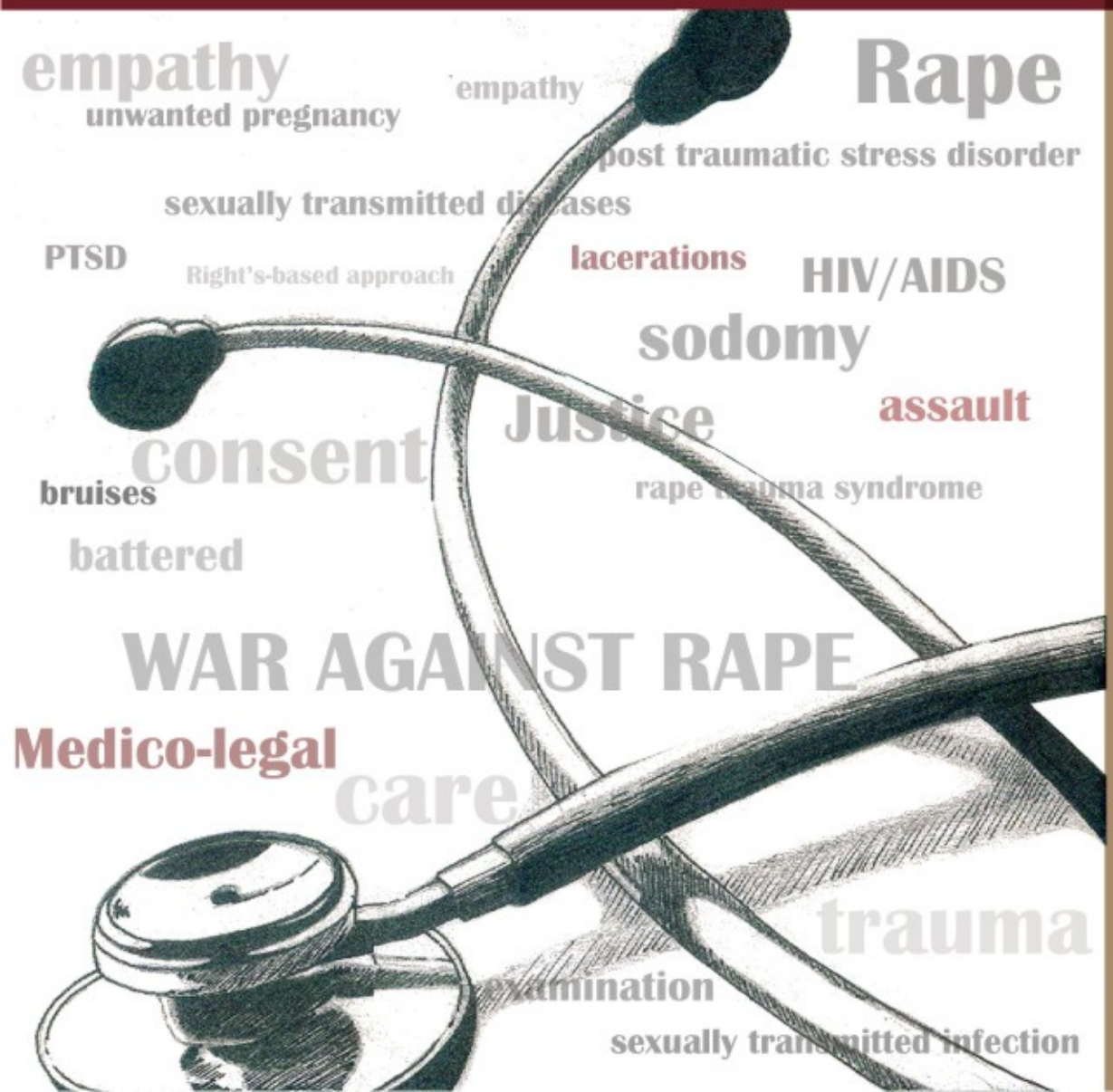
Best Practices in Medico-legal Care for Survivors of Sexual Assault

Introduction of Uniform Protocols in Medico-legal Services in Sindh Government Hospitals



War Against Rape (WAR)
Karachi

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Executive Summary

Violence against women is a problem of escalating proportions in Pakistan. Despite being a signatory of the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the Beijing Platform, and the Millennium Development Goals, the Government of Pakistan is struggling to address prevalent imbalances between men and women that lead to different kinds of discrimination and violence perpetrated against women and the girl child.

