CLINICAL CARE FOR SEXUAL ASSAULT SURVIVORS:

A PROTOTYPE FOR IRC HEALTH PROGRAMS

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CONTENTS

Adapted from the WHO/UNHCR *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced populations* with input from IRC field teams.

Introduction

This guide is intended to serve as a prototype for IRC field programs on the care of sexual assault survivors. It is not a training manual, but provides an organizational standard for all IRC staff. In its present form it may be used in emergency situations when there is not adequate time to develop a site–specific protocol, but within six months of starting a new program it should be adapted to the specific legal, medical and cultural context in which it is being used.

This guide is intended for use by qualified health care providers (medical doctors, clinical officers, midwives and nurses) in clinical settings and can also be used in planning care services and in training health care providers. The implementation of these protocols is the responsibility of the Health Coordinator and should be part of the job description for that position.

Sexual assault is defined as any type of unwanted physical violence or contact that is of a sexual nature. Sexual assault also includes rape, which is defined here as penetration of the vagina or anus with the penis, other body part or foreign object without consent. It also includes forced oral sex. It is not the responsibility of the health care provider to determine whether a person has been sexually assaulted or raped. That is a legal determination. The health care provider's responsibility is to provide appropriate care, to record the details of the history, the physical examination and other relevant information, and, with the person's consent, to collect any forensic evidence that might be needed in a subsequent legal action.*

While it is recognized that men and boys can be sexually assaulted, the overwhelming majority of individuals who are sexually assaulted and seek care are women or girls; female pronouns are therefore used in the guide to refer to sexual assault survivors, except where specifically referring to male survivors.

Survivors may react in any number of ways to sexual assault and their responses will likely change over time. Non–judgmental, compassionate care is essential to the healing process and the absence of this can have long–lasting effects upon the survivor’s mental and emotional state. Seeking medical care is very difficult for sexual assault survivors and when they do so they are acknowledging that physical and/or emotional damage has occurred and asking for help.

All staff should be appropriately trained, depending on their professional level and interaction with patients. Training materials are available (see Appendix 6) and IRC will be producing a training package in the near future.

It is the responsibility of the entire staff of the health facility (cleaners, guards, pharmacy staff, nurses, doctors, etc.) to treat the survivor with respect and to keep all information confidential.

* The purpose of the forensic exam is to enable the perpetrator to be brought to justice. It may not be possible to collect the evidence, store it safely, or there may be no legal authorities willing or able to prosecute. In such circumstances, it is best to do the minimum necessary exam and not take samples that will not be used.

PART I: THE BASICS

1. BASIC PRINCIPLES OF CARE AND RIGHTS OF SURVIVORS

Survivors have a RIGHT TO DIGNITY. This right has been violated by the attacker and must be emphasized and reaffirmed by all health service providers. In this context the right to human dignity means:

Right to health: Survivors of rape and other forms of sexual abuse have a right to good quality health services, including reproductive health care, to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way "re-victimize" sexual assault survivors. There is never any excuse for failing to address the mental, physical and emotional health needs of a sexual assault survivor. The protocols should be followed as closely as possible, but the absence of certain supplies or medications does not justify poor care.

Right to non-discrimination: Laws, policies and practices related to access to services should not discriminate against a person who has been sexually assaulted on any grounds, including race, sex, color, national or social origin, age or marital status. For example, providers should not deny services to women belonging to a particular ethnic group or because they are unmarried or underage. (In cases where the laws of the host country do discriminate, health staff should advocate with local organizations and the government for legal reform while doing their best to meet the needs of survivors without putting themselves at risk.) Furthermore, health services must be provided in a language the survivor understands well.

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

Right to information: Information should be given to each client in an individualized way so that she is able to make an informed choice. The survivor needs to know what is going on in her body, what kind of examination will be performed and why, and what the effects of prescribed medications will be. For example, if a woman is pregnant as a result of rape, the health care provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, adoption). If the individual provider is not willing to discuss the full range of legal options, another health care provider should be called to do so.

Right to privacy: Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment. To the extent possible, providers like laboratory staff should be brought to her so that she does not have to move to receive services.

Right to confidentiality: All medical and health status information related to survivors should be kept confidential and private, including from members of their family (unless the survivor is a minor – see section 10 on the care of children and youth). Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor. If someone is being charged in the case, the relevant information from the examination will need to be conveyed to the police or other authorities, but in a limited way (Part III).

A note on the care of children: It is important to be aware that the capacity of children to understand what has happened and the treatment being offered and to give informed consent will vary with age and developmental stage and to adapt the approach appropriately. The child's best interest must be the guiding principle when responding to a child survivor of sexual assault, but determining what this is may require special training or experience with children. (See section 10 for special considerations in the care of children and youth.)

2. OBJECTIVES OF THE CLINICAL CONSULTATION

The objectives of the clinical care of sexual assault survivors are:

- To identify and treat injuries and medical complications of sexual assault;
- to organize referral to other relevant services, including psychosocial, protection and legal services;
- and to collect forensic evidence for legal purposes.

