RAHAT is one of the projects of
Voice Against Torture - an interdisciplinary body for struggle against all forms of torture and for treatment and rehabilitation of torture survivors

Vol. 2, No. 3
August 2004

ISSN 1023-6805

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R A H A T

M e d i c a l J o u r n a l

Aims at instructing medical and allied practitioners
about torture, its consequences, and treatment

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Requests for new subscriptions should be sent to Editor,
RAHAT Medical Journal
House No. 340, Street No. 97, Sector G 9/4, Islamabad, Pakistan
E-mail: rahatmj@isb.paknet.com.pk
Website: www.voiceaganisttorture.org.pk

RAHAT
Medical Journal
Vol. 2, No. 3, August 2004

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EDITORIAL

RAHAT Medical Journal (RMJ) serves as a plinth for the healthcare and allied medical professionals in exchanging observations with their fellow professionals and others. Various contributions in the form of articles, research papers, and reports are published to discuss the situation of human rights with a special focus on torture, and the significant roles, the medical professionals are to contribute.

Dr. Rubya's article, “The Offence of Rape in the Islamic Law of Pakistan” discusses traditional Islamic laws, and presses the need for an objective re-interpretation of such splendid ideals. It also brings forth the situation arising from the admixture of religion and the patriarchal structure. Punishment of rape under tazir, and a woman's running into the risk of being implicated and accused in fornication/adultery, failing to convince the court that rape had taken place, has been discussed. The reason is that offence of fornication/adultery lies so close to the offence of rape that the severity of the rape offence as a heinous crime is reduced.

The “Istanbul Protocol” gives an overview of the manual drafted by various doctors and physicians, for the assessment of persons who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary or the relevant authorities, so that appropriate actions can be taken.

“Instructing Through Stomach” – a craftsmanship of Humayoun Awan, unfolds the hidden fact that food, basic of the necessities of life, need be provided to everybody and at any cost. Man has ever been tortured by the fellow being, and for this purpose food deprivation has proved to be one of the most effective of such methods. The whole of the discussion leads to the point that food deprivation may be termed as a form of torture, and that there is a need to revisit the existing definition of torture, making it more substantial.

“Neglected diseases, social justice and human rights: Some Preliminary observations” is a speech that was delivered during a conference International Workshop on Intensified Control of Neglected Diseases, Berlin, 10-12 December 2003. It has been found that the dimensions of neglected diseases arise particularly from the right to health, such as the accessibility/availability of quality essential drugs. Medicines and mechanisms devised to deal with neglected diseases do not always reach the masses,

living in poverty. Many of the drugs are expensive, or are simply not available in sufficient numbers, or may be inaccessible geographically a problem faced by rural areas, due to inadequate health systems. Three of the problems of availability, accessibility, quality of the drugs have been highlighted as well. Impact of neglected diseases on human rights, obligations of states, and other actors have been posed as well.

"Forensic Examination Regarding Children Whose Civil Rights Were Neglected" by Enache Alexandra, Petcu Magda, & Baboiu Oana-Eugenia,discusses the basic problem of determination of age of majority and that of minority, and many of the medical examinations are carried out for this purpose. It is thus the need to find out and noose crevices within the social, educational, economic or ethnic factors. Problem of age determination has been marked and the injurious methods used for it have been suggested to be worked with, since otherwise the existence of the person becomes questionable, without having any name in the registration list.

"Awareness About Child Sexual Abuse And HIV/AIDS Among School Going Children" is a worthwhile contribution by Fizza Sabir and Lala Rukh. Problem of Child Sexual Abuse and HIV/AIDS are prevalent throughout the world, and the worsening situation voices that the children may be protected by providing them with sex education. Educating the children can lead to the situation where children can be protected from such abuses. The subtle difference between sex education and education on sexuality has been discussed, and the need for such has been suggested. Sexual education inculcates in children the sensitization about the issue, leading to development of awareness towards sexuality. The role of parents in prevention of children from sexual abuse and HIV/AIDS has been mentioned as well.

Such contributions would serve as a bright star, proving to be advantageous in instructing the medical and allied connoisseurs towards getting a more tidy picture of the torturous activities rampant all over the world, thus providing them yet another opportunity to contribute to the well-being of masses in a further pragmatic manner.

Editor

TAKESH

The Offence of Rape in the Islamic Law of Pakistan

Rubya Mehdi*

In 1979, the Islamic regime of Pakistan introduced changes in the law of rape, providing Islamic standards of proof and punishment for this crime. The law concerning rape was made part of the ordinance, called ***The offence of Zina (Enforcement of Hudood ordinance, VII of 1979*** (The term ***zina*** encompasses adultery, fornication, rape and prostitution). The ordinance also deals with the crimes of fornication and adultery, which were not regarded as crimes in Pakistan before 1979 [1]. By contrast in most western countries, adultery is considered as immoral, but it is not punishable as a crime, the way it is in Islamic law. Fornication, on the other hand, is not even regarded as immoral, while it is also a major crime in the eyes of Islamic jurists. In almost every other country in the world rape is categorized as a crime different from fornication and adultery, but the ordinance of 1979 makes fornication and adultery, crimes similar to rape in Pakistan. This has complicated the already complex law of rape.

In 1977 General Zia took power after a military coup. When he failed to fulfill his promise of holding elections, he tried to justify his rule on the grounds that God had given him a special responsibility to turn Pakistan into a truly Islamic state. He made vast changes in the criminal law as well as in the constitution of Pakistan. Apart from ***zina***, he introduced Islamic punishments for theft and drinking of alcohol etc. General Zia's rule of ten years became known as a period of Islamization. He died in an air crash in 1988 and was succeeded by Benazir Bhutto. Her election campaign included the undertaking to abolish all laws discriminatory to women. But during her tenure she was not successful in reverting any of the laws passed under the movement of Islamization.

There was little discussion about the law of rape in Pakistan before 1979. This was probably because feminists (feminism in the context of Pakistan is not yet defined; roughly it means women fighting for women's problems/rights in Pakistan found other problems more important than the issue of rape. The changes to the Islamic law of rape in 1979 made women in Pakistan react strongly, because they posed a direct challenge to them. The definition of rape as it was provided in Islamic law of 1979 was similar to the definition provided in section 375 of the Pakistan Penal Code, prior to 1979, with the exception that the earlier law protected girls under the age of fourteen with whom sexual intercourse was prohibited with or without their consent. ***Zina*** ordinance does not

* Institute of Criminal Science, University of Copenhagen, Denmark

provide any protection to girls of less than fourteen. Moreover, the law before 1979 declared that rape in marriage is not considered as rape if the wife is over thirteen years of age. The major difference between the two laws is that the Islamic law has changed the punishment of imprisonment and fine (ten years' imprisonment and fine) into the punishment of whipping and stoning to death. The other major difference concerned the evidence about the offence of rape. In the 1979 ordinance very hard and fast rules have been prescribed for a witness, for example ***Tazkia-al-shahood*** enjoins upon a ***Qazi*** (Muslim judge) to inquire into the character of a witness and his credibility. The court must be satisfied that the witnesses are pious and abstain from major sins. Moreover, only Muslim male witnesses are accepted, which was not the case before 1979.

My purpose in this article is to focus on the issue that fornication and adultery have been made crimes similar to the crime of rape in the ***zina*** ordinance and subsequently emphasis on the crime of rape has been reduced. In a male dominated society such as Pakistan, this has given more power to men over women's bodies, in spite of the increase in severity of punishment. The Islamic Government of Pakistan maintained that the new law was in accordance with the Quran (the holy book of Muslims) and Sunnah (sayings and deeds of the prophet Muhammad pbuh), while feminists said it was a misinterpretation of the Quran. It may be that traditional Islamic law laid more stress on fornication and adultery than rape, because the phenomena of rape might not have been common in the early period or Muslim history. But whether or not this is the case, the traditional Islamic concept of rape is not applicable in Pakistan today, where women demand protection against rape.

The law of rape is unique in its nature, in the sense that its victims are female, and in practice the distinction between consensual sex and rape is very difficult to define in most cases, because non-consent is very difficult to establish legally. In western countries the main problem concerning this crime is the issue of how vulnerable the victim made herself to the rapist and thus it is easy to place the responsibility of the crime on the victim by focusing the blame on her. The dilemma facing the western legal system is that on the one hand a rapist should not go free; on the other an innocent man should not be convicted on the basis of an allegation made by a woman who consented to sexual intercourse.

The most usual form of rape in Pakistan (as far as we know at present) is the situation in which the rapist does not know his victim beforehand and the woman is suddenly attacked. Situations in which a man knows his victim are typically a landlord and peasant-women relationship or boss and lower class working women relationship etc. Young girls are more prone to fall prey to rapists, as the rapist can take advantage of their tender age and ensure that while raping they to not create too much of a racket. As a priority, women in Pakistan want protection from those forms of rape, in which there can be no question of consent on the part of the woman. Forms of rape in which the question of consent arises are usually when the offender knows his victim beforehand. This

situation is probably not very common in Pakistan because of the segregation of sexes, seclusion of women within their homes and the non-existence of free sexual morality.

I feel that criminologists and sociologists should not try to look at the rape phenomena in Pakistan the way it is looked at in western societies. Of course there are universal facts about the situation of women, but the problem should be looked at within the perspective of each individual country. For example, in the West the problem of rape is surrounded by discussions about genuine consent and victim-precipitated rape etc [1,2]. These are the issues that are found in almost all rape discussions in the west, whereas these issues are not relevant for Pakistan at all. What is important to focus on, when analyzing rape in Pakistan, is the political situation, because changes in rape law, along with other aspects of criminal law, were definitely made with political intentions. The Zia government used Islam as a means of obtaining legitimacy, i.e. to justify unconstitutional and illegal usurpation of power. In the process the govt. used Islam to deny women their rights. Making them special victims of these laws.

The next issue that is relevant to Pakistani and also western women is the gender role system and the need to understand patriarchal culture and male/female sex-role socialization. Pakistan is a Muslim patriarchal society, where a feminist interpretation of Islam has not really developed. The process of Islamization of laws has reinforced the already deeply rooted and staunch notions of male domination in Pakistani society. It has affected men's attitude towards women to the extent that when the movement of Islamization started and orders were issued for the women in government service to wear the chader (piece of cloth to cover their heads) incidents were reported, where men slapped women's faces in public for not covering their heads. This shows how Islamization made men feel powerful enough to control women. Feminists in Pakistan have not yet analyzed the rape phenomena within theses terms of reference. They are mostly engaged in agitating against the injustice done to women in particular rape cases.

The law of rape becomes more complicated when consensual sexual intercourse without valid marriage (i.e. fornication/adultery) is also considered a crime similar to that of rape in Muslim countries. Let us see the offence of rape as given in zina (enforcement of hudood) ordinance VII of 1979 of Pakistan.

Rape is defined, in the ordinance, as different from consensual sexual intercourse. It is defined as:
"… if he or she has sexual intercourse with a woman or man, as the case may be, to whom he or she is not validly married in any for the following circumstances, namely:

a. Against the will of the victim.
b. Without the consent of the victim.
c. With the consent of the victim, when the consent has been obtained by putting the victim in fear of death or of harm.

d. With the consent of victim, when the offender knows that the offender is not validly married to the victim and that the consent is given because the victim believes that the offender is another person to whom the victim is or believes herself or himself to be validly married."

In the non-Muslim world it is established that victims of rape are always female. But the zina ordinance makes females legally punishable for committing rape, i.e. the victim of rape could be a male. What it really means is not clear, since there has been no case where a woman would be accused of committing rape. Sabiha Sumar, a Pakistani writer on the subject argues that:

"… the concept of rape as defined in the zina ordinance defines a basic biological fact that a woman can not rape a man. Rape laws all over the world carry a certain bias against women and the accused is often freed on grounds that the woman may have seduced him. But since seduction implies consent on the part of man, as opposed to rape, which is pure force, a woman cannot be termed a rapist. Yet, ours is the only country where a woman can actually be punished for raping a man" [5].

Moreover the definition of rape excludes the possibility that a man may be guilty of rape, if he has sexual intercourse with his wife, knowing that she does not consent.

The ordinance, in accordance with traditional Islamic law makes rape liable to hadd punishment and to tazir punishment. The former are severe punishments in comparison to the latter. Hadd punishment for example includes stoning to death, amputation of limbs and whipping, while tazir punishment includes only whipping, imprisonment and fine etc. (for details explaining hadd and tazir) [5]. Rape categorized as liable to hadd is really of an academic nature, as the standards of proof required for it are so difficult to meet that there is very little possibility that a rapist would ever be punished for rape liable to hadd. Proof of rape liable to hadd could be in two forms. First, if the rapist makes a confession before the court. The confession can be retracted any time before the execution of punishment, in which case it cannot be carried out. Second, if at least four Muslim adult male witnesses, about whom the court is satisfied with regard to the requirements of Tazikayah-al-shuhood, that they are truthful, pious persons and abstain from major sins, give evidence as eye-witness of the actual penetration necessary to the offence. Now as far as the first form of proof is concerned it is difficult to imagine a rapist would come to court and confess his shameful act. Obviously there is a greater possibility that, if caught, he would try to refuse and plead not guilty, but a confession is deemed possible by Muslims, at least, in an ideal Muslim society. The second form of proof is also difficult to meet, because how could a rapist commit rape before four pious adult male witnesses? It should be noted that women and non-Muslims are not accepted as witnesses for this purpose. This is highly discriminatory against women and non-Muslims. The test to examine the credibility of the Muslim male witnesses, called Tazkiyah-al-shuhood is also very severe and difficult to meet, bearing in mind the moral

situation of Pakistani society. The rapist, knowing the law, would try to commit the offence when no men, at least Muslim men, are around. When even the evidence of the raped woman is not acceptable, this puts the offender in a very privileged position and it should be noted further that four pious male witnesses must have seen the actual penetration during the act of intercourse. It is not enough if three of them have seen the actual penetration and the fourth one has only seen the rapist running away from the place of offence.

For punishment liable to hadd, the status of the offender is a basic consideration. If the offender were a married person he would be stoned to death ("such the witnesses who deposed against the convict as may be available shall start stoning him and while stoning is being carried on, he may be shot dead, whereupon stoning and shooting shall be stopped"). If the offender is not a married person he would be punished with one hundred lashes in a public place and with such other punishment including the sentence of death as the court may deem fit, having regard to the circumstances of the case.

As I have mentioned above, there is very little possibility that hadd punishments would be inflicted on a rapist due to the strict standards of proof. This is why since the implementation of Hudood ordinance, no rapist has been awarded the hadd punishment.

According to the punishment, if the required standard of proof for hadd is not available, the offender would be liable to tazir, on the basis of other evidence. Punishment for rape liable to tazir is twenty-five years' imprisonment and thirty lashes. This is the working law of rape as almost all the cases are tried under tazir. For the purpose of punishment under tazir, no difference is made between a married and unmarried offender.