War Against Rape (WAR), Karachi, has been working on the issue of sexual and gender-based violence (SGBV) against women since 1989, with a view to providing timely services to survivors of rape, advocate for their rights and for the development of improved working procedures in public departments survivors come in contact with. WAR has more than 20 year's experience of working with public officials in the police, medico-legal, and judicial sector.

In 2010, WAR developed a Policy Paper for documentary reforms in the health sector's response to SGBV. A large-scale advocacy seminar was held in Karachi on 07 October, 2010, to direct attention to the medico-legal sector, which remains a neglected area within the Health department. Thereafter, a series of consultations were held in Karachi, Lahore and Islamabad, with focus-group discussions on the content, practicality and implementation strategy around the protocols contained in the Policy Paper. More than 60 experts from health, civil society, media, legislation, medico-legal sector, law enforcement and the legal sector were consulted with their inputs incorporated to give final shape to the recommendation in this Paper.

This document contains a complete set of protocols or Standard Operating Procedures (SoPs) for providing medico-legal care to women and child survivors of sexual assault.

We hope that relevant government departments will find this document of utmost benefit in taking policy decisions for improved health sector response to SGBV all over Pakistan.

Acknowledgements

This paper is a publication of War Against Rape and has been written based on the experiences of WAR in dealing with cases of rape in Karachi through direct intervention at the stage of medico-legal examinations. Since 2003, WAR has been dedicated to improvements in the health sector in its response to sexual and gender-based violence against women and the girl child. In this regard, a research study was conducted in 2005 with partner organizations including Aahung and the Human Rights Commission of Pakistan, which was subsequently published by Aahung in 2006. The study accesses the infrastructure of medico-legal centers in three major government hospitals in Karachi where these services are available to women and girl survivors of rape. The study suggested various recommendations for improving the working procedures of the sector vis a vis, facilities and equipment, budgeting, trainings and duties, documentation, monitoring and evaluation and ensuring a holistic approach to servicing. This document has been developed by WAR to address the last aspect of medico-legal care: comprehensive and rights-based approach to health care and service provision.

The people who have been involved in the process of advancement include, Amna Mehwish, ex-Project Coordinator of WAR, Rahal Saeed, ex-Director at Aahung, Marium Ahmed, Tanya Ghani, Nida Butt, Amber Zuberi at Aahung, Saba Zia, Saira Mazhar and Nadia Harron for contributing to the research design, the Sindh Health Department, Ayesha Khan at the Collective for Social Science Research, Danish Zuberi, Board Member at WAR and Aahung, and Sheena Hadi, present Director at Aahung.

A special thanks is also extended to Dr. Kaleem Sheikh, senior Medico-legal Officer at the Civil Hospital, Karachi, for providing useful insights into the workings of the medico-legal sector in Sindh and for supporting WAR in its work whenever approached.

Throughout 2010, the following individuals from the civil society worked with WAR from Karachi, Lahore and Islamabad for the final development of Sexual Assault Documentation Protocols (SADP), initially developed by WAR in the beginning of 2010:

Karachi:
Malik Irfan, Sanjog; Mahnaz Rahman, Aurat Foundation; Aisha Mehnaz and Dr. Shehnaz Yasin, Konpal; Abdul Hai, HRCP and Dr. Nusrat Shah, gynecologist.

Lahore:
Sidra Humayun, Coordinator WAR (Lahore); Mehboob Ahmed, HRCP; Advocate Misbah Kokab; Habana Naz and Asima Manzoor, Shirkat Gah; Saleha Javed, AASHA; Atif Adnan, Sahil; Shamsa Ali, APWA; Nabeela Shaheen and Naureen Zelma, Aurat Foundation; Dr. Naeem Zafar, Pehchaan; and Adv. Shamim Malik.

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State officials who contributed to the final SADPs included: Advocate Abdul Maroof, District Deputy Public Prosecutor, Sindh Ms. Keshwar Zehra, Member National Assembly; Ms. Humaira Alwani, Member Provincial Assembly, Sindh; SHO Abdul Sattar and SHO Muhammad Israr, Ms.Ayesha Javed, Member Provincial Assembly, Punjab.

The expertise that these individuals and institutions brought to the consultations helped fine tune the manual and make this document more comprehensive.

Finally, this report has been researched & written by Sarah Zaman, Director at WAR since 2006.