3. RESPONSE PLAN FOR SEXUAL ASSAULT SURVIVORS

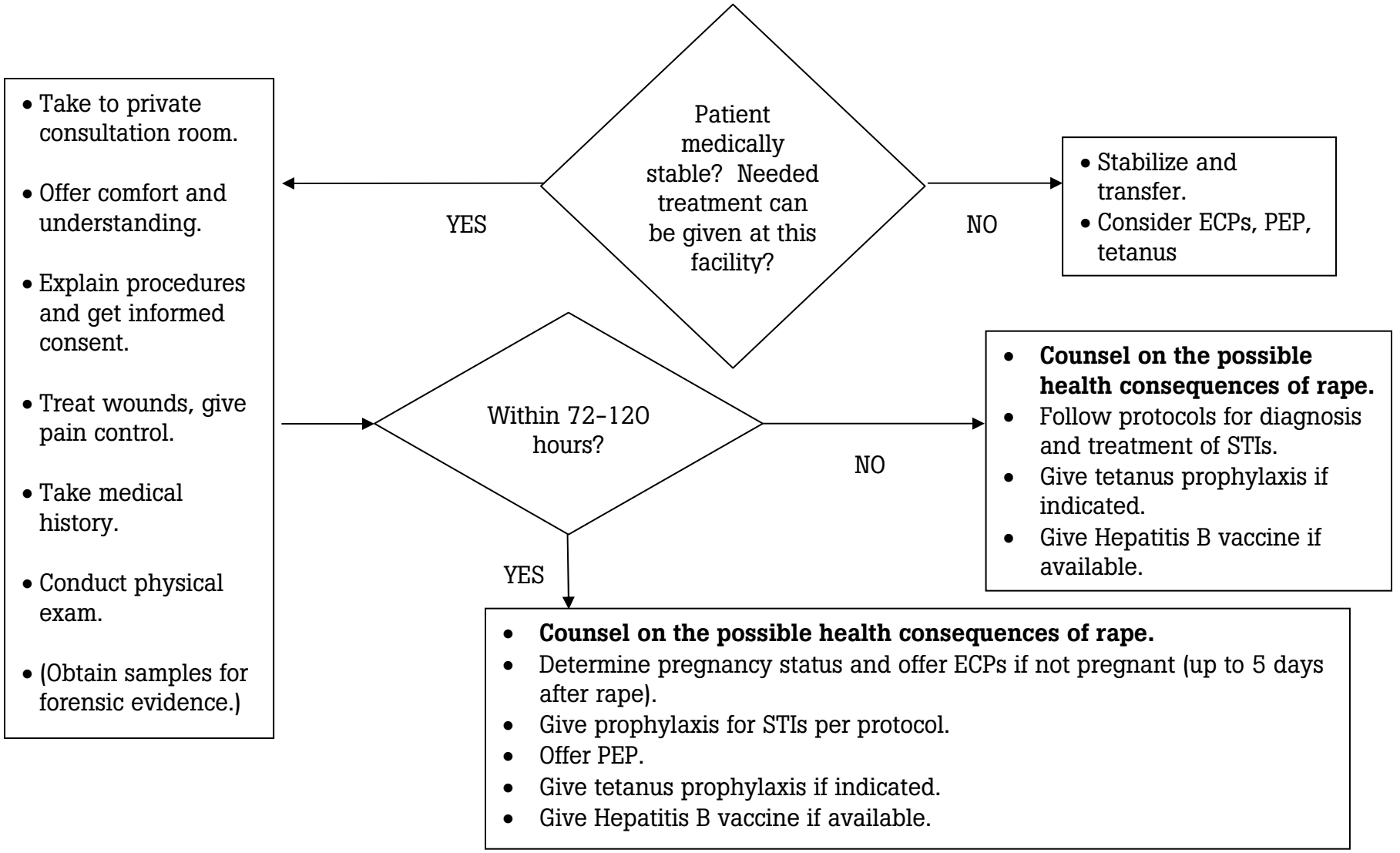
In addition to a locally adapted protocol (see Appendix 6 for issues to be considered when adapting the protocol to local conditions), perhaps the most important thing the health staff can to do is to prepare for the survivor. There needs to be a clear understanding that all sexual assault survivors will be seen immediately. A designated individual should be made responsible for ensuring that the health facility is prepared to receive a survivor and respond according to the guidelines at any time. Some programs have trained sexual assault response teams to handle these situations. This may not be possible in all programs, but in every case, an appropriately trained and prepared individual should be available at all times. Contact information for that individual should be posted where all staff can find it. There should be a designated and prepared place

and a stocked supply box or cupboard so that the interview and exam can be done without having to move the survivor. A separate room for both visual and sound privacy is preferable, but a curtained area with good light and easy access to a latrine will suffice.

The responsibility of the health clinic is to provide quality health care and ensure that the survivor has access to the best possible legal and psychosocial services. The best resources may be available through referral to another agency or organization. Resources for counseling and legal assistance need to be contacted in advance and a system put in place to assure good communication and proper follow–up. This may involve periodic meetings or case management reviews. In particular, careful consideration needs to be given to the security of a sexual assault survivor who does not have a safe place (home) to go.

4. CLINICAL PATHWAY FOR TREATMENT OF RAPE SURVIVORS

Patient assessed immediately. Rape crisis team or other designated clinician notified.
It is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination.



Discharge counseling and teaching: Make sure the survivor has a safe place to go. Reassure her that the rape was not her fault and advise her of the psychological and social problems that she may experience. Connect her to counseling and legal services. Encourage a follow-up visit in two weeks. Give clear simple instructions for any medications, wound care, etc.
DOCUMENT THE EXAM AND TREATMENT THOROUGHLY. KEEP ALL DOCUMENTS AND EVIDENCE CONFIDENTIAL AND SECURE.

