

Clinical Management of Rape Survivors

**A guide to assist in the development
of situation-specific protocols**

February 2002



**Inter-Agency Lessons Learned Conference:
Prevention and Response to
Sexual and Gender-Based Violence in Refugee Situations
27-29 March 2001
Geneva**

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For more information on this document, please contact:

World Health Organisation, Geneva - Reproductive Health and Research
fax: +41-22-791 4189/ 4171, e-mail: reproductivehealth@who.int,
website: <http://www.who.int/reproductive-health>

UNHCR - Health and Community Development Section
C.P. 2500, Geneva, Switzerland 1202
Fax: 41 22 739 7366 E:mail HQTS00@unhcr.ch Website: www.unhcr.ch

Preface

Sexual and gender-based violence is a world wide problem. Refugee women, men and children are particularly at risk as they are targets of this human rights abuse during every phase of the refuge cycle. Rape, one of the most hideous forms of sexual violence, is pervasive, and no society, country or region is immune from it. Rape, as a weapon war, is well documented as is rape in refugee situations.

Over the last five years, humanitarian actors have been working to put into place systems to respond to sexual and gender-based violence as well as support community-based approaches to prevent such violence. In March 2001, the international humanitarian community came together to document what they have been doing to respond to and prevent sexual and gender-based violence (SGBV) in refugee situations. Hosted by UNHCR, 160 refugee, non-governmental, governmental and United Nations representatives met in Geneva to share lessons learned on SGBV. The Clinical Management of Rape Survivors is an outcome of this conference. It was compiled under the leadership of the World Health Organisation with support from the International Committee for the Red Cross and the United Nations High Commissioner for Refugees.

A draft guide was disseminated widely to a variety of settings around the world and field-tested in several sites. Feedback received from these settings was included in this final draft. This final draft for field-testing again will be circulated widely and comments received will be incorporated into a final guide.

INTRODUCTION

This guide provides advice on state of the art (best practices) clinical post-rape management. It must be adapted for each situation based on national policies/practices and availability of materials and/or drugs.

Clinical Management of Rape Survivors provides guidance to health care providers for medical management after the rape of women, men, and children. It is not the health care provider's responsibility to determine whether a person has been raped or not. That is a legal determination. Rape may be a reason a survivor gives for visiting a health care service.

This guide assists health care providers to perform a thorough physical examination, record the findings and give medical care to someone who has been penetrated in the vagina, anus or mouth by a penis or other object. The protocol does not include advice on standard wound or injury care or psychological counselling, although such care may be required. This guide also does not give guidance on referral procedures to community support, police and legal services. Other reference materials do exist that describe this kind of care or give advice on creating referral networks. This guide is complementary to these references.

This guide is designed to assist qualified health care providers (medical co-ordinators, medical doctors, clinical officers, midwives, and nurses) to develop protocols for the management of rape survivors based on available resources, materials, drugs, and national policies and procedures. Managers and trainers of health care services can also benefit by using the guide to plan for survivor care and train health care providers accordingly.

Medical management of rape varies depending on how soon the survivor seeks medical care after the incident and on her¹ wishes as to what type of care she shall receive. This protocol describes what health care providers should do if the survivor presents themselves within 72 hours after the incident or later.

The essential components of medical care after a rape are:

- Forensic evidence collection.
- STI evaluation and preventive care.
- Pregnancy risk evaluation and prevention.
- Crisis intervention.
- Care of injuries.

Source: *Sexual Assault Nurse Examiner (SANE) Development and Operation Guide*.

¹ While it is recognised that men and boys are also survivors of rape, the survivors of rape are most often women and girls. Therefore, pronouns used in this guide are phrased in the feminine voice.

Steps in the clinical management protocol

- Be prepared to offer medical care for rape survivors.
- Preparing the survivor for the exam.
- Taking the history.
- Collecting forensic evidence.
- Performing the physical and genital examination.
- Prescribing treatment.
- Counselling the survivor.
- Follow-up care for the survivor.

Special considerations on care for children, men, pregnant and elderly women are also provided.

How to use this guide

This document should be used as a guide for health care professionals who are working in refugee, IDP, and other such settings to develop site-specific protocols for medical care for rape survivors. In order to do this a number of steps must be taken. Suggested steps include (not necessarily in the following order):

- Identify a team of professionals and community members who are involved in caring for survivors of rape.
- Convene meeting(s) with medical staff and community members.
- Create a referral network between the different sectors involved in caring for rape survivors (community, health, security, protection).
- Identify available resources in the country you are working (drugs, materials, laboratory possibilities), and the relevant national policies and procedures relating to rape (standard treatment protocols, legal procedures, abortion laws, etc.). See Annex 1 for an example of a checklist for the development of a local protocol.
- Develop a situation-specific medical care protocol, using this guide as a reference document.
- Train providers on the use of the protocol including what must be documented during an exam for legal purposes.

Rape is a traumatic experience, both emotionally and physically. Survivors may be raped by any number of people in a number of different situations; they may be raped by paramilitary soldiers, police, family members, friends, boyfriends, husbands, fathers or uncles; they may be raped while collecting firewood, using the latrine, in their beds at night or while visiting friends. They may be raped by one, two, three or more people, by men or boys, or by women. They may have been raped over a period of months or this may be the first time. Survivors can be women or men, girls or boys; but they are most often women and girls.

Survivors may react in any number of ways to such a trauma; whether their trauma reaction is lasting or not depends, in some part, on how they are treated when they seek help. By seeking medical treatment, the survivor has acknowledged that physical and/or emotional damage has occurred. She most likely has a health concern. The health care provider can address these health concerns and help survivors begin the recovery process by providing compassionate, thorough and excellent medical care, and by centring this care around the survivor and her needs and being aware of the setting specific circumstances that may effect the care provided.

Source: Center for Health and Gender Equity (CHANGE)

STEP 1 - Be prepared to offer medical care to rape survivors

Health care service must be prepared to provide a thorough and compassionate response to survivors of rape. The medical co-ordinator should ensure that qualified health care providers (doctors, medical assistants, nurses, etc.) are adequately trained to provide essential care, and have all the necessary equipment and supplies ready to respond. Female health care providers should be trained as a priority, although the lack of trained female health workers should not prevent care for survivors of rape.

Before starting a service, the following questions and issues must be addressed, and procedures standardised.

What should the community be aware of?

- Know *what* services are available after rape.
- Know *why* survivors would want to seek medical care for rape.
- Know *where* to go for services.
- Know that they should come *IMMEDIATELY* after the incident without bathing, changing clothes, etc.
- Know that they can *trust* the service, i.e. survivors will be treated with dignity, their security will be maintained, and all staff will respect confidentiality.
- Know that *there is* 24-hour access to services.

What are the host country's laws and policies?

- Which health care provider should provide what type of survivor care? If the survivor wishes to report officially to the authorities, the country may require that a certified/licensed medical doctor provide the care and complete any official documentation.
- What are the legal requirements with regard to forensic evidence?
- What are the national laws regarding possible medical consequences of rape (e.g. emergency contraception, post-rape abortion, HIV testing and use of preventive treatments etc.)?

What are the host country's resources and capabilities?

- What laboratory facilities are available for forensic testing (e.g. DNA analysis, acid phosphatase) or screening for diseases (e.g. STIs, voluntary counselling and testing services for HIV).
- Are there existing rape management protocols and "rape kits" for documenting and collecting forensic evidence?
- Is there a national STI treatment protocol, a PEP protocol, and a vaccination schedule? Which vaccines are available in the country?
- What possibilities are there for referral of the survivor to secondary health care facilities (e.g. psychiatric, surgical, paediatric, gynaecological/obstetric)?

Where should care be provided?

- Generally, a health care facility (clinic or outpatient service) already offering reproductive health services, such as antenatal care, normal delivery care, or management of STIs, can offer care for rape survivors. Referral services may need to be provided at a hospital level.

Who should provide care?

- All staff in health facilities dealing with survivors - from reception staff to health care professionals - should be trained to care for the survivors of rape. They should always be compassionate and respect confidentiality at all times.

How should care be provided?

- According to a protocol that is specifically developed for each situation.
- Protocols should include medical, psychosocial, ethical (responsibilities of the provider) and guidance on counselling options for the survivor.
- In a compassionate manner.
- Centred on the survivor and her needs.
- With an understanding of the provider's own attitudes and sensitivities, the socio-cultural context, the community's perspectives, practices, and beliefs.

What is needed?

- All health care for the survivor should be provided in one place within the health care facility so that the survivor does not have to move from place to place.
- 24-hour and 7-day access.
- All available supplies from the following checklist should be prepared/stocked in a special box/place so that they are readily available.

How to co-ordinate with others?

