the Areas of Both Rape and Prostitution Limit Women's Choices, Agency and Activities," it treated sexually assaulted and sex-working women as distinctly separate groups who are nonetheless "sexed, classed" and similarly cast as damaged and in need of enhanced state protection. In addition to the SAEK, I researched police rape warnings while Gillies conducted separate interviews and research regarding the procuring law and how the criminalization of third-party participation in prostitution has a negative impact on sex-working women. As we prepared to enter the editing phase of our project, the Conservative government of Stephen Harper cut funding to Status of Women Canada. The work remains unpublished.
- 6 For example: Christine Boyle *et al.*, "Tracking and Resisting Backlash Against Equality Gains in Sexual Offence Law" (2000) 20 *Can Woman Stud* 72; Susan Brownmiller, *Against Our Will: Men, Women And Rape* (New York: Simon and Schuster, 1975); Catharine MacKinnon, *Feminism Unmodified: Discourses on Life and Law* (Cambridge: Harvard University Press, 1987); Elizabeth Sheehy, ed, *Adding Feminism to Law: The Contributions of Justice Claire L'Heureux-Dubé* (Toronto: Irwin Law, 2004); Smart, *supra* note 3.
- 7 See the sources cited *infra*, note 36.
- 8 Janice Du Mont, Deborah White & Margaret McGregor, "Investigating the Medical Forensic Examination from the Perspectives of Sexually Assaulted Women" (2009) 68 *Soc Sciences & Med* 774, conducts similar research with important findings. My research, however, is differentiated from theirs on the basis that it was not influenced by medical institution regulations, language, or perceptions of authority from re-

address naming practices in feminist academia and research, and in the VAW movement in Canada, that designate sexually assaulted women as victims, survivors, and, recently, “thrivers.” The reduction of the complexity of raped women’s experience to three tiers of health status fits current medico-legal and social work bureaucracy requirements that do not work in women’s best interests. It promotes a survival of the fittest rubric that marks and defines raped women through our pain and suffering only and “others” us from other (seemingly) non-raped women. The terms reduce the diversity of women’s experience of sexual assault, denote passivity (victim), or infer violence (survivor), and severely limit sexually assaulted women’s narrative agency.⁹ I do not deny or minimize the suffering or horror raped women endure, nor am I in denial of our ability to exercise agency, choice, and control regarding our lived experience of the crime. I will use the terminology “women who have been sexually assaulted/raped” and or “sexually assaulted/raped women” throughout this paper. I encourage readers to similarly examine the very language of rape¹⁰ — to reclaim, redefine, and expand it in order to better understand its nature and to effect meaningful change.

In keeping with this critical attention to language, I do not use the discourse of victimization or uncritically impose a victimology analysis on women’s experiences.¹¹ I purposefully use the terms “rape” and “sexual assault” interchangeably to indicate the contested and unresolved meanings of those terms, that crime, and the understandings of sexual assault as “non-violent.”

I have used the term “experiential” to denote women who have “experienced” sexual assault and “key informant” for those who advocate for and work with them.¹² The term “experiential” might be sim-

spondents; it provides a critique of the role of the hospital and the police regarding the kit; and was conducted with women whose kit had or had not been used in the criminal trial process.

- 9 See Tami Spry, “In the Absence of Word and Body: Hegemonic Implications of ‘Victim’ and ‘Survivor’ in Women’s Narratives of Sexual Violence” (1995) 18 *Women & Lang* 27.
- 10 Susan Ehrlich, *Representing Rape: Language and Sexual Consent* (London: Routledge, 2001), examines the gendered nature of language used in sexual assault trials.
- 11 Certainly there are women who have experienced sexual assault/rape who choose such naming practices: I support their decisions completely.
- 12 I was reminded by an early reader of this paper that many women who work in community and institution-based agencies in the area of sexual assault have also experienced the crime, making the distinction less relevant. While this is undoubtedly true

arly used to refer to women who live with disabilities, poverty, or other factors that affect/define a woman's experience of life. Of late, the expression "experiential" has come to refer solely to sex-working women and in a negative or victimizing context. I propose to reclaim the word here, in solidarity with sex workers, and as phraseology that empowers women — when there is so little that does — and situates them as experts/witnesses/agents of their life histories.

I refer only to the experiences of adult women in this paper and include biological and transgendered women in that definition, although I am not informed directly by interviews with women who identify as transgendered. All names have been changed to ensure anonymity and participants were given the option to choose their own pseudonyms.

METHODOLOGY

In-depth, semi-structured interviews were conducted in four Canadian provinces with twelve women who had experienced sexual assault/rape. The crimes took place between 1999 and 2005.

Another eleven interviews were held with advocates in feminist community-based sexual assault and rape crisis centres (six), and with hospital-based social workers and health care providers (five).

Of those twenty-three women, two were Aboriginal (experiential), three were Black (one experiential, two key informants), and three were women of colour (two experiential, one key informant). Four were Quebecoise (two experiential, two key informant), and one was Acadian (experiential). Three women self-identified as Jewish, and eight (six key informant and two experiential) as lesbian. Five women disclosed that they lived at or below the poverty line (experiential), and two had previously been homeless (experiential). Ages ranged from twenty to sixty-three. The majority of key informant women were over forty years of age.

One-on-one semi-structured interviews lasted between one-and-a-half to two hours and took place between 2005 and 2006. Snowball and purposive sampling techniques¹³ were enhanced by my personal

and of note, I am mindful of the race, class, power, and access differences that can exist between both groups of women, however minor they might be.

13 Snowball sampling consists of identifying participants who then refer researchers to other participants. Purposive sampling is used to access a particular population of respondents. In this case, I distributed an email about my proposed work to community-based rape crisis and sexual assault care centres which then assisted me in accessing women who were interested in being involved. See Rowland Atkinson &

location as a woman who has experienced sexual assault and the rape kit, which allowed for greater access to a traditionally “hard to reach” group of women.

Because women with disabilities are sexually assaulted at twice the rate of the able-bodied,¹⁴ I felt it important to ask participants about ability status. One woman identified as deaf, another as hearing impaired, and one woman lived with fibromyalgia. Six experiential women identified post-traumatic stress syndrome or disorder, bi-polar disorder, panic attacks, and other obsessive behaviours as disabilities that had been diagnosed since their rapes or were negative factors in the outcome of their investigations/trials.

Prior to the interviews, women received written information about the nature of this research. Questions were closed and open-ended and focused on their prior knowledge of the kit, their experience of it, and what they thought of it now, which also led to other perceptions and comments. Women were advised that they could choose what to answer and could stop the interview process at any time. I was in contact with counselling services in their communities should these be requested/required by the women with whom I spoke. (They were not). Experiential women were paid a small honorarium (\$50) for their work and contributions.