This is the law of rape, as it stands in the zina ordinance. The next aspect is to view the ordinance on fornication/adultery in relation to rape.

Generally, a view has prevailed in the west that the ordinance fails to differentiate between rape and fornication/adultery. Lucy Carroll (1983), an American scholar, provided some defense for the ordinance that sufficiently differentiates the two offences. She was right to the extent that the punishment for rape is twenty-five years' imprisonment as opposed to ten years' imprisonment for adultery/fornication in tazir. If an unmarried rapist confesses in order to attract hadd punishment, punishment in that case is not confined to one hundred lashes (as in adultery/fornication), but he would also be subject to "such other punishment, including the sentence of death". In spite of these two distinctions, the ordinance in practice fails to make a distinction between the two offences [6]. (See Table 1 for a comparison between rape and consensual sex, provided in the ordinance.) As we can see the standard of proof provided for in both offences is the same. Moreover, in practice the ordinance has confused both issues; one which is with

the consent of the parties involved, and the other which is without the consent and entails violation of the victim's mental and physical integrity. By making fornication/adultery in itself a crime, the ordinance reduces the stress on rape as a heinous crime, since fornication/adultery are also similar crimes in the eyes of the ordinance (at least the punishment in hadd for fornication/adultery is the same as that for rape).

Division of offender into Muhsan and non-Muhsan	**Proof for Zina and rape liable to Hadd**	**Punishment for Zina and rape liable to Hadd**	**Proof for Zina and rape liable to Tazir**	**Punishment of Zina and rape liable to Tazir**
Zina (consensual sex) Married offender (adultery)	(a) Confession of the crime (b) Four Muslim adult Truthful male eye-witnesses.	Stoning to death at public place	No standard of proof is provided, at discretion of judge.	Imprisonment for a maximum of 10 years, 30 lashes and a fine.
Unmarried offender (fornication)	(a) Confession of the crime (b) Four Muslim adult Truthful male eye-witnesses.	One hundred lashes at public place	No standard of proof is provided, at discretion of judge	Imprisonment for a maximum of 10 years, 30 lashes and a fine.
Rape				
Married rapist	(a) Confession of the crime (b) Four Muslim adult Truthful male eye-witnesses.	Stoning to death at a public place	No standard of proof is provided, at discretion of judge.	Imprisonment for 25 10 years and 30 lashes
Unmarried rapist	(a) Confession of the crime (b) Four Muslim adult Truthful male eye-witnesses.	One hundred lashes at a public place and other punishments including death sentence	No standard of proof is provided, at discretion of judge.	Imprisonment for 25 10 years and 30 lashes

In the case of fornication/adultery, men and women are medically examined; the man for sexual potency and the woman for the condition of the hymen and the existence of tears, and vaginal swabs are taken to see if they are stained with semen. The medical examination of the victims of rape is also done in the same way.

In the cases of fornication/adultery, the woman might plead non-consent on her part (that she was raped) in order to avoid punishment. A man, on the other hand, would be in a better situation if convicted for fornication/adultery instead of rape, as he would prefer a punishment of ten years to that of twenty-five years. He cannot avoid thirty lashes in either situation. In fornication/adultery he would also be liable to a fine, which is not imposed on a rapist.

By making fornication/adultery a crime, the ordinance has created many hardships for women. The law confuses the issue of rape with fornication/adultery. The demarcation line between the two offences is so thin in practice that when a woman comes into the court with a case of rape, there is a possibility that she might herself be convicted of fornication/adultery, because of lack of evidence to prove the case of rape. The onus of providing proof in a rape case rests with the woman herself. If she is unable to prove her allegation, bringing the case to court is considered equivalent to a confession of sexual intercourse without lawful marriage. And if the woman is impregnated as a result of rape, it further goes on to prove that sexual intercourse without lawful marriage took place. Now if she fails to establish a case of rape, she is in danger of being punished for a maximum prison sentence of ten years, thirty lashes and a fine for fornication/adultery. This happened in the case Safia Bibi v. The State, where the bare confessional statement of the girl was the only evidence against the male accused, and it was held that in the absence of any other evidence the male accused could not be convicted on her confession. The victim in this case was a blind girl. This case received considerable publicity in the national and international press. Her conviction was, however, set aside because of public pressure. In a similar case, a thirteen-year-old girl became pregnant as a result of being rape. She was unable to convince the court that rape had occurred and since her pregnancy was taken as a proof that sexual intercourse outside marriage had taken place, she was awarded the tazir punishment of thirty lashes and three years' imprisonment. She gave birth to the child in prison. The appellant court later reduced her sentence. Because of this situation women are more afraid than before to bring a case of rape to court, and in turn this could, of course, encourage rapists.

Combining the offence of rape with fornication and adultery is also reflected in the official data about theses crimes provided by the Bureau of Police Research and Development, Ministry of Interior, Government of Pakistan, which published a number of cases in the year of 1983 and 1984 on fornication, adultery and rape under one heading of zina, thus categorizing rape with fornication and adultery.

The law of rape in a society shows its attitude towards women. In the Pakistani male dominated society where great stress is laid on women's modesty and chastity, a woman is more likely to be blamed for making herself vulnerable to the rapist or introducing an element of stimulation for him (The act of going out alone at night and not covering her body properly could easily be attributed by the courts as provocation on the part of the woman). This attitude is reflected in most of the cases decided under the ordinance. In the case of rape, it is considered important that there are signs on the victim's body that show strong resistance. In the case of Bahadur Shah v. The State, the conviction of rape was converted into fornication/adultery, because the female doctor while examining the victim….."Did not observe any injury on the thighs, legs, elbows, arms, knees, face, back and buttocks of the victim", and it was held that "she was bound to sustain injuries like bruises, contusions, scratches or abrasions on different parts of her body as she was supposed to put up resistance". Torn cloths and other injuries to the victim are also an important element in a case of rape, because the universal contention is that it is important that a woman is not falsely accusing an innocent man of rape due to her own sexual and emotional problems. Therefore, actual physical violence is considered by legal practitioners to constitute proof that consent did not take place. As anywhere else in the world, courts in Pakistan are more likely to put the blame on a woman in cases where strong resistance is not visible.

There is no doubt that in Pakistan men are fully guarded against any false accusations of rape, while women are more vulnerable to being made victims of rape and then accused of sexual crime. In Pakistan, cases where the rapist has been convicted are mostly those involving young girls, where the act has been carried out in a very brutal way and in which considerable physical injury is inflicted on the victim. Whenever there is a delay in reporting the case, or in the medical examination, the accused gets the benefit of the doubt.

Asma Jahangir (1989), a woman lawyer in Pakistan, has noted the increase of police involvement in rape cases. She reported 15 incidents during 1988/89 where women in police detention were raped by police officers. Moreover, she has mentioned a study of women prisoners in Multan, according to which 43% of women convicts complained of sexual exploitation by the police. In the case Abdul Kalam v. The State, bail was granted to a police officer for an alleged rape, since the victim was found to be "habitual". No explanation was provided for the word "habitual". This increase in police crimes against women might be because of the general attitude of the law to protect rapists [3].

In conclusion I would say that the situation of rape cases in Pakistan is very alarming. First, it is impossible to inflict the severe hadd punishment on rapists because of its high standard of proof. Hadd punishment, in fact, could only be inflicted if rape were committed in public. (Because of the extreme vulnerability of women in rape cases, one

section of women in Pakistan has demanded severe punishments for rapists while others regard these Islamic punishments as inhumane and demand a different kind of law altogether.) Secondly, the testimony of rape victims has less weight than the testimony of Muslim males. For hadd punishment, a woman's evidence has no value. Thirdly, for punishment of rape under tazir, a woman runs the risk of being implicated as an accused in fornication/adultery if she fails to convince the court that rape had taken place. Fourthly, the offence of fornication/adultery lies so close to the offence of rape that the severity of the rape offence as a heinous crime is reduced. This reflects the social attitude of legislation towards women, which was also reflected in the policies of the former Islamic regime of Pakistan.

Two trends are already visible in the Pakistani feminist movement in reaction to the Shariat laws. The first trend is the movement that is an opposition force to the implementation of Islamic laws. According to these feminists, classical Islamic laws are outdated and they should be replaced by other kind of laws altogether. The second trend is the movement holds the idea that traditional Islamic laws need re-interpretation and that religion should not be confused with a patriarchal social structure.

It is doubtful if the first trend could be popular in Pakistan, keeping in mind the social and cultural reality of Islam in the country. Therefore, feminists in Pakistan argue that an Islamic framework for women's movement is necessary. This trend has already given rise to feminist interpretations of Islam, and would pave the way for women theologians in future [4].

Notes

- Adultery was a crime before 1979, to the extent that if a man had intercourse with the wife of another person without his permission, he would be punishable for adultery. Women were not punishable for this form of adultery. Punishment for such adultery was imprisonment for a term which may extend to five years or with a fine, or both. See section 497 of the Pakistan Penal Code 1860.
- offence of Zina. (Enforcement of Hudood) Ordinance VII of 1979. Section 6.
- Ibid. Section 8.
- Tazkiyah-al-shuhood in an obligation on the part of the qazi (muslim judge) to ascertain the righteousness of witnesses, that they are truthful persons, and abstain from major sins. Major sins are, for example, adultery, theft, drinking alcohol, embezzlement, murder and false accusation.
- Ibid. Section 7.
- Ibid. Section 5(2).
- Ibid. Section 10(3).
- Ibid. Section 10(2). With this reference the case of Ghulam Rasool v. The state.

PLD. 1982 Fedreal Shariat Court 209, is interesting, when it was discussed whether a fine should be imposed on a rapist as well as on a fornicator and adultery/adulteress.

- PLD 1985 Federal Shariat Court 120.
- See also the case of Fehan Mive v. The State. PLD 1983 Federal Shariat Court, in which the pregnancy of a woman was held as proof of her sexual intercourse with someone outside marriage. She could not establish a case of rape and was convicted for zina. She was sentenced to three years plus ten lashes. But considering her state of pregnancy it was held that giving birth to and rearing a child is essential, and therefore the sentence of whipping and imprisonment was suspended by the Federal Shariat Court until the child reached the age of two.
- Ch. Abdul Majeed A. Auolakh. Crime, punishment and treatment in Islamic Republic of Pakistan. Lahore 1986. p. 54
- Abid Hussain v. The State. PLD 1983 Federal Shariat Court 200. The court found the appellant woman to be "of easy virtue accustomed to sexual intercourse". Conviction for rape was set aside. See also: Khoedad Khan v. The State PLD. 1980 Peshawar 139.
- PLD 1987 Federal Shariat Court 11.
- See Sanaullah v. The State PLD. 1983 Federal Shariat Court 192. Khoedad Khan v. The State. PLD 1980. Peshawar 139.
- NLR 1986 SC 61.

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The Istanbul Protocol:The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment

[1] *Caroline Schlar,* [2] *Vincent Iacopino,* [3] *Önder Özkalipçi*

The Istanbul Protocol is the result of three years of analysis, research, and drafting undertaken by more than 75 forensic doctors, physicians, psychologists, human rights monitors, and lawyers who represent 40 organisations and institutions from 15 countries. The project was conceived in March, 1996, after an international symposium on "Medicine and Human Rights" held at the Department of Forensic Medicine, Cukurova University Medical Faculty, in Adana by the Turkish Medical Association. Co-ordinated by Physicians for Human Rights USA (PHR USA), the Human Rights Foundation of Turkey (HRFT) and Action for Torture Survivors, Switzerland, the drafting process culminated at a meeting in Istanbul in March, 1999, when the manual reached its final form.

Purpose of the Istanbul Protocol

The Istanbul Protocol is the first set of international guidelines for the assessment of persons who allege torture and ill treatment, for investigating cases of alleged torture, and for reporting such findings to the judiciary or the relevant authorities and any other investigative body and for documentation to provide evidence of torture and ill treatment so that perpetrators may be held accountable for their actions and the interests of justice may be served.

The documentation methods contained in the manual also apply to other contexts, including human rights investigations and monitoring, assessment of individuals seeking political asylum, the defence of individuals who "confess" to crimes during torture, and assessment of needs for the care of torture victims. In the case of health professionals who are coerced to neglect, misrepresent, or falsify evidence of torture, the manual also provides an international point of reference for health professionals and adjudicators alike.

[1] Caroline Schlar, licensed psychologist (former Action for Torture Survivors) and Swiss Red Cross, Switzerland

[2] Vincent Iacopino, MD, Ph.D, Senior Medical Consultant, Physicians for Human Rights-USA

[3] Önder Özkalipçi, MD, Staff Physician, Human Rights Foundation of Turkey, Istanbul

The Principles

The Istanbul Protocol also outlines minimum standards for state adherence to ensure the effective documentation of torture in its "Principles on the Effective Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment". These principles summarise the most salient features of the Protocol and represent minimum standards for States in order to ensure the effective documentation of torture. The guidelines contained in the manual are not designed as a fixed protocol, rather, they represent an elaboration of the minimum standards contained in the "Principles" and should be applied in accordance with a reasonable assessment of available resources.

International Recognition

The Istanbul Protocol has been submitted to the United Nations High Commissioner for Human Rights in August 9th 1999 and United Nations Special Reporter on Torture quoted the Istanbul Protocol in his annual report to the General Assembly in November 4th, 1999.

United Nations Human Rights Commission adopted the Principles of the Istanbul Protocol in April 20th, 2000. Furthermore, the Manual has been published in the professional training series (No.8) of the United Nations Office of the High Commissioner for Human Rights in the six official languages.

Future Perspectives: The Istanbul Protocol Implementation Project

In the beginning of 2003, the European Commission accepted a project proposal submitted by the International Rehabilitation Council of Torture Victims. The overall objective of this project is to establish a framework for the universal implementation of the Istanbul Protocol through the initial training and dissemination in the five following countries all over the world: Georgia, Mexico, Morocco, Sri Lanka, Uganda. Hereby, the aims of the Istanbul Protocol Implementation Project are to increase awareness, to obtain national endorsement and to provide an important and sustainable contribution to the prevention of torture.

Four organisations, the World Medical Association (WMA), the Human Rights Foundation of Turkey (HRFT), Physicians for Human Rights USA (PHR USA) and the International Rehabilitation Council for Torture Victims (IRCT) have joined together in order to implement the project between March 2003 and March 2005. Based on the Istanbul Protocol, a generic training manual and a short-form torture detection format are currently under construction and initial training sessions for health professionals and legal experts will be hold in all of the five countries before the end of 2004.

Official Publication

The Manual on Effective Investigation and Documentation of Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (the "Istanbul Protocol") is available in a number of languages on the United Nations website: (**http://www.unhchr.ch/pdf/8istprot.pdf**)

"Non-violence means avoiding not only external physical violence but also internal violence of spirit. You not only refuse to shoot a man, but you refuse to hate him."

(Martin Luther King, Jr.)