5. CHECKLIST FOR CLINICAL CARE OF SEXUAL ASSAULT SURVIVORS

Protocol
☐ Written medical protocol in the language of the provider.
Staff
☐ Trained (local) health care professionals (on call 24 hours/day).
☐ For female survivors, a female health care provider speaking the same language or a female health worker (or companion) should be in the room during the examination.
Setting and Equipment
☐ Room (private, quiet, accessible, with access to a toilet or latrine).
☐ Examination table and light.
☐ Resuscitation equipment.
☐ Access to an autoclave to sterilize equipment.
☐ Speculum (small and medium).
☐ Sterile medical instruments (kit) for repair of tears, and suture material.
☐ Supplies for universal precautions (soap, gloves, receptacle for disposal of contaminated and sharp materials).
☐ Needles, syringes.
☐ Cloth or sheet to cover the survivor during the examination.
☐ Napkins for feminine hygiene (pads or local cloths).
☐ Pregnancy tests and pregnancy calculator (optional depending on local protocols for ECPs and the use of antibiotics).
Medications
☐ For prevention or treatment of STIs per country protocol (may include Hepatitis B vaccine).
☐ For post–exposure prophylaxis of HIV (PEP) as per IRC/country protocol.
☐ For pain relief (e.g. paracetemol) and anxiety depending on local conditions/protocols).
☐ Emergency contraceptive pills.
☐ Local anesthetic for suturing.
☐ Topical antibiotics for wound care.
☐ Tetanus toxoid.
Administrative supplies
☐ Medical chart with pictograms.
☐ Consent forms.
☐ Information pamphlets and referral materials for the survivor (in the local languages).
☐ Safe, locked cabinet for keeping confidential records.
For forensic evidence collection
☐ Comb for collecting foreign matter in pubic hair.
☐ Magnifying glass.
☐ Ruler for measuring the size of bruises, lacerations, etc.
☐ Supplies for collecting blood samples.
☐ Glass slides for wet and/or dry mounts (microscope and trained technician required).
☐ Cotton–tipped swabs/applicators/gauze pads for collecting samples.
☐ Laboratory containers for transporting swabs.
☐ Paper sheet for collecting debris as the survivor undresses (flip chart paper).
☐ Paper bags and tape for collecting and labeling containers/bags.
☐ Camera (optional).

Part II. CARE OF THE SURVIVOR

1. RECEIVING THE SURVIVOR AND INITIAL ASSESSMENT

The survivor should be treated at all times in accordance with the principles of human dignity outlined above, the most important being RESPECT, COMPASSION AND CONFIDENTIALITY.

All staff of the facility should be trained to respond immediately to any individual who reports being raped or who appears to have suffered any form of violence. The sexual assault response team should be notified immediately.

Staff should be sensitized to the needs of all victims of GBV and informed of the policies spelled out in this document or a locally adapted document. Attitudes that view survivors of sexual assault as shamed or defiled or that blame the victim for the assault need to be addressed, but cannot always be eliminated. It must be made clear however that all staff are expected to treat survivors with compassion and respect in accord with the IRC protocol.

As with anyone seeking medical care, the first concern is for their physical well–being. An individual who requires emergency care should immediately be treated or referred as appropriate. Even if the survivor requires emergency referral, consideration should be given to aspects of the post–rape treatment that are time sensitive, such as emergency contraception, STI prevention and PEP. A woman in extreme pain or anxiety should be offered appropriate medication (e.g. paracetemol); sedatives for the management of stress or anxiety (e.g. diazepam) should generally be withheld and only given in exceptional circumstances.

Once a sexual assault survivor is identified and determined to be in stable condition, she should immediately be taken to a private place where the history and the examination can be done. If the person initially receiving the survivor is not specifically trained to provide clinical care to a sexual assault survivor, a trained clinician should be notified and attend to her as soon as possible. A compassionate staff member should stay with the survivor until the trained provider arrives. A female clinician is preferable and where one is not available, a female chaperone should be present during the exam. **It is not the responsibility of the health care provider to determine whether a person has been sexually assaulted.** That is a legal determination. The health care provider's responsibility is to provide appropriate care, to record the details of the history, the physical examination and other relevant information, and, with the survivor's consent, to collect any forensic evidence that might be needed in a subsequent legal action.

As few people as possible should be involved in the process. The staff member escorting her to the private consultation room should introduce herself, offer reassurance and explain briefly that she will be seen by a trained clinician who will ask her questions and examine her. Answer any questions she has. It should be made clear that the whole process is entirely voluntary. She should be asked to agree to each step in the process of

her care. Let her know that she may say "no" to any procedure or ask to stop at any time. She should be allowed to have one person of her choice with her. Others should be asked to wait outside.

Physical injuries and wounds should be treated immediately with attention paid to the survivor's mental state. In cases where a survivor was previously circumcised or infibulated (an extreme form of female genital cutting) and there are vaginal tears, it is preferable not to perform a re–infibulation. From the medical perspective, repair immediately following trauma carries a higher risk of infection and is best avoided. Female genital cutting or circumcision carries with it a number of long–term risks and is never medically indicated. IRC personnel should never be involved in female genital cutting and repairs should leave genitalia in as natural a state as possible.