RACE AND RAPE

It is my contention that rape and race can never be separated and certainly that is reflected in reactionary responses to the crime. There is a convenient and popular belief, for instance, that Aboriginal and racialized women are raped more and report their rapes less because their cultures promote violence against women, and they are more subject to shame, community censure, disbelief, and the fear of powerful men, than are white women.¹⁵ While such strictures certainly exist, it is the nature and consequence of colonialism, racism, and systemic racist beliefs and stereotypes that further inhibit racialized women from

John Flint, “Accessing Hidden and Hard to Reach Populations: Snowball Research Strategies” (2001) 33 *Soc Sciences Update* 1.

- 14 For a recent discussion see: Statistics Canada, “Criminal Victimization and Health: A Profile of Victimization Among Persons with Activity Limitations or Other Health Problems” *Canadian Centre for Justice Statistics* (May 2009), <http://www.statcan.gc.ca/pub/85fo033m/85fo033m2009021-eng.pdf>.
- 15 Margaret Wentz, “Wired for Submission” (4 November 2006) *The Globe and Mail* A 23.

reporting to the police or accessing the legal system. Sherene Razack examines the degree to which we allow the term “culture” to replace words like “racism” in and outside of the courtroom, especially for Aboriginal, racialized and immigrant women:

A knowledge of cultural difference of the Other helps those in dominant groups to classify and manage subordinate groups. The eagerness with which theories of cultural difference are taken up in the justice system, while racism, and sexism remain unnamed is a reminder that culture is a treacherous ground to travel in a white supremacist and patriarchal society.¹⁶

In writing about the Indian subcontinent, Ratna Kapur speaks of competing understandings between “the West and the Rest” and the essentializing of gender, culture, and victim rhetoric:

The exclusive focus on violence against women does not reveal the complexity of women’s lives, but only the different ways in which they may experience violence. Thus, culture is involved primarily to explain the different ways in which women experience violence, in the process often reinforcing essentialist understandings of culture and representing particular cultures as brutal and barbaric.¹⁷

In response to my research question, “Do you think that ‘different’ women are treated differently when they have been sexually assaulted?” there was unanimous agreement from participants that Aboriginal, racialized and immigrant women endure racism when they report their rapes. Young women, poor women, lesbians, trans-women, and sex-working women were also identified as less likely to be believed by police and the courts because of their social placement, and therefore less likely to report.

THE BIRTH OF THE KIT

The 1980s were a significant time for the women’s movement in Canada. Because of the movement’s frontline work in the 1970s to identify and stop the murder, beatings, and rape of women by men, and subsequent government lobbying, a network of shelters and rape

16 Sherene H Razack, *Looking White People in the Eye: Gender Race and Culture in Courtrooms and Classroom* (Toronto: University of Toronto Press, 1998) at 80.

17 Ratna Kapur, *Erotic Justice: Law and the New Politics of Postcolonialism* (London: Glasshouse Press, 2005) at 104.

crisis centres was established across Canada.¹⁸ Workers and allies used a feminist language of anti-oppression that identified gender, and intersected race, class, sexual orientation, and ability. Male violence against women was acknowledged (by some) as a systemic and gendered crime that affected women's safety of the person and their equal status.

In 1983, changes in sexual assault legislation, progressive at the time, expanded the definition of rape to include forms of sexual assault other than penetration. Bill C-127 established three levels or degrees of sexual assault, and the need for third-party corroboration or witnessing was removed as an essential element for proving the crime.

In the same period, feminists working in community-based rape crisis or sexual assault centres argued that hospital staffs were not responding adequately, or at all, to women who arrived at Emergency because of having been sexually assaulted. In addition, the evidentiary needs of the legal system to found and prosecute the crime were not being met.¹⁹ The conception of the hospital-based Sexual Assault Care and Treatment Centre [SACTC] to provide health care, feminist advocacy, and counselling was the response. SACTCs were also mandated to regulate the collection of medical forensic evidence for use in the police investigation in a SAEK, also known as the rape kit.²⁰

The kit itself is a sturdy sealed cardboard box that contains instructions, diagrams, and containers for the collection of biological specimens taken from raped women's bodies. The contents undergo forensic analysis to determine, confirm, or establish the identity of the perpetrator, whether force was used, and time of the assault as a means of independently and scientifically corroborating the raped woman's personal narrative of what occurred.²¹

18 Lee Lakeman, *Canada's Promises to Keep: The Charter and Violence Against Women* (Vancouver: Canadian Association of Sexual Assault Centres, 2003).

19 Georgina Feldberg, "Defining the Facts of Rape: The Uses of Medical Evidence in Sexual Assault Trials" (1997) 9 CJWL 89.

20 The first Sexual Assault Treatment Centres [SACTS] was established in Ontario in 1979. Known as Sexual Assault Care Centres, the "treatment" designation was added in the 1990s to better reflect their purpose. In 2004, Ontario SACTCs were restructured again to become Sexual Assault and Domestic Violence Treatment Centres. This paper focuses on sexual assault and I will use the term SACTC when referring to hospital/clinic-based sexual assault care centres in all regions. The inclusion of "domestic violence" in the SACTC mandate is also an issue of concern and debate in the VAW shelter sector.

21 Janice Du Mont & Deborah Parnis, "An Overview of the Sexual Assault Care and Treatment Centres of Ontario" [revised and expanded] (2002) *World Health Organization*, online: <http://www.womensresearch.ca/PDF/programs/whoapr2003.pdf>.

The SACTC has developed to such an extent that it currently employs teams of nurses, doctors, and social workers. The evolution of the SACTC, however, is such that it now purports to serve multiple agendas in addition to the interests of the woman who has been sexually assaulted. Government ministries and interests have expanded the scope and number of SACTCs so that, consequently, they have replaced many shelters and rape crisis centres by (i) relocating them within the hospital or clinic environment; (ii) reallocating their funding within the hospital budget; and (iii) mandating corporate models of governance and operation.²² Initially a combination of feminist politics, government agendas, and good faith, hospital-based services for women who have been sexually assaulted have transformed into a nationwide infrastructure of highly regulated medical and social work teams that provide services to women, the police, Crown and defence lawyers, and not necessarily in that order.

Andy worked in a rape crisis centre in central Canada and has this to say:

So when the sexual assault care and treatment centres came into being, for rape crisis workers at the time, it was like: “how come our saying out loud what was important for women has turned into a whole other service that has the potential for not being really great for women?” It’s kind of like anti-violence activists identifying that children witnessing violence was a problem, and then that turns into a whole terrible legislation that CAS uses to take kids away from mom.

THE INSTITUTIONALIZATION OF SEXUAL ASSAULT

Feminist writers and researchers have begun to examine what is referred to as the professionalization or corporatization of the VAW movement.²³ They refer to, among other things, the adoption and subsequent co-optation of advocacy and counselling services for adult women who experience sexual assault by institutions of medicine/health and social work. One result they document is the defunding and de-

22 Mandy Bonisteel & Linda Green, “Implications of the Shrinking Space for Feminist Anti-Violence Advocacy” (2005), online: www.crvawc.ca/.../ShrinkingFeminist-Space_AntiViolenceAdvocay_OCT2005.pdf.