Instructing Through Stomach

Humayoun Awan

"OF Mans First Disobedience, and the Fruit
Of that Forbidden Tree, whose mortal taste
Brought Death into the World, and all our woe
With loss of Eden."

(Paradise Lost)

It was the advent of Adam that caused the jubilation on this otherwise serene and rather dull planet of earth. But the story of the descent of man has really been heart-rending. John Milton in his illustrious epic, ***Paradise Lost***, has opened the epic by mentioning the disobedience of human being; and the thing to be noticed is that the cause of disobedience has been the "***bread***" and nothing else. Adam and Eve were exiled from Eden for having harboring the desire of tasting the "forbidden fruit." The thing of note is that god created man to live in heavens but the lust for food became the cause of exile. The riddle is to find as to whether the price paid for the exile was worth it or not?

Ultimately the human being was brought on earth and got surrounded by multiple problems. There on earth man started fighting and creating divisions and subdivisions. As a consequence, society got a huge influx of economic, social, cultural, religious, political, ethnic, and many more divisions.

The economic division in the society marked the onset of problematic settings, leading to the torturous effects on the poor. Those in possession of affluence went to harass the deprived for any of their unwanted actions. Poor, even within their own legitimate precincts were never given their due and the basic right. They have been seen living on crusts of bread, and sometimes for days without having a single morsel.

History has a ruthless aspect of putting down the real happenings of life, chronically; however, literature has got a queer quality of exhibiting the stark realities of life in a mellow manner, and the objective of course remains the reformation of the society, through the employment of satiric and ironic instruments. Following verses by Robert Browning bring forth the shallowness of the people and the sham openhandedness exhibited towards poor. While delineating the character, in his poem, Fra Lippo Lippi, the author puts the conditions under which the child had been living in the society, of which he claimed to be an integral part; while on the other hand, the maltreatment of the society

Today the world has turned out to be a bit modern with the advent of globalization, so the individual happenings have been transformed into mass victimizations. Despite the fact, there have ever been efforts to make people live the full-lengths of their life spans and that they may be in a position to justify their living, by playing the part, they are born to; nonetheless, the provision of food has ever been neglected at the same time.

At the very onset it may appear debatable, but the fact remains that man is the only being, capable of rationalizing things, still seldom employing this rare faculty. It has been witnessed that through ages man has been hunting down its counter part for no specific reason whatsoever. The proclamation of being the wisest and the crown of creation dashes to the ground when it comes to the practical façade of life. When the practical aspect of life comes to the wiser, everything is put aside and what gets on the grey matter is simply choking the fellow, and nothing less. Man has devised a lot of methods as to bring another human being down to earth. Out of these, major being employed is strangling the one with whom you happen to disagree by cornering and snatching away the food, so that the lamenting enemy be subjugated without being involved in a duel. When it comes to the countries, the stronger the power, the greater the chances of putting others to task, in case of any unwanted or problematic happening. It is observed that the poor have ever been at the verge of certainty and uncertainty. It is never known as to when the mightier will be annoyed and ultimately annex and subdue the already trampled nation; and military has made this business a bit too easier.

Countries do always claim to be the civilized societies of the world, but this civility always comes up with a further gruesome self-portrayal at one point in time or the other. The greater the claims of being refined, the obnoxious have been the arrays of crimes, and sadly the whole of the human history has been speckled with such instances, wherefore reflecting the sorry state of affairs of the so-called civilized world.

There have been certain happenings in the world wherein the natural calamities do play a pivotal role in shaping up the destiny of the world, but the fact cannot be denied that man has really played its part with full participation. Countries have been made to suffer by the imposition of sanctions of various kinds food sanctions being the worst of all. Today the Americans maintain to be the torch bearers of the literate world. Atrocities that are being committed in the name of terrorism or injustice, amount to torture, even if the ***enemies*** are annexed or not. They may not do anything other than simply imposing sanctions on the countries so as to garrote them, ultimately bringing the rebellious down to knees.

Food serves as a stretch over to abridge life and death otherwise poles apart. The situation worsens when either the natural or the man-made calamities leads to breaking of this twiggy bridge of life, causing a fiasco. Most of all it is thought to be the admixture of both natural and man-made problems leading to knotty happening, but the fact

remains, that human being creates problem for the other fellow being and puts the yolk on the shoulders of nature, thus fulfilling the axiom, “we make our fortunes and we call them luck.”

Those stronger, have been known to be showing their strength towards the weaker in all possible way. Man in possession of power exhibits it towards the frail by maneuvering them; same holds true for countries, where the mightier have been trying to vanquish the weaker. In short, irrespective of the claims of being the beacons of light for the rest of humanity, power has made its possessors, dive deep from the heights of morality down to the mire of misdemeanor.

Recent happenings in Iraq may serve as an eye-opener for the rest of the world. Those living under sanctions for more than a decade, had still to pay far more than what they were convicted of committing. A nation that had to live under various sanctions for years had already been dashed to ground. Destruction of food-processing plants, water-treatment facilities, pharmaceutical plants, hospitals, communication channels, and military bases further crumpled the already down-to-earth nation. Now it seems all the more ridiculous finding American forces dropping parcels of food, medicine, baby-food, diapers, or even toys for those who have been deprived by the American forces themselves.

In case of Afghanistan, those who could not be easily subjugated, were shackled by sanctions and the purpose; however, was proclaimed to be noosing the despots of the country. The thing to be pondered over is that whether such sanctions imposed against the countries do play a role in taming the ruling class or the ones being ruled by such oppressors. It becomes evident that whether or not such cruel rulers are brought to the preconceived rectilinear path, the general public suffers both at the hands of their masters at home, and that of the self-proclaimed benefactors of humanity from around the world. By the imposition of sanctions the miseries of the poor are aggravated and in actuality nothing more than this is achieved.

In both the above cases masses have been made to suffer by not being provided with food a thing that caused the expulsion from Eden, and made man to inhabit the world. Those in problems have further been found to be plunged into situations where they are neither able to put up with life, nor able to drop the burden from their shoulders, and live in abject misery.

If one is not provided with food it may cause the end of life, while the want of food can be even more hazardous. It can cripple people to an extent that the life becomes an agonizing burden for them, nudging them to a warren from where they would never be able to recover. It is not possible to encircle the physical and psychological problems resulting from hunger. Worst cases of food-deprivation have been seen where one

human being was at the helm of the ruthless fellow being. Prisoners of wars (POWs) have been found to be forming the best puppets against whom the nastiest of vengeance has been exhibited. The maltreatment that the prisoners of wars (POWs) have been subjected to, by the conquerors, is one of the most torturous acts shown by the fellow beings towards their brethren. The POWs have been kept hungry for longer periods of time a thing that not only revealed the character of the mighty but also resulted into a large number of health-related problems.

Although the appreciable association between increased prevalence of ischemic heart disease later in life among POWs and self-reported symptoms of edema in prison camp is new, the acute cardiac effects of nutritional deprivation are well known. Unlike the situation for psychiatric conditions, the reporting of edema in prison camp is not only a general measure of stress but also indicates a specific nutritional deficiency, beriberi [2].

Needless to mention that nutritional deficiency makes the human beings vulnerable to host diseases. Starvation not only induces many physiological and behavioral changes in the human body. As body mass drops, metabolism slows, to conserve energy and resources. Intensely malnourished individuals may develop amenorrhea (in females), bradycardia, hypothermia, reduced bowel motility, hypothyroidism, etc.

The phenomenon of impulsivity, irritability, and hyperactivity may be interpreted by the therapist as a manifestation of obsessive-compulsive disorder or depression, when in fact these behaviors are likely normal adaptive responses to starvation honed by millions of years of natural selection. Normal individuals facing severe dietary restriction may develop an obsessive preoccupation with obtaining and consuming food, and this shapes impulsive behavior such as hoarding, bingeing, or stealing food.

This phenomenon has been exploited for centuries in prisoner-of-war camps, forced labor camps, and with slave labor. Although one might think a well-fed prisoner or slave would be more productive, in actuality, a slightly malnourished, hungry slave will tend to be more submissive if their cooperation is rewarded with food, and their failure to cooperate is punished by withholding access to food. You can readily observe this phenomenon in domestic dogs, which are generally much more eager to please and obey their masters when they are hungry, than when their appetites are satiated [1].

Today we find millions of people are undernourished. The reasons of course may be natural catastrophes or the man-made predicaments food sanctions, political preferences, racial prejudices, religious bigotries, and many more. About "842 million people worldwide were undernourished in 1999 to 2001, the most recent years for which figures are available" and the number of hungry people has recently been increasing [3].

Conclusion

The whole of the discussion reveals that man is a master of his own fate. Man has concocted techniques of trouncing his fellow beings, and the cheapest and the most effective has proved to be snatching the morsels of bread. But the fact remains that this effective method of eliciting answers, prove to be detrimental to the respondents' physical and psychological conditions, thus amounting to torture. It does proliferate multitudes of problems which remain uncontrolled even after years of occurrence.

So the man that got an exile from Eden for the sake of bread, was further deprived of the same while being on earth. There in Eden, it was the serpent that instigated the tragic happening, while now on earth it is none other than the human being, robbing the fellow of the very prerequisite of life. Need of the hour is to realize the problem and to pin it down, since the exile from heaven led to inhabitation on earth, whereas, an exile from earth can lead to lamentable catalogs of human history only.

Thus keeping in view various connotations mentioned above, well-thought-out efforts are needed so as to steer the outlook of the masses in the apposite direction. United Nations is a globally acknowledged organization, providing all-inclusive definitions regarding various rights of individuals, countries, and the like. Therefore, right and access to food may be added to the definition of torture, given by the United Nations. It would of course further substantiate the existing definition of torture, making it more invasive.

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Neglected Diseases, Social Justice and Human Rights: Some Preliminary Observations

Paul Hunt [1]

I have been asked to speak today on social justice aspects of neglected diseases. Given my background and current work in human rights, I am going to focus on using human rights as a strategy for social justice. My presentation covers three topics. Firstly, I introduce my work as UN Special Rapporteur on the right to health, including on neglected diseases. I then explain in fairly broad terms what I believe to be the 'value-added' of human rights to social justice. Finally, I make some preliminary observations about neglected diseases and human rights. Which human rights are affected, and how are they affected, by neglected diseases? And what does human rights law say about responsibilities on States and other actors in relation to neglected diseases?

I. The Special Rapporteur on the Right to Health

In April 2002, the UN Commission on Human Rights adopted a resolution establishing a UN Special Rapporteur on the right to health [2] . Nominated by New Zealand, I was appointed as Special Rapporteur in September 2002.

A Special Rapporteur is an independent expert appointed to monitor, examine and repor publicly on either a country human rights situation, or on a major thematic human rights problem. Special Rapporteurs work in cooperation with relevant actors States, international organisations, donors, NGOs, the private sector and so on - to further the promotion and protection of human rights. This cooperation generally involves attending meetings, visiting countries on official missions, cooperating on projects relating to the right to health and so on. I report annually to the UN Commission on Human Rights and to the UN General Assembly and in these reports I consider, in some detail, different aspects of the right to health.

In my preliminary report to the UN Commission, I set out my main three broad objectives [3]. Each reflects what I see as a key challenge confronting the right to health:

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1. I am very grateful to Judith Bueno de Mesquita, Senior Researcher at the Human Rights Centre, Essex University, for her major contribution towards the preparation of this paper.
2. UN Commission on Human Rights, Resolution 2002/31, E/CN.4/2002/31, 22 April 2002.
3. Preliminary Report of the Special Rapporteur to the UN Commission on Human Rights, E/CN.4/2003/58, 13 February 2003, para.37-40; Interim Report of the Special Rapporteur to the UN General Assembly, A/58/427, 10 October 2003.

First objective, to promote - and to encourage others to promote - the right to health as a fundamental human right. The right to health is unquestionably part of international human rights law, but still - in my experience - many people do not grasp that it is a fundamental human right.

They feel intuitively that the right to a fair trial and freedom of expression are human rights, but they do not instinctively regard the right to health as a human right. In other words, the right to health has not yet gained the same human rights currency as more established rights. So my first objective is to work with others to enhance recognition of the right to health as a fundamental human right.

Second objective, to clarify the contours and content of the right to health. There is a growing national and international jurisprudence on the right to health, but still the legal content of the right is not yet well established. This is unsurprising given the historic neglect of the international right to health. So I would like to clarify the contours and content of the right to health by drawing upon evolving national jurisprudence (over sixty constitutional provisions include the right to health or the right to health care); by drawing upon the evolving international jurisprudence on the right to health, such as General Comment 14 of the UN Committee on Economic, Social and Cultural Rights [4] ; and also by going back to the basic principles that animate all human rights, such as equality, non-discrimination and the dignity of the individual [3]. My work on neglected diseases relates to this objective. In other words, I want to examine what domestic and international jurisprudence on the right to health says about neglected diseases.

Third objective, to identify good practices for the operationalization of the right to health at the community, national and international levels. We have to move from fine-sounding norms to effective policies, programmes and projects in relation to various actors including Governments, the courts, national human rights institutions, health professionals, civil society organizations and international organizations. My work on neglected diseases also relates to this objective. Once we have worked out what the right to health says about neglected diseases (objective two), I hope it will be possible to put this into practice.

To make these challenging objectives more manageable, my work focuses on two main themes. ***On***e, poverty and the right to health. And ***tw***o, discrimination, stigma and the right to health. These themes will enable me to give particular attention to those living in poverty, gender issues, racial and ethnic minorities, indigenous peoples, people living with HIV/AIDS, and other vulnerable groups. Poverty and discrimination/stigma are both, of course, extremely important in relation to neglected diseases.

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[4] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, E/C.12/2000/4, 11 August 2000.

Beyond these objectives and themes, there are a number of specific issues and interventions which I am addressing, resources permitting, in my capacity as Special Rapporteur.

These issues include the problem of neglected diseases. Since my appointment, I have addressed neglected diseases several times. For example, in July 2003, I undertook a mission to the World Trade Organization, where I discussed, among others, the problem of TRIPS and neglected diseases with members of the WTO Secretariat and Ambassadors and other delegates to the WTO. I also wrote about neglected diseases in my preliminary report to the UN Commission on Human Rights and in my recent report to the UN General Assembly. This month, I am going on an official mission to Mozambique where neglected diseases will be one of the topics I address with the Government, intergovernmental organizations and nongovernmental organizations.

I am also currently starting to pursue a human rights analysis of neglected diseases in cooperation with HO-TDR I will return to the substance of this analysis shortly. I intend to continue my analysis and advocacy about this issue, which is a great concern from a human rights and a humanitarian perspective.