- Inter-agency and inter-sectoral co-ordination should be established to ensure comprehensive care for survivors of sexual violence.
- Be sure to include representatives from social/community services, protection, police/legal justice system, and security. Depending on services available in your setting, others may need to be included.
- As a multi-sectoral team, establish referral networks, communication systems, co-ordination mechanisms, and follow-up strategies.

Remember: the wishes of the survivor should be respected at all times.

Checklist of Supplies/Equipment Needed

Protocol	Available
Written medical protocol translated in language of provider*	
Personnel	Available
Trained (local) health care professionals (on call 24 hours/day)*	
For female survivors, a female health provider speaking the same language is optimal. IF this is not possible a female health worker (or companion) should be in the room during the examination*	
Furniture/Setting	Available
Room (private, quiet, accessible, access to a toilet or latrine)*	
Examination table*	
Lighting, preferably fixed (a torch may be threatening for children)*	
Magnifying glass (or colposcope)	
Access to an autoclave to sterilise equipment*	
Access to laboratory facilities/microscope/trained technician	
Weighing scales and height chart for children	
Supplies	Available
"Rape Kit" for collection of forensic evidence, could include:	
▪ Speculum* (preferably plastic disposable, only adult sizes)	
▪ Comb for collecting foreign matter in pubic hair	
▪ Syringes/needle (butterfly for children)/tubes for collecting blood	
▪ Glass slides for preparing wet and/or dry mounts (for sperm)	
▪ Cotton tip swabs/applicators/gauze compresses for collecting samples	
▪ Laboratory containers for transporting swabs	
▪ Paper sheet for collecting debris as the survivor undresses	
▪ Tape measure for measuring the size of bruises, lacerations, etc*.	
▪ Paper bags for collection of evidence*	
▪ Paper tape for sealing and labelling containers/bags*	
Supplies for universal precautions (gloves, box for safe disposal of contaminated materials and sharps, soap)*	
Resuscitation equipment for anaphylactic reactions*	
Sterile medical instruments (kit) for repair of tears and suture material*	
Needles, syringes*	
Cover (gown, cloth, sheet) to cover the survivor during the examination*	
Spare items of clothing to replace those that are torn or taken for evidence	
Sanitary supplies (pads or local cloths)*	
Pregnancy tests	
Pregnancy calculator disk to determine the age of a pregnancy	
Drugs:	Available
▪ For treatment of STIs as per country protocol*	
▪ For post-exposure prophylaxis of HIV transmission (PEP)	
▪ Emergency contraception pills and/or IUD*	
▪ Tetanus toxoid, tetanus immuno-globulin	
▪ Hepatitis B vaccine	
▪ Pain relief* (e.g. paracetamol)	
▪ Anxiolytic (e.g. diazepam)	
▪ Sedative for children (e.g. diazepam)	
▪ Local anaesthetic for suturing*	
▪ Antibiotics for wound care*	
Administrative Supplies	Available
▪ Medical chart with pictograms*	
▪ Forms for recording post-rape care	
▪ Consent forms*	
▪ Information pamphlets for post-rape care (for survivor)*	
▪ Safe locked filing space to keep confidential records*	

* The marked items are the minimum requirement for examination and treatment of a rape survivor

STEP 2 – Prepare the survivor for the examination

The survivor has experienced trauma and may be in an agitated or depressed state of mind. She often feels fear, guilt, shame, and anger. The health workers must prepare the survivor for the examination and undertake this care in the most caring, compassionate, systematic, and complete fashion.

To prepare the survivor for the examination:

- Ensure a trained same-sex support person or trained health worker accompanies the survivor throughout the examination.
- Explain what is going to happen during each step of the examination - why it is important, what it will tell you, and how it will influence the care you are going to give her.
- Explain that she is in control of the pace, timing and components of the examination.
- Reassure the survivor that the exam findings will be kept confidential.
- Ask her if she has any questions.
- Ask if she wants to have a specific support person present.
- Review and have the survivor sign the consent form (see Annex 2).
- Limit the number of people allowed in the room during the exam.
- Undertake the examination as soon as possible.
- Do not force the survivor to do anything against her will.

STEP 3 – Taking the history

General guidelines

- Any documents or paperwork brought by the survivor to the health centre should be reviewed before taking the history.
- Let the survivor tell her story the way she wants.
- Be careful not to ask questions that were already asked and documented by other people involved in the case.
- If the interview is conducted in the treatment room, cover the instruments until they are to be used.
- Questioning should be done gently and at the survivor's own pace.
- Sufficient time should be allotted to collect all required information without rushing.
- Avoid any distraction/interruption during history taking.
- Explain what you are going to do.
- All staff should create a climate of trust.

A sample history and examination form is included in Annex 3. Using this form as a guide, the main elements of history taking are:

General information

- Name, address, sex, date of birth (or age in years).
- Note the date and time of the examination and the name(s) of any staff or support person (someone the survivor may request) present during the interview and exam.

Description of the incident

- Ask the survivor to describe what happened. Allow the survivor to speak at her own pace. Do not repeatedly interrupt for details. Follow-up with clarification questions after she finishes telling the story. Explain that she does not have to tell you anything she does not feel comfortable with.
- It is important that the health worker understands the details of exactly what happened in order to check for possible injuries. Explain this to the survivor, and reassure her of confidentiality if she is reluctant to give detailed information. The form in Annex 3 includes details needed.

History

- If the incident occurred fairly recently, determine whether the survivor has bathed, urinated, vomited, etc. since the incident. This may affect the collection of forensic evidence.
- Existing health problems, allergies, use of alcohol/drugs, vaccination and HIV status will help you to determine the best treatment to provide, counselling needed, and follow-up health care.
- Evaluate for possible pregnancy. Ask detailed information about contraception use, last menstrual period, etc.

Some 2% of rape survivors have been found to be pregnant at the time of the rape in developed country settings (SANE). Not all were aware of the pregnancy. Try to confirm a pre-existing pregnancy by a pregnancy test or by history and examination. The following guide may be useful if you do not have pregnancy tests.

A Guide for Confirming Pre-Existing Pregnancy <i>(adapted from FHI protocol (Lancet 1999))</i>		
No		Yes
1.	Have you given birth in the past 4 weeks?	
2	Are you less than 6 months postpartum and fully breast feeding and free from menstrual bleeding since you had your child?	
3	Did your last menstrual period start within the past 10 days?	
4	Have you had a miscarriage or abortion in the past 10 days?	
5	Have you gone without sexual intercourse since your last menses (apart from the incident)?	
6	Have you been using a reliable contraceptive method consistently and correctly? (check with specific questions)	

If the survivor answered **NO** to all the questions, ask and look for signs and symptoms of pregnancy. If pregnancy *cannot* be confirmed provide her with information on emergency contraception to help her arrive at an informed choice (see Step 7).

If the survivor answers **YES** to at least 1 question and she is free of signs and symptoms of pregnancy: provide her with information on emergency contraception to help her arrive at an informed choice (see Step 7).

STEP 4 – Taking forensic evidence

The main purpose of the examination is to provide medical care. However, forensic evidence may be collected to help the survivor pursue legal redress. The survivor may choose not to have evidence collected. Respect her choice.

Good to know before you develop your protocol:

- ◆ Not all countries and locations have the same legal requirements and the necessary facilities (laboratory, refrigeration, etc.) to perform tests. Therefore, national and local resources and government policies determine the selection of evidence that should be collected. *Do not collect evidence that cannot be processed.*
- ◆ In some countries, it may be the medical doctor's legal obligation to have an opinion on the physical findings found. Find out what the role of the healthcare provider is in reporting medical findings in a court of law. Ask a legal expert to write a short briefing about the local court proceedings in cases of rape and what to expect to be asked in court when giving testimony.

Purpose of evidence collection

- To confirm recent sexual contact.
- To show that force or coercion was used.
- To possibly identify the assailant.
- To corroborate the survivor's story.

Collect evidence as soon as possible after the incident (within 72 hours)

Documenting injuries and collecting samples of different materials such as blood, hair, saliva, sperm, etc. within 72 hours of the incident may help to corroborate the survivor's story and might help to identify the aggressor(s). If the survivor presents more than 72 hours after the rape, the amount and type of evidence that can be collected will depend on the situation.

Documenting the case

Record the interview and your findings at the examination in a clear, complete, objective, non-judgmental way.

- Completely assess and document the physical and emotional state of the survivor.
- Quote important statements made by her, such as threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements such as "the patient states" or "the patient reports".
- Avoid the use of the term "alleged". It can be interpreted as meaning the survivor exaggerated or lied.
- Note down exactly which samples you have taken.