Introduction

Sexual assault is a common, widespread and insidious problem that has serious physical, psychological, emotional and social consequences. (White, 2007)[1] It is also one of the least reported gender-based criminal offences committed against women worldwide. Data from different countries indicate that, in some parts of the world at least, one woman in every five has suffered an attempted or completed rape by an intimate partner during her lifetime. Furthermore, up to one-third of women describe their first sexual experience as being forced.[2]

Among the many health consequences of sexual assault are unwanted pregnancies, unsafe abortions, sexual dysfunction, infertility, urinary tract infections, pelvic pain and pelvic inflammatory disease, sexually transmitted diseases and infections (STDs and STIs), human immunodeficiency virus/ acquired immunodeficiency syndrome (HIV/AIDS) and adoption of risky sexual behaviors (e.g. early and increased sexual involvement, and exposure to older and multiple partners).[3] Physical injuries and wounds may also result. Psychological, emotional and general mental health consequences of sexual violence can be equally, if not more long lasting. These include foremost Post-traumatic Stress Disorder (PSTD) and Rape Trauma Syndrome, the effects of which can be relatively mild to fatal, including suicides and substance-related deaths. Multiple research studies show that survivors of sexual assault require more hospitalization and medical care due to a myriad of health problems they face post-assault.

As the health consequences of sexual violence are varied, often severe and may get progressively worse if care is not provided in a timely and efficient manner, it is essential to recognize and treat sexual violence as a health care issue, which demands a concerted and sophisticated response from health care providers. In the case of Pakistan, this help can be provided at a primary level through the medico-legal sector.

However, a research[4] conducted by WAR in collaboration with its partner NGOs in Karachi on the medico legal-sector of the city and WAR's own interaction with the medico legal-sector over the past 20 years have consistently shown that medico-legal services in Karachi remain woefully inadequate in dealing with cases of sexual violence effectively, i.e. with regard to physical treatment and psychological recovery. Although the medico-legal sector in Karachi has been developing and improving services[5], reform efforts have not been consistently applied across the province of Sindh[6] and even between the various medico-legal centers in Karachi. Consequently, minimum standards of care as enshrined in various international human rights covenants are not being met. This is contrary to some of the measures for improving medico-legal services in Sindh, as enshrined in the Health Policy, Sindh, 2005[7].

Therefore, there is an urgent need to address some of the more blatant problems afflicting this sector, in order to not only improve the thoroughness of examinations, the comprehensiveness of reports prepared post-examinations, the quality of care given to survivors, but also to enhance women and child survivors' access to justice and legal redress.

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[1] White, J. D. (2007). *The Uses and Impacts of Medico-legal Evidence in Sexual Assault Cases: A Global Review.* Geneva: World Health Organization.

[2] Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002. 149" 181

[3] *Guidelines for medico-legal care of victims of sexual violence.* World Health Organization, Geneva, 2003.

[4] WAR, Aahung and HRCP. (2006). *A Research Study on the Medico-legal Sector in karachi.* Karachi. Pakistan: Aahung.

[5] There is some evidence to the contrary, such as the dwindling number of Women MLOs, which was 8 in 2005 and has now gone down to 4, catering to an ever growing population in the city of Karachi.

[6] The accessibility and quality of medico-legal services is purportedly worse in other cities of Sindh compared to Karachi.

[7] Health Ministry, Sindh. (2005). *Health Policy*. Sindh.

Definition of Sexual Violence

The World Health Organization (WHO), defines sexual violence as 'any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, included but not limited to home and work.'

'Coercion' can include physical force, as well as psychological intimidation, blackmail or other threats, or when the person aggressed is unable to give consent.

In the most basic of terms, sexual violence can be defined as a wide array of non-consensual sexual activities, with the use of physical or emotional force or to engage in abusive sexual contact, which may be perpetrated by partners, friends, family, acquaintances, or strangers[8].

While rape is one of the most obvious forms of sexual violence, it can include a wide range of unwanted sexual contact including child sexual abuse, incest, exhibitionism, voyeurism, obscene phone calls, fondling, and sexual harassment[9], ridiculing a woman to try to limit her sexuality, controlling her reproductive choices, withholding sexual activity in an attempt to punish or hurt her, anthologizing or treating women as immoral or sinful for expressing sexual needs or desires[10].

Types of Sexual Violence

1. Rape

Rape refers to forced sexual intercourse against a person's will. it is a violen, thostile assault that a person commits to dominate, overpower and humiliate the other person.
Rape may or may not involve actual overt violence. A person can be raped if he/she is coerced into performing a sexual act. Coercion may take a variety of forms. It may involve physical force, threats of bodily harm, financial deprivation or dire consequences. A common feature of this coercion is the abuse of power to control the victim.