Following the presentation of my reports to them, both the UN Commission and the UN General Assembly passed human rights resolutions on neglected diseases. The UN Commission resolution specifically: "requests the Special Rapporteur to pursue his analysis of the issues of neglected diseases, including very neglected diseases."[5]

The UN General Assembly Resolution

"Recognizes the need for further international cooperation and research to promote the development of new drugs, vaccines and diagnostic tools for diseases causing a heavy burden in developing countries, and stresses the need to support these countries in their efforts in this regard, taking into account that the failure of market forces to address such diseases has a direct negative impact on the progressive realization in these countries of the right of everyone to the highest attainable standard of physical and mental health."[6]

II. Value Added of Human Rights to Social Justice

The main focus of my talk today is a human rights analysis of neglected diseases. However, I would like to make some brief observations about what contribution human rights can make to social justice, in other words to creating a fair and equal society. This raises two questions. What are human rights? And what is the valued added of human rights?

[5] UN Commission on Human Rights, E/CN.4/2003/L.32, 11 April 2003, para.16.

[6] UN General Assembly, A/C.3/58/L.53, 17 November 2003, para.13

What are human rights?

Briefly, human rights can be defined as "that which a person is entitled to have, and do, or to receive from others, and which is enforceable by law."[7]

Human rights include a wide range of economic, social, cultural, civil and political rights. They include the rights to health; education; housing; food; a fair trial; freedom of religion; and freedom from torture.

Human rights have a preoccupation with values and processes at the heart of social justice, such as dignity, equality and non-discrimination, participation and access to Justice.

Human rights are recognized in international law. International human rights law creates a framework of obligation and responsibility for human rights, with the primary obligation falling on States. Yet in recent years there have also been a number of initiatives to develop a clearer understanding of the responsibilities of other actors, including the private sector.

Human rights provides a compelling framework for the formulation of national and international policies for social justice, including in relation to neglected diseases:

Human rights are underpinned by universally recognized moral values and reinforced by legal obligations. By introducing international legal obligations, the human rights perspective adds legitimacy to social justice as a primary goal of policy-making.

The norms, values and obligations enshrined in human rights have particular potential to empower marginalized communities and neglected populations. Empowerment can follow from the introduction of the language of human rights into policy, advocacy and law. Once this happens, the rationale is that social justice focuses not on needs, but on rights on entitlements which have legal obligations on others. In other words, social justice becomes more than a moral obligation, it becomes a legal obligation.

Perhaps the most significant value-added of human rights is the framework of accountability it creates for policy makers and other actors whose actions impact on human rights. Human rights primarily create obligations on States. Through ratifying international human rights treaties, States accept obligations - which are binding under international law - to give effect to the recognized rights. States may also, of course, have obligations to give effect to human rights when these are enshrined in domestic law, as they are in a great many countries around the world. International and national obligations require transparent, effective and accessible mechanisms of accountability.

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[7] OHCHR, ***Human Rights in Development: What, Why and How,*** Geneva, 2000.

If States fail to do give effect to rights, there are a number of accountability mechanisms which may be available to hold States to account for these failures, such as tribunals, parliamentary processes, Health Ombuds, international human rights treaty monitoring bodies, and so on.

For example, and of particular relevance to neglected diseases, is the growing body of human rights case law at domestic and regional tribunals relating to the failure by States to make accessible drugs for HIV/AIDS and other diseases. Two cases relating to drugs for HIV/AIDS are ***Cortez v El Salvador*** which was considered by the Inter-American Commission on Human Right***s,*** and ***the Treatment Action Campaign v Minister of Health*** case in South Africa. In the ***Viceconte Case*** in Argentina, the Courts ordered the Argentine Government to make available a vaccine against the Argentine Hemorrhaging Fever for three and a half million people. This decision was particularly important since the vaccine is the most effective health measure to combat the disease, which is difficult to diagnose and affects people living in an area with poor access to healthcare.

Such litigation can be an effective way of holding States to account. However, human rights accountability is not limited to litigation before tribunals. There are - and should be more -non- judicial mechanisms of accountability.

Finally, human rights often provide a useful analytical framework for social justice issues, including neglected diseases. It is this framework to which I now turn. In other words, what does human rights say which is relevant to neglected diseases? And what form of guidance does human rights provide on neglected diseases?

III. A Human Rights Analysis of Neglected Diseases

There are different ways of defining neglected diseases. A recent WHO publication describes them as those diseases that "affect almost exclusively poor and powerless people living in rural parts of low-income countries."[8] It is this definition, which forms the basis of my work on neglected diseases.

As has been extensively documented, neglected diseases result from several problems, including:

Existing medicines and mechanisms for neglected diseases do not always reach people living in poverty in developing countries. Many of the drugs are too expensive, or are not available in adequate numbers, or are inaccessible geographically, which is a problem particularly in rural areas, because there are inadequate health systems to deliver them.

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[8] WHO, ***Global Defence against the Infectious Disease Threa***t, 2002, p.96.

The so-called 10/90 gap, which refers to the phenomenon whereby only 10% of global health research is focused on conditions accounting for 90% of the global burden of disease.

Diseases, which occur mainly among poor communities living in developing countries, have attracted particularly little research and development (R&D). The market mechanism, which increasingly determines R&D, fails these so-called "neglected diseases" since they do not promise a good return on investment in R&D. At the same time, there is a crucial failure in public policy to adequately address this problem. As I will explain, both the 'neglected diseases' and the 'neglected communities' dimensions of the problem have human rights implications.

There are, of course, differences between different neglected diseases and this has important implications for human rights. For example, leprosy is now treatable, while buruli ulcer is poorly understood and difficult to treat. HIV/AIDS represents a global emergency - while there are now drugs which help treat the disease and prevent mother-to child transmission, these drugs are still not accessible to millions of people living with HIV/AIDS in developing countries. In the case of sleeping sickness, there is resistance to existing drugs, which are also highly toxic, and R&D is urgently needed to find new treatment solutions and a vaccine.

The human rights community is becoming increasingly aware of neglected diseases and addressing problems associated with access to drugs. The issue has been raised in the UN Commission on Human Rights, and, in many countries, civil society organizations are starting to use human rights to strengthen campaigns relating to access to medicines. Today I wish to begin a preliminary analysis on neglected diseases from the point of view of human rights. I should stress that this analysis is highly preliminary and I will welcome your comments today, or informally over the course of this meeting, and after this meeting, when I hope to develop this work. I particularly welcome this opportunity to engage with the group of experts gathered here experts who come from different sectors, countries and academic backgrounds. This provides a rich opportunity to learn from different perspectives and develop my understanding of the many complexities and nuances in the debate on neglected diseases. It is vital that the human rights analysis takes account of these.

Here I will confine my analysis to two human rights which have a close connection to the issue of neglected diseases, (i) the right to health, and (ii) the right to enjoy the benefits of scientific progress and its applications.

How do neglected diseases impact on these human rights? What entitlements do these human rights include that is relevant to neglected diseases? And what obligations on States and on other actors do these human rights give rise to?

A- The Right to Health

Under international human rights law it is recognized that everyone has the right to the highest attainable standard of physical and mental health. This fundamental human right is subject to progressive realization: it cannot be realized overnight.

There are many norms both freedoms and entitlements arising from the right to health. Here I focus on one set of entitlements which is an integral element of the right to health and which has particular importance in relation to neglected diseases. For a further discussion of the sources and scope of the right, see my preliminary report to the UN Commission on Human Rights.[9]

This set of entitlements is to make available and accessible quality health care services, facilities and goods, and this includes essential medicines[10]. Many of the existing drugs for neglected diseases are essential medicines as defined by WHO. This set of entitlements means that essential medicines must be ***availabl***e, ***accessible*** and of ***good qualit***y. If essential medicines must be available, accessible and of good quality - what might this mean in relation to neglected diseases?

Availability means that essential drugs must be made available ***in adequate numbers*** within countries where there is a need for them. Of course, a significant problem relating to drugs for neglected diseases is that many drugs are not available. In other words, they do not exist in sufficient numbers within particular countries.

Accessibility means that they should be made accessible geographically, economically and on the basis of non-discrimination to the people who need them. In recent years, the UN Commission on Human Rights has emphasized the particular importance of access to medication it has adopted resolutions stating that "access to medication in the context of pandemics such as HIV/AIDS, malaria and tuberculosis is one fundamental element for achieving progressively" the right to health[11]. Yet without targeted interventions by governments, international organizations of pharmaceuticals, drugs for neglected diseases are not always economically accessible and they are also not always geographically accessible for communities who need them.

Quality means that the drugs have to be scientifically and medically approved and of good quality. I would add to this that the drugs administered should be effective in relation to any particular strain of a disease which is prevalent in a given setting.

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[9] Preliminary Report of the Special Rapporteur to the UN Commission on Human Rights, E/CN.4/2003/58, 13 February 2003, para.10-36.

[10] For completeness I note that the analytical framework mentioned here includes a fourth component-acceptability-which I have omitted in these remarks in the interest of brevity. Acceptability is identified in CESCR´s General Comment 14.

[11] For example, see E/CN.4/2003/L.33, 11 April 2003, para 1.

What do these availability and accessibility and quality aspects look like in practice? Perhaps I can best illustrate this with some examples.

WHO's new "3 by 5" campaign is a promising move from the point of view of the right to health on account of its aim to provide three million people in developing countries, and countries in transition, with anti-retroviral therapy. In other words, it is aiming to make these drugs ***available*** and ***accessibl***e.

The Argentine case I referred to previously involved a decision ordering the government to manufacture vaccines for 3.5 million people at risk of Argentine Hemmaeorghic fever. This represented an important victory to make the vaccine ***available.***

In Brazil, the decision of the government to provide anti-retrovirals free of charge to all who need them helped make these drugs ***economically accessibl***e.

The decision of pharmaceutical companies to lower significantly the prices of drugs, or provide them free of charge, as Novartis (to give just one example) has committed to do to combat leprosy, can also be seen to contribute to the realization of the right to health. Novartis has ensured that drugs for leprosy are economically accessible to those who would not otherwise be able to afford them and this has had a significant impact on combating the disease.

These cases all refer to making ***existing*** drugs available and accessible. But how does the availability and accessibility analytical framework relate to diseases for which there are no drugs? R&D is an essential component of making drugs ***available*** in the first place.

In other words, in relation to some diseases where there is no vaccine, such as AIDS or malaria, or no treatment, such as drug-resistant strains of tuberculosis, there is a responsibility on States, and other actors, to do all they can to make drugs ***available*** in the first place, through R&D.

A further dimension of this right to health framework, in addition to availability and accessibility of drugs, is the ***quality*** of the drugs on offer. The drugs available to people living in poverty in developing countries are not always of adequate quality. This is dramatically illustrated by the problems surrounding access to drugs for malaria in Africa. Up to 80% of malaria in Africa is resistant to chloroquine, the cheapest standard drug against the disease. Other effective drugs such as malarone or doxycycline - are too expensive for most people in African countries with high incidence of malaria. In the case of sleeping sickness, there are drugs available which can cure the disease, but which are, as I understand it, toxic and ineffective. The right to health entitles people to good quality drugs in other words, States and others must find a way to ensure that

quality drugs are available. This may involve initiatives to make existing quality drugs available, or where there are none, R&D must be conducted to make these drugs available.

I will return to talking about the nature of responsibilities, and the duty-bearers of these responsibilities, shortly. I wanted to quickly sum up my comments about neglected diseases from the point of view of the right to health. Essentially, people are denied the enjoyment of their right to health:

(1) where there has been inadequate R&D into developing appropriate and effective drugs. A human rights approach focuses on addressing the needs of the most disadvantaged communities neglected populations- and yet the 10/90 gap clearly illustrates this is not occurring in practice.

(2) where there are appropriate and effective drugs, but they are often not economically.

accessible for poor people living in developing countries; intellectual property regimes have meant that many people have not had access to cheaper generic versions, and even where cheaper generic versions are available, these may still be too expensive.

(3) where there are affordable and appropriate drugs, they often fail to reach neglected communities who need them because of inadequate health infrastructures to deliver them.

B- The Right to Enjoy the Benefit of Scientific Progress and its Applications

The right to health is closely linked to the realization of the right to enjoy the benefit of scientific progress and its applications[12]. Over the past decades, many important developments in molecular biology and biotechnology have created or improved techniques to prevent, treat or cure a wide variety of diseases[13]. However, these developments have been biased towards conditions which are prevalent in developed States, and not towards neglected diseases which primarily affect people living in poverty in developing countries. This is effectively denying neglected populations their right to enjoy the benefits of scientific progress.

However, there are some recent initiatives which give hope for the fulfilment of this right For example, the Drugs for Neglected Disease Initiative (DNDi) is a particularly welcome development from the point of view of human rights, since its basic objective is to

[12] International Covenant on Economic, Social and Cultural Rights, art 15.1(b)

[13] Médecins Sans Frontières, Access to Essential Medicines Campaign, ***Fatal Imbalanc***e, 2001, p. 16

develop and apply scientific progress to those diseases which hinder the realization of the right to health for many people around the world.

C- Obligations

As I mentioned earlier, part of the value-added of human rights is, firstly, their recognition in international law, and, secondly, that States and other actors have obligations towards making these rights a reality. International law establishes a framework of obligations on States and other actors.

(i) What are the Obligations on States?

When States ratify international human rights treaties, they have an obligation to give effect to its provisions. 147 States around the world have ratified the International Covenant on Economic, Social and Cultural Rights. In relation to the right to health, this treaty imposes an obligation on States to take steps necessary for:

"the prevention, treatment and control of epidemic, endemic, occupational and other diseases."(Article 12)

To give effect to the right to enjoy the benefits of scientific progress, States which have ratified ICESCR have an obligation to:

"take steps necessary for the development and diffusion of science."(Article 15)

If we read these provisions together, States may be considered to have an obligation to take steps necessary for the development and diffusion of science for the prevention, treatment and control of diseases. The importance of the obligation to make essential drugs available has been recognized by the UN Committee on Economic, Social and Cultural Rights, a body composed of independent experts which is responsible for monitoring ICESCR. This Committee has stated that this obligation is a “core obligation” on States. In other words, if a State is not making essential drugs available, it is failing to fulfil its international legal obligations towards the right to health.

While the opinion of the Committee is not legally binding, it has been influential in shaping opinion of States, regional and domestic courts, and civil society. In other words, the Committee's opinion is widely considered to have significant legal weight. So what is the exact nature of these obligations on States? How are States supposed to give effect to these obligations to make quality drugs available and accessible?

I do not have time to elaborate extensively on the nature of obligations on States. But I would like to make several brief points in relation to the following questions (i) What types

of actions must States take to be considered in compliance with obligations under ICESCR? (ii) How should we interpret the obligation 'to take steps' which I just mentioned? (iii) Do States just have obligations at the domestic level or do they also have an international responsibility towards the promotion and protection of these rights in other countries?

(ii) Types of Actions

States are considered to have three types of responsibilities towards human rights under international human rights law: obligations to ***respec***t, ***protec***t, and ***fulfil***.