Possible samples that can be collected as evidence

- Injury evidence: physical and genital trauma are proof of force.
- Clothing evidence: torn or stained clothing is useful to prove force was used.
- Foreign material (e.g. soil, leaves, grass) on her clothes or body or in her hair may corroborate her story.
- Hair evidence: foreign hairs found on the survivor's clothes or body. Pubic and head hair from the survivor is plucked or cut for comparison.
- Sperm and seminal fluid evidence: specimens are taken from the vagina, anus or oral cavity (if ejaculation took place in these locations) to look for the presence of sperm and for prostatic acid phosphatase analysis.
- DNA analysis can be carried out on material found on or in the survivor's body or at the place of aggression which might be soiled with blood, sperm, saliva or other biological material from the assailant (e.g. clothing, sanitary pads, handkerchiefs, condoms, bite marks, semen stains, fingernail cuttings, swab samples from involved orifices). In this case, blood from the survivor must be drawn to distinguish her DNA from foreign DNA found.
- Blood or urine for toxicology testing (if the survivor was drugged).

Forensic evidence collection and medical examination are performed simultaneously.

It is necessary to obtain the consent of the survivor for the collection of evidence.

Work systematically according to the medical examination form (sample form in Annex 3) and explain everything you do and why you are doing it.

Inspection of the body

- Examine the survivor's clothing with a good light source before she undresses. Collect any foreign debris on clothes, skin or in the hair (e.g. soil, leaves, grass, foreign hairs). She can be asked to undress while standing on a paper sheet (provide a gown). Collect torn and stained items of clothing, but **only** do so if you can give her replacement clothes.
- Document all injuries (see Step 5).
- Collect samples from all places where there could be saliva (where the attacker licked or kissed or bit her), or semen on the skin, with the aid of a cotton bud swab, lightly moistened with sterile water, for DNA analysis.
- The survivor's pubic hair may be combed for foreign hairs.
- Take samples and swab the oral cavity if ejaculation took place in the mouth, for direct examination for sperm, DNA, and acid phosphatase analysis.
- Take a blood and urine sample if indicated.

Inspection of the anus, perineum and vulva

Inspect and swab the skin around the anus, the perineum and vulva (in that order) with cotton-tipped swabs moistened with sterile water for DNA analysis.

Examination of the vagina and rectum

Lubricate a speculum with normal saline or clean water (other lubricants interfere with the forensic analysis).

- Collect some of the fluid in the posterior fornix for examination for sperm
- Take specimens of the posterior fornix and the endo-cervical canal with cotton-tipped swabs. Let them dry at room temperature for DNA analysis.
- Collect separate samples from the cervix and the vagina or the rectum. This can be analysed for acid phosphatase.
- Obtain samples from the rectum, if indicated, for examination for sperm, DNA, and acid phosphatase analysis.

Direct examination for sperm

Put a drop of the fluid collected on a slide, if necessary with a drop of NaCl (wet-mount) and examine it under the microscope for sperm. Note their mobility. Smear what is left over on a second slide and air-dry the slides for further examination at a later stage.

Bacteriological tests

Tests for STIs are usually not collected as forensic evidence. A pre-existing STI could be used against the victim in court. In some settings screening for gonorrhoea, chlamydia, syphilis, and HIV is done for children presenting with a history of sexual abuse (see section on Children).

Maintaining the chain-of-evidence

It is very important to maintain the chain-of-evidence at all times, so the evidence will be admissible in court. Maintaining the chain-of-evidence means that the evidence is collected, labelled, stored, and transported properly. Documentation must include a signature of everyone who had possession of the evidence, from the individual who collected it to the individual bringing the evidence to the courtroom, to prevent any possibility of tampering.

If it is not possible to bring the samples immediately to a laboratory, precautions must be taken.

- All clothing, cloth, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper bags (not plastic bags). Samples can be tested for DNA many years after the incident, provided the material is well dried.

- Blood and urine samples can be stored in the refrigerator for 5 days. To keep the samples longer they need to be stored in a freezer. Follow local laboratory instructions.
- All samples should be clearly labelled with a confidential identifying code (not the name of the survivor), date, time, and type of sample (e.g. what it is, from which location it was taken) and put in a container.
- Seal the bag or container with paper tape across the closure of the container – again write the identifying code and the date and sign your initials across the tape.
- In the adapted protocol, clearly write down the laboratory's instructions for collection, storage, and transport of samples.

Evidence should only be collected and released to the authorities if the survivor decides to proceed with a case.

The survivor may consent to have evidence collected but not to have the evidence released to the authorities at the time of the examination. In this case you can advise her that you will keep the evidence in a safe locked secure space in the health centre for one month before it is destroyed. If she changes her mind during this period she can advise the authorities where to collect the evidence.

Reporting medical findings in a court of law

If the survivor wishes to pursue legal redress and the case comes to trial, the health worker who has examined her after the incident may be asked to report on the findings in a court of law. Only a small percentage of cases will actually go to trial. Many health workers may be anxious about appearing in court or feel that they have not enough time to do this. Nevertheless, providing such evidence is an extension of their role in caring for the survivor.

- In cases of rape, the prosecutor (not the health care provider) must prove three things^{*}:
 - some penetration, however slight, of the vagina or anus by a penis or other object, or penetration of the mouth by a penis;
 - this penetration occurred without the consent of the woman;
 - the identity of the perpetrator.
- In most settings the health care provider is expected to give evidence as a factual witness (that means to reiterate your findings as you recorded them), not as an expert witness.
- Meet with the prosecutor prior to the court session to prepare your testimony and be informed about the significant issues involved.
- Conduct yourself professionally and confidently in the courtroom:
 - Dress appropriately.
 - Speak clearly, slowly, and make eye contact with whomever you are speaking.
 - Avoid the use of medical terms.
 - Answer questions as thoroughly and professionally as possible.

^{*} Widney Brown A. Obstacles to women accessing forensic medical exams in cases of sexual violence. Unpublished WHO background paper, 2001.

- If you do not know the answer to a question, say so, do not make the answer up and do not testify about matters that are outside your area of expertise.
 - Clarify questions that you do not understand. Do not try to guess the meaning of the question.
- The notes written during the initial interview and examination are the mainstay of the findings to be reported. It is difficult to remember what was not written down. This underscores the need to record **all statements, procedures and actions in sufficient detail, accurately, completely and legibly**. This is the best preparation for an appearance in court.

STEP 5 – Performing the physical / genital examination

The examination and forensic evidence collection are performed simultaneously.

The primary objective is to provide medical care for the survivor.

Only collect evidence specimens that can be processed

Work systematically according to the medical examination form.

(See sample form in Annex 3)

This chapter is divided into two parts, depending on how soon after the incident the survivor presents; Part A: up to 72 hours after the incident or; Part B: more than 72 hours after the incident.

General guidelines

- Make sure the equipment and supplies are prepared.
- **Always look at the survivor first, before you touch her.**
- **Always tell her what you are going to do and ask her permission before you do it.**
- Assure her that she is in control, can ask questions, and can stop the examination at any time.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).
- The initial triage may reveal severe medical complications that will have to be treated as a matter of urgency, and for which the patient will have to be admitted. The treatment of these complications is not covered here in detail. Such complications might be:
 - Extensive trauma (genital region, head, chest or abdominal trauma).
 - Asymmetric joint swelling (septic arthritis).
 - Neurological deficits.
 - Respiratory distress.
- Obtain voluntary informed consent for the examination and to obtain required samples for forensic examination (see sample consent form in Annex 2).

PART A: Survivor presents within 72 hours of the incident

Physical examination

- Never ask her to fully undress or uncover. Examine the upper half of her body first, then the lower half or give her a gown to cover herself.
- Minutely and systematically examine the patient's body, starting at the head. Do not forget to look in the eyes, nose, mouth and in and behind the ears, and to examine forearms, wrists, and ankles. Take note of the pubertal stage.
- Look for signs that are consistent with the survivor's story, such as bite and punch marks, marks of restraints on the wrists, patches of hair missing from the back of the head, or torn eardrums as a result of slapping.
- Note all your findings carefully on the examination form and the chart with the body figure (see sample in Annex 4), taking care to record the type, size, colour, and form of any bruises, lacerations, ecchymoses and petechiae.
- Take note of the survivor's emotional state (withdrawn, crying, calm, etc.).
- Take samples of any foreign material on the survivor's body or clothes (blood, saliva, sperm, swabs of bite marks, etc.) according to your local evidence collection protocol.

Examination of the genital area

Even on examination of female genitalia immediately after the rape there is identifiable damage in less than 50% of cases. Do the gynaecological examination as indicated below. Collect evidence as you go along, according to your local evidence collection protocol. Note the location of any tears, abrasions and bruises on the pictogram and the examination form.