Rape is commonly further sub-divided into other categories:

(a) Marital / Partner rape is defined as sexual acts committed without a person's consent and/or against a person's will when the perpetrator is the individual's current partner (married or not), previous partner, or cohabiter. Marital rape is one of the least talked about forms of sexual assault due to personal and societal barriers to reporting it. This form of rape is further divided:

i. **Battering rape**- the experience of both physical and sexual violence within a relationship. Some may experience physical abuse during the sexual assault. Others may experience sexual assault after a physical assault as an attempt to "make up."

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[8] "The Facts About Sexual Violence", http://www.vaw.umn.edu/documents/inbriefs/sexualviolence
[9] Is Islam and Muslims Oppose Violence Against Women; A guide for Muslim Women, Islamic Womens Welfare Council fo Victoria 2010
[10] *Ibit.*

ii. **Force-only rape**- motivated by a perpetrator's need to demonstrate power and maintain control. Therefore, he/she asserts his/her feelings of entitlement over his/her partner in the form of forced sexual contact.
iii. **Obsessive / Sadistic rape**- involves torture and perverse sexual acts. Such rape is characteristically violent and often leads to physical injury.

(b) Acquaintance assault involves coercive sexual activities that occur against a person's will by means of force, violence, duress, or fear of bodily injury. These sexual activities are imposed upon them by someone they know (a friend, date, acquaintance, etc.).

(c) Stranger rape is further divided into three major categories:

i. **Blitz sexual assault**- The perpetrator rapidly and brutally assaults the victim with no prior contact. Blitz assaults usually occur at night in a public place.
ii. **Contact sexual assault**- The suspect contacts the victim and tries to gain her or his trust and confidence before assaulting her or him. Contact perpetrators pick their victims in parties, lure them into their cars, or otherwise try to coerce the victim into a situation of sexual assault.
iii. **Home invasion sexual assault**- When a stranger breaks into the victim's home to commit the assault.

(d) Systematic rape during war. This is where rape is used as a weapon of war, whether to spread fear or as a tool for ethnic cleansing, etc.

2. Sexual assault
Unwanted sexual contact that stops short of rape or attempted rape. This includes sexual touching and fondling (some use this term interchangeably with rape).

3. Sexual harassment
Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature in which submission to or rejection of such conduct explicitly or implicitly affects an individual's work or school performance or creates an intimidating, hostile, or offensive work or school environment.

4. Voyeurism
Watching for the purposes of sexual gratification, people engaged in a private act, for example undressing, urinating, or engaging in sexual activity, without their consent.

5. Exhibitionism
Compulsion to reveal a body part, often one's genitals, to an unsuspecting stranger.

6. Sexual photography
Taking photographs of a sexual nature without the consent of the subject(s) and/or public display of images taken in a private context without the subject's consent

7. Forced marriage or co-habitation

A forced marriage is a marriage that is performed under duress and without the full and informed consent or free will of both parties.

8. Denial of rights of bodily integrity

Denial of right to use contraception or to adopt other measures to protect against sexually transmitted disease. Other examples could include forced abortions.

9. Violent acts against the sexual integrity of women

This could include female genital mutilation, obligatory inspections for virginity and customary practices such as marrying women to the Quran.

10. Child sexual abuse

Sexual contact by force, trickery, or bribery where there is an imbalance in age, size, power, or knowledge.

Contact can include fondling; obscene phone calls; exhibitionism; masturbation; intercourse; oral or anal sex; prostitution; pornography; and any other sexual conduct that is harmful to a child's mental, emotional, or physical welfare

11. Incest

Incest is where sexual contact between persons who are so closely related that their marriage is illegal (e.g., parents and children, uncles/aunts and nieces/nephews, etc.). This usually takes the form of an older family member sexually abusing a child or adolescent.

12. Child Abuse

Child abuse takes place when a child is harmed by someone else physically, psychologically, or by acts of neglect.

13. Sexual exploitation by a helping professional

Sexual contact of any kind between a helping professional (doctor, therapist, teacher, priest, professor, police officer, lawyer, etc.) and a client/patient.

14. Forced prostitution and trafficking of people for the purpose of sexual exploitation

The term 'Forced Prostitution' refers to the process of coercing women, men, children to exchange sexual services for money or other payment against their will. Individuals can be threatened with violence and/or sexual abuse, falsely imprisoned, held through debt-bondage, or in other ways coerced; The 'owner', exploiter or 'pimp' will sometimes split the revenue from the sexual act with the prostitute, sometimes simply offer the prostituted individual a minimum by which to live[11].