The obligation to ***respect*** means that States must, among other things, refrain from actions which deny people their right to health. There are several examples of obligations to respect which apply to neglected diseases. One of these relates to an obligation on States to ensure that their policies, and actions within the framework of international institutions, are respectful of the right to health in other countries. I will return to this obligation when I talk about the international dimension of States obligations.

The obligation to ***protect*** means that States should, for example, ensure that privatization of the health sector does not constitute a threat to the availability, accessibility and[14] quality of health care goods, services and facilities. This obligation has a relevance to neglected diseases since increasing reliance by States on the private sector to conduct R&D has meant that the market, to a large degree, determines R&D.

The obligation to ***fulfil*** includes an obligation to promote medical research. It also includes an obligation to take positive measure that enable individuals and communities to enjoy their right to health. Clearly in the case of neglected diseases, positive measures are required.

(iii) The Obligation to Take Steps

The right to health includes a range of entitlements. It is clear that many of these entitlements are difficult to provide immediately; it will take time to develop and implement strategies to meet entitlements. Finding new ways of preventing or treating neglected diseases, finding solutions to lowering the costs of drugs, and building up health systems to deliver these drugs where they are needed all these interventions will take time. However, States must show that they are taking steps towards providing essential medicines or promoting R&D into new drugs in a deliberate, concrete and targeted way.[14]

[14] Committee on Economic, Social and Cultural Rights, General Comment 14, The right to the highest attainable standard of health, E/C.12/2000/4, 11 August 2000, para.30-33.

(iv) Domestic and International Obligations[15]

International human rights law imposes obligations on States to give effect to human rights within their jurisdictions. With regard to neglected diseases, the governments of developing countries must take targeted steps towards ensuring that effective drugs are made available and accessible to the populations that need them.

However, international human rights law also recognizes that States have international responsibility towards the right to health. These arise from human rights provisions of international assistance and cooperation. Thus, states should take actions that promote and protect the right to health in other countries, and they should refrain from taking actions that jeopardize the right to health in other countries. This may involve a responsibility on rich countries to promote R&D into neglected diseases even though these diseases do not have a high incidence, or occur at all, within rich countries. It also involves an obligation to promote international policies, either bilaterally or within the framework of inter-governmental institutions, that are conducive to addressing the problem of neglected diseases.

Let me give an example to illustrate what I mean by these international obligations in relation to the right to health. On 30 August 2003, the WTO decided that countries producing generic copies of patented drugs under compulsory licence could now export drugs to countries with no or little drug manufacturing capacity this was an important decision and consistent with the human rights concept of international assistance and cooperation. Moreover, last month, the Canadian Government introduced a Bill into the Canadian Parliament to amend the Patent Act and Food and Drugs Act in a way which would make it easier for Canadian companies to produce, and developing countries to import, generic lower cost drugs. The Canadian patent law is not currently restricted to a narrow range of diseases. The Canadian initiative is an important example of how developed countries can help to improve access to medicines to fight diseases in poor countries: it reflects Canadian human rights responsibilities of international assistance and cooperation.

(v) The Role of Non-State Actors: NGOs and the Private Sector

International human rights law imposes obligations on States. In general, it does not impose obligations on non-State actors. However, it is increasingly responding to the increasing role played by non-state actors in the economic and social spheres, for example by providing guidance on the types of responsibilities that non-state actors have. While ultimate responsibilities lies with states, a resolution recently adopted by the UN Sub-Commission on the Promotion and Protection of Human Rights states that even

[15] General Comment 14, E/C.12/2000/4, para. 38-42; Preliminary Report of the Special Rapporteur to the UN General Assembly, A/58/427, 10 October 2003., para.30-34.

though States have the primary responsibility towards human rights, "transnational corporations and other business enterprises, as organs of society, are also responsible for promoting and securing the human rights set forth in the Universal Declaration of Human Rights." The Universal Declaration on Human Right recognizes that everyone has the right to a standard of living adequate for the health and well-being, including medical care. This resolution also emphasizes that TNCs and other business enterprises shall respect and contribute towards the realization of the right to health and refrain from actions which obstruct or impede the realization of this right. The relationship between the right to health and the private sector raises important issues but need further careful attention.

(vi) Conclusions on Obligations

As I have noted, international human rights law recognizes that the primary obligation lies with States to develop solutions to the problem of neglected diseases. Due to the fact that the right to health gives rise to domestic and international obligations, all States should be considered to have a responsibility under international law to take action to address neglected diseases, in other words, to redress the failure of the market and public policy that is currently hampering the fight against neglected diseases.

This is not to imply that pharmaceuticals are free of responsibilities in relation to the international right to health. There is increasingly recognition of the crucial role and responsibilities of the private sector in the promotion and protection of the right to health. There are examples of domestic legal systems where legislation has been used to address the policies of pharmaceutical companies. Recently, the Competition Commission in South Africa found GlaxoSmithKline in breach of the South African Competition Act for excessive pricing of its antiretrovirals[16]. On the other hand, pharmaceuticals have taken action conducive to enjoyment of the right to health. On the same day as this finding by the Competition Commission, GlaxoSmithKline reduced the not-for-profit price of Combivir the backbone of HIV/AIDS treatment regimens currently recommended by the World Health Organization (WHO) from US$ 0.90 cents to 0.65 cents per day.[17]

IV. Concluding remarks

In my preliminary report to the UN Commission on Human rights and in my recent interim report to the UN General Assembly, I have characterized neglected diseases as a major human rights issue. In this paper, I have begun the process of explaining some of the human rights dimensions of neglected diseases and the 10/90 gap.

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[16] Media Release from the Competition Commission, 16 October 2003

[17] Http://Www.Gsk.Com/Press_Archive/Press2003/Press_10162003.Htm

Some human rights dimensions of neglected diseases arise from the general features of human rights, such as its preoccupation with disadvantaged individuals and neglected populations, as well as its emphasis on informed participation and transparent mechanisms of accountability.

Other human rights dimensions of neglected diseases arise specifically from the right to health, such as the availability and accessibility of quality essential drugs.

In this paper, I have done no more than signal some of these human rights and right to health dimensions. All require much closer attention. In the meantime, your comments and suggestions will be most welcome.

Note: This paper was presented by Professor Paul Hunt in "International Workshop on Intensified Control of Neglected Diseases" at Berlin, 10-12

Forensic Examination Regarding Children Whose Civil Rights Were Neglected

[1]Enache Alexandra, [2]Petcu Magda, [3]Baboiu Oana-eugenia

The currently prevailing concept of child abuse contains four major types of abuses: emotional abuse, neglect, sexual abuse, and physical abuse.

The lack of physical and mental development of children and the difficult living conditions of children, in various countries of the world, have led to the necessity of a special protection for the child, enshrined into law. In 1924, at Geneva, the "Declaration Regarding the Rights of Children" was adopted, proclaiming the necessity of special protection.

Principle 2 of the "Declaration of the Rights of the Child" of 20 November 1959, proclaims: "The child shall enjoy special protection, and shall be given opportunities and facilities, by law and by other means, to enable him to develop physically, mentally, morally, spiritually, and socially in a healthy and normal manner and in conditions of freedom and dignity. In the enactment of laws for this purpose, the best interests of the child shall be the paramount consideration." In the "Convention on the Rights of the Child" proclaimed by General Assembly of the United Nations on November 20, 1989 (which Romania became part of on September 27, 1990) calls upon the Member States to take all appropriate legislative, administrative, social, and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse.

Article 2 of the “Convention on the Rights of the Child” requires to "respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his/her parent's or legal guardian's race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status." Article 24 (1) of the ICCPR states, "Every child shall have, without any discrimination as to race, color, sex, language, religion, national or social origin, property or birth, the right to such measures of protection as are required by his status as a minor, on the part of his family, society and the State."

1. Department of Forensic Medicine - University of Medicine and Pharmacy Victor Babes, Timisoara, ROMANIA
2. Institute of Forensic Medicine (IML) Timisoara, ROMANIA
3 SUNY Syracuse, New York, USA

The basic problem however, remains the determination of age of majority and that of minority, and many of the medical examinations are carried out for this purpose. The state institutions must assure the methods of accomplishing the civil rights, but some social, educational, economic or ethnic factors have got certain crevices. Some people do not possess birth certificates, so these are the persons who straightaway do not exist for the public state authorities. Thus the procedure of certification of the birth of a person needs a forensic examination, for estimating the age of the individual. One of the possibilities of the age determination is done with the help of a forensic exam of the wrist, by x-ray.

Yet this method is not preferred because of the exposure to radiation and the experts warn that bone x-rays have a very high margin of error and expose children to unnecessary radiation.

The Separated Children in Europe Program a joint initiative of the UN High Commissioner for Refugees (UNHCR) and the International Save the Children Alliance in Europe, notes that "existing bone directories are out-of-date and are based largely on the physical measurements of white people. These physical methods neglect the impact of ethnic, geographical, social, environmental and nutritional factors, thus should not be used for age assessment." The program recommends that age determination "should stress approaches that are based more on psychological than physical factors."

A professional medical attitude considers it important to note that age assessment is not an exact science and a considerable margin of error is called for. However, in the process of age determination, separated children must be given the benefit of the doubt.

From the few legal references presented above, which did not consider all the legal regimentations concerning child protection, it is possible to observe a wide and conclusive legal climate. Despite this legal situation, children all over the world are still being abused by adults.

The abuse syndrome is a complex clinical entity consisting of any kind of abuse or neglect of the child from any other person who has the care of the child, responsible of the physical and mental distress.

Cases of parents showing abusive attitude towards their children have been witnessed and studied. This abuse refers to the neglect of the social status of the child that was observed at different periods of age. The parents ought to declare the childbirth at the local townhall. However, not declaring the birth, represents the inexistence of the newborn child as a person and a citizen of the state. Though the physical existence of the child can not be denied, still the legal status remains obscure. It was observed that the majority of children born without proper documentation belong to a certain ethnic minority, the Rroma.

In this study, it was revealed that the characteristics of the persons examined for age determination with the purpose of registration in the vital statistics database (these persons were not registered at birth and did not have birth certificates).

The 10th of December 1948 marks the moment of the creation of the modern human rights, by signing of the Universal Declaration of Human Rights. All states stand obliged to assure the universal and effective observance of all the human rights, stipulated by the International Pact concerning the political and civil rights… "The states must act so as to give the possibility of the endorsement of legislative or other natured measurements."

The analysis of examinations was done at the request of physical and juridical persons from the years 1999-2001. In the Timis county (pop. 750000), of the total of 9523 examinations on living persons, 100 had the purpose of establishing the age.

	1999	**2000**	**2001**
All forensic expertises	2942	3198	3383
Age	31	31	48

Table 1

The examination was based on somatometric data (height, perimeters, weight), associated with information offered by the parents, as well as data from observation sheets of the newborn child, obtained from the hospital where the birth occurred, if the child was born in a hospital.

Results

The 100 examined individuals are classified:

Suckling period	12 cases
First childhood period	15 cases
Second childhood period	37 cases
School period	18 cases
Puberty period	10 cases
Teenage	8 cases

Table 2

Dental criteria used for establishing the age were:

temporary teeth eruption (after Kronfeld, Adler)	27 cases
permatent teeth eruption (after Logan, Kronfeld modified by Schour)	42 cases
mixed teeth	31 cases

Table 3

Birth documentation:

official hospital papers	64 cases
unofficial the personal declaration of the mother	12 cases
the declaration of other relatives	10 cases
without any proof of the time of birth	14 cases

Table 4

* 85% of these children are of Rroma ethnic origin.

A special situation is represented by the teenaged pregnant girls, which necessitated a double expertise, for obtaining the civilian documents and age license for marriage (in Romania it is compulsory for girls between 16-18 years).

From all cases, 62 of the examined children are boys.

	1999	**2000**	**2001**
Female	6	11	21
Male	15	21	27

Table 5

The minimum age is 3 months and the maximum age is 17 years, with an average age of 5, 6 years. About 85% of these children are of Rroma ethnic origin.

The wide variation in results of age assessments, based solely on a physical examination, without adequate allowance for a margin of error, highlights the arbitrary nature of these assessments and the determinations based on them.

Despite the fact that the speciality literature contains many complementary methods of age determination, we must state that, in our study, we used somato-metric methods.

The methods used for the estimation of age, based on wrist bone examinations should have a margin of error of at least 20 months. In Romania, at the age of 18 years, the teenager is considered to be an adult. Thus the authorities should focus on extending the protections accorded to minors, in cases where an individual cannot be identified as an adult.

Conclusions

We have noted a progressive annual growth for the number of requests for this type of examination, although the age range of the children examined in 2001 was not much different from the age range of the previous years. Massive involvement of non-governmental organizations, as well as state institutions, in remedying the civil situation of these children, whose civil rights were neglected, has been witnessed.

The following have different attributes for the application of the human rights the Parliament, Church, Ministries, Judicial institutes, and Non-governmental organizations.

Whose main objective is protecting the human rights and educating the population to respecting the general human values.

Following the recommendations of the Separated Children in Europe Program, suggested that for age determination, children must present other credible evidence of their age, such as a medical document, or testimony from individuals who know the child, like one of the parents, or one of the family members.

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"In violence we forget who we are."

(Mary McCarthy)

Awareness About Child Sexual Abuse and HIV/AIDS Among Schoolgoing Children

*Fizza Sabir & Lala Rukh**

The present study was conducted to investigate the level of awareness about child sexual abuse and HIV/AIDS among school going children. A sample of 60 school children (boys n=30,girls n =30) of class 7th and 8th were taken from two schools of Gujar Khan city. An indigenously developed questionnaire was used to measure the level of awareness among children with high alpha coefficient reliability and face validity. Result indicated that children are highly aware about child sexual abuse and HIV/AIDS. It was also found that both boys and girls are comparatively more aware about child sexual abuse as compared to HIV/AIDS. The results showed non-significant difference in level of awareness about child sexual abuse and HIV/AIDS among girls and boys.

There may be various kinds of abuse including emotional, physical, and sexual abuse. Sexual abuse may be explained as when an older person uses his/her authority with sexual intent, to indulge in any sort of sexual activity with a person, it is termed as sexual abuse.

Mrazek & Kempe1 [4], believed that the term "child sexual abuse" is not universally accepted and is frequently interchanged with "sexual exploitation", "sexual misuse" and sexual assault." Rather than referring to any specific type of sexual behavior, the term "sexual abuse" may mean anything from exhibitionism and genital manipulation to intercourse and child pornography. The researchers further defined child sexual abuse in a broad sense as, "including all kinds of sexual activities committed by an adult with or in the presence of minors; these are activities which are determined to normal development of the sexuality of the child or which curtail or inhibit his/her self-determination." Within legal frame of reference, sexual abuse is classified by criminal act, such as rape, incest, unlawful sexual intercourse, buggery, and indecent assault. Legal and medical definition of sexual abuse of children includes consideration of:

- An explicit description of what occurred nature of sexual act, frequency (single incident or continuum of act over time), and occurrence of violence or threats of bodily harm.
- Information about the age and development of the people involved age differences, intelligence, and mental status.
- An understanding of the nature of the relationship between the people involved

* M. Phil Student of Qaid-i-Azam University, Islamabad

whether or not they know each other and in what context, the quality of other aspects of their relationships, their perception and feelings regarding what occurred and why.

