Imposition of virginity testing: a life-saver or a license to kill?

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Abstract

Little is known about medical and juridical (medicolegal) responses to sexual abuse in Palestinian society. Conventional wisdom posits that the actions of the medicolegal community help victims of sexual abuse and deter offenders. This study focuses on the prevailing practice of imposing a virginity test (IVT) on women in Palestinian society when questions of sexual abuse or perceived misconduct arise. We found that the continuing practice of uncritically collecting forensic reports and the refusal to closely examine the specific dynamics of oppression (medical, cultural, legal, political) in which the victims of sexual abuse are necessarily implicated actually increases the power of medicine and law to adversely function as tools of oppression. However, as I elaborate below, despite the localized factors in play, it is critically important not to view the process of virginity testing merely through the rubrics of “culture”—an approach that more often than not impedes understanding and fails to contextualize what we observe.

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Manal was 14 when she was raped. She has written:

…..I walked with the Mukhtar (tribal head), my father, my brother, and others, like a lost person. Never knew where they are taking me…. A day before, my 13-year-old sister told me that my father is planning to kill me. She said that she could help me to run away before something bad happened she said that the Mukhtar explained to our father that such cases end up in [the person] being slaughtered—Bidbahoheen Dabehe….How could I bring shame to my family? I kept on walking….is it my last walk? We entered into a big place, maybe a hospital…I saw men wearing white gowns carrying in a dead body—another girl like me who was raped? Was [she] killed by her family?….I decided to trust my mom…she was with me, and I know very well that she will never allow my father to kill me. He could beat me, imprison me…but not kill… The physician asked me to sit on that big chair, a chair that I will never forget in my life—a chair that keeps chasing me. And he asked the nurse to take off my underwe… I refused….she with the help of my mother did that by force. They seated me on that chair, and he started hurting me down there… he was doing wrong things… and he looked angry….I started crying in a loud voice, but he totally denied my tears. He kept searching inside me….searching and searching….until I lost my power to resist….lost my power to cry or talk….just forgot where I was, and what I am doing. He then said to the nurse: “this girl started enjoying it, we better finish fast!”

My mother’s reaction was [to] slap me, why?…and after so much pain, torture, and so much time, the doctor all of a sudden said: “Hay Min Marrah Kharbaneh….Il Salam Aleha..la ghesh’a wala sh’hhar.”

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(She is totally rotten, no hope at all... There is no hymen and no crap.)

(Manal was later married to her rapist and came to my attention when she discovered the Al-aman women-in-need hot line. She wrote the letter I have quoted passages from above, following a long process of therapy, while she was studying social work. She hoped that by speaking of her ordeal she could convince the Mukhtars, and the physicians not to do to other women what had been done to her.)

This is one of the many unheard voices that asks us to look closely at the way in which the medical and legal communities react to abused women (Mills, 1999; Harris, 2000; Snider, 1998) within the given socio-cultural contexts. Literature on violence against women (VAW) has articulated certain common principles that have sometimes resulted in more optimistic policies regarding VAW. However, despite innovations in analyzing and reacting to issues of women and violence (Strang & Braithwait, 2002), recent debates continue to show that as we harness new possibilities to address VAW, we should take into account—among other issues—the socio-political and religious contexts of a specific society during a specific period of time in which the violence occurs (Dadeghi-Fassaei & Kendall, 2002).

Using the phenomenon of imposed virginity testing (IVT), which is commonly used in the region to "investigate" crimes of sexual abuse, as its focus, this essay examines the interaction between medical and juridical discourses within the specific political legacies and culture of Palestine, in order to study the power dynamics at play which often further oppress the victims of abuse. In this regard, my general objection to relativizing (and thereby dismissing) the problem of sexual abuse in the Middle East by invoking "culture" becomes even more acute: I am arguing that the cultural specificities of sexual abuse—while they must be accounted for—do not supersede the politics. In other words, as this essay is conceptualized, "culture" and "politics" are not interchangeable.

Understanding such interconnections as manifested in the practice of the IVT is the core focus of this article. I intend to examine how social control agents react to sexual abuses in the context of the Palestinian case study. Since 1948, Palestinians have been struggling against the Israeli occupation, and such ongoing political struggles often paralyze social institutions and adversely affect the legal apparatus (Bisharat, 1989), often at the expense of women, resulting in further oppressions (Shalhoub-Kevorkian, 2003). My own research indicates that this has been the inevitable and repeated pattern, due to the continuation of occupation and despite the arrival of the Palestinian Authority within the Occupied Territories following the Oslo agreement (Abdo, 1999).