Prostitution and trafficking are sexual offences that result in economic profit for perpetrators. Described by survivors as "paid rape," prostitution provides buyers (johns, tricks, dates) constant sexual access to women and children.

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[11] Sex work and Sexual Exploitation in the European Union, http://people.exeter.ac.uk/watupman/undergrad/aac/index.htm

Trafficking is a direct result of cultural and economic forces which sweep a woman or child into prostitution including not only coercion, manipulation, deception, initial consent, and family pressure but also past or present family and community violence, economic deprivation, racism, and conditions of inequality between the sexes[12]. Since pimps/traffickers move people to wherever they are sold for sex, a better definition of trafficking would include movement of people within a country as well as across international borders for the purpose of sexual exploitation

15. Dating and domestic violence

Any act, attempt, or threat of force by a family member or intimate partner against another family member.

Dating and domestic violence occurs in all socio-economic, educational, racial, and age groups. The issues of power and control are at the heart of family violence. The batterer uses acts of violence and a series of behaviors to gain power and control. Examples of such behavior include intimidation, threats, isolation and emotional abuse.

16. Stalking

The exact definition of stalking varies, but in general, stalking refers to "a course of conduct directed at a specific person that involves repeated visual or physical proximity, non-consensual communication, or verbal, written, or implied threats, or a combination thereof, that would cause a reasonable person fear." Examples of this behavior include:

- Repeated undesired contact (phone calls, emails, letters, show up unexpectedly, etc.).
- Following or laying in wait for the individual.
- Making threats to the individual or her/his family.
- Any other behavior used to contact, harass, track, or threaten the individual.

17. Drug facilitated assault

This is defined as when drugs or alcohol are used to compromise an individual's ability to consent to sexual activity. In addition, drugs and alcohol are often used in order to minimize the resistance and memory of the victim of a sexual assault.

18. Hate crime

Hate crimes are defined as the victimization of an individual based on that individual's race, religion, national origin, ethnic identification, gender, or sexual orientation.

Acts of such crimes include rape, sexual assault, physical assault, verbal or physical harassment, vandalism/robbery and attacks on homes or places of worship.

While any targeted group can experience rape and sexual assault as a form of hate crime, women are one of the most noted victims of this particular form of hate crime. Many believe that all violence against women, including rape and sexual assault, is a hate crime because it is not simply a violent act, but is "an act of misogyny or hatred of women" (Copeland & Wolfe, 1991).

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[12] "*Prostitution and Trafficking of Women and Children from Mexico to the United States*", Marisa B. Ugarte, Laura Zarate, and Melissa Farley, Journal of Trauma Practice (2003) 2 (3/4): 33-74; Also appears in: Farley, Melissa (ed) (2003) *Prostitution, Trafficking, and Traumatic Stress*. Binghamton: Haworth Press.

Effects of Sexual Assault & Rape

The health consequences of sexual violence are various and range from physical impairment and ailment to psychological trauma. Some to the physical problems caused by an assault may include:

- unsafe abortion;
- sexually transmitted infections (STIs), including HIV/AIDS;
- sexual dysfunction;
- infertility;
- pelvic pain and pelvic inflammatory disease; and
- urinary tract infections.

Some of the psychological problems include:

- distressing memories or dreams;
- loss of interest in what were once meaningful activities;
- emotional numbing;
- increased anger feelings;
- increased health problems (somatoform);
- feelings of detachment or separation from others and self (social withdrawal);
- restricted range of emotions, such as inability to have loving feelings; and
- Major Depressive Disorder; such as
- *Post Traumatic Stress Disorder* (PTSD), and
- *Rape Trauma Syndrome.*

Rape Trauma Syndrome

Rape trauma syndrome occurs in three stage: the acute stage, the outward adjustment stage and the resolution phase. The acute stage in characterized by severe psychological turmoil with possibly physical problems.

Common symptoms over the stages include:

- mood swings;
- feelings of humiliation;
- degradation;
- shame;
- guilt;
- embarrassment;
- self-blame;
- defenselessness;
- hopelessness;
- anger;
- revenge;
- fear of another assault.

Post-traumatic Stress Disorder (PTSD)

PTSD is more common in survivors that have experienced a violent attack with weapons or facing a life threatening situation at any stage of the assault.

Symptoms of PTSD may manifest as intrusions and avoidance.

Intrusions involve reliving the experience and include:

- flashbacks;
- nightmares; and / or
- recurrent, intrusive thoughts that stay in the mind.