- A description of the attitudes and involvement of the other family members and of the prevailing cultural attitudes about the sexuality in the community.

The child abuse, Prevention and Treatment Act (Public Law93-247), originally passed in 1974, defined child abuse and neglect as follows:

“Sexual abuse of children refers to sexual behavior between a child and an adult or between two children when one of them is significantly older to or uses coercion. The perpetrator and the victim may be of the same sex or from different sexes. The sexual behaviors include touching breasts, buttocks, and genitalia, whether the victim is dressed or undressed; exhibitionism; fellatio; cunnilingus; and penetration of the vagina or anus with sexual organs or with objects. Pornographic photography is usually included in the definition of sexual abuse.”

Types of Child Sexual Abuse

The activities ranging from looking or touching to penetration are the criminal activities and are considered as child sexual abuse:

1. **Voyeurism:** An adult gaining sexual satisfaction through watching naked children.
2. **Sexual comments:** An adult making suggestive comments to a child, which are sexual in nature; i.e. commenting a child about his/her body.
3. **Exhibitionism:** An adult revealing his/her private parts to a child.
4. **Pornography:** Encouraging or forcing a child to read/watch pornography, giving pornographic literature, pictures or movies, or using the child in pornographic material (photos, videos etc).
5. **Touching:** Touching the body of a child for personal sexual pleasures and thus making the child uncomfortable or confused.
6. **Kissing:** Kissing a child with sexual undertones/inclinations.
7. **Fondling:** Fondling a child's breasts or genital. Also, if the abuser forces a child to fondle his or her genitalia.
8. **Obscene calls:** Invasion of a victim's privacy with sexually suggestive messages over the telephone, email, fax, etc, in an effort to shock, intimidate, or sexually arouse a victim.
9. **Sadistic abuse:** Sexual abuse where the offender incites or tries to incite reactions of dread, horror, or pain in the victim as a means of increasing the offender's sexual arousal during the abuse. It may involve use of physical restraint, quasi-religious rituals, multiple simultaneous perpetrators, use of animals,

	insertion of foreign objects, mutilation or torture.
10. Masturbation:	Encouraging or forcing a child to masturbate with the child as either a participant or observer.
11. Frottage:	Rubbing genitals against a child's body or clothing.
12. Oral sex:	Encouraging or forcing a child into oral sex (using one's own or the child's mouth in a sexual act).
13. Rape:	An act where a person vaginally penetrates a female child.
14. Gang rape:	An act where two or more persons have penetrated a female child.
15. Rape murder:	When a child is killed after being raped.
16. Sodomy:	When a man anally penetrates a child.
17. Gang sodomy:	An act where two or more persons have penetrated a male child.
18. Sodomy murder:	When a child is killed after sexual penetration.
19. Incest abuse:	Incest refers to sexual activity between individuals who are closely related. Incest involving a child is one form of child sexual abuse.

Child sexual abuse most frequently occurs within the context of family. The perpetrator is usually the trusted family member (father, mother, stepfather, stepmother, single parent's paramour, other relative) or trusted person close to the family like babysitter, neighbor [2].

Prevalence of Child Sexual Abuse

Sexual abuse of the children, in the broadest sense, encompasses a wide range of behavior including physical and genital fondling, molestation, exhibitionism, forcible statutory rape, sexual assault, commercial exploitation of children in pornography, pedophilia, incest, and abuse. Children may be sexually maltreated by parents, a family member, a significant other person trusted by the child, or a stranger. Historical and social taboos are strongest against incest (sexual relations between persons so closely related that they are forbidden by law and custom to marry). The taboo is particularly strong where parent-child incest is concerned. Physical violence is often associated with sexual abuse by strangers.

In 1978, the Americans were shocked to learn about the sexual exploitation and murder of young males in Houston, Texas. This and other similar publicized cases seem to infer that child sexual abuse frequently results in the death of the victim, and that it is committed predominantly by strangers. Actually, most child sexual abusers are respected members of the community and often are family members [2].

Family Factors Involved in Child Sexual Abuse

- Delayed attachment or bonding with the parent within the first few days of life, especially due to the infant's pre-maturity or illness
- Marital conflict
- Domestic violence
- Employment/financial stress
- Crisis due to stressful events (death in the family, recent move, fighting, etc.)
- Geographic isolation/lack of transportation
- Lack of social support
- Large family with several preschool-aged children (heavy childcare responsibility)
- Severe sibling rivalry

However there is no one factor that predisposes someone to abuse his or her children. But, if several of these factors are present in one's life, one should be cautious in use of discipline. Angry or stressed parents often hurt their children without special intention to abuse.

Indicators and Effects of Child Sexual Abuse

Due to the clandestine child sexual abusive relation, its coming up to the surface is often extremely difficult. Similarly, the threats of punishment or harsh consequences in case of any disclosure further add to the existing situation. Children do rarely find courage to directly reveal the heinous act to parents or other adults about the abuse and often the following indicators serve as the only signs of child's sufferings. These indicators may be physical, behavioral, or a combination of both. They alert the adult or parent due to need for further investigation upon the possibility of abuse.

Physical Indicators

Genital and Anal area

- Bruises, scratches or other injuries not consistent with accidental injury.
- Itching, soreness, discharge or bleeding.
- Painful and frequent urination.
- Signs of sexually transmitted infections.
- Semen in the vagina, anus or external genitalia or on clothing.

General

- Bruises, bite marks or other injuries to breasts, buttocks, lower abdomen or thighs.

- Difficulty walking or sitting.
- Torn, stained or bloodied underwear.
- Pregnancy in adolescents where the identity of the father is vague or secret.
- Recurrent urinary tract infections.
- Persistent headaches or recurring abdominal pains.
- Unexplained pain in the genital area [5].

Behavioral Indicators

Behavioral indicators must be attributed to the individual child's level of functioning and developmental stage.

Sexual

- Over-attention to adults of a particular sex.
- Displaying unusual interest in the genitals of others.
- Acting out adult sexual behavior with adults, dolls or other children.
- Open displays of sexuality, e.g. repeated public masturbation.
- Precocious knowledge of sexual matters.
- Promiscuity, repetitious sexually precocious behavior.

General

- Sudden changes in mood or behavior.
- Difficulty in sleeping, nightmares.
- Regressed behavior bed wetting, separation anxiety, insecurity.
- Change in eating patterns including preoccupation with food.
- Lack of trust in familiar adults, fear of strangers, fear of men.
- Lack of appropriate role boundaries in family child fulfils the parental role.
- Acting out behavior aggression, lying, stealing, unexplained running away, drug.
  or alcohol abuse, suicidal attempts.
- Withdrawn behavior passivity, excessive compliance, mood swings, depression.
- Learning problems at school loss of concentration, unexplained drop in school performance.
- Poor relationships family and/or child appears socially isolated.
- Reluctance to undress, e.g. for school sporting functions.
- Excessive bathing.
- Inappropriate displays of affection between child and parent (usually father), that appears lover-like than parent-like, (father may be excessively over

protective towards daughter, restrict her social activities or inquisitive of sexuality) [3].

Sibling Sexual Abuse Indicators

These may include:

- A brother and sister who behave like girlfriend and boyfriend.
- A child who fears being left alone with a sibling.
- A brother and sister who appear to be embarrassed when found alone together.
- It is important to note that all sex play and intercourse between siblings is abusive or harmful [6].

Police Treatment With Sexually Abused Children

Many of our daily newspapers often report experiences, telling us that children in jails are many a times abused by police. All such vice stems from the fact that there is no separate jail for the juvenile delinquents so they do not have to live with the elder criminals. The elder criminals make them easy source of abuse. Children here are severely exploited. And if they do complain against it, they are threatened to face bitter consequences. So most of the cases, even in the police stations, remain unreported because police officials are usually involved in this act.

The role or attitude of police toward the victim of child sexual abuse is usually disapproving. When they approach a child or if any child goes to seek help, no heat is paid to such cases at first, and if they do so the exploitation of the child and the parents gets going. Investigation of the problem in very taunting and insulting ways, as if child was willingly involved in this brutal act. Parents are also questioned in a very humiliating manner and in addition the prorogation of the matter is done for the sake of their own prestige, instead of reaching to the solution. One major complaint that is commonly voiced from the public corridors is that police writes the report in very abusive words that really shake a child's personality psychologically. But the thing of note is that police can play a significant role in protecting children, leading to the declined rate of child sexual abuse by approaching the abusers and punishing them.

Protecting children from Child Sexual Abuse

- The typical advice "Don't Talk to Strangers" doesn't apply in this case. Most sexual perpetrators are known to their victims.
- Teach your children basic sexual education. Teach them that no one should touch the "private" parts of their body. A health professional can also help to communicate sex education to children if parents are uncomfortable doing so.
- Teach your children that sexual advances from adults are wrong and against

the law. Give them the confidence to assert themselves against any adult who attempts to abuse them.

- ✐ Do not instruct children to give relatives hugs and kisses. Let the children express their affection on their own terms.
- ✐ Develop strong communication skills with your children. Encourage them asking questions and talk about their experiences. Explain the importance of reporting abuse to you or another trusted adult.
- ✐ Make an effort to know children's friends and their families.
- ✐ Instruct your child never to get into a car with anyone without your permission.

AIDS

AIDS stands for Acquired Immunodeficiency Syndrome. An HIV-infected person receives treatment for AIDS after developing one of the CDC-defined AIDS indicator illnesses. An HIV-positive person who has not had any serious illnesses also can receive an AIDS diagnosis on the bases of certain blood tests (CD4+ counts).

A positive HIV test result does not mean that a person has AIDS. A diagnosis of AIDS is made by a physician using certain clinical criteria (e.g., AIDS indicator illnesses). Infection with HIV can weaken the immune system to a point that it has difficulty fighting certain infections. These types of infections are known as "opportunistic" infections because they take the opportunity a weakened immune system gives to cause illness.

Many of the infections that cause problems or may be life-threatening for people with AIDS are usually controlled by a healthy immune system. The immune system of a person, suffering from AIDS, is weakened to the point that medical intervention may be necessary to prevent or treat serious illness.

Today there are medical treatments that can slow down the rate at which HIV weakens the immune system, similarly, there are other treatments as well that can prevent or cure some of the illnesses associated with AIDS. As with other diseases, early detection offers more options for treatment and preventative care.

HIV

HIV (Human Immunodeficiency Virus) is the virus that causes AIDS. This virus is passed from one person to another through blood-to-blood and sexual contact. In addition, infected pregnant women can pass HIV to their babies during pregnancy or delivery, as well as through breast-feeding. People with HIV have what is called HIV infection. HIV infection results in the development of AIDS.

The body fluids that have proven to be spreading HIV:

- Blood
- Semen
- Vaginal fluid
- Breast milk
- Other body fluids containing blood

Additional body fluids that may transmit the virus that healthcare workers may come into contact with:

- Cerebrospinal fluid surrounding the brain and the spinal cord
- Synovial fluid surrounding bone joints
- Amniotic fluid surrounding a fetus

How HIV is Transmitted

HIV is spread by the use of syringes or needles used by an infected person (primarily for drug injection), or less commonly (now very rarely in countries where blood is screened for HIV antibodies) through transfusion of infected blood or blood clotting factors. Babies born to HIV-infected women may become infected before or during birth or through breast-feeding after birth.

In the healthcare setting, workers have been infected with HIV after being stuck with needles containing HIV-infected blood or, less frequently, after infected blood gets into a worker's open wound or a mucous membrane (for example, the eyes or inside of the nose). There has only been one instance of patients being infected by a healthcare worker in the United States; this involved HIV transmission from one infected dentist to six patients. Investigations have been completed involving more than 22,000 patients of 63 HIV-infected physicians, surgeons, and dentists, and no other cases of this type of transmission have been identified in the United States.

Some people fear that HIV might be transmitted in other ways; however, no scientific evidence to support any of these fears has been found. If HIV were being transmitted through other routes (such as through air, water, or insects), the pattern of reported AIDS cases would have been much different from what has been observed. For example, if mosquitoes could transmit HIV infection, many more young children and preadolescents would have been diagnosed with AIDS.

All reported cases suggesting new or potentially unknown routes of transmission are thoroughly investigated by state and local health departments with the assistance, guidance, and laboratory support from CDC. No additional routes of transmission have been recorded, despite a national sentinel system designed to detect just such an occurrence.

The following details specifically address some of the common misperceptions about HIV transmission.

AIDS in Pakistan

Pakistan has predominantly narrow opportunities to act immediately and decisively to prevent a widespread HIV/AIDS epidemic. Although the estimated HIV/AIDS burden is still low around 0.1% of the adult population the threat due to risk factors is significant. Without vigorous and sustained action, Pakistan runs the risk of experiencing the overwhelming social and economic impact of a full-blown HIV/AIDS epidemic. In recognition of this threat, the Government of Pakistan has decided to scale up and strengthen its National AIDS Control Program. Pakistani Government has developed and endorsed a national HIV/AIDS strategic framework, which needs to be prioritized and operationalized for a significant expansion and scaling up of the program in selected areas.

It is estimated that 70,00080,000 persons, or 0.10% of the adult population in Pakistan, are infected with the HIV virus. Although the prevalence of HIV infection is still low, the country is highly vulnerable due to a number of significant risk factors that make the disease an important threat to the health of Pakistanis. HIV infections have been reported in all four provinces of Pakistan including Federally Administered Tribal Areas, and Azad Jammu and Kashmir. By the end of year 2000, 1,549 HIV cases and 202 AIDS cases had been reported to the National AIDS Control Program although this is almost certainly an under-estimate of the true prevalence. Heterosexual transmission accounts for about 40% of reported cases, and exposure to infected blood or blood products for about 19%. The mode of transmission for the remaining 35% of cases is not known. To date, the majority of infected cases are among males, with a male/female ratio of 7/1, which is to be expected in the early stages of an HIV epidemic. Most cases are in the age group of 20-40 years of age, and an increasing number of HIV cases have been found among high-risk groups. As in many other countries, those living with HIV/AIDS in Pakistan not only suffer the physical anguish of the disease but also experience isolation, discrimination, and abuse.

Future Risk

There are serious risk factors that put Pakistan to a danger of experiencing a widespread epidemic if immediate and vigorous actions are not taken:

Injecting Drug Users

In most Asian countries, those injecting drugs are the first community to be affected by HIV. The number of drug dependents in Pakistan is currently estimated to be 3 million, out of whom an estimated 60,000100,000 inject drugs. A few studies, though limited in

scope, suggest a possible increasing trend to injecting drugs.