Ostensibly, IVT is a contemporary medical and legal practice that aims at providing an "expert's" medical evidence and testimony towards resolutions of sexual assault cases, and/or when the patriarchal structures and customs in place dictate the use of the test. As we shall see, the results of such an examination as reflected in this study are not just a matter of clinical concern, but could indeed be—in some cases—a matter of life or death (Shalhoub-Kevorkian, 2002, 2003). The phenomenon of the IVT allows us to study the culture and systems of power that are brought to bear on women who claim to have been sexually abused. It is critically important to think of the IVT process as a "phenomenon" which definitionally suggests a nexus of various factors that come into play, stressing and fracturing the cultural/political foundations of the region in various ways. Following a brief section on methodology, my investigations regarding "virginity" testing, are conceptually presented in three interrelated segments:

i. The contextualization of "virginity" in the region.
ii. The social history and the material practice of the virginity test.
iii. The emotional trauma of the test on women and the place of those experiences and the test within the larger social fabric.

Methodology

The data presented here are but one component of a very large study that the author directed for the Women's Legal Aid and Counseling Center-Palestine (WCLAC) and the Jordanian Women's Union—Jordan (JWU). It studied disclosure of child sexual abuse both in Jordan and Palestine and was funded by the United Nations organization UNIFEM. The data collection for this section began in January 2002, and continued through June 2002. Our first step in gathering this data was to listen to those young women who have suffered from the practice of the IVT. We then decided on the major research questions and began our interviews with social control agents. The use of focus groups was the last step used to validate our previously collected data and ensure that we understood all the themes affecting the process of IVT, while discussing it with those who deal with the issues on a daily basis.

Given the ways in which the various issues related to the study of women's virginity and sexuality can be nuanced, and the obstacles to conducting research on the subject that prevail, we had to be particularly careful during our interview process and the gathering of data. The use of qualitative research methods used foregrounded the fact that above all this study is historically positioned and locally situated, and its meaning is "radically plural, always open and ... there is politics in..."
every account” (Bruner, 1993, p. 13). Therefore, it cannot be considered a politically neutral study. Each of the respondents—whether of the women interviewed or the social control agents involved—reflected their own position in the social hierarchy, their degree of political involvement and the degree of influence exerted upon them by social and political players (Acker, Barry, & Esseveld, 1983).

This article is based on various sources of information from the northern, middle and southern regions of the West Bank as follows:

1. Interviews with seven women, all of whom were under the age of 21, who underwent IVT and who shared their experience with the author. These women were among those who initially called the Al-Aman hotline for victims of sexual abuse during 1998–2002. (Al-Aman is part of the activities of the WCLAC; it was the first hotline for abused women in Palestine, established in 1994.)

2. Interviews with 17 police officers who work with cases involving sexual abuse of and domestic violence towards women: Four of them were from Nablus city, four from Ramallah city, three from Bethlehem, two from Hebron, and one from each of the following: Jerico, Qalqilia, Salfit, and Jenin. Only one was a female police officer.

3. Interviews with two physicians in the only formal forensic medical center in Palestine, as well as six gynecologists (from Nablus, Ramallah, Bethlehem, Hebron and Jenin) who are known for performing virginity tests, and were brought to our attention by the police, prosecutors, lawyers and social workers.

4. Interviews with seven prosecutors who deal with such crimes and who agreed to be interviewed (some prosecutors we had approached for interviews refused us).

5. Focus groups consisting of four female lawyers as well as four female social workers who work in Al-Aman and are in daily contact with various service providers and social control agents.

In attempting to establish our research parameters, we began with a set of direct questions that were based on the author’s clinical experience and the main concern of the victims. These included questions such as: Is the IVT a legal medical procedure? Is it used in all reported cases of female sexual abuse? Who conducts such testing? How are the tests conducted? Are the results consistently reliable and accurate? We also tried to learn whether interviewees addressed any social, legal or psychological ramifications of the obtained test results. The contents of the interviews were later transcribed, shared with the research team in addition to two lawyers, two social workers, and two women activists who worked at WCLAC and were willing to help read the transcripts and organize the responses thematically. In reviewing our research data, three main areas of analyses were evident: the first relates to medico-legal issues, the second addressed formal and informal legal issues, and the third focused on socio-psychological issues. This paper focuses on the first category, i.e., medico-legal issues.