Avoidance symptoms include:

- feelings of numbness;
- self-imposed isolation from family, friends and peers;
- intellectualizing the incident;
- distractions;
- increased drug or alcohol use;
- engaging in high-risk behaviors; and/or
- avoiding places, activities or people that remind them of the assault.

Other common PTSD symptoms include dissociation, hyper-vigilance, irritability and emotional outbursts.[13]

[13] *Guidelines for medico-legal care of victims of sexual violence.* World Health Organization, Geneva, 2003.

Role of the Medico-legal Sector

The medico-legal sector in Pakistan is responsible for conducting medico-legal examinations in cases of traffic accidents, alcohol and drug abuse, gun violence, bomb blasts, post mortems of all unnatural deaths (suicide and homicide) and rape/sodomy (of both the survivor and the accused). Medico-legal Officers (MLOs) who can only be found at designated Government hospitals conduct these examinations and issue medico-legal certificates which constitute medical evidence in litigation and suggest such things as the use of force, coercion or physical violence during sexual intercourse by the perpetrator or resistance by the victim.

Traditionally, the role of MLO is limited to conducting medico-legal examinations, collecting forensic evidence and issuing a report of their findings. However, in terms of sexual assault, medico-legal officers are increasingly fulfilling curative functions in many parts of the world, along with providing psychosocial support, counseling and preventing communicable diseases such as AIDS, HIV, STDs and STIs.

The Need for Standard Protocols for Care

The examination of survivors of alleged sexual offences is one of the most difficult tasks in forensic medicine. The danger of allowing true offences to go unpunished as well as the injustice of wrong convictions make the responsibility of the examining physician very heavy (D'Souza, November 1998, Updated December 2004).[14] It is therefore mandatory that the MLO restrict her/his duties to high levels of professionalism and objectivity, free of bias and jugement. It should be borne in mind that it is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination (World Health Organization/ United Nations High Commissioner for Refugees, 2004)[15].

Standard protocols for medico-legal evidence collection and documentation have long been in use by developed countries, whereas we in Pakistan are still struggling to institutionalize this approach. Most cases of sexual assault result in acquittals due to non-substantive medico-legal and forensic evidence in the form of carefully documented reports. This has serious implications for the criminal justice system in terms of its duty to mete out justice to those whose rights have been violated. According to one study in particular, documented injury extent has a significant positive association with both filing of charges and conviction (of accused)[16]. In the absence of such evidence, courts extend '*benefit of doubt*' to the accused, with the result that rapists are acquitted to the detriment of other potential victims and the efficacy of the entire criminal justice system is undermined.

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[14] DSouza, D. L. (November 1998, Updated December 2004). *Sexual Assault of Women and Girl Children: Collection of Medical and Forensic Evidence, Medical Treatment and Psycho-social Rehabilitation; A Manual and Examining Kit for the Examining Physician.* Mumbai, India: Center for Enquiry Into Health and Allied Themes (CEHAT).

[15] World Health Organization/ United Nations High Commissioner for Refugees. (2004). *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced* . Italy: WHO/UNHCR.

[16] McGregor MJ, Du Mont J, Myhr TL. Sexual Assault Forensic Medical Examination: Is Evidence Related to Successful Prosecution? Ann Emerg Med. 2002.

Steps Included in this Protocol

The steps covered in this protocol include:

Human Rights of Survivors of Rape[17]

Rape is a form of sexual violence, a public health problem and a human rights violation. Rape in war is internationally recognized as a war crime and a crime against humanity, but is also characterized as a form of torture and, in certain circumstances, as genocide. All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Governments have a legal obligation to take all appropriate measures to prevent sexual violence and to ensure that quality health services equipped to respond to sexual violence are available and accessible to all.

Health care providers should respect the human rights of people who have been raped.

Right to health:

Survivors of rape and other forms of sexual abuse have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way "revictimize" rape survivors.

Right to human dignity:

Persons who have been raped should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.

Right to non-discrimination:

Laws, policies, and practices related to access to services should not discriminate against a person who has been raped on any grounds, including race, sex, color, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.

Right to self-determination:

Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment (e.g. emergency contraception and pregnancy termination, if the law allows) are personal ones that can only be made by the patient herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.

Right to information:

Information should be provided to each client in an individualized way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, adoption). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.

Right to privacy:

Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment.

Right to confidentiality:

All medical and health status information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor. In cases where a charge has been laid with the police or other authorities, the relevant information from the examination will need to be conveyed.