- Systematically inspect the mons pubis, inside of the thighs, perineum and anus, labia majora and minora, clitoris and urethra, introitus and hymen.
 - Note any scars from previous female genital cutting.
 - Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
 - Look for any sign of infections, such as ulcers, vaginal discharge or warts.
 - Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and adolescents (see section on Children).
 - Take samples according to your local evidence collection protocol.
- If indicated by the history (vaginal penetration), gently insert the speculum, lubricated with water or normal saline. **NO speculum examination of children** (see section on Children).
 - Under good lighting inspect the cervix, followed by the posterior fornix and the vaginal mucosa for trauma, bleeding or signs of infection.
 - Take swabs and collect vaginal secretions according to your local evidence collection protocol.
- If indicated by the history and the rest of the examination, do a bimanual examination and palpate cervix, uterus, and adnexae, looking for signs of abdominal trauma, pregnancy and infection.

Note: In some cultures, it is unacceptable to penetrate the vagina of a woman who is a virgin with anything, including a speculum, finger or swab. In this case you may have to limit the examination to inspection of the external genitalia, unless there are symptoms of internal damage.

Examination of anus and rectum

- For the anal examination you may have to change the position of the patient. Write down the position in which you examined her (supine for genital examination; supine, prone, knee-chest, or lateral recumbent for anal examination).
- Note any fissures around the anus, presence of faecal matter on the perianal skin, anal shape, tone and dilatation, and possible bleeding from rectal tears.
- If indicated by the history, collect samples from the rectum according to your local evidence collection protocol.
- If indicated, do a rectovaginal examination, and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding or discharge. Note the sphincter tone.

Laboratory testing

If the survivor presents within 72 hours, there are no additional laboratory samples to be collected other than those collected for evidence, unless indicated by the history or the findings on examination. Tests for STIs may be collected for medical purposes.

- If she has complaints that indicate a urinary tract infection, collect a urine sample for erythrocytes and leukocytes, and possibly culture.
- Do a pregnancy test, if indicated and available (see Step 3).
- Other diagnostic tests, such as X-ray and ultrasound may be of use to diagnose fractures and abdominal trauma.

PART B: Survivor presents more than 72 hours after the incident

Physical examination

It is rare to find any physical evidence more than one week after an assault. If the survivor presents within a week or presents with complaints, do a full physical exam, as above.

- Note size and colour of bruising and scarring.
- Note evidence of any complications of the rape (e.g. deafness, fractures, abscesses, etc).
- Note her mental state (e.g. normal, withdrawn, depressed, psychotic, suicidal).

Examination of the genital area

If the assault occurred more than a week ago and there are no signs of bruises, lacerations and no complaints (i.e. of vaginal or anal discharge or ulcers), there is less indication to do a pelvic examination. However, if you are in a setting with laboratory facilities, samples may be taken for STI screening purposes from the vagina and anus.

Laboratory screening

Screen for STIs if possible, depending on the setting. Follow local laboratory instructions, for example:

- Screen for syphilis with an RPR.
- Screen for gonorrhoea (gram stain and culture).
- Screen for chlamydia (culture or ELISA).
- Screen for HIV after voluntary counselling.

STEP 6 – Prescribing treatments

This chapter is divided into two parts, depending on how soon after the incident the survivor presents; Part A: up to 72 hours or; Part B: more than 72 hours after the incident.

PART A: Survivor presents within 72 hours of the incident

Prevent sexually transmitted infections (STIs)

Good to know before you develop your protocol:

Antimicrobial resistance to several antibiotics of *Neisseria gonorrhoea*, the bacteria that causes gonorrhoea, is widespread. Many countries have developed local STI treatment protocols based on local resistance patterns. Find out the local STI treatment protocol in your setting and treat survivors according to this protocol.

- Survivors of rape should be treated with antibiotics to prevent gonorrhoea, chlamydia and syphilis. If you know that other STIs are prevalent in your area (such as trichomonas or chancroid), add preventive treatment for these infections to the regimen.
- Give the woman the shortest possible courses available in the local protocol, which are easy to take. For instance: 2 grams of azithromycin orally plus one injection of benzathine benzylpenicillin will be sufficient treatment for all three infections.
- Be aware that women who are pregnant should not take certain antibiotics.

- Examples of WHO recommended STI treatment regimens are included in Annex 5.

Prevent HIV transmission

Good to know before you develop your protocol:

At the time this guide was published, there were no conclusive data on the effectiveness of Post-Exposure Prophylaxis (PEP) for preventing transmission of HIV after rape. However, PEP is available in some settings for rape survivors (see Annex 6). Before you start your service, make sure you know if PEP is available in your setting and make a list of provider names and addresses for referrals.

- If this service is available, PEP is usually given for 28 days as a mono, bi- or a triple-therapy of a combination of 1, 2, or 3 anti-retroviral drugs (ARV). There are many problems and issues surrounding the prescription of PEP, not the least of which is the difficulty of counselling the woman on HIV issues at a time like this. If you wish to know more about PEP, see the Further Readings.
- If it is possible in your setting for the woman to receive PEP, refer her as soon as possible (up to 72 hours after the rape) to the relevant centre. If she presents after this time, counsel the survivor on VCT services if available in your area.

Prevent pregnancy

- Taking emergency contraceptive pills (ECP) within 72 hours of unprotected intercourse will reduce the chance of a pregnancy between 74-85%, depending on the regimen chosen and the timing of starting the course (see Annex 7).
- As described by WHO, “emergency contraceptive pills (ECPs) work by interrupting a woman’s reproductive cycle – by delaying or inhibiting ovulation, blocking fertilisation or preventing implantation of the ovum. ECPs do not interrupt or damage a pregnancy and thus are not considered a method of abortion”.
- Some people believe that ECPs are abortifacients. Health workers holding such belief may be precluded from providing this treatment. Women who request this service should be offered counselling so as to reach an informed decision.
- A health worker who is willing to prescribe ECPs should always be available to prescribe them to rape survivors who may wish to use them to prevent pregnancy. If the survivor is a young child who has reached menarche, also discuss EC with her and her mother/guardian who can help her to understand and take the regimen, if indicated
- If an early pregnancy is detected at this stage, either with a pregnancy test or by completing the history and examination (see Steps 3 and 5), it can be helpful for the woman to know that a confirmed pregnancy is not the result of the rape.
- There is no evidence of contraindication to giving ECPs at the same time as antibiotics.

Provide wound care

- Clean any tears, cuts and abrasions and remove dirt, faeces, and dead or damaged tissue. Decide if there are any wounds that need suturing. Suture clean wounds within 24 hours. After this time they will have to heal by second intention or delayed primary suture. Do not suture very dirty wounds. In case of major contaminated wounds, consider giving appropriate antibiotics and pain medication.

Prevent tetanus

Good to know before you develop your protocol:

- Tetanus toxoid is available in several different preparations. Check local vaccination guidelines for recommendations.
- Tetanus immunoglobulin (antitoxin) is expensive and needs to be refrigerated. It is not available in low-resource settings.

TT	Tetanus toxoid
DTP	Triple antigen: Diphtheria and Tetanus toxoid and Pertussis vaccine
DT	Double antigen: Diphtheria and Tetanus toxoid, given to children up to 6 yrs
Td	Double antigen: Tetanus toxoid and reduced diphtheria content, age 7 years and over
TIG	Anti-tetanus immunoglobulin

- Tetanus prophylaxis, if not already current, should be given when there are any breaks in skin or mucosa, unless the survivor has been fully vaccinated.
- Based on the table below, decide whether to administer tetanus toxoid (TT), which gives active protection, and anti-tetanus immunoglobulin (TIG), if available, which gives passive protection.
- When vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and separate sites of administration.
- Advise survivors to complete the vaccination schedule (2nd dose at 4 weeks, 3rd dose at 6 months - 1 year).