Contextualizing “virginity”

A considerable body of existing literature has convincingly shown that in the Middle East, North Africa and the Muslim world women’s sexuality is perceived as something that must be controlled by both the informal (family and tribal) and formal (state) apparatus (Mernissi, 1982; Abu-Odeh, 2000; Ilkkaracan, 2000). The complex and intricate connections between the need to control women’s bodies and their sexuality through patriarchal/politically sanctioned medical and legal practices have not yet been fully explored. Women’s sexuality is conceptualized as dangerous, evil and nothing short of an omnipotent and boundless sexual energy (Mernissi, 1975; El-Sadaawi, 1980). Our discussions and the ongoing process of social activism regarding the transformation of the status of women in Arab countries shows once again that despite the willingness of human rights and women’s organizations to effect change, the fear of being “Westernized” and the panic of some social, political and religious power-holders about dealing with values connected to the colonial oppressive legacy, results in women’s bodies becoming a site of resistance. Consequently, only minor changes have been made in social practices and the criminal codes (Shalhoub-Kevorkian, 2003).

Conceptually, “virginity” is seen as a highly consequential in Muslim culture, but the evidence would show that some form of what amounts to IVT occurs in many countries. However, its form and intent are often obscured behind discourses and practices that present virginity testing within the parameters of “medical and legal necessities” (Al-Khayyat, 1990; Shalhoub-Kevorkian, 2000, 2002; Cindoglu, 2000). Some of the social reasons and scenarios given for performing these tests include: sexual assaults, consensual sexual intercourse between minors, certification that intercourse has not taken place prior to marriage or divorce (in cases when the husband has claimed not to be sexually active), because of a failed virginity examination, no vaginal bleeding after first marital intercourse, and certification of virginity before marriage (Women’s Health Information Center, http://www.amaasnn.org/special/womh/library/readroom/vol_282a/jil90016.html). The “material” evidence of the loss of virginity and corresponding evidence of pre-marital sex have been important taboos (and arguably continuing concerns) in many cultures,
demonstrated by studies conducted in Chinese (Zhou, 1989), and Mediterranean (Mernissi, 1982; Peristiany, 1966) societies and Islamic cultures (Basnayake, 1990) among others. While the importance of “virginity” is necessarily contextualized in culturally specific ways, we should be cautious of orientalist approaches that then use the local as a way to stigmatize the data and the culture: a sleight-of-hand I encounter all too often in hegemonic discourse, where “culture” comes to represent the other. Questions regarding the analysis of power hierarchies and the construction of the “other” are central to Edward Said’s paradigmatic study Orientalism (Said, 1978). Said explains that all cultural activity is inevitably bound up with the matrix of power—and here we refer to the colonial legacy and occupation—and suggests that our role is to illuminate the disguised, embedded structures of power and privilege. Said’s scholarly strategy stresses the importance of critically challenging traditional assumptions, and enables us to attempt to redefine feminist advocacy within a Middle Eastern context, allowing for the emergence of a feminist voice that is both dynamic and context-specific (Al-Ali, 2000).

As we have stated, the concept of “virginity” can be localized in various ways, but its ostensible importance in patriarchal society is manifested through applied practices aligned with many different types of social phenomena. In every case, both the concept and preservation of “virginity” result in attempted patriarchal control over women’s bodies which is translated and codified as issues of honor and shame that further extends the attempt to control their sexuality as well. Thus, patriarchal practices relativize women’s value by looking at her through the rubrics of purity and contamination, the entire spectrum of which process is arbitrated by men. As Delaney (1987) has shown, in certain cultures a man’s honor is aligned with his power to protect his property (the woman being his most prized possession). The slightest erosion of such vigilance is ultimately perceived as a threat to the security of men. Thus “virginity” comes to be conceptualized as an issue of ‘protection’ that ostensibly extends from the individual woman to the family as a whole, and ultimately to the collective patriarchal system. Women’s bodies and their ‘virginity’ mutate from a private, personal matter, to being involved in a much broader power dynamic sanctioned by the patriarchal state itself (Abu-Odeh, 2000).

The social anxiety over women’s virginity as manifested through their hymen, accompanied by the unchanging needs of patriarchy to continually secure its power, has resulted in the creation and ritualization of many gender oppressive practices. These practices range from celebrations in the groom’s family upon getting the ‘bloodied sheet’ that proves the bride’s virginity and the groom’s virility, to the imposition of early marriage to control female sexual desire (Lazreg, 1994), to hymen reconstruction (also known as “virginity restoration surgery”) (Mernissi, 1982), and even to the socially sanctioned refusal to criminalize the killing of women, under the rubric of “crimes of honor” or femicide.