2. OBTAINING INFORMED CONSENT AND THE HISTORY

Informed consent (see Appendix 1: Sample Informed Consent Form)
The provider who will perform the examination should review the procedure with the survivor (and parent/guardian if she is a minor) in language she can understand and ask for her consent for the history, the physical exam, the pelvic exam and specimen collection as appropriate. With children it can be helpful to use a doll to demonstrate prior to performing the actual exam. The survivor can refuse any part of the exam that she wishes; never force a child or any survivor to undergo an examination. A consent form should be completed at this time with the survivor's signature or fingerprint.

The history (see Appendix 2: Sample History and Exam Form):
The purpose of the history is not to determine whether or not sexual assault has occurred, but rather to gather information necessary to provide appropriate medical treatment. Extraneous questions such as manner of dress or behavior prior to the attack should not be asked. Not all persons will want or be able to talk about the assault. Listen and record the story in her own words. Reassure her that nothing she says will be made public unless she chooses to have it released, for example if she takes legal action. Ask clarifying questions as necessary after the survivor finishes her story.

The history should include the following components:

- A description of the incident: when? where? use or threat of violence or weapon; penetration.
- Did the survivor know the perpetrator previously? Are his whereabouts known?
- What the survivor did after the incident: bathed, changed clothes, urinated, cleaned teeth, etc.
- Menstrual/obstetric history to determine pregnancy status/risk.
- Medications, allergies, existing health problems.
- Vaccination status (tetanus, Hepatitis B).
- HIV status (if known).

When documenting the history use qualifying statements, such as "patient states" or "patient reports;" avoid the use of the term "alleged," as it can be interpreted as meaning that the survivor exaggerated or lied.

3. PERFORMING THE PHYSICAL AND GENITAL EXAMINATION (See Appendix 2: Sample History and Exam Form)

Even after the survivor has consented to the exam, the provider needs to explain each step as she goes along and give the survivor an opportunity to ask questions. Do not hurry the exam. Never ask the survivor to undress or uncover completely.

General Appearance

Prior to the more detailed physical examination, observe and record the general appearance of the survivor. Take note of her mental and emotional state (withdrawn, crying, calm, anxious, etc.). Observe her hair (e.g. combed or not) and clothing (e.g. torn, soiled, neat, etc).

General Examination

Commence with the vital signs, including pulse rate and blood pressure – this will appear routine and may help to calm the patient's anxiety. Examine the upper half of her body first, then the lower half; give her a gown or sheet to cover herself.

Thoroughly inspect the survivor from head to toe for any signs of injury – bruising, burns, cuts, etc. and document the findings carefully on the examination form and the body figure pictograms; take care to record the type, size, color and form of any bruises, lacerations, and petechiae (tiny red spots, often seen in the eyes after strangling). Be cautious during palpation to identify areas of tenderness without excessively aggravating the pain from an injury, such as a fracture. Check the scalp, eyes, ears, nose and mouth. Examine the chest and abdomen, as well as the back and arms and legs.

Pelvic Examination

Particular care should be exercised with the genital and pelvic exam. **A pelvic exam should be performed only if indicated**: for example, if there is vaginal bleeding, discharge or suspected pregnancy, or if forensic evidence is being collected. In some cases, a medical finding of sperm in the vagina is useful to prove penetration. This exam is usually emotionally difficult for the patient, even if she has given permission. Be gentle and explain what you doing as you go along. If a speculum is required, lubricate it with warm water or saline. Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen looking for injuries and signs of infection. Document all findings in detail on the medical record.

Note: The collection of forensic evidence is described in Part III. If indicated, it should take place at the same time as the physical examination.

4. INVESTIGATIONS

In many cases no laboratory or diagnostic tests will be required. Injuries and symptoms should be evaluated as they would in any other case, while maintaining privacy and confidentiality.

If trained counselors are available and it is indicated, an HIV test may be offered. However, a positive result would represent prior HIV infection; the absence of an HIV test should in no way affect the decision to offer PEP.

The same is true for pregnancy testing, which will only reveal pre–existing pregnancy. A positive pregnancy test will eliminate the need for emergency contraceptive pills (ECPs) and affect the choice of medications prescribed.

Investigations may include the following:
- Urinalysis for urinary symptoms
- Pregnancy testing
- Blood tests for syphilis and/or HIV
- X–rays for injuries

5. PRESCRIBING TREATMENT

The specific treatment regimen will depend on local protocols, the availability of medications, disease prevalence in the population and the circumstances of the patient (see Clinical Pathway above). **Note that there is no medical reason for withholding any of the following treatments from children, although some of the doses may need to be adjusted depending on weight (see section 10 on special considerations in the care of children and youth).**

PEP and Prophylaxis against STIs

Survivors seen within 72 hours who have experienced penetration should be offered Post–Exposure Prophylaxis (PEP) for HIV and prophylaxis against the most prevalent sexually transmitted infections (STIs), generally syphilis, gonorrhea and chlamydia. Depending on the context, metronidazole for trichomoniasis and Hepatitis B vaccine may also be given. The Hepatitis B vaccine is effective up to two weeks after exposure.

HIV testing is not necessary prior to prescribing PEP and a survivor who cannot or does not wish to be tested should still be offered PEP if indicated. However, for survivors who are HIV positive, there is no benefit from using PEP. An HIV positive survivor should be given counseling and referral information just as any other HIV positive person.