Guide for administration of tetanus toxoid and tetanus immune globulin in cases of wounds <i>(Adapted from Benenson AS, Control of Communicable Diseases Manual. AMPH 1995.)</i>				
History of tetanus immunisation (number of doses)	If wounds are clean and <6 hours old or minor wounds		All other wounds	
	TT*	TIG	TT*	TIG
Uncertain or <3	Yes	No	Yes	Yes
3 or more	No, unless last dose >10 years ago	No	No, unless last dose >5 years ago	No

**For children less than 7 years old, DTP or DT is preferred to tetanus toxoid alone. For persons 7 years and older, Td is preferred to tetanus toxoid alone.*

Prevent hepatitis B

Good to know before you develop your protocol:

- Find out the prevalence of Hepatitis B in your setting and the country of origin's and the host country's vaccination schedules.
 - There are several hepatitis B vaccines available, each with different recommendations for dosage and vaccination schedules. Check the dosage and vaccination schedule for the product that is available in your setting.
-
- Whether you can provide post-exposure prophylaxis against hepatitis B will depend on the setting you are working in. The vaccine may not be available as it is relatively expensive and requires refrigeration.
 - There exists no information on the frequency with which hepatitis B virus (HBV) infection occurs following rape. However, HBV is present in semen and vaginal fluid and is efficiently transmitted by sex. Survivors of rape should receive post-exposure immunisation with hepatitis B vaccine within 14 days, if possible.
 - In those countries that have started infant immunisation programmes routinely using hepatitis B vaccine, a survivor may already have been protected by vaccination. If they are known to be protected through inspection of their vaccination record card, no additional doses of hepatitis B vaccine are needed.
 - The usual vaccination schedule is at 0, 1 and 6 months. However, this may differ for different products and settings. Give the vaccine IM in the deltoid (adults) or the anterolateral thigh (infants and children). Do not inject into the buttock, because it is less effective.
 - The vaccine is safe for pregnant women and for people who have chronic or past HBV infection and it can be given at the same time as tetanus vaccine.

Provide mental health care

Initiation of social rehabilitation and psychological counselling (see Step 7) are essential components of care for the survivor. Most survivors of rape will regain their psychological health through emotional support and understanding from trusted persons, the community counsellor and through support groups. All rape survivors should be referred to the community SGBV focal point.

Occasionally a survivor may present with severe symptoms of post-traumatic stress (PTSD). These symptoms can include anxiety, nightmares, inability to sleep, constant crying, etc.

In **exceptional** cases, if the level of anxiety is such that it is disrupting the survivor's everyday life, give **one tablet** of diazepam (Valium) 10 mg, to be taken at bedtime. In this case she should be referred to a trained health professional and her symptoms reassessed the next day

PART B: Survivor presents after 72 hours of the incident

Sexually transmitted infections

Treat if necessary, which means either:

- Laboratory screening for STIs has revealed an infection; or
- She is symptomatic.

Treat according to the syndromic approach. Follow national protocols.

HIV transmission

While in some settings testing can be done as early as six weeks after the rape, it is more recommended to refer the survivor for VCT three to six months later, in order to avoid repeated testing. Check the VCT services available in your setting and their protocols.

Pregnancy

- In case the survivor is already pregnant, try to ascertain if she could have become pregnant at the time of the rape if this is an issue for her. Counsel the woman on the possibilities available to her in your setting if she is already or should become pregnant as a result of the rape (see Step 3 - Taking the History and Step 8 - Counselling the Survivor).
- If the survivor presents after 72 hours, but up to and including five days after the rape, insertion of an IUD is a reliable way of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies). The IUD can be removed at her next menstrual period or be left in place for future contraception. A skilled provider should counsel the patient and insert an IUD.

Bruises, wounds and scars

Treat, or refer for treatment, all unhealed wounds, fractures, abscesses, other injuries, and complications.

Tetanus

Tetanus has an incubation period of three to 21 days, but it can be many months. Refer survivor to the appropriate level of care if you see signs of the tetanus infection. If she has not been fully vaccinated, vaccinate now, no matter how long after the incident. If there remain major, dirty, unhealed wounds consider giving antitoxin, if this is available (see above section, Prevention of Tetanus for incidents within 72 hours).

Hepatitis B

Hepatitis B has an incubation period of on average two to three months. Refer if possible or counsel if you see signs of an acute infection. If the person has not been

vaccinated and it is appropriate in your setting, vaccinate, no matter how long after the incident (see Resource Materials section).

Mental health

Initiation of social rehabilitation and psychological counselling (see Step 7) are essential components of medical care for the survivor. Most survivors of rape will regain their psychological health through emotional support and understanding from trusted persons, the community counsellor and through support groups. All rape survivors should be referred to the community SGBV focal point.

Occasionally a survivor may present with severe symptoms of post-traumatic stress (PTSD). These symptoms can include anxiety, nightmares, inability to sleep, constant crying, suicidal thoughts, etc.

In **exceptional** cases, if the level of anxiety is such that it is disrupting the survivor's everyday life, give **one tablet** of diazepam (Valium) 10 mg, to be taken at bedtime. In this case she should be referred to a trained health professional and her symptoms reassessed the next day

STEP 7 - Counselling the survivor

Survivors seen at the health facility immediately after the rape will most likely be experiencing psychological trauma and may show signs of anxiety and/or depression. Survivors in this state are unlikely to remember counselling and advice given at this time. It is important to repeat the counselling during follow-up visits. It is also useful to prepare standard advice and counselling information in writing, and give the survivor a copy before she leaves the health facility (even if survivor is illiterate, someone can read it to her later).

Psychological and emotional trauma

- Medical care for survivors of rape/sexual assault includes care and referrals for psychological trauma.
- The majority of sexual assault survivors never tell anyone about the incident. If the survivor has told you what happened, she has demonstrated that she trusts you.
- Sexual assault causes psychological and emotional trauma as well as physical injury. Survivors may experience a range of post traumatic symptoms, including:
 - Self blame.
 - Uncontrollable emotions such as fear, anger, guilt, shame, anxiety.
 - Mood swings.
 - Nightmares, sleeping disorders.
 - Eating disorders.
 - Suicidal thoughts, attempts.
 - Drug/alcohol use.

- Most cultures tend to blame the survivor in cases of rape and sexual assault. Assure the survivor that she did NOT deserve to be raped, that the incident was NOT her fault, that it was NOT caused by her behaviour, manner of dressing, etc.
- Tell the survivor that she has experienced a serious physical and emotional trauma. Advise her about the post-traumatic symptoms (emotional and physical) that she may experience.
- Advise the survivor that part of the care she needs is emotional support. Encourage her to confide in someone she trusts and to ask for this emotional support, perhaps a family member or friend.
- Refer the survivor to the counselling service for psychosocial assistance.
- Ask the survivor if she has a **safe place** to go, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to, care should be taken to find her a safe place. Enlist the assistance of the counselling services, community services provider, and/or policy/security officer (see Step 1).
- In some cases, the survivor is seriously traumatised and experiences severe emotional/psychological dysfunction, becoming unable to manage day-to-day living. Referral for psychological evaluation and more in-depth counselling may be needed. Find out what services are available in your area.

Medical consequences due to rape

Give the survivor the opportunity to ask questions and to voice her concerns.

- Female survivors of rape are going to be very concerned of the possibility of becoming pregnant as a result of the rape. Emotional support and clear information is needed to ensure that she understands the choices available to her if she is or becomes pregnant.
 - There may be services for adoption and/or foster care in your area. Determine the services available and give this information to the survivor.
 - In many countries the law allows termination of pregnancy in case of rape. Furthermore, local interpretation of abortion laws in cases of mental and physical health may include indications for rape survivors as well. Find out whether this is the case in your setting. Determine where safe abortion services are available so you can refer the survivor to this service if she so chooses.
 - Advise the survivor to seek support from someone she trusts – perhaps a religious leader, family member, friend, or community worker.
- Both men and women may be most concerned about the possibility of becoming HIV positive as a result of rape. Although the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded. Compassionate and careful counselling around this issue is essential. The health care worker may also discuss the risk of HIV/STI transmission to partners following a rape.
 - The survivor could be referred to an HIV/AIDS counselling service if available.
 - Condom use with any/all partners for a period of 6 months (or depending on result of HIV screening tests) should be recommended.
 - Advise on signs and symptoms of possible STIs.

- Give advice on proper care for any injuries following the incident, such as infection prevention (including perineal hygiene, perineal baths), signs of infection, antibiotic treatment, when to return, etc.
- Give advice on how to take treatments and possible side effects of treatments (see Annex 7).

Follow-up care at the health facility

- Inform the survivor that she can return at any time to the health service if she has questions or other health problems. She should be encouraged to return in two weeks for follow up STI and pregnancy evaluation.
- Give clear advice on any follow-up needed for wound care or vaccinations.

STEP 8 – Follow-up care of the survivor

There is a possibility that the survivor may not or cannot return for follow-up care. Provide a maximum amount of input during the first visit, as this may be the only visit.

In case the survivor is started on post-exposure prophylactic treatment (PEP) with antiretroviral drugs, the follow-up schedule may be different from the one below. Discuss this with the PEP provider.

Two week follow-up visit

- Evaluate for pregnancy and provide counselling (see information about pregnancy in Steps 5, 6, 7).
- Evaluate for STIs, treat as appropriate, counsel on HIV testing.
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Six month follow-up visit

- Evaluate for STIs, treat as appropriate.
- Possible voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer as needed (see Step 7).