It is not surprising, then, that the pervasive cultural belief that women must be controlled sexually, and the political fear any change to this belief, has resulted in the fabrication of social/political practices that severely punish women when they disobey those gender-biased sexual codes and manifest sexual desire (Shalhoub-Kevorkian, 2002, 2003). But this need for control has also given rise to contemporary medical practices such as “hymen reconstruction”, which restores an illusory ‘virginity’. However, it is important to note that while the politics of hymen reconstruction are hardly optimistic, often reinstating the daily oppressions women so valiantly struggle against, reconstructive surgeries of this type can become nothing short of a life or death matter—even saving them from punishments such as femicide (Shalhoub-Kevorkian, 1999a, b, 2003; Mernissi, 1982). It is precisely because of this that I urge a more elastic feminism that takes into account the specificities of “contexts”, without incorporating that term into an orientalist, progressive/regressive, us/them binary.

**Virginity testing: history and applications**

Just as gender-biased social customs and rituals are often translated into laws and regulations which are used as social tools to control women’s sexuality, modern medicine and its applications are now also being used as methods of control (Nandy, 1998). Literature has shown that the hegemony of the contemporary medical apparatus, and the possibilities of violence inherent therein, often cause human tragedy rather than healing. In this context, it is not surprising that “invasive investigation” would be an acceptable medical concept, and the active invasion of women’s bodies its corresponding practice (Kothari & Mehta, 1998).

To begin with, the Palestinian legal system is a hybrid of British and French colonial law, Jordanian and Egyptian laws, Israeli military orders as well as the religious tenets which are in place. The two Palestinian uprisings have effectively militarized the surroundings for Palestinian women (Shalhoub-Kevorkian, 2003), who now live under conditions of unequal personal and systematic power, and with the prospect of violence in their daily lives (Daly, 1994).

Criminal laws regarding sexual abuse in Arab countries in the Middle East are going through a process of transformation. Yet the reluctance to criminalize certain acts in the modern criminal code, such as marital rape or female genital mutilation, or to
give exemptions or reduced sentences for the so-called "crimes of honor", the practice of de-criminalizing rapists when they "accept" the marrying of their victims, and the continual privileging of testimony by men in such cases over the statements or claims of women, make a socially sanctioned and innate injustice legally acceptable (Wing, 1993, 1994). The tendency to de-criminalize some acts, while omitting others from the law, has enabled the societal control of women's bodies and further given the state the power to define what is "appropriate sexual behavior"—most notably for only one segment of the population. These gender discriminatory practices are clearly in opposition to international standards of human rights.

Looking closely at the processes of disclosure that initiate the investigation of sexual abuses, one learns that the very concept of legal and medical "expertise" itself reveals their collusion with the pervasive patriarchal system that exercises authority over women's bodies and their sexual freedom (Shalhoub-Kevorkian, 1999b). Law enforcement agents, including medical personnel and forensic experts, apply laws that are congruent with existing social stereotypes that conform to their cultural expectations of women. Additionally, law enforcement agents use other systems of power (such as medicine, tribal systems, religious tenets, etc.) to promote their interest. Thus these localized expressions of law and medicine reflect the political struggles and social perceptions that are ongoing within a specific culture (Lees, 1994).

All the social control agents interviewed stated that IVT is a legal examination required of all victims of rape, incest or other forms of sexual abuse. Police officers and prosecutors explained that primarily any young and non-married females who disclose any kind of abuse to the law enforcement systems, run the risk of being forced to undergo IVT. Moreover all the victims interviewed stated that sexually abused women, who spoke of their abuse to the family or tribal system, asking for help, also had the virginity test imposed on them. It was noticed that women who had the financial resources to repair the hymen did not evade the cultural and physical trauma as a result of claiming sexual abuse, but nevertheless managed to protect themselves from social scandal or femicide, while those without adequate financial resources became further traumatized, abused and in some cases were killed.