23 *Ibid*; see also Betsy A Harvie, *Regulation of Advocacy in the Voluntary Sector: Current Challenges and Some Responses* (Ottawa: Voluntary Sector Initiative, 2002) and Carol Latchford, “Gimme Shelter in 2006” (2006) 25 *Can Woman Stud* 6.

valuing of autonomous, feminist, anti-oppression apparatuses in women's anti-violence agencies. Another is the medical pathologizing of women's response to sexual assault as diagnosed in the fourth edition of the Diagnostic Statistical Manual [DSM IV], the medical psychiatric "bible" that defines and dictates forms of mental illness and competence.

This collusion of medical and legal institutions to assess a woman's claim of sexual assault has become the new standard in sexual assault investigation and prosecution. According to a conference paper delivered by Mandy Bonisteel and Linda Green:

In the past few years, the enormous uptake of medicalized approaches to trauma treatment has overtaken investment in non-medical, alternative supports. In institutional settings, psychiatric best-practice guidelines have been developed for the treatment of post-traumatic stress disorder (PTSD), for the treatment of women diagnosed with Borderline Personality Disorder and for women who self-harm. Some studies have begun using women in shelters to test and develop psychological measures ... Differences in the power of medicine in relation to [anti-violence] sectors result in credibility differences regarding who is best suited to deal with social issues [when in] reality numerous perspectives and strategies are required to take up social issues and provide community alternatives for those who seek support.²⁴

Today, the largest subspecialty of forensic nursing is the provision of care to women who have been sexually assaulted. This role is filled by the Sexual Assault Nurse Examiner [SANE], "an experienced nurse who provides comprehensive care to sexual assault victims, usually after completing a brief but extensive training programme plus clinical supervision within a local institution. Their instructors include professionals from the fields of law enforcement, criminal justice, forensic science, nursing and medicine."²⁵

THE KIT AS A FORENSIC TOOL

The process of administering the full sexual assault evidence kit takes about four hours (although some women I interviewed reported seven and eight hours), and women who undergo it are required to sign a consent form, as is common for most medical procedures. Uncom-

24 Bonisteel & Green, *supra* note 22..

25 Susan Kagan-Krieger & Gail Rehfeld, "The Sexual Assault Nurse Examiner" (2000) 96 *Can Nurse* 26.

monly, women must also give additional written consent to hand the test results over to police officers to be used as part of the investigation into their sexual assaults.

The purpose of the kit is as follows:

Forensic evidence is collected to establish three things: that a recent assault has occurred, that force occurred during the assault and that the identity of the assailant has been confirmed (through DNA analysis). The collection of evidence is done in a systemic, controlled and consistent manner. Such an operation ensures that the highest quality of objective evidence is collected, and minimizes the potential for loss of evidence. Furthermore the evidence is more reliable and has a greater chance of admissibility in court if it is collected according to standard protocol.²⁶

In examining the actual application of the kit, however, researchers have identified that there is no standard practice or protocol regarding the number, nature, or collection of the tests that compile the SAEK.²⁷

The kit requires the administration of physical “tests” as well as documentation in which the woman involved answers questions about the assault and her current and past medical history. SANEs record all visible injuries on diagrams indicating their type and size and are required to document any signs or reports of physical resistance as kit components. In some regions, health professionals who administer the kit provide written assessment of the woman’s emotional status, scrape under fingernails, and ask if she scratched or otherwise “fought back.” Kit requirements and evidence of this sort can reinforce the myths that “real” rape involves a certain emotional response and attendant physical injury and that “good” women resist.

Some urban hospitals have modified their kits in response to the recommendations of coalitions and committees that include representatives from SACTCs, policing, law, government, and medicine in their attempt to make it more user friendly. In some cases, women who work in community-based rape crisis centres have been at those tables. On the other hand, experiential women, those who have had the kit conducted on their bodies, are not included.²⁸

²⁶ *Ibid* at 25.

²⁷ Feldberg, *supra* note 19 and Du Mont & Parnis, *supra* note 21.

²⁸ My repeated attempts and inquiries, over a period of years, to consult with such committees were not responded to by government and hospital-based personnel charged

Esther, a community-based rape crisis counsellor who prefers that her agency not be identified in any way, sits on such a committee:

There was endless discussion at this round table that we were a part of where you'd have police, prosecutors, and doctors talk about the slides that should be used to take samples and how they should pull hair out. Totally disembodied from the reality of what that must mean to a woman who has just been sexually assaulted. Sitting around a table for years, it was Kafkaesque, and at one point we became infuriated and left. We felt that it was a diversion of the issues that we were asking to be addressed and the problems of the criminal justice system.

For sexually assaulted women who consent to it, photographs, clothing, swabs, urine, hair, and blood samples appear to be standard requirements in all kits. Blood and urine are taken to determine women's alcohol and drug consumption levels. Health care in the form of medication for STDs, HIV, and pregnancy prevention is administered except in Catholic hospitals where the morning-after pill is not available to any women.²⁹ Three participants indicated that the large doses of antibiotics and the "morning-after" pill caused them to feel ill. One of them said she felt that her expressed preference to see her own doctor for the medication caused suspicion on the part of the SANE and worked to her disadvantage.

A vaginal examination or internal to detect injury and the detection of sperm or semen is a critical component of the process. The procedure is conducted without a lubricant to prevent contamination of evidence. Some centres have adopted protocols that include the use of a "harmless" blue dye (Toluidine) to "stain" the external genital area (one of my research participants spoke of her shock at "peeing blue" shortly after being stained) to better detect injuries. Another is a procedure called a colposcopy, which allows for the magnifying and photographing of the vagina to identify microtrauma not visible to the naked eye. Kits must be conducted within 72 hours of the assault in order to detect evidence. All of the women I interviewed agreed that the internal (vaginal and/or anal) examination, which (if consented to) is standard when penetration has occurred, is painful, humiliating, intrusive, and/or a violation

with overseeing the kit, its functions, and its requirements.

29 In some Catholic hospitals, strategies to include the morning-after pill in the kit have been developed.

— a veritable second assault.³⁰ As Scarlett, one of the experiential women I interviewed said

The internal was painful, but I didn't say anything. The nurse was already talking about all the things that weren't there. While she was doing [it] she was saying there are no lacerations, no signs of rape, no bruising. I wondered if they were going to believe me and where this was going to go.

Michelle, an advocate and health care practitioner in central Canada, voices the concerns of many women:

For the love of god, why do they have to get DNA from 80,000 different areas? I go for a Pap test myself and I have a complex about my own doctor doing it. I hate it. Vaginal tearing would be the only reason that I could actually see a need for it. Other than that, they've got nails, they've got clothing, they've got skin to skin. I don't see a need for it.