[17] World Health Organization (WHO), 2004

Steps in Providing Medico-legal Care to Survivors of Rape

Preparing the Survivor for the Examination

Concern for the welfare of the patient extends to ensuring that patients are able to maintain their dignity after an assault that will have caused them to feel humiliated and degraded. In addition, medical and forensic services should be offered in such a way so as to minimize the number of invasive physical examinations and interviews the patient is required to undergo.[18]

To prepare the survivor for the examination:

- Introduce yourself and ask how you can be of assistance;
- Ascertain that the survivor understands why s/he has come or been brought to you;
- Explain what is going to happen during each step of the examination - why it is important, what
- it will tell you, and how it will influence the care you are going to give her;
- Explain that she is in control of the pace, timing and components of the examination;
- Reassure the survivor that the exam findings will be kept confidential;
- Ask her if she has any questions;
- Ask if she wants to have a specific support person present;
- Review and have the survivor sign the consent form;
- Limit the number of people allowed in the room during the exam;
- Undertake the examination as soon as possible; and
- Do not force the survivor to do anything against her will.

Obtaining Informed Consent

Medico-legal Officers (MLOs) should obtain informed consent from the client before proceeding with the examination. They should use non-technical and simple terms to inform the client of the purpose of the examination, outline the various steps involved in the examination, and notify the client about his/her right to refuse the examination.[19]

Obtaining informed consent for the examination and for the release of information to third parties is a crucial component of the service. Obtaining informed consent means explaining all aspects of the examination to the survivor. It is advised that emphasis is laid on the matter of the release of information to other parties, including the police, magistrates and courts. This may be necessary if there are obligations on the MLO to disclose information to relevant authorities because of the nature of charge. However, the survivor should be given the option to refuse giving consent on disclosure of examination findings to anyone, especially if she/he does not wish to prosecute.

Survivors' consent should be obtained in a non-threatening and non-intimidating manner, one in which they feel in control of the situation, understand the options available to them and that the ultimate choice of disclosure belongs to them. This is particularly important as survivors have

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[18] *Guidelines for medico-legal care of victims of sexual violence.* World Health Organization, Geneva, 2003.

[19] Code of Ethics, National Association of Social Workers (1999), http://www.socialworkers.org/pubs/code/code.asp

recently been subjected to an act where their rights were violated in a traumatic episode over which they felt no control. Primarily as health care providers, MLOs have to duty to respect the wishes of survivors at all times.

Documenting Medical History

The primary purpose of taking a medical history is to obtain information that may assist in the clinical management of the patient or may help to explain subsequent findings, e.g. easy bruising or loss of consciousness or memory (Guidelines for Medico-legal Care of Victims of Sexual Violence, 2003).

Obtaining medical history is important as it allows examining doctors to know if there are pre-existing conditions that may interfere with any treatment prescribed, if the survivor was pregnant prior to or has conceived as a result of the assault (in which case, gynecological checkups including ultrasounds become necessary), or if there are any other health problems that may require further treatment (infections, diseases, wounds, injuries). For this reason, it is suggested that medical history be taken to ensure that appropriate care is provided.

Taking Sexual Assault History

Taking sexual assault history should be done as patiently and meticulously as possible as it may have serious legal implications. Since the time between a medico-legal examination and evidence presentation in court may be substantial, it is important to document as many details while the memory of the assault is still fresh in the survivor's mind. It is also important to record these details as they may not be reported in the First Information Report (FIR) lodged by the Police. It should be borne in mind, however, that survivors may be embarrassed to disclose and may even omit some details of the assault especially if it involves masturbation of the survivor by the assailant, anal and oral sex. There is most often a sense of shame and a need for concealment associated with sexual violation, which should be understood and respected at all times.

Since the medico-legal examiner may be the only person who gets to hear the survivor's story (if she/he decides not to prosecute), it is important that details of the assault be brought on record as much and as clearly as possible. Narration by the survivor may also provide clues to where the examining officer may look for evidence during the examination.

Documenting Forensic Evidence

Professor Edmond Locard, a pioneer in forensic science observed in his published work, *Traité de Criminalistique*, that, *"Wherever he steps, wherever he touches, whatever he leaves, even without consciousness, will serve as a silent witness against him. Not only his fingerprints or his footprints, but his hair, the fibers from his clothes, the glass he breaks, the tool mark he leaves, the paint he scratches, the blood or semen he deposits or collects. All of these and more, bear mute witness against him. This is evidence that does not forget. It is not confused by the excitement of the moment. It is not absent because human witnesses are. It is factual evidence. Physical evidence cannot be wrong, it cannot perjure itself, it cannot be wholly absent. Only human failure to find it, study and understand it can diminish its value."*

Emphasizing the value of forensic evidence in criminal cases and attributing lack of forensic evidence to a failure of investigators, was made in 1931 by Locard. Careful examinations and clear documentation of forensic evidence are critical to the legal process and survivors' ultimate access to legal redress.