Given the prevalence of these inequalities, both the social and legal inquiries with regard to crimes of sexual abuse place an undue emphasis on the forensics of individual cases. Since conventional wisdom posits that forensic evidence plays a crucial role in successful prosecution (Du Mont & Parnis, 2000; Rambow, Adkinson, Frost, & Peterson, 1992), this type of evidence has increasingly become the focus of attention for medical, legal and social researchers, making the process of gathering such evidence expensive, time-consuming, and intrusive (Feldberg, 1997; Tucker, Ledray, & Werner, 1990). Sexual Assault Care and Treatment Centers have been established to address the social, psychological, physical and forensic needs of abused persons (Martin, DiNitto, Maxwell, & Norton, 1985). On-call medical teams especially trained to assess and treat injuries and gather medico-legal evidence are in place (Rambow et al., 1992). Du Mont and Parnis (2000) have noted that many non-medical variables were also brought into play during investigations, such as the victim's age, use of alcohol, resistance to and relationship with the abuser, as well as any corroborating evidence that witnesses might provide related to the charges. However, this emphasis on (ostensibly) verifiable material evidence is, in fact, used to effectively mask the operant gender oppressions within any attempt to investigate the crime and also hides broader patterns of social power. Kandiyoti (1987), for example, has argued that as an ideological system, Islam provides some unifying concepts that profoundly influence women's experiences of their sexuality, and initiate an ongoing process of subordination through various mechanisms. Thus the culturally defined ways of controlling women's sexuality, along with sex-segregated social networks and the extensive informal support systems that continually stress patriarchal notions of women's honor and the domestic and nurturing roles to which they are obligated, continually define women's experiences in different Muslim and Middle Eastern countries. These culturally sanctioned roles are a result of both colonial histories and social policies.

Additionally, the efficacy of forensic evidence is at best questionable, and formal studies report little or no correlation between the documentation of injury and legal outcomes (Tintinalli & Hoelzer, 1985; Penttila & Karhunen, 1990). While research is only beginning on sex crimes in Muslim societies, the poor correlation between forensics and criminal prosecution of sex offenders has been illustrated repeatedly. Surveys done in various Middle Eastern countries reproduce these findings: They showed that in most cases women ended up being killed despite the medical results that assured family members that the tested female was a virgin. Similar results were found in Palestine (Shalhoub-Kevorkian, 2002), and this study also revealed that any gossip or rumors regarding women who had claimed sexual abuse often took precedence over any empirical medical evidence and resulted in the victim's death. In addition, disclosure of a sexual assault to the family, tribal group, or other formal agencies increased the probability of femicide.

As our interview process unfolded, it was clear that social control agents were reluctant to address solutions to the problem of sexual abuse. Similarly, it was noted that most individuals we spoke to (except three), despite
their apparent awareness of the socio-political contexts that pertain to women and issues of virginity or “honor” in the region, also avoided searching for viable options to imposed testing. We believe that this reluctance is mitigated by the stigma that cases of sexual abuse carry in the culture.

Focus group meetings showed that women were extremely fearful of and indeed felt terrorized by IVT. For some women, it was clear that the process of virginity testing was as significant a trauma as the sexual abuse. Their feelings of fear and invasion were manifested in a variety of ways: by their refusals to sit on the examination chair, through crying, screaming, pushing, freezing-up, being silent, fainting, etc. One social worker told us that the “IVT whether by choice or imposition—for basically it is culturally imposed—was found to affect the women’s future decisions and life. The degradation they felt was profound to the degree [to make] two of my clients think of committing suicide.” Similarly, another social worker stated: “One client decided to put a burqa (veil) and cover her face out of fear and embarrassment, and three days later she was hospitalized for attempted suicide.”

Virginity testing: emotional trauma and the social fabric

Almost all the interviewees (except two) described the harsh trauma and aftermath of both the initial sexual assault as well as the medical examinations afterward. But despite this, almost all involved in investigating sexual abuse stressed the need for virginity testing: One police officer bluntly stated that “I must oblige her to conduct a virginity test so as to be sure that the girl is not lying, or have no personal interest in filing a complaint against a man.” For another police officer, the trauma of the test for women was brought home by what he had witnessed. He recounted his experiences to us: “I never thought how hard it is to send a woman to the forensic doctor for virginity testing until I personally accompanied a father with his 11-year-old daughter. The girl was crying in a loud voice, she kept on fighting the doctor to examine her. Her voice, her way of begging her father not to allow the doctor to touch her made both of us cry….I really hope I will never have girls”.