Commercial Sex

Commercial sex is widespread in major urban areas, on truck routes, and near labor camps. Commercial sex workers and their clients have insufficient access to information about HIV and STDs. A 1996 study of sex workers in Karachi found that only 44% believed HIV was sexually transmitted. Furthermore, the sex workers often lack the power to negotiate safe sex or seek treatment for STDs.

Partial Blood Transfusion Screening and Professional Donors

It is estimated that 40% of about 1.5 million annual blood transfusions are not screened for HIV. Whereas screening in the public sector has made a bit of progress, private blood banks; however, remain mixed. Professional donors also are common. In 1998, the AIDS Surveillance Center in Karachi conducted a study of professional blood donors and found that 20% were infected with Hepatitis-C, 10% with Hepatitis-B, and 1% with HIV.

Sexually Transmitted Diseases and Low Condom Use

STDs facilitate the spread of HIV infection and serve as an indicator for low condom use and other high-risk sexual behaviors. STDs are prevalent and appear to be inappropriately addressed as a public health problem. For example, in a sample of 402 STD clinic attendees in Karachi, 17.1% were found to be positive for syphilis and 2.9% for gonorrhea. Condom use for disease prevention was negligible.

Migration and Refugees

Large number of workers leave their villages to seek work in larger cities or on industrial sites. A significant number of Pakistanis are employed overseas or serve in international armed forces, thus staying away from their homes for extended periods of time. They become vulnerable to HIV infection and are at higher risk for having unprotected sex and/or drug abuse. Those infected, bring STDs and HIV back to their spouses, partners, or contacts. HIV-positive Pakistanis who were repatriated from the Gulf countries have received public attention, largely because this group is systematically tested. Migrant laborers and transport workers are especially vulnerable to HIV infection along the principal trade routes within the country. Furthermore, more than one million Afghan refugees are displaced in the country, which exacerbates their vulnerability.

Unsafe Injection Practices

With 4.5 injections per capita, Pakistan has one of the highest annual ratios of injection per capita. Studies indicate that 94% of injections are administered using re-used injection equipment. There is widespread use of unsterilized needles at medical facilities. According to WHO estimates, unsafe injections account for 62% of Hepatitis B, 84% of Hepatitis C, and 3% of new HIV cases.

Low Levels of Literacy and Education

Low levels of literacy and education especially among women, are major constraints to HIV prevention. Efforts to increase awareness about HIV among the general population are hampered by low literacy levels and cultural influences. Younger groups are especially vulnerable. About two thirds of the population is below the age of 25. One study shows that awareness even among practitioners and hospital physicians is limited; 63% of general practitioners and 35% of hospital doctors were not aware that HIV could be transmitted from mother to child.

Special Vulnerability of Women due to Social and Economic Disadvantages

Restrictions on women's mobility limits access to information, and preventive and support services. Similar vulnerabilities are faced by youth in addition to influence by peers, unemployment frustrations, and the availability of drugs. In addition, some groups of young men are especially vulnerable due to the sexual services they provide, notably in the transport sector. Furthermore, young women and men from impoverished strata may be sexually exploited and abused by members of their own families.

Donors

UNAIDS has established a Theme Group and Technical Working Group on HIV/AIDS to coordinate the response of United Nations Agencies and to provide assistance to the GOP in the strategic development of activities. The theme group includes UNAIDS co-sponsors (WHO, UNICEF, UNFPA, UNDP, UNDCP, UNESCO, ILO, and the World Bank). The World Bank is also supporting the GOP's HIV/AIDS efforts through the Social Action Program II (1998-2003) and through the proposed HIV/AIDS Prevention Project (US$35 million). This project would help scale up existing activities, ensure that the program focuses on those interventions that would do the most to interrupt transmission of HIV, and make sure that interventions are designed taking full advantage of international experience to date. Other donors include DFID, JICA, and Norway supporting NGO programs and UNAIDS respectively. Small-scale projects are also supported by International NGOs including SCF USA, SCF UK and Catholic Relief Services.

NGOs in Pakistan

At least 54 NGOs are involved in HIV/AIDS public awareness, and care and support for persons living with HIV/AIDS. These NGOs also work on education and prevention interventions targeting sex workers, truck drivers, and other high-risk groups. NGOs serve as members of the Provincial HIV/AIDS Council, which has been set up in all four provinces to coordinate HIV/AIDS prevention and control activities. The NGOs are active in HIV/AIDS prevention activities; however, it is believed that they are reaching less than 5% of the vulnerable populations.

Priority Areas

1. Increase investment for program implementation and capacity development.
2. Build technical and management capacity for an expanded response both in the public and non-governmental sector, particularly at the provincial level.
3. Increase resource availability for an expanded program in selected areas.

The actions in prioritized areas include:

Vulnerable and High-Risk Groups

✐ Expand information access and coverage of high-risk groups through effective peer education initiatives.
✐ Implement harm reduction initiatives for IDUs and safe sex practices for CSWs.
✐ Make available effective and affordable STD services for high-risk groups and the general population.

General Awareness and Behavioral Change

✐ Improve delivery and access to effective awareness and prevention messages and health promotion interventions including peer education.

Blood and Blood-Product Safety

✐ Ensure mandatory screening of blood and blood products for all blood-borne infections in the public and private sector.
✐ Conduct education campaign for voluntary blood donation.

Injection Safety

✐ Create a consumer demand for safe injections through social marketing.
✐ Promote international norms and standards in injection delivery.
✐ Implement a national healthcare waste management system.

Surveillance and Research

- Strengthen and expand the surveillance and monitoring system.
- Carry out prevalence and behavioral studies to enhance understanding about the scope and spread of STDs and HIV, sexual attitudes and behaviors, and health care-seeking behaviors related to STDs.

Youth

Improve access to effective HIV/STDs prevention through formal and non-formal sectors[1].

Protection from HIV/AIDS

Though there is no proper cure of HIV/AIDS but one can protect oneself by taking some precautionary measures.

- First of all people should be careful while using the blood. It should be tested from laboratory to confirm that it is germs-free.
- People should not use public toilets where there is always a great possibility to be the victim of HIV/AIDS.
- People should not swim in such swimming pools where they think some AIDS patients are swimming.
- Don't use used eraser while shaving.
- Always use disposable syringe.
- Sex relations should be limited to your wife.

Child sexual abuse and HIV/AIDS not only prevails in Pakistan but in every corner of the world thus, there is a great need to protect our children. Educating our children on sexuality can play a significant role in this regard. Sex education and education on sexuality is not the same thing. Sex education covers human reproduction only, which is physical aspects and related issues such as sexually transmitted diseases (STDs and AIDS). This education on sex only teaches children about biochemical issues but does not teach about the difference between right and wrong, proper and improper, beautiful and ugly, the beauty of relationships and that too about responsible sexual reproductive behavior.

Education in sexuality inculcates in children the positive values and attitude towards sexuality, and helps them to develop self-esteem and skills for making rational and responsible decision related to sexual and reproductive behavior in the context of their

particular society.

In order to protect children from sexual abuse and HIV/AIDS parents can also play an important role. But it is not always comfortable for the parents to have a discussion on sexuality with their children. Parents do not realize that they are unconsciously imparting a more negative perception of sexual education through their attitudes than through the use of words. Their personal attitude to their own sexuality is what they are imparting to their children. Parents should:

- ✐ Develop friendly relationship with children and create an environment at home where they are not afraid to speak about anything.
- ✐ Train child to say "no" to an older person if he/she behaves in a way that makes him/her uncomfortable, or if an adult wants to have his private parts touched. Teach the child about the names of his/her private body parts like breast, anus, vagina and penis. Children need to know these words to express what is happening to them.
- ✐ Always impart some basic information about serious and infectious sexual and other diseases to enrich their knowledge that will help them in protecting themselves.
- ✐ Always be ready to listen children and believe them if they are reporting abuse.
- ✐ Be alert to small changes in behavior. It could be time to talk with the child about these changes.
- ✐ We should try to create maximum awareness among people about these issues and we should provide basic information to our children to decrease the level of occurrence of these problems.

METHOD

Aims and Objectives of the Study

- ✐ To find out the difference in level of awareness about child sexual abuse and HIV/AIDS among school going children.
- ✐ To find out the difference about the awareness of child sexual abuse and HIV/AIDS among the school going girls and boys.

Sample

A sample from the population of all schools was not easily accessible so only convenient sampling was done for this study. A sample of 60 students in class 7th and 8th from two schools was approached to collect the data. The sample group was further, subdivided into 30 boys and 30 girls.

Instrument

Indigenously developed questionnaire including the questions about child sexual abuse and HIV/AIDS was used to measure the awareness about child sexual abuse and HIV/AIDS in school going children. Alpha co-efficient reliability of scale was found very high that is 0.66 and face validity was also very good. Inter-item correlation was found out to be well correlated. After the pre-testing final data was collected from the sample of 60 students which were equally distributed into 30 boys and 30 girls.

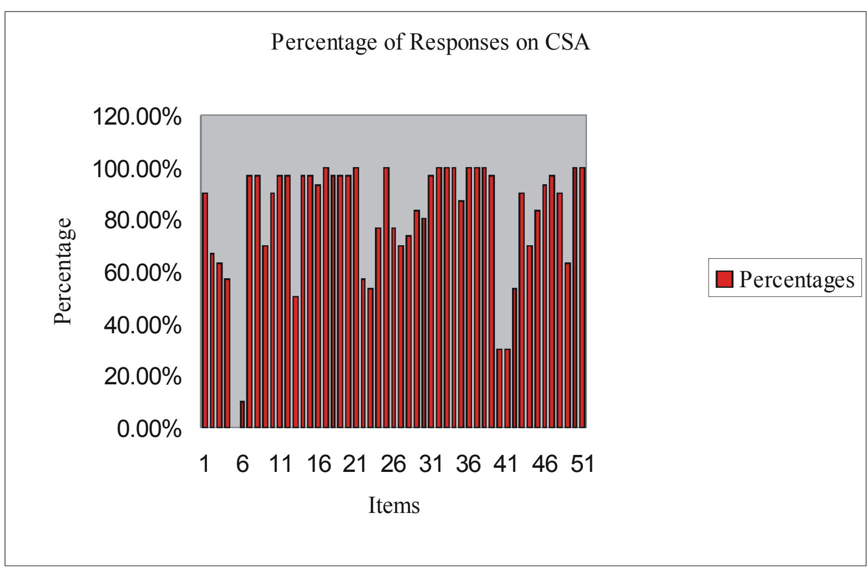
Procedure

The participants were approached in schools. After their consent to be the part of the study, questionnaire of awareness about child sexual abuse and HIV/AIDS was given to students; 15 boys and 15 girls were selected from each class.

The data was collected in group form. Initially rapport was developed with all participants. The participants in the groups were told about the nature of the study and they were assured that the information provided by them would be kept confidential and would be used for the research purpose only. After giving the instructions, the questionnaire was handed over to them. They were asked to read each statement written in the questionnaire carefully and then respond. The researcher read each item and then participants were asked to respond. They were told that there was no time bar for them.

Results and Discussion

Graph 1 is showing level of awareness among school going children about child sexual abuse and HIV/AIDS. The graph shows that both girls and boys are well aware about the child sexual abuse. Items showed that children are very concerned about what is going on around their world and they know how to behave in a specific situation and how to deal with people. They seem to be very keen observers and don't trust people very easily. “Grown ups can always be trusted.” On this item most of the children responded in “no” that indicates that children don't trust people easily whether they are relatives or strangers.



Graph 1

In the similar way children showed a high level of trust in their parents by showing the intention that they should share everything with their parents to save themselves if anything bad is happening to them.

Communication between parents and children is very important and those parents who create hurdles in such relation, their children suffer a lot and they also become part of the game. When there is good communication between both parties then children can get important information about what is right and what is wrong. So they can differentiate between places where they can move freely and without any danger. Same thing children showed in their responses to be careful in schools, hospitals and shops because these areas can be dangerous for the children; along with these places is another area; i.e. parks. Parks are the places, where abusers can get hold of children or can to approach them because children sometimes play alone in the evening, making it very easy for the abusers to approach. But surprisingly enough still most of the children said that they should play in the parks alone perhaps because they feel that parks are safe and no harm can be done to them.

There is a possibility that children might have a different concept of play within their minds, which may be too positive without having any fears of experiencing something bad.

One interesting finding in this research is that children are aware of right and wrong as they responded in positive way that the children who run away from their home are more vulnerable to child sexual abuse. They also know that they should not allow strangers to enter their home while parents are out. It is parent's careful attitude and training due to which children develop this kind of attitude. Another important thing is to educate children about their different body parts. Though this thing is very rare in our society that parents give children knowledge about their body parts but now values and time has been changed.

Results showed that children are aware that this is bad to undress while in presence of others because parents teach this thing to their children. So children considered it bad to undress even in the presence of the father, mother, brother, and relatives etc. Along with this, results showed an interesting finding in which individuals expressed that they would show some reaction if something is happening to their body that makes them uncomfortable. Most of the children said that they would be sadder, confused and scared rather than happy to know if something bad is happening to them. Besides all this children know that no one should be permitted to touch any private part of the body. This item showed very high percentages in term of awareness. It means that children know when someone tries to do act in this manner with bad intentions; the reason is that touching is the first and the most dangerous step leading towards child sexual abuse.

Children also know that adults are not always very kind, honest and they can be dangerous for the children at any time by becoming abusers. They also showed positive response that they should tell everything to their parents if an adult is trying to up set them. It shows that children are aware of what child sexual abuse is.

As children know what is child sexual abuse, they also consider it very important that they should get knowledge about it because it is crucial to save oneself from facing any critical situation of child sexual abuse as indicated in the form of a very high frequency and percentages in item asking: Do you think it is important to get some knowledge about it? It is important to mention here that child sexual abuse questions were structured in a way that they were not the very directly stated questions but they were formed very sensitively and in a manner that children do not become defensive rather can respond to them comfortably.

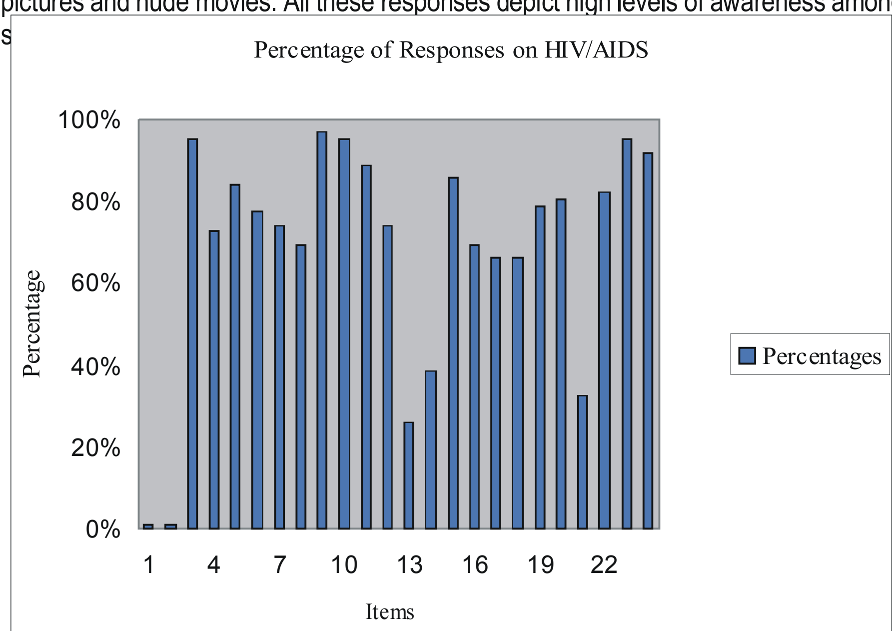
Children are aware of child sexual abuse and they consider that it is important to get knowledge about it, in the similar way they know that different people can harm them e.g. they indicated that doctors, policemen, neighbors, shopkeepers can abuse the children and most of them agreed that there is comparatively a lesser chance for the strangers abusing children since in most of the cases abusers are the trustworthy ones.