- Pregnancy may be the result of a rape. All options available, e.g. keeping the child, adoption and abortion, should be discussed with the woman concerned, regardless of the individual beliefs of the counsellors, medical staff or other persons involved, in order to enable the woman to make an informed decision.
- Where safe abortion services are not available, women with unwanted pregnancies may undergo unsafe abortions. These women should have access to postabortion care, including emergency treatment of abortion complications, postabortion family planning counselling, and linkages to other reproductive health services.
- Children born as a result of rape may be mistreated or even abandoned by their mothers and families. They must be closely monitored and support should be offered to the mother. It is important to ensure that the family and the community do not stigmatise either the child or the mother. Foster placement and, later, adoption, should be considered if the child is rejected, neglected or otherwise mistreated.

Care For Children Survivors

Good to know before you develop your protocol:

- In your setting, if there is obligatory reporting of cases of child abuse, obtain a sample of the national child abuse management protocol and information on customary police and court procedures.
- In settings where the health worker is expected to go to court as an expert witness, he/she should receive special training in examining child abuse survivors.
- Health care providers should be knowledgeable about child development and growth as well as normal child anatomy.

General

The initial triage may reveal severe medical complications that will have to be treated as a matter of urgency, and for which the patient will have to be admitted. The treatment of these complications is not covered here in detail. Such complications might be:

- Convulsions.
- Child vomits everything.
- Stridor in a calm child.
- Lethargic or unconscious child.
- Child is unable to drink or breastfeed.

In children younger than 3 months also:

- Fever or low body temperature.
- Bulging fontanel.
- Grunting, chest indrawing, breathing more than 60 breaths/minute.

Create a safe and trusting environment

- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that they are not in any trouble.
- Ask a few questions about neutral topics; e.g., school, friends, who they live with, favourite activities.
- Take special care to determine who should be present during the interview and examination. (Remember that it is possible a family member is the perpetrator.) The child's parent/guardian may wish to be present. Ask the child if it is okay to examine him/her while parent/guardian wait outside. Respect the child's wishes. The child may wish to have another support person with him/her during the interview and examination.

Take the history

Begin the interview by asking open-ended questions, such as “Why are you here today?” or “What were you told about coming here?”

- Assure the child it is okay to respond to any questions with “I don’t know”.
- Be patient, go at the child’s pace, don’t interrupt his/her train of thought.
- Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.

The dynamics of the sexual abuse in children is generally different from adult abuse. For example there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

- The home situation (has the child a secure place to return to?)
- How the rape/abuse was discovered?
- The number of incidents and the date of the last incident.
- Was there any bleeding, did (s)he have difficulty walking?

Prepare the child for examination

- As with adult examinations, there should be a support person or trained health worker in the examining room with you who is the same sex as the survivor.
- Encourage the child to ask questions about anything he/she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the exam, using terms a child can understand.
- With adequate preparation, most children will be able to relax and participate in the exam.
- It is possible that the child has **pain** and cannot relax for that reason. If in doubt, give paracetamol or other simple painkillers to relieve pain. Wait for these to take effect.
- **Never** restrain or force a frightened, resistant child to complete an exam. Restraint and force are often part of sexual abuse; and if used by those attempting to help, will only heighten the child’s fear and anxiety, and worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment/supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

Conduct the examination

Conduct the examination as for adults. Special considerations for children are:

- Note the child’s, weight, height and pubertal stage. Ask girls about menstruation. She may be at risk of pregnancy.

- Small children can be examined on mother's lap. Older children should be offered the choice of sitting on a chair, on mother's lap or lying on the bed for examination.
- The anus can be examined in the supine or lateral position. Avoid the knee-chest position, as the assailant often uses it.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and **gently** pulling outwards and downwards. Note presence and location of fresh and healed tears of the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Digital examination (assessing the size of the vaginal orifice by the number of digits inserted) is **NOT** recommended.
- Look for vaginal discharge. In the prepubertal girl, vaginal specimens can be collected with a dry cotton sterile swab.
- A speculum examination in the prepubertal girl is **NOT** done because it is extremely painful and may cause severe injuries.
- Speculum insertion is **only** recommended when there is suspected penetrating vaginal injury and bleeding from an internal source. In this case, speculum examination in the prepubertal child is usually done under general anaesthesia. Depending on the setting, this may require referral to another level of health care.
- In boys check for injuries at the frenulum of the prepuce, and anal or urethral discharge and take swabs if indicated.
- Conduct an anal examination in both boys and girls.
- Record the position of anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of sodomy, but also of constipation.
- Digital examination to assess anal sphincter tone is **NOT** recommended

Laboratory testing

In some settings, screening for gonorrhoea (culture), chlamydia (culture), syphilis, and/or HIV is done for all children presenting with a history of rape. The presence of these infections may be indicate rape (if the infection is not likely perinatally or blood transfusion acquired*). Follow your local protocol.

In rare cases when the child is highly agitated and examination is vital

ONLY if the child cannot be calmed down, AND ONLY IF within 72 hours of a rape, AND evidence collection or treatment is vital should the examination be performed under sedation, using **one of the** following drugs:

* American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. Pediatrics 1999;103:186-191.

Sedation for Post-Rape Examination of Children USE ONLY IN RARE, EXTREME, AND URGENT SITUATIONS	
Drug	Dose
Diazepam, tablet 2 mg or 5 mg. By mouth OR	0.15 mg/kg, maximum 10 mg
Promethazine hydrochloride, syrup, 5 mg/5 ml. By mouth	2 – 5 years: 15 – 20 mg (= 15 – 20 ml) 5 – 10 years: 20 – 25 mg (=20 – 25 ml)

The above drugs do not provide pain relief. If you think the child is in pain, **give simple pain relief first**, such as paracetamol; 1–5 years 120 – 250 mg, 6-12 years 250 – 500 mg, and wait for this to take effect.

Oral sedation will take 1 to 2 hours to take full effect – in the meantime allow the child to rest in a quiet environment.

Treatment

Routine STI prevention is usually not recommended for children in settings where screening can be done. However, in low-resource settings high prevalence of sexually transmitted diseases, preventive STI treatment is often part of the protocol (see Annex 5 for examples).

Follow-up

As for adults. If a vaginal infection does not clear, consider the presence of a foreign body or continued sexual abuse.

Special Considerations for Men Survivors

Counselling

- Male rape survivors are even less likely to report than women because of the extreme embarrassment that they typically experience. Although the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.
- When a man is anally raped, pressure on the prostate can cause an erection and even orgasm. Reassure the survivor that if this has occurred during the rape, this is a physiological reaction and it does not mean that his body has betrayed him.

Genital examination

- Examine scrotum, testicles, penis, periurethral tissue, urethral meatus and anus.
- Note if the survivor is circumcised.
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
- **Torsion of the testis is an emergency and requires immediate referral.**
- The urine may contain large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check rectum and prostate for trauma and signs of infection.
- If relevant, collect material from the anus for direct examination under the microscope for the presence of sperm.

Treatment

Men need the same STI preventive treatment and vaccinations as described for women.

Special Considerations for Pregnant Women

Women who are pregnant at the time of the rape are physically and psychologically more vulnerable. In particular they are susceptible to miscarriages, hypertension of pregnancy and premature births.

Counsel her on these issues and advise her to attend antenatal care services regularly during this pregnancy (see Step 8).

Special Considerations for Elderly Women

Elderly women who have been vaginally raped are at increased risk for vaginal tears and injury and transmission of STIs and HIV. Decreased hormonal levels following menopause result in a reduction in vaginal lubrication and cause the vaginal wall to become thinner and more friable. If collecting evidence or screening for STIs is indicated, use a thin speculum or insert a swab only as trauma may occur when inserting a speculum.

ANNEXES

Annex 1 Information Required to Develop a Local Protocol

Checklist developed for Tanzanian refugee camps

Certain information is needed before a local protocol can be developed. The following table shows the information that was collected in Tanzania and where this information was found.