Our interviewees, from all segments of the legal and medical apparatus, repeatedly stressed the mandatory nature of the test. As a prosecutor told us: “Basically there is no case, nor a criminal file without a medical report…and yes it is hard—I mean putting her genitals under the microscope—but it is a legal requirement”. Echoing the same sentiments, a district attorney stressed: “Although it is hard to put a woman under such medical examination, we face lots of cases whereby women falsely claim that they were raped, and we need to be sure about their claims, and punish them if they lie…we also need to decide if it is [a] case of indecent assault where there is no full penetration [since to file a rape charge], vaginal penetration [must occur]”. However, beyond establishing evidence of sexual abuse, virginity testing, as I have been contending, often betrays the cultural stereotypes that accrue with regards to women’s sexuality. As the district attorney continued, “I am sure that [the women’s] fear and anxiety from the medical examination would double if they refuse to conduct the test. Her refusal could also tell us who is she? I mean what kind of woman is she?” In this statement we can observe the slippage between stereotyping and legal requirements.

In addition to the physical and emotional traumas we have been discussing, the social consequences and ramifications of virginity testing are far from negligible. Results from both personal interviews and focus groups show that the victim’s state of mind was inevitably ignored and pushed aside to focus on the impending social ridicule that the victim’s family might potentially face following the discovery of the abuse.

In fact, victims’ voices are often lost or muted beyond hearing within the myriad of other concerns that come into play culturally. Interestingly, these findings are most apparent in the ways in which victims of sexual abuse perceived and contextualized their own abuse. I want to return to the woman whose words opened our essay—Manal. For her recollections and reflections reveal, in startling detail, the social fabric in which the concept of virginity testing is necessarily embedded.

Amal, a 21-year-old woman, addressed the social worker she had turned to for help after being sexually abused by her university professor. She relayed the story of her abuse:

He tried to be sexually close to me…and I was very scared…but was shy to tell him to stop…was totally paralyzed….All I know is that I was crying while holding on to him and asking him to stop. The second time I went to his office because I needed to get his approval for the final topic of my seminar… I think that time he Fatahni (deflowered) me. I really do not know how…and what exactly happened for I ended up running away from the office…I know I am to be blamed…I shouldn’t have gone to him. My family trusted me and I betrayed them all.

Amal reached the social worker in a hysterical state; she asked for her help in having the virginity test conducted. Her disclosure of abuse, and the accompanying fear, self-anger and blame were emotionally overwhelming. What aggravated her already depressed psychological mood was having to plan the process of getting tested: choosing the place, the time, and securing
the funding to cover the expenses of the test caused her sleeplessness, severe weight loss, an inability to concentrate and, ultimately, an inability to function. The social worker stated that for more than six months Amal continued to hesitate whether she wanted to have the medical procedure or not. Amal had scheduled the IVT three times only to cancel it a day or two before the actual dates due to her apprehensions, fear and psychosomatic reactions. It was noted that she had developed an ulcer and suffered from severe hysterical reactions, such as an inability to move her legs and walk. On the day of the medical examination, the social worker accompanied Amal. She recalls vivid details from the visit:

The clinic was very quiet, but she was shivering all the time while waiting for her turn. The physician tried to calm her down, and explained that if she will be calm and relaxed the whole procedure won’t last long. The process was very painful, she was crying, screaming, holding my hands very tight. She later said to me ‘I wanted to do it and calm down. I wanted to know if I lost my honor. I paid money to learn that I lost my honor.

It should be noted here that social workers who accompanied women to be tested also stressed their own emotional tensions, and said they felt helpless. One social worker articulated her feelings by revealing how much she was torn by the whole procedure: “From one side, I really wanted her to know her condition, so as to plan for the future, and make it a safer one. But I also felt it is so unfair to be sexually abused, and then [have to] go through such a vicious process of torture … to run away from a culturally inhumane destiny…a destiny that might end up in her killing”.

It was reported that Amal’s medical examination revealed that she had indeed lost her “virginity” and that her hymen was “totally rotten”, and that she needed to search for a way to save herself from the deadly consequences that awaited her. Eventually, Amal was engaged to a young man, and one day when he slept over at her house Amal came to the realization that the engagement might be a way out. The desperation of these women is revealed by her narrative:

I decided that the best way not to go back to that awful chair (the chair where the IVT had been conducted) and not to allow anybody to touch me down there to get carried away with my fiancée and then allow him to sleep with me. I know I will be cheating on him, [meaning that she is cheating his trust by pretending to be a virgin] but he will forgive me for I have no other choice. …otherwise I will be killed, or should go back to repair the hymen…and no…I can’t go back to that awful place. My feeling that I am evil, and [my] anger on my self increased that night, for when he penetrated me, I started bleeding that meant that I was a virgin. My anger towards myself, the physician and towards the social worker that told me that this is a very trusty doctor increased, I became very nervous and very sad. Now… I lost my virginity and my honor with my fiancée when I could have enjoyed it with him like all young girls on my wedding day. I was facing one problem, that is my fear of losing my virginity, now I have two more problems, my fear that my fiancée will tell someone or take advantage of the fact that I Salamet nafsi (gave my self to him willingly), maybe he will leave me, maybe in the future he will use it against me. …he might tell my children that he married me to Yusturni (prevent my social ridicule). I also need to find a way to face my in-laws and family if they ask to see the blood, my honor, on my wedding night. To conclude, I had one problem, now I have to face many more.”

Given the context in which Amal’s narrative takes place, in which women are perceived as having an evil and omnipotent sexuality, the fact that they would blame themselves is no surprise (Mernissi, 1975) Their narratives reveal that the examinations to test virginity were often cursory, and the results of the IVT were not precise and neither were the reports accurate. When juxtaposing the voices of victims with the voices of other interviewees, one learns that being under the threat of femicide or what is otherwise termed ‘entering the death zone’ (Shalhoub-Kevorkian, 2002) increased the anxiety and fear of the victims, thereby allowing social control agencies (medical, legal, and cultural) to gain further authority over the victims.

One model that was developed to help victims disclose their abuse in a safer milieu was termed “Blocking Her Exclusion”. This model activates potential familial, religious, tribal and other socially acceptable resources to support victims in coping with their abusive trauma, while building a victim-centered pro-active model of intervention (Shalhoub-Kevorkian, 2000). For example, the model uses existing resources such as cultural and religious anecdotes to convince the victim’s family and other officials that the ethics of victim protection is ingrained within the culture and not an imported, Western value. In doing so, the therapist, along with a lawyer and the approval of the parties involved, prepares a document that precisely states the agreed upon value of protecting the victim, and outlines the necessary steps that would facilitate that protection (for more details and actual examples of victim protection contracts see Shalhoub-Kevorkian, 2000).

However, legal professionals continue to stress the importance of conducting the IVT regardless of the psychological ramifications for the victims, as one prosecutor told us: “We need to refer all cases of sexual
abuse to the forensic medical doctor for a virginity testing. Even cases where a man touched, played or kissed without any penetration, we need legally to refer her for [an] examination—otherwise we accuse her of lying…and women do lie”. During our interviews, these professionals tended to generalize women and their behaviors based on their experiences with sexual abuse cases. They discussed case-studies, explaining that some victims reacted in (what they defined as) a “normal manner” as opposed to others who presumably reacted in an “exaggerated manner” that incriminated them. It should be noted here that the respondents definitions of “abnormality”, “normality”, or “exaggeration” were arbitrary and varied from one observer to another. While one perceived a woman’s silence or crying as normal, another gauged the same behavior to be obviously incriminating. However, the problem remains that such subjective opinions are repeatedly presented as “scientific” findings. And using this ostensibly “scientific-medical objectivity” approach to justify legal proceedings made some legal personnel look at the medical reports as non-negotiable empirical documents. Yet in four of our interviews with police officers and prosecutors, we learned that they used to read the content of the report to the tribal head, the woman guardian, or the prosecutor, and only after weighing their reactions would they decide whether, when and how to use the medical report.

One police officer stated: “In one of the cases, the Mukhtar wanted to help the victim’s family—so he asked me to give him a copy of the medical report, and I did. Then the family reached a resolution whereby the cousin was willing to marry the victim, and I needed to call the forensic doctor and ask him to change the report and state that the girl is still a virgin. He totally refused, and [that] caused so much pain to the whole family. In the end, the girl’s father dropped the charges, and she married the cousin.” Another prosecutor shared with us the case history of a 17-year-old girl who was raped by her uncle. The medical examination affirmed that she had lost her “virginity.” Subsequently, the medical report was given to her father and the Mukhtar, and they both decided to marry her to a 49-year-old mentally challenged man. The prosecutor concluded: “Now she is living with him, and just had her first child—at least she was lucky.”

In other instances, we learned that medical professionals were willing to change their reporting. A lawyer stated: “I worked [on a] case whereby the report was changed four times”. When asked about such a claim a forensic doctor stated, “I need to survive, and if I won’t write what they ask me too, the tribe, or the police might cut my electricity or my water…the family could even hurt my kids”.