Results showed that children don't trust people very easily so they considered it very

wrong to accept something from a stranger and then keeping it secret. If at all this kind of attitude is shown, it means that something wrong is about to happen. Children also showed high frequency of “no” on the item: Does anybody have a right to say anything good/bad about your private body parts?

According to results children considered homes, shops, workshops and factories as unsafe places for the children to work but they considered restaurants as still more unsafe. So far protection of children in concerned responses showed that boys need less protection, girls need a little more protection, while majority of the individuals responded that both boys and girls need equal protection because anyone can be a victim of abuse regardless of being a boy or a girl. Children don't blame parents, but the circumstances, teachers, and relatives become a cause of sexual abuse incidents.

Researches have shown that pornography is one leading cause of child sexual abuse. Results of this research showed that children considered it very bad to watch nude pictures and nude movies. All these responses depict high levels of awareness among s



Graph 2

Graph 2 is showing the level of awareness about HIV/AIDS in the form of percentages. It is very obvious from the results that like child sexual abuse children are highly aware

about HIV/AIDS. Children have the understanding of the term HIV/AIDS; not only this but they also know the cause of this disease. They completely agreed that people could get such disease through injection, transfer of blood that is not tested in laboratory before use. In the same way they negated the misconception that people can get this disease through kissing and sharing food with the suffers of HIV/AIDS.

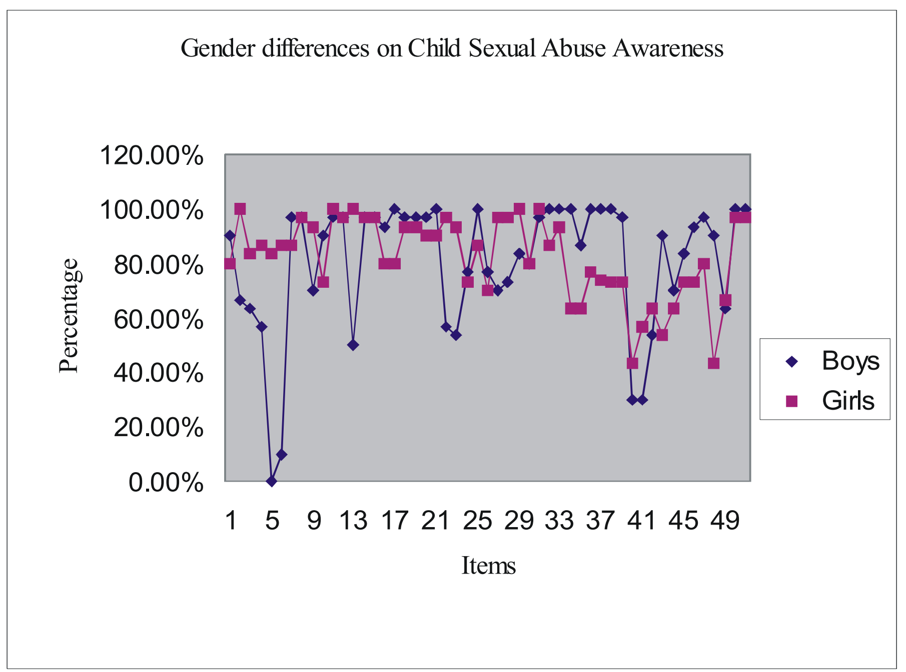
Children are not only aware about the causes of HIV/AIDS but they also know that this is an infectious disease and is not treatable. They have full understanding that this disease can lead to other serious diseases like hepatitis B and C.

Results showed that major source of information about HIV/AIDS for children are T.V and Internet. It means both these media can play very important role in raising awareness among masses to decrease the ratio of HIV/AIDS. Other than TV and Internet, other two major sources of knowledge about the HIV/AIDS are cable and age-mates. As we know friends and age mates serve as one of the very important part of the child's socialization, so children can get information about many things by their friends. Parents are rated as one source and contribute least in providing information about HIV/AIDS. So parents have to be conscious in this respect to save their children from this life threatening disease. Children also showed high level of interest in knowing more about HIV/AIDS.

Children are not much aware about the prevalence rate of HIV/AIDS in Pakistan in comparison with the rest of the world. Some misconceptions are prevailing in our society related to HIV/AIDS as touching patients of AIDS/HIV can lead to developing the same disease. Besides this awareness, children don't want to make friendship with those who are the victim of HIV/AIDS. It may be due to our society's mood and set up. But children know that if someone becomes the victim of HIV/AIDS it is not the parents' fault but many factors might have contributed to the whole of the tragedy. At the same time they are keen observers of everything, as they know that sharing public toilets and swimming pools with the patients can lead people to falling prey to the same disease.

At the same time children consider that discussing the topic of HIV/AIDS in cartoon movies is good source of raising awareness among the children. They responded that they did remember such cartoon movies but they got the hidden message of such movies as to love the sufferers.

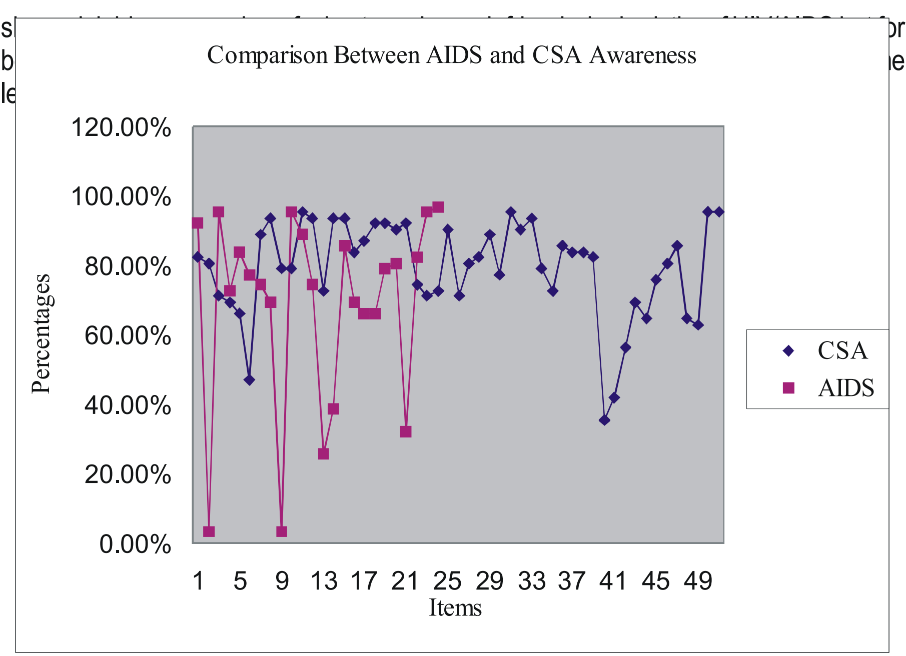
Graph 3 shows gender differences on awareness about child sexual abuse. It is a comparative analysis to find out how much girls and boys differ in their responses toward child sexual abuse.



Graph 3

Both girls and boys are well aware of child sexual abuse but girls showed more awareness on some items for example on item: Should we tell everything to our parents? All girls agreed completely while 63.70% boys agreed with this statement; showing that girls are more careful than boys. While girls considered schools, hospitals and shops unsafe places where anything bad can happen to, on the contrary boys think that these places are not dangerous and are safe places. Girls thought that it is unsafe to play in the parks alone while boys strongly disagreed that playing in the parks could be dangerous. This difference might be due to our socialization of children because our girls are trained to be careful while moving anywhere; on the other hand boys are trained as more independent so they consider it unimportant to show any careful behavior in such places.

Boys showed high level of awareness about child trafficking while girls are not much aware of it. Girls responded that both boys and girls need equal protection. Responses have shown high level of awareness among boys who considered that relatives are not always good they can be harmful but girls negated this by showing responses that showed their trust on relatives. Except for these items, both girls and boys showed more



Graph 5

Graph 5 shows comparison between level of awareness about child sexual abuse and HIV/AIDS in terms of percentages. It becomes clear that children are more aware about child sexual abuse in comparison with HIV/AIDS.

Conclusion

As we know different problems prevail throughout the world but some problems are so serious that it becomes crucial to solve them, otherwise generations after generations the problems survive and even go worse. Child sexual abuse and HIV/AIDS are such kind of problems that need to be focused very minutely. It is very important to raise awareness among people to protect their lives. Lack of awareness is the major problem of our country. People are ignorant about many things due to lack of education and social set up. Still social set up should not be a barrier in raising awareness among mass. So everyone should do their best to make people more knowledgeable about the different

issues. We should provide special education to our children to increase their level of awareness about child sexual abuse and HIV/AIDS to protect their lives. This is the best way to solve and to decrease the level of occurrence of such problems.

Limitations

Every study is a new step towards understanding the solution to problems:

- Only small sample was included in the study. Due to our social values that prevent us from studying such topics, the data was collected from only two schools of Gujar Khan city. So findings cannot be generalized for the lager population.
- Convenient sampling was done, as it was very difficult to use any other sampling technique.

Recommendations

As there is no problem existing in this world that is without solution, so we can also suggest some further steps to make this study better in future.

- Data should be collected from a large population to increase its generalizability. For this purpose all data should be collected from the different schools of different cities and it may be used for comparison purposes.
- This type of study should be conducted in rural areas as well, making it possible to check the difference in level of awareness among school going children of rural and urban areas.

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Note to Contributors

RAHAT Medical Journal is the world's unique medical journal offering scholars a forum in which to present the subject of epidemiology, etiology and pathogenesis of torture, and rehabilitation of torture survivors. RAHAT is dedicated to dissemination of ideas and issues of interest to medical practitioners and general public worldwide.

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The preferred maximum length of research articles is 3,000 to absolute maximum 5,000 words (including references). The research articles should also have an Abstract (not exceeding 100 words). The format of papers should include introduction/theoretical formulation/literature review, methods used in research (data collection tools, description of the sample etc.), results, discussion, and conclusion; references or bibliography, should also be provided. Authors are encouraged to follow APA style. Any tables, graphs, or illustrations should be sent in camera-ready form whenever possible.

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Final date for submission: 30th September 2004

Contact:

RAHAT Medical Journal
P. O. BOX 2428, Islamabad, Pakistan.

Tel: +9251 2256882, Fax: +9251 2250716
E-mail: **rahatmj@isb.paknet.com.pk**
Website: **www.voiceagainsttorture.org.pk**

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20th Sep15 Oct 2004 Lund, Sweden.	**The Equal Status and Human Rights of Women** Raoul Wallenberg Institute of Human Rights and Humanitarian Law For further information, contact: Raoul Wallenberg Institute of Human Rights and Humanitarian Law Attn: HUWO 04 P.O. Box 1155 SE-221 01 Lund SWEDEN **Tel:** +46 46 222 1200 **Fax:** +46 46 222 1222 **E-mail:** zophie.landahl@rwi.lu.se **Web:** http://www.rwi.lu.se

New Project
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For further queries please contact:
School of Human Rights
St. 34, house # 109
G-9/1, Islamabad
Pakistan.
Tel: +92-51-2256882, 2260143
Fax: +92-51-2250716
E-mail: shr@voiceagainsttorture.org.pk
Website: www.voiceaganisttorture.org.pk

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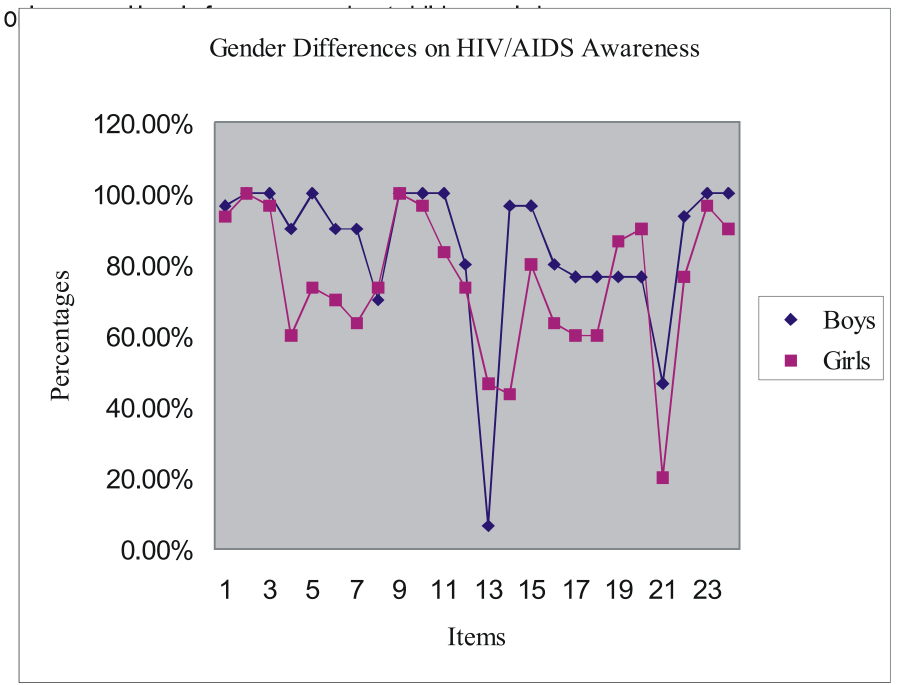

Graph 4

Graph 4 is showing gender differences in level of awareness about HIV/AIDS in form of percentages. It is showing that both girls and boys are well aware of HIV/AIDS, still some differences do exist. Girls are having misconception that sharing food with the patient of HIV/AIDS can lead to some disease while boys showed high level of awareness by negating this misconception. Girls also declared that kissing a victim of HIV/AIDS could cause same disease in others. While boys are well aware of what is the fact, girls considered HIV/AIDS treatable and boys showed high responses by accepting this reality that it not a treatable disease.

Boys did not consider cable as an important source of getting knowledge about HIV/AIDS while girls agreed that cable is an important source of knowledge. Girls