ECP

Emergency contraceptive pills can be effective up to 120 hours (five days) after the incident, but are more effective if given earlier. The progestin–only regimen has the

fewest side effects. If a progestin–only regimen is not available, oral contraceptive pills containing both estrogen and a progestin can be used to obtain two doses of either 500 micrograms of levonorgestrel or 250 micrograms of norgestrel 12 hours apart. A pregnancy test is not required before dispensing ECPs; the menstrual history should guide the provision of ECPs.

Tetanus

Survivors with open wounds should be given tetanus toxoid if there is any doubt as to their immunization status. If they have not previously been vaccinated, they should be advised to finish the course for a total of two doses.

Sample Treatment/Prevention Regimens for Rape Survivors

Time since incident	Within 72 hours	Within 72–120 hours	More than 120 hours
Pregnant*	• Ceftriaxone 125mg IM • Erythromycin 500mg QID x 7 • Benzathine penicillin 2.4m IU in divided dose • PEP • Metronidazole 2g PO x 1 • Tetanus toxoid	• Syndromic management of STIs • Tetanus toxoid	• Syndromic management of STIs • Tetanus toxoid
Not Pregnant	• ECPs • PEP • Ceftriaxone 125mg IM • Azithromycin 1g PO x 1 • Benzathine penicillin 2.4m IU in divided dose • Metronidazole 2g PO x 1 • Tetanus toxoid	• ECPs • Syndromic treatment of STIs • Tetanus toxoid	• Syndromic treatment of STIs • Tetanus toxoid

*Determination of pregnancy will depend on local protocols. A pregnancy test is not required before dispensing ECPs.
ECPs – Emergency Contraceptive Pills.
PEP – Post–Exposure Prophylaxis for HIV.

Sample Regimens for Post-Exposure Prophylaxis of HIV

Drug	Strength/Form	Dose	Duration
Adults Including Lactating Women and Adolescents > 40 kg			
Zidovudine(AZT) **and**	300 mg tablet	1 tablet every 12 hours	28 days
Lamivudine (3TC)	150 mg tablet	1 tablet every 12 hours	28 days
Prevention of HIV Children < 2 yrs Old*			
Zidovudine(AZT) **and**	10 mg/ml	7.5 ml every 12 hours	28 days
Lamivudine (3TC)	10 mg/ml	2.5 ml every 12 hours	28 days
Prevention of HIV Children 10 – 19 kg			
Zidovudine (AZT) **and**	100 mg/ml	1 capsule three times a day	28 days
Lamivudine (3TC)	150 mg/ml	½ tablet twice a day	28 days
Prevention of HIV *Children 20-39 kg*			
Zidovudine (AZT) **and**	100 mg capsule	2 capsules twice a day	28 days
Lamivudine (3TC)	150 mg tablet	1 tablet twice a day	28 days

Patient Teaching Messages – Prevention of HIV

- HIV can be transmitted during rape. In order to prevent HIV infection as a result of rape, the patient must take two separate medications (pills) for 28 days.
- Each medicine is taken in the morning and again at night every day for 28 days.
- The medications **do not treat** HIV or AIDS. If the medicines are started within 72 hours, they may prevent the disease from developing. They are not always effective.
- The patient may experience headache, mild body aches and slight nausea during the 28 days. These are normal side effects of the medication. **The medication should continue to be taken even if such side effects occur.**
- If the patient is worried about any side effects or feels unwell, she should return to the clinic for assessment.
- The medications are safe to use during pregnancy.
- The medications should not be given to anyone else and especially kept away from children.

Sample Regimens for Emergency Contraception

Type	Dose	Taken
Levonorgestrel *Postinor-2* (Progestin only)	1500 micrograms (two 750 mcg tablets)	⇨ Two tablets at the clinic
Combined oral contraceptives (Ethinylestradiol + progestin)	The equivalent of 500 micrograms levonorgestrel or 250 of norgestrel	⇨ One dose at the clinic ⇨ **and** a second dose 12 hours later

Patient Teaching Messages – Emergency Contraceptives

- EC does not cause a girl or woman to become sterile. The effects last only a few days – until the danger of pregnancy from the rape is past.
- EC does not cause abortion. If the woman was pregnant at the time of the rape, EC will not harm the fetus.
- EC is most effective when taken as soon as possible after rape. It is effective up to 120 hours but most effective when taken within the first 72 hours after rape.
- The EC might cause slight nausea. This occurs only within the first 24 hours of taking the EC pills.
- If vomiting occurs within one hour of taking the EC, repeat the dose. Return to the clinic to replace the pill(s) that was lost (vomited).
- EC can cause small spots of bleeding from the vagina. This does not indicate illness. If the bleeding is heavy or causes worry, return to the clinic.
- Some women and girls have mild breast pain during the first 24 hours after taking EC. This is normal and the pain will not cause any harm.
- The patient's next menstrual period will come on time or slightly early. If her menstrual period does **not** arrive she should return to the clinic for a pregnancy test.

6. THE MEDICAL CERTIFICATE (See Appendix 3)

Medical care of a survivor of sexual assault includes preparing a medical certificate. This is a legal requirement in most countries and forms should be obtained from local legal authorities. It is the responsibility of the health care provider who examines the survivor to make sure such a certificate is completed and is kept confidential. The medical certificate constitutes an element of proof and is often the only evidence available, apart from the survivor's own story. The health care provider should provide one copy to the survivor and keep one copy locked away with the survivor's file, in order to be able to certify the authenticity of the document supplied by the survivor in a court if requested. The survivor has the sole right to decide whether and when to use this document.