As a forensic tool, the rape kit requires that the bodies of raped women function as crime sites, much as would occur in a homicide investigation where the (deceased) body is mined for evidence, or the site of a bank robbery, where areas are closed off except for police access and inspected for clues, especially DNA. Raped women are instructed not to wash, urinate, or defecate, and their outer and undergarments are required for inspection and evidence.³¹

THE KIT AS CORROBORATIVE EVIDENCE

Neveah was sexually assaulted and says this about how the contents of her kit were used in court:

I wore a skirt and it was leopard and velvet, not to mention that my underwear were thongs. So that was a big deal. "And your pink thong underwear!" was what they [defence lawyer] kept going on about, and they took them

³⁰ Feldberg, *supra* note 19.

³¹ Women who must urinate/defecate are warned not to "wipe" for fear that sperm/ semen evidence will be destroyed. In the CBC TV movie "The Many Trials of One Jane Doe" (2002), the Jane Doe character sits on her toilet, guarded by police officers as she instructs them that the urethra should never be confused with the vagina. See also *The Story of Jane Doe*, *supra* note 3 at 30.

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out in court and held them up. They even put it in the paper. I was mortified. It was terrible.

Pamela, who also underwent the kit, adds:

They had big bags of plastic to take my clothes while they were undressing me, shaking them, it was very odd, I don't know much about the kit, I knew it was about DNA but the clothes thing was just really, really odd, you know? The semen was there, they had pieces of my hair — what else do you need? Isn't that enough?

Women I interviewed reinforced the view that their lived experience, their first-person evidence as to the crime — what they saw, knew, believed — was not sufficient evidence. It appears to be required instead that they measure up to rape mythology that qualifies “good” or “real” rape as “an act of forceful penetration committed by a stranger during a blitz attack in a public, deserted place. The victim is portrayed as a morally upright white woman who is physically injured while resisting.”³²

Anne was a key informant in this research and has a fifteen-year history of work in a community-based rape crisis centre:

We see that the 1983 legislation removed the onus to provide third-party corroboration that a rape had occurred. The idea being that women were lying. But that myth still informs us. The third party is now the kit. The doctor is the third party or the nurse who collects forensic evidence from the woman's body, primarily through a pelvic examination to corroborate what she is saying. To prove to the courts that she is not lying. If they don't find semen, if she isn't cut or bruised, well—good luck with the investigation. If, in addition to that, she's a woman of colour or English isn't her first language or she has any prior convictions or conflict with the law, she's going to have a bad time, can be seen as bad, not virtuous enough or innocent enough.

Michelle, the central region health care worker and advocate, agrees:

Why do we do the kit? Why do we need that validation? It's intrusive, it's demeaning, it's insulting. I think it's entirely because women aren't believed. We have such a high ability to get DNA off so many things. Why do we keep

32 Janice Du Mont, Karen Lee Miller & TL Myhr, “The Role of ‘Real Rape’ and ‘Real Victim’ Stereotypes in the Police-Reporting Practices of Sexually Assaulted Women” (2003) 9 *Violence Against Women* 469.

subjecting women to this? Why do we need a doctor to validate? Someone else who was not present, a man in most cases who has eight years of school to say yes she's telling the truth!

Such accounts confirm Feldberg's claim that the laying of charges and any subsequent prosecution of sexual assault continue to rely on corroborative evidence as gathered in the rape kit.

While conducting this research, I learned that there is controversy and debate amongst SANEs, community advocates, police, and forensic scientists about kit requirements, especially hair samples, which are taken from the woman's head and/or pubic area, sometimes by the root. Increasingly, some hospital protocols do not require hair samples at all. Paradoxically, in cities with two SANEs or more, some take hair and some do not. As key informants Esther and Brenda, respectively, report

If they don't take hair, the Crown or the defence lawyer can argue that standard procedure was not followed and that works against the woman.

We don't do any hair samples. We already have DNA, you don't need more. Besides, many young women [I have examined] don't have pubic hair these days. They shave themselves.

There is an initiative in one province to add a test that would require additional head hair sampling to be taken one month after the assault to detect the presence of "date rape" drugs in the new hair growth follicle. Marie, a nurse examiner from western Canada, decried the worth of an additional test:

That won't work in court. All you have to do is suggest that she ingested the drugs herself after she finished the kit and it raises what is called reasonable doubt. Plus, how do you ensure that women will return a month later?

Lillian, who works in a rape crisis centre in a central province, was clear on the matter:

We need to look at root cause not root hair. The collection of hair or anything else in the kit does not prevent sexual assault or resolve it.

RCMP kits, as administered in regions and provinces under their law enforcement jurisdiction, absolutely require hair, skin cell and nail scrapings, and saliva samplings, as do some cities and regions with

their own police forces. The ongoing debate on the gathering and use of raped women's hair is indicative of the conflict and in many cases confusion that define the kit, as well as its relevancy.

To determine the type of forensic evidence that needs to be collected, the SANE obtains a thorough sexual assault and medical history. To do so women are questioned about recent consensual sex, pregnancy (in some cases they are asked about past pregnancies, miscarriages, and abortions), any current medication including anti-depressant or other mental-health related medications, and recent intake of alcohol or recreational drugs. Five of the women I interviewed who had undergone the kit had no memory of this Q&A component.

Research questions put to experiential women, specific to the timeline in conducting the kit and its storage, elicited conflicting responses. For example, when a woman consents to undergo the sexual assault evidence kit, she is informed by some SANEs that she can do part of the kit or stop the process at any time. But this is in no way standard and the practice can differ between nurse examiners at the same hospital. Nor are sexually assaulted women always informed that they can wait 72 hours after the assault to have the kit conducted or that the completed kit can be stored for between two to six months before the woman decides to press charges. Four of the experiential women I interviewed denied that these options had been presented to them at all, and three could not remember. This must lead us to question the reality of raped women's "options" and the validity of their "consent" to undergo the kit.

WHOSE KIT IS IT, ANYWAY?

None of the experiential women interviewed for this research were aware that upon completion rape kits became the property of the police and all evidence they contain must, under law, be made available to the accused, their lawyers, and the office of the Crown Attorney. They were not informed at the time that the kit was collected that it may work to their disadvantage, rarely contributes to conviction, and is unlikely to even be used in court.³³ Women were not aware of where the kit is stored, for how long, or what happens to it after trial. Except for three participants, women had no knowledge of how the kit is compiled or its cost per unit. Key informants in western regions told me that in one

33 Feldberg, *supra*, note 19; see also Margaret McGregor & Janice Du Mont, "Sexual Assault Forensic Medical Examination: Is Evidence Related to Successful Prosecution?" (2002) 39 *Annals Emerg Med* 639.

city, the kit is assembled by a volunteer group of nurses and counsellors who come together regularly, and in other areas of the province, kit assembly is labour conducted by prison inmates.

There is an understanding embedded in practices and policies about the SAEK that information regarding the kit's purpose and use must be restricted in order to ensure against contamination of what is considered scientific evidence for use in a court of law. Researchers suggest that the physical evidence obtained via the kit has marginal influence on the outcome of a trial but instead can be used to discredit the woman who consented to undergo it.³⁴ They argue that forensic medicine is a nascent science, inaccurate, and without regulations, and they query the legal dash to enshrine it as scientific evidence in a rape trial. This scepticism is supported in a report published in November of 2006 by Statistics Canada that states that DNA and other technology-based crime-solving tools have not affected the rate of crime solving in police forces across Canada.