 Needless to say, stereotypical beliefs and prevailing gender discriminations regarding women’s behavior, personal history, and sexual acts, affected the direction of the investigation and influenced how legal and medical professionals acted. In addition, the intervention of the tribal system in searching for “solutions” and asking the assistance of medical professionals to provide them with medical reports, inflicted new abuses upon the victims such as coercing them to marry their rapists or institutionalizing them as “protection” from femicide. Moreover, as one social worker stated: “Some of the physicians know very well the cultural importance of female honor, and they use the victim and in some cases rape her, while promising to repair her hymen….”. Another physician told us: “Lately I examined a 15-year-old girl who was complaining from abdominal pain, [and] I found out that she was pregnant. I was so afraid to tell her parents, for we all come from the same village. I referred them to another physician in Hebron’s hospital, who told them her situation. The hospital informed the police and everybody knew about her. I know I could have saved her from her bitter destiny if I reacted differently, but I was worried about my clinic, my life, and my children….when it is a girl’s virginity, it became a matter of life and death……yes, she was stabbed…she was tortured, and she ended up burning herself to death…..you think I don’t feel that they might have killed her…but this is not my business.”

Moreover, beyond ethical and moral issues, the results of the focus groups raise the question whether such medical examinations violate basic international human rights for women. Our group discussions revealed that police officers, prosecutors, and other (formal and informal) legal personnel knew very well that the so called medical testing—in most cases—was nothing more than a means to perpetuate culturally sanctioned narratives which would often make it possible for the rapist to marry the woman involved, for families to kill women, and for judges to blame women for being abused in the first place. The cultural/political legacies and systems, in which the immediate medical and legal apparatus are embedded, add to the on-going failure of the society in general to acknowledge the victim’s voice, need, pain and rights, as well as the onset of the two Intifadas and the political oppression Palestinian society was subject to created a chaotic system of social control.

Conclusion

Our investigations into IVT reveal its hegemonic power not only to control and oppress the victim, but also to contribute to the victim’s social degradation or even death. Attitudes towards IVT are tied to larger views about women’s status in general and political attempts to control women and their sexuality. The ways in which social agents respond to IVT reflects the international debate on all forms of violence against
women, emerging from and reinforcing the social relationships that give men power over women. This hegemonic power is further empowered by the use of the medical system and the IVT as a patriarchal tool to inhibit women from gaining autonomy over their bodies. The quest for such autonomy is further hindered in areas of conflict, where political and social stability are absent and the social infrastructure cannot function independent of that conflict. Ironically, the liminal condition of Palestinian statehood—as a culture and material space continually in transition and stressed to the limits—also provides an opportunity for re-visioning a more optimistic social structure, one that urges policy makers to pay close attention to how women are implicated within the existing social nexus.

This study indicates that contemporary medical and juridical practices can indeed be used as tools of oppression, not surprisingly reflecting the dynamics of the political struggle between systems of domination, political legacy, and pervasive gender oppression. The political legacy facing Palestinian society, with its limited social resources, has not privileged discussions about the independence of women. In such a sociopolitical atmosphere, procedures such as the IVT become an almost easy mode of oppression. Our examination of the Palestinian case reveals the importance of the political project of the state in shaping and re-examining current medical and juridical practices that objectify women, particularly during periods of political conflict.

Theoretically, one should first remember that the examination of crimes against women cannot be divorced from the larger political and cultural contexts. Thus narrowing the analyses of sexual crimes to evidentiary, medical and individual aspects strips away the context of oppression. An analysis that insists on a more materialistic politics would be more pro-active in helping these women. Our policy implications suggest that we train medical and legal personnel and social workers to be more aware of the power struggle between systems of domination and to be sensitive to victims’ ordeals in such a social context. Medico-legal remedies may not be the only way to achieve change, but building a movement to eliminate IVT, to prevent professionals from abusing their power and to encourage professionals to respect women’s basic human rights must be a beginning: The intersections and interconnections between women’s rights as circumscribed and reflected in medical and legal policies and practices, professionals’ inability to listen to victims voices or pain, and the pervasive gender discrimination in the collective patriarchal context that inevitably increases in areas of political conflict demonstrate the urgent need to pose more challenging inquiries. Scholarship and research in this domain need to admit that medicine is political and not inherently or solely practical. We must therefore remain critical without abandoning medicine as a site of struggle. Second, we must recognize the power of medicine as a technology of gender. Our study calls for more research that would trace how women negotiate constructions of gender while refusing to slip into newer forms of determinism that keep women both powerless and helpless.

References