INFORMATION NEEDED ON	WHERE TO FIND THIS INFORMATION
<i>Medico-legal laws and procedures</i>	
Abortion laws	Ministry of Health
Emergency Contraception use	Ministry of Health
Foster placement and adoption laws and procedures	Ministry of Community Development, Women Affairs and Children
Crime reporting requirements and obligations, for adult or child survivors	Ministry of Justice
Police and other forms required	Ministry of Home Affairs
<i>Forensic evidence</i>	
Which medical practitioner can give medical evidence in court (e.g. doctor, nurse, etc)?	Ministry of Justice
Training for medical staff on forensic examination (of adult or child survivors).	Ministry of Health
Evidence allowed/used in court for adult and child rape cases that can be collected by medical staff	Ministry of Justice
Forensic evidence tests possible in country (e.g. DNA, acid phosphatase)	Forensic laboratory at capital level
How to collect, store and send evidence samples	Forensic laboratory at capital level
Existing "rape kits" or protocols for evidence collection	Referral hospital at regional or capital level
<i>Medical protocols</i>	
National Sexually Transmitted Infections (STI) protocol	Ministry of Health
Vaccination availability and schedules	Ministry of Health
Location of Voluntary Counselling and Testing (VCT) services	National AIDS Control Program Ministry of Health
Confirmatory HIV testing strategy and laboratory services	UNHCR, National AIDS Control Program Ministry of Health, Regional Medical Officer
Possibilities/protocols/referral for Post-Exposure Prophylaxis (PEP) of HIV transmission	National AIDS Control Program Ministry of Health
Clinical referral possibilities (e.g. psychiatry, surgery, paediatrics, gynaecology/obstetrics)	Referral hospital at regional level

Annex 2
Sample Consent Form

Name of Facility _____

Note to the health worker: read the entire form to the survivor, explaining that she can choose any (or none) of the items listed. Obtain signature or thumb print with witness signature.

I, _____, authorise this health facility to perform the following (print name)

(Mark with an X all that apply)

___ Collect evidence, including hair combings, blood sample, photographs, body fluid samples, scraping of fingernails, and collection of clothing.

___ Conduct a medical examination, including pelvic examination.

___ Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow up care provided.

Signature: _____

Date: _____

Witness: _____

Annex 3 Sample History and Examination Form

1 of 4

CONFIDENTIAL

CODE:

Medical History and Examination Form – Post Sexual Violence

1. GENERAL INFORMATION

First name:		Last name:	
Address:			
Sex:	Date of birth:	Age:	
Date / time of exam /		In the presence of:	

In case of child include: Name of school, name of parents and/or guardian

2. THE INCIDENT

Date of incident:		Time of incident:		
Description of incident (survivor's description):				
Physical violence	Yes	No	Describe type and location	
Type (beating, biting, pulling hair, etc.)				
Use of restraints				
Use of weapon(s)				
Drugs/alcohol involved				
Penetration	Yes	No	Not sure	Describe (oral, vaginal, anal, type of object)
Penis				
Finger				
Other (describe)				
Ejaculation	Yes	No	Not sure	Location (oral, vaginal, anal, other location).
Condom used				

If the survivor is a child, also ask about: Has this happened before, how long, who is the perpetrator, is (s)he still a threat, etc. Also ask about bleeding per the vagina or per rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, etc.

3. MEDICAL HISTORY

2 of 4

Contraception use					
Pill			IUD		
Injection			Other (specify)		
Menstrual history					
Last menstrual period			Menstruation at time of event	Yes	/No
Evidence of pregnancy			Yes	/No	Number of weeks pregnant
				_____ weeks	
After the incident, did the survivor		Yes	No		No
Vomit				Rinse mouth	
Urinate				Change clothing	
Defecate				Wash/bathe	
Brush teeth				Use tampon	
History of consenting intercourse					
Last consenting intercourse within a week prior to the assault		Date:		Name of individual:	
Existing health problems					
History of female genital cutting, type					
Allergies					
Alcohol, medication, drug use					
Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments	
Tetanus					
Hepatitis B					
HIV/AIDS status	Known		Unknown		

4. MEDICAL EXAMINATION

3 of 4

Appearance (clothing, hair, etc., obvious physical or mental handicap?)		
Mental state (calm, crying, anxious, co-operative, etc.)		
Weight:	Height:	Pubertal stage (pre-pubertal, pubertal, mature):
Physical findings <i>Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae, marks, etc. Document type, size, colour, form and other particulars. Be descriptive, do not interpret the findings.</i>		
Head and face		Mouth and nose
Eyes and ears		Neck
Chest		Back
Abdomen		Buttocks
Upper Extremities		Lower Extremities

5. GENITAL AND ANAL EXAMINATION

Vulva/Scrotum	Introitus and hymen	Anus
Vagina/Penis	Cervix	PV/PR
Position of patient (supine, prone, knee-chest, lateral, mother's lap)		
For genital examination:		For anal examination:

6. INVESTIGATIONS DONE

Type and location	Examined/sent to lab	Result

7. EVIDENCE TAKEN

Type and location	Sent to.../stored	Collected by/date

7. PRESCRIBED TREATMENTS

Treatment	Yes	No	Type and Comments
STI prevention			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Other			

8. COUNSELLING, REFERRALS, FOLLOW UP

General psychological status	
Survivor plans to report to police OR has already made report Yes__ / No__	
Survivor has a safe place to go Yes__ / No__	Has someone to accompany Yes__ / No__
Counselling provided:	
Referrals	
Follow-up required	
Date of next visit	
Name of health worker conducting exam/interview: _____	
Title: _____	Signature: _____ Date: _____

Annex 4
Pictograms

Annex 5 Sexually Transmitted Infections (STIs) Protocols

Examples of WHO recommended treatments for adults

*NB: These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow existing **local** treatment protocols for sexually transmitted infections.*

STI	Treatment
Gonorrhoea	<p>Azithromycin 2 g orally (<i>not recommended in pregnancy</i>) (<i>Note: in this case you do not have to give chlamydia treatment</i>)</p> <p>or</p> <p>Ciprofloxacin 500 mg orally, single dose (<i>contraindicated in pregnancy</i>)</p> <p>Or</p> <p>Cefixime 400 mg orally, single dose</p> <p>Or</p> <p>Ceftriaxone 125 mg IM, single dose</p>
Chlamydia	<p>Doxycycline 100 mg orally, twice daily for 7 days (<i>contraindicated in pregnancy</i>)</p> <p>Or</p> <p>Azithromycin 1 g orally, in a single dose (<i>not recommended in pregnancy</i>)</p>
<i>Chlamydia if pregnant</i>	<p>Erythromycin 500 mg orally, four times/day for 7 days</p> <p>Or</p> <p>Amoxicillin 500 mg orally, three times daily for 7 days</p>
Syphilis	Benzathine benzylpenicillin 2.4 million IU, IM, once only (<i>give as two injections in two separate sites.</i>)
<i>Syphilis if allergic to penicillin</i>	<p>Doxycycline 100 mg orally twice daily for 15 days</p> <p>Or</p> <p>Tetracycline 500 mg orally, 4 times daily for 15 days (<i>both contraindicated in pregnancy</i>)</p> <p>(<i>Note: both these antibiotics are also active against chlamydia</i>)</p>
<i>Syphilis if pregnant and allergic to penicillin</i>	Erythromycin 500 mg orally 4 times per day for 15 days (<i>Note: this antibiotic is also active against chlamydia</i>)
Trichomonas	Metronidazole 2 g orally, in a single dose or as 1 g 12 hourly for one day (<i>contraindicated in the first trimester of pregnancy</i>)

Give one easy to take, short treatment for each of the infections that are prevalent in your setting.

Example

Presumptive treatment for gonorrhoea, syphilis and chlamydia for a woman, not pregnant and not allergic:

- Azithromycin 2g orally + benzathine benzylpenicilin 2.4 million IU IM,
- or
- Ciprofloxacin 500 mg orally single dose + benzathine benzylpenicilin 2.4 million IU IM + doxycycline 100 mg twice daily for 7 days

If trichomonas is prevalent, add 2 g of metronidazole orally, single dose.

Examples of WHO recommended treatments for STIs in children and adolescents.

*NB: These are examples of treatments for sexually transmitted urogenital infections. There may be other treatment options. Always follow existing **local** treatment protocols for sexually transmitted infections and use drugs and dosages that are appropriate for children.*

STI	Weight or Age	Treatment
Chlamydia	< 45 kg	Erythromycin 50 mg/kg/day orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	≥ 45 kg but < 12 years	Erythromycin 500 mg orally, 4 times daily for 7 days Or Azithromycin 1 g orally, single dose
	≥ 12 years	Doxycycline 100 mg orally, twice daily for 7 days Or Azithromycin 1 g orally, single dose Or Erythromycin 500 mg orally, 4 times daily for 7 days
Syphilis		Benzathine penicillin 50 000 IU/kg IM (up to a maximum of 2.4 million IU), single dose
<i>If allergic for penicillin</i>		<i>Erythromycin or doxycycline in the dosages as recommended for chlamydia for 14 days</i>
Gonorrhoea	< 45 kg	Ceftriaxone 125 mg IM, once only Or Spectinomycin 40 mg/kg IM (up to a maximum of 2 g), single dose. or (if > 6 months) Cefixime 8mg/kg orally, single dose
	≥ 45 kg	Treat according to adult protocol
Trichomonas	< 12 years	Metronidazole 5 mg/kg orally, 3 times daily for 7 days
	≥ 12 years	Treat according to adult protocol

Based on: "Tailoring Clinical Management Practices to Meet the Special Needs of Adolescents: Sexually Transmitted Infections", WHO/CAH 2002, WHO/HIV/AIDS 2002.03, in print.