Women who consent to undergo the kit are treated as if the body fluids and samples it contains do not belong to them, as if the crime that has been committed against them is separate from them. And when raped women sign the required consent forms that give authority of the kit over to police investigators, that separation becomes official.

Ronnie, whose kit was not used, attempted to have it returned to her:

The nurse gave me the written part. She was so awesome. I'm with a legal clinic to try and get a Freedom of Information to get my kit and my interview back. They [police] are appealing the Information, so it could be months.

Scarlett did not get that far:

[When I asked to have it back] The detective laughed. My counsellor thought I was exhibiting signs of post-traumatic stress or something.

34 Feldberg, *supra* note 19; see also Janice Du Mont & Deborah Parnis, "Symbolic Power and the Institutional Response to Rape: Uncovering the Cultural Dynamics of a Forensic Technology" (2006) 20 *Can Rev Soc & Anthropology* 73; Margaret J McGregor & Grace Le, "Examination for Sexual Assault: Is the Documentation of Physical Injury Associated with the Laying of Charges? A Retrospective Cohort Study" (1999) 160 *Can Med Ass J* 1565.

THE KIT AND INFORMED CONSENT

Georgina Feldberg's groundbreaking research on the medicalizing of women's experience of sexual assault examines what she refers to as the "medico-legal" use or purpose of the SAEK: "[the kit] can obfuscate issues of consent, serve as a vehicle for introduction of information about past sexual history, and create a power imbalance between the voice of the claimant and that of the experts that contributes to the victim's negative experience of the trial."³⁵ She concludes that in Canada, as in the US, medical evidence obtained in the SAEK makes few positive contributions to the raped woman's case.

If Feldberg broke ground and silence in exposing the negative influence of the kit and its protectionist nature, the contributions of Janice Du Mont, Deborah Parnis, Margaret McGregor, Karen Lee Miller and others noted below, map a route to better understand the use and efficacy of forensic evidence as collected in the sexual assault evidence kit.³⁶ Du Mont and Lana Stermac conducted an exploratory study that scrutinizes the "consent to be contacted" forms obtained from women who attended at a Toronto SACTC. On signing, sexually assaulted women agree to be contacted for requests to participate in future related research conducted through the hospital. Du Mont and Stermac's findings were that 93.3% of the interviewed women did not recall signing a consent form at the time of contact with the Women's College Hospital Sexual Assault Care Centre. The authors conclude, "Such 'forgetfulness' may be specific to women under the stress of a recent sexual assault. If so, consent given during a crisis admission may seldom be informed."³⁷

If sexually assaulted women are not remembering their signed consent to participate in research studies, what does that say about the

35 Feldberg, *supra* note 19 at 70.

36 See sources cited *supra* notes 21, 33, 34, 43, 44, 45. See also Janice Du Mont & Deborah Parnis, "Judging Women: The Pernicious Effects of Rape Mythology" (1999) 19 *Can Woman Stud* 74; Janice Du Mont *et al.*, "Predicting Legal Outcomes from Medicolegal Findings: An Examination of Sexual Assault in Two Jurisdictions" (2000) 1 *J Women's Health & L* 219; Janice Du Mont & Deborah Parnis, "Sexual Assault and Legal Resolution: Querying the Medical Collection of Forensic Evidence" (2000) 19 *Med & L* 779; Janice Du Mont, Deborah Parnis & Brydon Gombay, "Co-operation or Co-optation? Assessing the Methodological Benefits and Barriers Involved in Conducting Qualitative Research Through Medical Institutional Settings" (2005) 15 *Qual Health Research* 686; and Janice Du Mont & Deborah Parnis, "Rape Laws and Rape Processing: The Contradictory Nature of Corroboration" (1999) 5 *Can J Human Sexuality* 74.

37 Janice Du Mont & Lana Stermac, "Research With Women Who Have Been Sexually Assaulted: Examining Informed Consent" (1996) 5 *Can J Human Sexuality* 185 at 189.

nature of their consent to the kit itself and the release of its contents to investigating police officers?

My observations are that the twelve experiential women I interviewed have one of three experiences: (i) they have no memory of giving consent; (ii) they felt coerced into agreeing; or (iii) they believed that their consent was necessary for the state to pursue criminal charges or otherwise “protect” them. Some of their comments follow:

I didn’t understand. I just did everything they asked me to. I was numb and confused and scared.

— Aimee, kit used at trial

I figured I had to do it. It was my role as a victim. I knew it [the kit] was a waste of time but saying no would have made them suspicious. I wanted to be compliant in order to be believed.

— Scarlett, kit not used

I don’t think I did [sign]. I don’t remember them asking. I remember thinking that everything I did was necessary.

— Neveah, kit used

I don’t remember anything like that. I was out of my mind. He [her assailant] put something in my drink.

— Rachele, kit not used

I don’t remember. I think they just informed me that it was a long process and I’m either kind of in it or I’m not.

— Pamela, kit not used

I signed a release at the beginning saying I was consenting to the kit and another that I was willing to relinquish all medical records [to the police]. I did it all. I knew I wanted to lay charges and I knew about the kit and that I would have to do it. If you deleted parts of it, what’s the point of doing it at all? I know that the police would say, “Why’d you stop? Well, this wasn’t a real rape because you didn’t even get a vaginal done or you opted not to take this [medication]. Why? What are you hiding?”

— Hermione, kit not used

Participants who work in community-based rape crisis/sexual assault centres were concerned about definitions of informed consent, given that the extreme nature of the harm of sexual assault invariably results

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in emotional, psychological, and physical reactions and, in many cases, trauma. Following are some of their comments and analyses:

It's considered a treatment women say yes to with an educated consent, but it's not.

— Andy, key informant

My experience is that women are not given a choice. Women I have accompanied were not told of the six-month waiting option.

— Michelle, key informant

When you're assaulted you are so vulnerable, there is total disarray and confusion, you're not thinking about court and are in no state to make decisions.

— Frankie, key informant

I'm sure that they are asked if they consent but it's not informed and is made under duress. It's the kind of consent that would get thrown out of court in another crime.

— Ramat, key informant

My experience has been that they have not been given a choice. One woman [I know of] was slipped a date rape drug and wanted [a kit] and one was not done on her.

— Michelle, key informant

Esther is the community-based rape crisis worker who sits on a committee struck to examine the design and use of the SAEK in her province. Her comments regarding the issue of consent to undergo the kit are as follows:

Why would someone who had just been raped want to have someone else in their vagina pulling out hairs? It's basically asking them to undergo torture after they have just been tortured. Theoretically the woman has the right to refuse [consent] but it is seen as questioning procedure and ruffles feathers or causes serious damage to the woman's case. Everything is presented and defended with "we're only trying to help women" so she feels that she has to consent in order to get help. This is how it's always presented. "Why wouldn't you want to do the kit? It's going to help you!" "You should tell this to women who come to see you [we are advised]." "It's going to help them; it's a good thing!"