7. RELEASE OF INFORMATION

The survivor should be made aware of what information will be released and to whom. Anonymous information regarding the location and nature of the attack should be passed on to protection staff so that action may be taken to prevent future attacks against others. Any information that could be used to identify the survivor may be released only with her consent (see Appendix 5: Sample consent for release of information).

8. COUNSELING THE SURVIVOR

In addition to careful patient teaching regarding her treatment, the survivor will need to hear some other important messages. An individual who has just suffered an attack may

not be able to absorb everything she is told, but a calm approach, simple statements and repetition will help.

Patient Teaching Messages – Psychosocial Counseling:

- The survivor has done nothing wrong and is not to blame for the assault.
- Whatever she is feeling now is normal, whether confusion, anger, guilt or numbness.
- She may experience many different emotions and they can change very rapidly. These emotions can take time to settle down.
- She is not alone. She can come back any time if there is a problem or just to talk.
- She should return in two weeks for a follow–up visit. (Survivors who have received PEP should return in one week.)

The survivor may have psychosocial, legal or safety issues that the health care provider cannot help with. The provider should offer referrals for these services.

Ask the survivor if she has a ***safe place*** to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. Enlist the assistance of the counseling services, community services providers and law enforcement authorities, including police or security officer as appropriate. If the survivor has dependants to take care of and is unable to carry out day–to–day activities as a result of her trauma, provisions must also be made for her dependants and their safety.

When discharging the survivor, demonstrate compassionate behavior as an example to the family and, with her permission, share aspects of her medical condition that may help them to support her. The survivor's right to confidentiality should be respected at all times.

9. FOLLOW–UP CARE OF THE SURVIVOR

Ideally follow–up should be done at two–, six– and 12–week intervals. But whenever the survivor returns the following issues should be addressed:

- Evaluate mental and emotional status; refer or treat as needed.
- Evaluate for pregnancy and provide counseling, including referral for abortion services if legal.
- Check that survivor has taken the full course of any medication.
- If a survivor was diagnosed with a sexually transmitted infection, advise her that her regular partner should also receive treatment.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate.
- Provide advice on voluntary counseling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed.

10. SPECIAL CONSIDERATIONS IN THE CARE OF MALE SURVIVORS

Male survivors of sexual assault are even less likely than women to report the incident, because of the extreme shame and embarrassment that they typically experience. While the physical effects differ, the psychological trauma and emotional after-effects for men are as difficult as those experienced by women. When a man is anally raped, pressure on the prostate can cause an erection and even orgasm. If this has occurred during the rape, reassure the survivor that it was a physiological reaction and was beyond his control. If the male survivor agrees to an examination, it should be as thorough as that of the female and documented in the same way, using the male pictograms. Specific concerns include injury to the testicles or testicular torsion, which is a medical emergency. The survivor should also be evaluated for prostate infection and a rectal exam done if indicated based on the history.

11. SPECIAL CONSIDERATIONS IN THE CARE OF CHILDREN AND YOUTH

Introduction

The purpose of this section is to highlight specific issues relevant to child survivors of sexual assault (e.g. special considerations related to rights, history, examination and treatment) and to guide health care providers on their care and referral. In addition to child-centered clinical care, child survivors and their families will benefit from ongoing support from a trained counselor. If possible, it is recommended that health care staff work closely with child protection social workers to address the psychological and social needs of children and their families.

As with all survivors, the safety of the child is paramount. Sexual violence can have a devastating effect on a child's physical and mental health, and her ability to participate fully in society. The degree to which children will be affected will depend on the type and extent of violence, the child's age and resilience, relationship to the perpetrator(s) and the quality of emotional support and health services received afterward.[2]

Children think, feel and act differently than adults. While some issues will be common to all children, it is important to know that children's needs and capacities vary with age and individual ability. This knowledge must be reflected in key ways when working with children who have been victims of sexual violence in relation to their participation in decisions concerning their care.[3]

The Rights of the Child

Children have the same rights as any person, although their specific needs will depend on their age and level of maturity (see Section 1 on the rights of survivors). In addition, children have specific rights that have been outlined in The Convention on the Rights of the Child (CRC). The CRC defines a child as a person under the age of 18, unless the relevant national laws state an earlier age of adulthood. This means that the CRC can be

[2] Draft "Sexual Violence Against Children" Training Module. Inter-Agency Child Protection in Emergencies Training Modules.
[3] Ibid.

applied to everyone up to 18 years of age, unless it is shown that she/he is an adult under national law. In brief, the principles spelled out in the international Convention on the Rights of the Child are:

- the best interests of children must be a primary consideration;
- states shall protect children from physical or mental harm and neglect, including sexual abuse or exploitation;
- the views of the child should be given due weight "in accordance with the age and maturity of the child."

While the best ways to realize these rights will differ depending on the situation and context, the health care provider should know and respect them at all times.

Mandatory Reporting and Other Legal Issues

Find out about specific laws in your setting that determine who can give consent for minors and who can go to court as an expert witness.

If, in your setting, it is mandatory to report cases of child abuse to government authorities, you should know the national child abuse management protocol and standard police and court procedures (see Appendix 6 on Adapting the Protocol to Local Conditions). Evaluate each case individually — in some situations, reporting suspected sexual abuse of a child can be harmful to the child if protection cannot be assured.