Annex 6

Protocols for Post-exposure Prophylaxis (PEP)

Example 1

From: Bamberger, JD. et. al., Postexposure prophylaxis for human immunodeficiency virus (HIV) infection following sexual assault. The American Journal of Medicine, 1999. 106, 323-326.

Treatment regimen (28 days)

Zidovudine (AZT), 300 mg twice a day or 200 mg 3 times per day, and
Lamivudine (3TC), 150 mg twice a day,

Alternative regimen (28 days)

Didanosine (ddl), 200 mg twice a day, and
Staduvudine (d4T), 40 mg twice a day

*Consider adding**

Nelvinavir 750 mg three times a day, or
Indinavir, 800 mg three times a day

- Although antiretroviral medications rarely cause important laboratory abnormalities, baseline tests may be useful.
- Monitoring should include complete blood count and hepatic enzyme levels as clinically indicated.
- HIV antibody testing is recommended at baseline, 6 weeks, 3 months, and 6 months following the assault.

**In settings where the assailant is likely to be infected with HIV resistant to reverse transcriptase inhibitors, it is recommended to add a protease inhibitor.*

Example 2

From: Treatment guidelines of the use of AZT (zidovudine) for the prevention of the transmission of human immunodeficiency virus (HIV) in the management of survivors of rape. The Department of Health, Western Cape Province, South Africa

Treatment regimen (28 days)

AZT (Zidovudine), 300 mg twice a day

- Survivors are given a one-week supply of the drug and an appointment date to return for reassessment in one week.
- Survivors are seen at one week for an evaluation and to obtain the results of their blood tests. They are given the remainder of their 28-day dose of AZT.
- The next visits are at 6 weeks and 3 months after the rape. HIV testing is performed at both these visits.

Annex 7 Emergency Contraception Protocols

Emergency Contraceptive Pills

- There are two emergency contraceptive pill (ECP) regimens that can be used, Levonorgestrel-only regimen (this is the recommended regimen) or the Combined Oestrogen-Progesterone regimen (Yuzpe).
- Both regimens require taking a first dose as soon as convenient, but not later than 72 hours after the rape, and a second dose 12 hours later. There are products that are specially packaged for emergency contraception, but at present they are registered only in a limited number of countries. If specially packed pills are not available in your setting, emergency contraception can be provided using combined or progesterone-only oral contraceptives, which are available for family planning purposes. See the Emergency Contraception table below for guidance.
- Counsel her about how to take the pills, which side effects she can expect and the effect it may have on her next period. Also make it clear to her that there is a small risk that the pills do not work and if her next period does not come before or at the expected time, she should return to discuss the options in case of pregnancy.
- *Side effects:* Especially if the Yuzpe regime is used, nausea can occur. If vomiting occurs within 2 hours of taking a dose, repeat the dose.
- Most patients will have a normal menstruation within 21 days after the treatment. Menstruation may be up to a week early or, if treatment is given after ovulation, the onset of her period may be delayed a few days. If she has not had a period 21 days after the treatment she should be advised to have a pregnancy test.

(Adapted from: Consortium for Emergency Contraception, Emergency Contraceptive Pills, Medical and Service Delivery Guidelines, 2000)

Regimen	Formulation (per pill)	Common brand names	1 st dose (no. tablets)	2 nd dose 12 hours later (no. tablets)
levonorgestrel-only	LNG 750 µg	Levonelle-2, NorLevo, Plan B, Postinor, Postinor-2, Vikela	1	1
	LNG 30 µg	Microlut, Microval, Norgeston	25	25
	LNG 37.5 µg	Ovrette	20	20
Combined	EE 50 µg + LNG 250 µg Or EE 50 µg + NG 500 µg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovrán, Tetragynon/PC-4, Preven, E-Gen-C, Neo-Primovlar 4	2	2
	EE 30 µg + LNG 150 µg Or EE 30 µg + NG 300 µg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4	4

Abbreviations: EE = ethinylloestradiol LNG = levonorgestrel NG = norgestrel

Emergency Intra-uterine Device

- If the survivor presents after 72 hours, but up to and including 5 days after the rape, insertion of an intra-uterine device (IUD) is a reliable way of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies).
- A skilled provider should counsel the patient and insert an IUD.
- The IUD can be removed at her next menstrual period or be left in place for future contraception.

Annex 8

Minimum Care for Rape Survivors in Low-resource Settings

Checklist of supplies

Protocol	Available
Written medical protocol translated in language of provider	
Personnel	Available
Trained (local) health care professionals (on call 24 hours/day)	
A “same language” female health worker or companion in the room during examination	
Furniture/Setting	Available
Room (private, quiet, accessible, access to a toilet or latrine)	
Examination table	
Lighting, preferably fixed (a torch may be threatening for children)	
Access to an autoclave to sterilise equipment	
Supplies	Available
“Rape Kit” for collection of forensic evidence, including:	
▪ Speculum	
▪ Tape measure for measuring the size of bruises, lacerations, etc.	
▪ Paper bags for collection of evidence	
▪ Paper tape for sealing and labelling containers/bags	
Supplies for universal precautions	
Resuscitation equipment for anaphylactic reactions	
Sterile medical instruments (kit) for repair of tears and suture material	
Needles, syringes	
Cover (gown, cloth, sheet) to cover the survivor during the examination	
Sanitary supplies (pads or local cloths)	
Drugs:	Available
▪ For treatment of STIs as per country protocol	
▪ Emergency contraception pills and/or IUD	
▪ Pain relief (e.g. paracetamol)	
▪ Local anaesthetic for suturing	
▪ Antibiotics for wound care	
Administrative Supplies	
▪ Medical chart with pictograms	Available
▪ Consent forms	
▪ Information pamphlets for post-rape care (for survivor)	
▪ Safe locked filing space to keep confidential records	

Minimum forensic evidence collection

Evidence should only be collected and released to the authorities with the survivor's consent.

- A careful written recording of all findings during the medical examination, which can support the survivor's story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence if the case goes to court.
- Samples of damaged clothing (if you can give her replacement clothing) and foreign debris present on her clothes or body, which can support her story.
- If a microscope is available, a trained health care provider or laboratory worker can examine wet-mount slides for the presence of sperm, which proves penetration took place.

Minimum examination

The medical examination should only be done with the survivor's consent. It should be compassionate, confidential, and complete, as indicated and described in Step 5.

Minimum treatment

According to the situation, compassionate and confidential treatment as follows:

- Treatment and referral for life threatening complications.
- Treatment or preventive treatment for STIs.
- Emergency contraception.
- Care of wounds.
- Supportive counselling.
- Referral to social rehabilitation and psychosocial counselling services.

Additional Resource Materials

General information

Sexual Assault Nurse Examiner (SANE) Development and Operation Guide. United States Department of Justice, Office of Justice Programs, Office for Victims of Crime.
<http://www.sane-sart.com/SaneGuide/toc.asp>

Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. UNHCR, 1999.

<http://www.who.int/reproductive-health/publications> or

<http://www.rhrc.org/fieldtools>

Basta! A newsletter from IPPF/WHR on integrating gender-based violence into sexual and reproductive health. International Planned Parenthood Federation

<http://www.ippfwhr.org/whatwedo/basta.html>

Sexual Violence Against Refugees: Guidelines on Prevention and Response. UNHCR, 1995

Mental health of refugees. WHO, 1996

Information on sexually transmitted diseases

WHO. Guidelines for the management of sexually transmitted diseases. WHO/RHR/01.10

<http://www.who.int/reproductive-health/publications>

Information about post-exposure prophylaxis (PEP) of HIV transmission

Management of Possible Sexual, Injecting-Drug-Use, or Other Nonoccupational Exposure to HIV, Including Considerations Related to Antiretroviral Therapy Public Health Service Statement. MMWR 47(RR17);1-14, CDC, 1998

<http://wonder.cdc.gov/wonder/prevguid/m0054952/m0054952.asp>

PHS Report Summarises Current Scientific Knowledge on the Use of Post-Exposure Antiretroviral Therapy for Non-Occupational Exposures, CDC, 1998

<http://www.cdc.gov/hiv/pubs/facts/petfact.htm>

Information on emergency contraception

Emergency Contraception: A guide for service delivery. WHO, 1998

<http://www.who.int/reproductive-health/publications>

Detailed information on the abortion policies of countries

Abortion Policies, A Global Review, UN Department of Economic and Social Affairs, Population Division, 2001:

<http://www.un.org/esa/population/publications/abortion/profiles.htm>