Documenting injuries and collecting samples, such as blood, hair, saliva and sperm, within 72 hours of the assault may help corroborate the survivor's story and might help identify the aggressor(s) (through semen and DNA samples). If the person approaches the medico-legal examiner more than 72 hours after the rape, the quality of evidence available may be compromised. Whenever possible, forensic evidence should be collected during the medical examination so that the survivor is not to undergo multiple examinations that are invasive and most likely to be experienced as traumatic.

Documenting Injuries

The General Examination allows MLOs to look for signs and evidence of injuries that may be present on the survivor's body at the time of examination. It allows for observation of injuries/wounds resulting from bites, blows, burns, defensive responses, dragging, falls, fingernail scratches, flight, grasping, hair pulling, injections, kissing, ligature (manual compression), penetration, restraint, squeezing/pinching and whipping with a rope/cord.

All these evidences are important to record, in order to corroborate the testimony of the survivor and build a strong case for litigation. It is recommended that MLOs not only examine the survivor's person thoroughly but also to document any findings in a clear and concise manner, with due details of obvious and partially healed injuries.

Documenting Treatment and Prophylaxis

As mentioned earlier, the purpose of a medico-legal examination is two-fold: to provide individuals with basic and immediate healthcare; and to collect and record medical and forensic evidence.

The former assumes that the examining doctor will not only record important medical and forensic evidence but also provide care for inflictions and ailments that a survivor may present. Thus it becomes important for the MLO to check for and prescribe treatment for Sexually Transmitted Diseases (STDs), unwanted pregnancies, injuries and also to refer the survivor for psychological assessment and counseling, given that she/he may still be severely traumatized post-rape.

Primarily as a health care provider, MLOs need to include treatment and necessary prophylaxis as part of their routine work. Since survivors may present serious health issues, as discussed earlier, or may be in need of treatment for excessive bleeding, STI/STDs, injuries, wounds, etc, it is imperative that care and prophylaxis be provided as soon as possible.

Receipt for Forensic Evidence

The MLO after a thorough examination is required to send case property and forensic evidence for chemical and forensic testing. At this stage, critical evidence is handed over to relevant authorities of which, the examining MLO/hospital should have a record. This is suggested through the use of a *Receipt of Evidence*, also known in some parts of the world as a *discharge slip*.

In order to strengthen accountability and the chain of custody of important case property, this receipt should be duly filled and kept for record.

Issuing Medico-legal Certificate

After the completion of all relevant examinations and the documentation of crucial evidence, examining doctors should issue certificates to survivors or their guardians (in case of children), which is for their record. It is material evidence of the examination and is presented in court as such. It is prepared on the basis of the findings of the examination and also contains a provisional opinion of the MLO regarding the clinical findings.

Annexure - Rape Laws in Pakistan

Pakistan Penal Code, 1860; Criminal Laws Amendment, 2006

375.	**Rape:** A man is said to commit rape who has sexual intercourse with a woman under circumstances falling under any of the five following descriptions: (i) against her will. (ii) without her consent (iii) with her consent, when the consent has been obtained by putting her in fear of death or of hurt, (iv) with her consent, when the man knows that he is not married to her and that the consent is given because she believes that the man is another person to whom she is or believes herself to be married; or (v) With or without her consent when she is under sixteen years of age. **Explanation:** Penetration is sufficient to constitute the sexual intercourse necessary to the offence of rape.

376.	**Punishment for rape:** (1) Whoever commits rape shall be punished with death or imprisonment of either description for a term which shall not be less than ten years or more, than twenty-five years and shall also be liable to fine. (2) When rape is committed by two or more persons in furtherance of common intention of all, each of such persons shall be punished with death or imprisonment for life."

Best Practices in Medico-legal Care for Survivors of Sexual Assault
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For copies and more information, please contact:

WAR AGAINST RAPE
102, Pearl Crest, 18-C, 4th Commercial Lane,
Zamzama Boulevard, Defence Housing Society,
Phase V, Karachi - 75500
Tel: +9221 35373008; Fax: +9221 35830903
Email: waragainstrape.khi@gmail.com, info@war.org.pk
Website: www.war.org.pk