Andy worked in a rape crisis centre in Ontario and is a trained nurse who spoke of a normalized deference to authority in the hospital or health care setting:

When a health care worker says to the patient: “we’re going to do such and such, do you give your permission?” the client, the patient, the health care user is predisposed to say yes. That’s why they’re there. I think patients are mostly obedient because they already know they have less power and the practitioner has lots of technique to shift lack of obedience. One way to do it is just to carry on, and say, “I’m going to put some lubricant on this or I’m going to pull some hair” which is different from saying “Now the next thing I’m going to do is get some hair samples, do you give me permission?”

Charlene works for a Sexual Assault Centre in eastern Canada:

Women do not necessarily understand what [consent] is going to involve. And you can only inform them to a certain degree because we don’t know what’s going to happen either. Once the ball gets rolling, you’ve lost control. You have no control of how it will unfold. And it’s really hard to provide that information to people so that they can make an informed decision.

Several of the community-based feminist rape crisis workers interviewed were unaware of the range of harm the kit can inflict or the fact that it is seldom used as evidence in court. Advocates seem to believe that despite its invasive and violent nature, the kit serves as critical evidence in support of a woman’s rape claim. And it is true that in some cases, especially if she does not know the man who raped her, the kit can produce critical DNA evidence. Even in cases where it is not used, a “successful” kit can encourage the Crown’s office to proceed to trial, the legal logic being that if the woman involved co-operated in undergoing the kit and there is forensic evidence to assist in establishing that she is telling the truth, the odds for conviction are better.³⁸ (Or, is it trial by ordeal — if she submits she must be telling the truth?) But what of the vast majority of women who undergo the kit, believing that it is an opportunity for them to effect justice, whose kit is not used, whose rapist is not convicted? What about the women whose cases are not “founded” because the kit was not conclusive? What of the women who are not believed? The women who do not report? The seventy-five per-

38 Feldberg, *supra* note 19.

cent majority of raped women who know the identity of the man who has raped them?

Gracia has worked as a counsellor in a Rape Crisis Centre and in a SACTC in a central region of the country:

I think that in order [for women] to make an informed decision, they have to know that the kits are rarely used and that the conviction rate is negligible. If they knew that, their choices would be different. “Why am I going through this if there’s a really, really slim chance that it’s going to be of any benefit?” But that information is not out there. I don’t think even people working within this field [community rape crisis centres] know that. Women are guilted into having a kit. “Well ... if you don’t do it — what if he doesn’t get caught? So the kit kind of presents itself as the only time the woman is actually involved, has any agency, and yet that agency is so limited, is so negative ... and still we cling to it.

It is problematic that the Sexual Assault Evidence Kit, which women experience in such harmful ways, can ironically be one of the few small areas where they feel they have been given agency and control. Several experiential women explained that regardless of any negative feelings about the kit, undergoing it made them feel that at least they were doing *something*, including protecting other women. Whether the administration of the kit is an intentional manipulation or not, those who advocate its use often do so without full knowledge of its purpose, harms, and consequences. We like to believe that the kit can provide health care, although it is not designed to serve that purpose (and is not called the Sexual Assault *Health Care* Kit), but we excuse ourselves from understanding the kit’s larger political context and the injury it can cause. Feminist anti-violence workers and social workers must examine the degree of complicity that occurs when we do not inform ourselves and each other of the paternalistic and protectionist nature of the SAEK. We must question if the kit is dangled, almost as bait, to reinforce beliefs that limit definitions of women’s sexuality to good or bad, virtuous or fallen. Is it implied that women can regain control and power by having a kit done? If so, is their consent contrived? Is it informed? If women knew that the kit can be used against them and is seldom used at all, would they consent? Why is that information being withheld?

The Sexual Assault Nurse Examiners I interviewed also had contradictory opinions and understandings of the kit. The lack of standardization accounts for a great deal of the differences of opinion, but they have much to add on the matter. An eastern community-based Sexual

Assault Care Centre, for example, has pioneered an alternative to the institutional SAEK used in other regions. Their SANEs are administered and trained by them and accountable to them versus a medical/health institution. A centre employee commented:

When the nurses are hired, the process is one whereby they are looking at the Centre's mission statement and guiding principles and what governs how we work as a woman-centred feminist organization. The nurses are asked to review this and if they have some difficulty with that they wouldn't be asked to join the team. So I think that's unique compared to many of the other similar programmes.

In practice, these SANEs receive training and education developed and delivered by the centre, are on call 24/7, and operate in pairs. They are keen on involving sexually assaulted women in the kits' administration, including the internal. They support the use of the kit but have strong constructive critiques and understand it to be "traumatizing and invasive." They have modified it considerably and actively encourage women to wait before consenting to its collection.

In an interview, one of their SANEs stated:

The thing is, we don't push it. We encourage women to come back within the 72 hours to do the kit. Our number one concern is their medical care, if they need it.

In a western region, where SANEs are called SARTs [Sexual Assault Response Team] and kits are provided by the RCMP, some nurses who administer them and deliver training to other nurses have also significantly modified their process to reduce the number of tests, body parts probed, and secretions collected.

Like no other health institution I interviewed, these SART nurses were clear and unconflicted about their role and the actual benefits of the Sexual Assault Evidence Kit. The frankness of their approach was matched with a commitment and dedication to providing the best health care for raped women.

Regarding consent to undergo the kit, a SART member offered the following:

It has nothing to do with whether we think the kit should be done, or if the victim thinks the kit should be done. It's the police decision.

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SARTs travel to the hospital or clinic and do not offer kit storage. They do it then, or it's not done at all:

We sit down with the victim, the client, the patient, and we say to them "tell us what happened." This is after we go through the consent and say that we do the same [physical] exam with or without the police, but the police are the ones that can decide whether the kit's done. We write their story as they tell it. We don't medically summarize it, we don't change the words.... We have a direct number for the sex crime detective who is on call. We talk to them, tell them what the history was that the patient gave us. And at that point the sex crime detective will make the decision to do a kit or not do the kit. Usually, they do the kit.