It is not the responsibility of the health care provider to determine whether the child has been sexually assaulted. That is a legal determination. The health care provider's responsibility is to provide appropriate care, to record details of the history, the physical examination, and other relevant information, and, with the survivor's (and/or parent's) consent, to collect any forensic evidence that might be needed in subsequent legal action.

Informed Consent

A parent or legal guardian should sign the consent form for examination of the child and collection of clinical information, unless he or she is the suspected offender. In this case, a representative from the police, the child welfare agency, the community support services or the court may sign the form. Adolescents may be able to give consent themselves depending on local laws. The child should never be examined against his or her will, whatever the age, except in the rare situation where the examination is necessary for urgent medical care.

Initial Assessment

As with adults, children should initially be assessed for signs of illness of injury requiring immediate medical treatment or referral (e.g. fever, dehydration, excessive bleeding, abdominal injury, pelvic injury). The treatment of these conditions is not covered here.

The Health History

The function of the medical or health history is to find out why the child is being brought for health care at the present time and to obtain information about the child's physical or emotional symptoms. It also provides the basis for developing a medical diagnostic

impression before a physical examination is conducted. The medical history may involve information about the alleged abuse, including verbal and physical elements, but only insofar as it relates to resulting health problems, such as bleeding at the time of the assault, or constipation or insomnia since that time. The medical history should be taken by a health professional.

Create a safe environment

The number of people present during the history and examination should be limited to as much as possible. Ideally there will be two people in addition to the survivor: a female clinician and a trusted, non–threatening adult. If no female clinician is available, then a female chaperone will also be necessary. Unless the parent or guardian accompanying the child is suspected in the abuse she or he should be present. Older children should be asked privately who they would like to have with them and their wishes should be respected. However, someone besides the provider and the child must be present during the examination.

Checklist for interviewing a child[4]

1. Begin by introducing yourself, explaining who you are; build some trust, perhaps by asking a few questions about neutral topics, e.g., school, friends, who the child lives with, favorite activities.

2. Communicate clearly that the child is not in trouble.

3. Make sure the child is as comfortable as possible (e.g. Does the child need food or water, a blanket, etc.?)

4. Ask the child if she knows why she is there and listen carefully to the response to help you judge her comprehension of the situation and level of stress.

5. Explain what this interview is about.

6. Tell the child that she can ask questions at any time if she doesn't understand something. Assure the child it is okay to respond to any questions with "I don't know."

7. Check that it is okay to take notes and explain why you need them.

8. The amount of information and the questions that you will need to ask may vary. Invite the child to describe what happened, listen carefully and record the details. Be patient; go at the child's pace; do not interrupt or interrogate.

9. Ask only one question at a time. Keep questions short and simple.

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[4] Draft "Sexual Violence Against Children" Training Module. Inter–Agency Child Protection in Emergencies Training Modules. Adapted from Save the Children UK's Child Protection Reporting and Investigations: Procedure and Guidance for Managers; Version 4, Jan 2003.

10. Give enough time for the child to complete her answers – be patient and don't interrupt.

11. Make sure that the child can understand the words you use and the questions you ask. Think about the child's age and make sure you use the right level of language.

12. Make sure you understand what the child is saying to you. This is especially important and difficult in relation to some of the words used to describe the genitals and sexual activity.

13. Some children might want to communicate in another way – have paper, crayons, pencils and a doll available in case children are more comfortable drawing pictures or demonstrating on the doll.

14. If the child is very distressed, stop and offer to take some time. Recognize and respond to the child's emotions during the interview. Demonstrate concern and understanding.

15. Show honesty, especially in response to the child's questions. Never promise things that you cannot guarantee.

16. Provide reassurance and give the following messages:
    - it was not her fault
    - she deserves help not blame

17. Explain to the child his or her options and potential outcomes.

18. If you need to share any information, explain to the child who you will share the information with, what will be shared and what will be done with this information. Ask the child to identify any concerns with this. Discuss any potential consequences to the child's safety that may result from sharing this information.

19. Thank the child and explain what will happen next, including any referrals to other services you plan to make – don't make promises or offer false hope.

Elements of the history

For girls, depending on age, ask about menstrual and obstetric history. Find out whether she has been circumcised and if so when.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse and physical force is less often used as children are relatively easily coerced or manipulated into unwanted sexual acts. To get a clearer picture of what happened, try to obtain information on:

- the home situation (has the child a safe place to go?);
- how the rape/abuse was discovered;
- who did it, and whether he or she is still a threat;
- if this has happened before, how many times and the date of the last incident;

- whether there have been any physical complaints (e.g. bleeding, dysuria, vaginal discharge, abdominal pain, pelvic pain, difficulty walking, etc.);
- whether any siblings are at risk.

Examining the child

Prepare the child for examination (See checklist on page 8)

As for adult examinations, there should be a support person or trained health worker whom the child trusts in the examination room with you. Although consent should have already been given, explain again what the exam involves and allow the child to ask any questions she may have. Remind her that she can ask you to stop at any time. Use terms the child can understand. It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, flashlight, etc.; allow the child to use these on the doll. Do not do a speculum exam on pre–pubertal girls. Cover instruments you will not use.