SACTCs in three of the four provinces in which I travelled employ social workers to provide counselling services to women who attend at their hospital/clinic. The counselling is short term (although it can be extended), one-on-one with group sessions, and is offered free of charge. In some provinces, SACTC social workers also assist women who have been sexually assaulted with housing, legal matters, criminal injuries compensation, and other services. They practise a clinical model of social work versus a feminist, anti-racist, anti-oppression advocacy model as is offered in most community-based rape crisis/sexual assault centres. SACTC social workers perform their jobs in tandem with psychiatric and other medical personnel who ascribe to psychiatric diagnoses as listed in DSM IV, especially post-traumatic stress disorder [PTSD], that assign disorders and syndromes to women who have experienced sexual assault. While it might sometimes be relevant to do so, the root cause of the violence against the woman does not factor into their medical findings, prescriptions, or prognosis:

Feminist anti-oppression and anti-violence supports developed originally as a reaction to the insufficiency and ill fittingness of psychiatric and psychological responses to women's experiences of violence and social inequity. And as a corrective to the misnaming of these experiences as illnesses and disorders.³⁹

The professional associations and licensing bodies to which medical and social work professionals belong require adherence to intern-

39 Bonisteel & Green, *supra* note 22 at 27.

al guidelines — before any responsibility to the clients/patients/consumers/victims who seek their services. Doctors, for instance, are responsible to the guidelines, regulations, and principles of the College of Physicians and Surgeons, nurses to their provincial nurse association or College of Nurses. Similarly, social workers are responsible to the institution that employs them and, in some provinces, have their own College of Social Work. The regulations, mandates and codes of behaviour of such professional affiliations supersede how members work or want to work in a smaller group that draws on its own overriding ethics or principles in determining policy, practice, and protocol.

So, as Andy, a key informant explains, while many women working in hospitals as counsellors or nurses are feminist advocates, the competition of cultures that takes place privileges the institution that employs them over feminist practice or community concerns:

Even though you have caring, benevolent, political thinking people working in a place that's actually an institution, you can only be as flexible as the overarching institution will allow ... so even if the SACTC has some core staff that have some very strong, feminist, demystifying peer-skills, when they do counselling, even if the medical oversight of that sexual assault care and treatment centre has good politics, they still have [medical] residents, they have all kinds of people coming through it. There's more purpose to it [the hospital] than just being the [SACTC] centre. In a Rape Crisis Centre, they would be in control of who they trained and who was on the crisis line. And just that — the system of the organization itself being in control of who does the work, that becomes lost in a Sexual Assault Care and Treatment Centre. Which means that no matter how well it tries to provide different service, it has its limitations. Because they don't have anyone there that *doesn't* have the professional credentials. And they are not functioning in an organization that allows for the sort of ongoing personal and professional, anti-oppression, anti-racist, anti-misogyny constant kind of work that we know feminism requires.

Hermione, who experienced a sexual assault, reported to the police, and underwent a kit, has this to say:

This city has a very large problem with the police and sexual assault. The hospital is doing a follow up for people who report to the police, but it's like a private social work investigation. When I went for my follow-up I filled out a questionnaire so I know that they are wary of the police and I think that nurses are trying their best to be there for women and are on the wo-

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man's side. But they're also nurses in an institutionalized setting — and there are no feminist nursing classes.

And from Gracia, who was employed as a counsellor in a SACTC:

A lot of them [SANEs] just do the obligatory. You know, a preliminary collection of forensics like the pulling of hair and all that. A lot of them are not aware of the dynamics, what the patients need and how they need to be supported. We hear time and time again, people say “my introduction into the system with that nurse! If that's how I was treated by the nurse, then I certainly don't want to get into counselling, you guys are supposed to know better!” It's a problem, definitely an issue, so much so that the managers asked the counsellors to do training for the nurses. But it's not happened yet.

In a central province, where hospital and health-care-centre-based SACTCs are referred to as “designated centres,” they utilize two kits. One is to collect legal evidence while the other is “psycho-social.” Kits have different parts or modules to facilitate requests/offers that only portions of the kit be conducted. They have a team of social work counsellors on call who manage the intervention. A doctor performs the medical exam. There is a provincial training program and each centre adapts it to their needs. Paulette, the SANE I interviewed, said that she practiced from a feminist perspective, but that “The kit is a legal tool and people are concerned about interjecting politics.” Her centre is part of a group that includes police, lawyers, and representatives from the VAW community who are currently meeting to assess the kit and its process. She feels that it is important “to work within the system and to try and effect change from within, in a less political way.” Paulette continued to explain how she understands her work versus that of community-based agencies:

We don't run groups; clients aren't counsellors — that kind of stuff has happened before. People are realizing that just because we experienced the same thing [sexual assault] we can't share together. We are not offering self-help. We've never felt that there is something wrong in having an education, and professionals are not bad people.

FULL CIRCLE?

Has the privileging of the SACTC and its workers regarding sexual assault contributed to the exclusion of community-based anti-violence feminists in policy design and direction? Has funding also been

affected? There is additional concern that SACTC social workers, who increasingly provide practical and critical resources for sexually assaulted women, such as housing, have better access to the institutions that can provide it. While there is no doubt that such services (versus the collection of forensic evidence) are what women need most, their provision should not be partnered with attendance at a SACTC:

Pressure on the feminist anti-violence sector to medicalize anti-violence work has intensified in direct relationship to credentialism and funder control. The language of post-traumatic stress disorder and PTSD symptomatology is being used more frequently in the feminist anti-violence sector because of these pressures, and perhaps because alternative feminist language used to name the severe distress of women's oppression lacks medical credibility. Some organizations in the anti-violence sector have responded by promoting a mental health treatment approach (Yellow Brick House 2003; Brown, Gallant and Junaid 2002) and by adopting hiring practices that some feminists argue support the medicalization of oppression.⁴⁰

And, according to Feldberg, "The SACTC has come to represent the standard of care for women who experience sexual assault."⁴¹

The medical professionals and social workers I interviewed, who work in SACTCs or their counterparts, do not believe that there is an institutional bias or pressure to encourage women to consent to undergo the kit in a speedy manner, or at all. As one central-Canadian SANE, Paulette, said

We have a role in the kits, filling them out if you want, and giving them off to the police. It's part of a chain, a continuum. We are always trying to work that out to improve it, in the best interests of the women we see. It's working as well as can be expected. We feel that the kit is an option a possibility, whereas it's an evidence thing for the police.

The view is quite different, however, from that expressed by experiential and key informant women like Andy:

I think that there is a lot of law and order institutional paranoia and the belief is that we are doing something like this because the police need it, and the

40 Bonisteel & Green, *supra* note 22 at 35.

41 Feldberg, *supra* note 19 at 114.

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kit's not right if you don't do it a certain way. I don't know how a client would perceive the nurse examiner administrating the kit as separate from the police. Even if the police are not in the room — which they never should be.

Barbara was sexually assaulted by a man she knew in central Canada:

The [SANE] nurse was a good friend of the [sexual assault] detective and said she would call the detective and speak with her about me that night. She said “[Officer's name] is my good friend.”

Ramat, who works in a feminist community-based centre in western Canada, says this:

There is a perception that the nurses have your best interests at heart. The nurses are soft spoken and doing a lot of uhm-hmms which limits the woman's allowance to be angry. The women are asked if they want the police called, but there is definitely a push to have them called. The sexual assault nurses don't get any analysis [in their training] about using the police.

Gracia, a SACTC counsellor, adds:

The police sit in the waiting room [of the SACTC] and they complain about how long this [the kit] is going to take and that we don't have good reading material. The nurses tell the women they don't have to undergo the kits, that is what they're supposed to say, but I have it on very good authority that some of the nurses are known to be more persuasive, let's just say, than others.

POLICE TRAINING AND THE KIT

During the course of conducting this research project, I had the opportunity, through related work, to observe sexual assault investigation training delivered to Toronto police officers at a police training facility in Ontario.⁴² In the training module titled “Sexual As-

42 In 1999, as a result of my case, Toronto City Council ordered an audit or inquiry into how police investigate sexual assault and how they treat women who report the crime. I worked with other VAW activists to establish a committee that included us as consultants. See Jeffrey Griffiths, *Review of the Investigation of Sexual Assault—Toronto Police Service* (Toronto: Toronto Audit Services, 1999) produced 57 recommendations for change. In 2006 after seven years of additional community lobbying, Beverly Bain and I were permitted to observe the two-week Sexual Assault and Child Abuse investigative training course delivered at CO Bick Police College in Ontario. For more detailed information see, Jane Doe, Amanda Dale & Beverly Bain, “A New

sault and Forensic Biology,” learners (police detectives who were training to qualify as sexual assault investigators) were given information that contradicts and even negates the mandates and policies of the province’s Sexual Assault Care and Treatment Centres. For instance, the biologist who delivered the police training material stated that SANEs take samples (in the SAEK) that are not relevant, and her forensic team does not accept them. Officers were instructed to get only the relevant samples based on the case history, as the Centre of Forensic Science will only accept fifteen items. They were encouraged to collect hair samples and the option of freezer storage for later use was discouraged due to lack of proper storage space. Other presenters on the kit, including a provincial Crown Attorney, stressed the importance of conducting the kit immediately, and its use as a tool to corroborate the victim’s story.⁴³ My observations of police training further illustrate the divergent interpretations of the use and purpose of the rape kit by legal players who utilize it in their job performance.

WHO BENEFITS?

Canadian academic and research experts on the sexual assault evidence kit have established a significant body of work on its use and efficacy. In a collaborative paper, researchers McGregor, Du Mont, and Li extrapolated data from 462 women who consented to the rape kit between 1993 and 1997. They report that: “Charges were laid in 151 (33%) cases, perpetrators were found guilty as charged in 18 (3.9%) cases, and convictions secured in 51 (11%) of the 462 cases examined.” They also note that their conclusions are “similar to findings in hospital-based studies in the United States and slightly lower than those reported in the Scandinavian literature,” and “that two decades of legal reforms designed to improve prosecution and legal reforms [in Canada] have not been entirely successful.” The authors go on to state:

The greater than threefold increased likelihood of charges being filed in the presence of forensic samples collected by the examiner, irrespective of the test results, suggests that a victim’s willingness to submit to a forensic examination might play a role in assessing the strength of a case. Specifically the examiner’s collection of biologic samples for submission to police appears

Chapter in *Feminist Organizing: The Sexual Assault Audit Steering Committee*” (2010) 28 *Can Woman Stud* 6.

43 From course material presented in 2006 at the Sexual Assault Child Abuse Course, CO Bick Police College, Toronto, Ontario.

to provide some perceived scientific validation of a victim's allegations. The fact that most examples were run *only after charges were filed* suggests that the presence of sperm-semen plays a limited role in the police processing of sexual assault cases⁴⁴ [*italics mine*].

In her 2004 paper presented at the Global Forum for Health Research in Mexico City, Du Mont relied on data collected from a central and a western Canada SACTC to conclude: "Nor was the presence of a positive sperm-semen sample related to conviction."⁴⁵ In additional research, Du Mont and Parnis suggest that "medico-legal evidence may be socially constructed... Comprehensive and systemic investigation of court transcripts and first-hand experiences of women who have undergone a medico-legal exam and testified in court may be the key to determining whether the kit serves to perpetuate negative stereotypes in the rape mythology, most notably that women lie about being sexually assaulted."⁴⁶ Georgina Feldberg writes of the symbolic value of the rape kit as opposed to any evidentiary worth and that "lack of evidence [collected in the kit] seems to do more harm than its presence does good."⁴⁷

My primary finding from my interviews is that the nature of the consent women give to undergo the kit is seldom informed legally or otherwise. It is supported by a decade of research on the subject of the SAEK and cannot be divorced from additional data in this research and in others that clearly indicate that:

- Women experience the kit as a second assault
- Consent to undergo the kit influences the filing of charges by the police
- The kit does not influence conviction
- The kit can be used to negatively influence the outcome of a trial and to discredit the woman involved

44 Margaret McGregor, Janice Du Mont & Terri L Myhr, "Sexual Assault Forensic Medical Evidence: Is Evidence Related to Successful Prosecution?" (2002) 39 *Annals Emerg Med* 645.

45 Janice Du Mont, "Documenting the Health Impacts of Sexual Violence: An Evaluation of Two Forensic Protocols." Paper presented at Global Forum for Health Research, Forum 8, Ministerial Summit on Health Research, Mexico City, 16–20 November 2004, at 6.

46 Janice Du Mont & Deborah Parnis, "Constructing Bodily Evidence Through Sexual Assault Evidence Kits" (2001) 10 *Griffith L Rev* 63. See also Margaret McGregor & Grace Le, "Examination for Sexual Assault: Is the Documentation of Physical Injury Associated with the Laying of Charges? A Retrospective Cohort Study" (1999) 160 *Can Med Ass J* 1565.

47 Feldberg, *supra* note 19 at 107.

- The kit's most invasive test, the internal, is not related to conviction
- There is no formal standard of practice in SAEK collection, content, or administration.

Such conclusions force the question — why are we using the Sexual Assault Evidence Kit? If it denies women agency, choice, and control and its detrimental impact so grossly outweighs any gain, who benefits from its use?

Women who have had the kit conducted on their bodies and those who support and advocate for them respond:

The police benefit, they feel it strengthens their investigation and allows them to determine who is a real victim. The state benefits, the assailant benefits.

— Esther, key informant

They want to get it done and they want to get it over with and they're not concerned about who you are. You get lost.

— Neveah, experiential

The police benefit and the legal system. Good old justice benefits, not women.

— Hermione, experiential

It [the kit] is a “feel good.” As a nurse I get to feel like I've done something good at the end of the day. But the day a [raped] woman came in and said “I don't want to do a kit. I want you to get me housing so that I won't get assaulted again,” I understood that it was a waste of time.

— Christine, key informant

It [the kit] may have been groundbreaking in its time, even ahead of its time — before DNA. It's outlasted its use though, and now it's just because the police, the judiciary system refuse to change.

— Michelle, key informant

I don't remember the kit so I don't really know.

— Ronnie, experiential

It's for legal. That's all. The victim can benefit if it provides the DNA that will find a stranger assailant.

— Marie, key informant

WHO BENEFITS FROM THE SEXUAL ASSAULT EVIDENCE KIT?

It makes the police look good. It's of no use to the woman, just another traumatizing event. It was a waste of time.

— Scarlett, experiential

The Crown benefits. Rapists benefit.

— Ramat, key informant

Not me.

— Barbara, experiential

This paper is dedicated to Georgina Feldberg (1956–2010) with great respect and appreciation.