Never restrain or force a frightened, resistant child to complete an examination. If the child is too agitated to consent to the exam, it may have to be deferred or abandoned. If the child is in pain, give paracetamol (acetaminophen) or other simple painkillers, and wait for them to take effect. Sedatives should never be used unless necessary to give urgent medical care. Only if the child cannot be calmed down and physical treatment is vital, the examination may be performed with the child under sedation, using one of the following drugs:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg; or
- promethazine hydrochloride,
    - two–five years: 15–20 mg syrup, by mouth
    - five–ten years: 20–25 mg syrup, by mouth
    - If a child is vomiting or will not take anything by mouth, IM promethazine may be used: one mg/kg up to 12.5 to 25 mg

These drugs do not provide pain relief. If the child is also in pain, give pain medication at the same time. Oral sedation will take one to two hours for full effect. In the meantime allow the child to rest in a quiet environment with a trusted adult.

Conduct the examination

Conduct the examination in the same order as an examination for adults: general appearance; general examination; pelvic examination (see page 12 of the adult protocol).

Special considerations for children are as follows:

- Note the child's weight, height, and pubertal stage.
- Small children can be examined on the mother's or caregiver's lap. Older children should lie on the bed.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and **gently** pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not useful indicators of penetration.

- Do **not** carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size).
- Look for vaginal discharge. In pre–pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre–pubertal girls; it is extremely painful and may cause serious injury.
- A speculum may be used **only** when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a pre–pubertal child is usually done under general anesthesia at a hospital. For small girls, a nasal speculum may be more appropriate than a vaginal speculum.
- In boys, check for injuries to the frenulum of the prepuce/foreskin, and for anal or urethral discharge; take swabs if indicated.
- Examine the anus in all children. Help the child into the supine or lateral position. Avoid the knee–chest position, as assailants often use it.
- Record the position of any anal fissures or tears on the pictogram.
- Do **not** carry out a digital examination to assess anal sphincter tone.

Laboratory Testing
If forensic evidence collection is appropriate it should be done the same way as for adults, keeping in mind the physical differences between adults and children and the need both to involve children in decision–making and to obtain consent from a parent or other responsible adult.

Testing for STIs if available can be done if two weeks or more have passed since the assault or if the child has symptoms.

Treatment
With regard to STIs, HIV, hepatitis B and tetanus, children have the same prevention and treatment needs as adults but may require different doses depending on weight. Child–specific protocols should be followed for all vaccinations and drug regimens.

<u>Treatment of injuries</u>
If vaginal repair is required, the survivor will need to be referred to a facility where anesthesia can be given and specialty care is available. Speculum exams in pre–pubertal girls should be avoided except in emergency situations. If the bleeding cannot be controlled referral should be made immediately. Other associated injuries should be treated as appropriate, including referral when needed.

<u>Prevention of pregnancy</u>
ECPs are safe for any female who has reached the age of menarche. Pregnancy can occur even prior to the first menses. All pubescent girls should be evaluated for sexual maturity and offered ECPs if at risk for pregnancy.[5]

[5] See *How to be reasonably sure a client is not pregnant*, FHI/USAID 2006. http://www.fhi.org/en/RH/Pubs/servdelivery/checklists/pregnancy/index.htm.

Prevention of sexually transmitted infections

In most cases testing for STIs will not be available and follow–up of the child is uncertain; therefore post–exposure prophylaxis of STIs is recommended for all children. The same is true for HIV prophylaxis. The suggested regimens for prevention of STIs in children are outlined below, but should be adapted to local contexts.

Sample regimens for STI prevention in children and adolescents

STI	Weight/age	Drug	Dosage
Gonorrhea	under 45kg	ceftriaxone **or** spectinomycin **or** cefixime	125 mg IM single dose 40 mg/kg, IM (up to a maximum of 2g) single dose 8 mg/kg orally, single dose
	45 kg or over	Treat according to adult protocol	
Chlamydia	under 45kg	azithromycin **or** erythromycin	20 mg/kg orally, single dose 50 mg/kg per day, orally (up to a maximum of two g), divided into four doses a day for seven days
	45 kg or over but < 12 years	azithromycin **or** erythromycin	1 g orally, single dose 500 mg orally, four times a day, for seven days
	12 years +	Treat according to adult protocol	
Syphilis*	under 45kg	benzathine benzyl penicillin	50 000IU/kg IM (up to a maximum of 2.4 m IU), single dose
	45 kg or over	Treat according to adult protocol	
If allergic to penicillin		erythromycin	50 mg/kg per day, orally (up to a maximum of 2 g), divided into four doses a day for 14 days
Trichomoniasis**	under 12 years	metronidazole	5 mg/kg orally three times a day for seven days
	12 years +	Treat according to adult protocol	

* ***Note:*** *treatment for syphilis may be omitted if the presumptive treatment regimen includes* ***azithromycin****, which is effective against incubating syphilis, unless resistance has been documented in the setting.*

Note: *Prevention of trichomoniasis is not generally recommended for pre–pubescent girls, and is only indicated in cases with vaginal or anal penetration. For older children metronidazole may be included, especially in areas where trichomonas infection is common. When this treatment is not given, children and their parents should be told what symptoms to look for and encouraged to return for follow–up care.*

Post-exposure prophylaxis of HIV

Post-exposure prophylaxis of HIV (PEP) is recommended for all children potentially exposed to HIV through sexual contact. The guidelines for determining whether to recommend PEP are the same for children as adults: there must have been penetration with exposure to blood or semen less than 72 hours prior to beginning treatment. HIV testing is not necessary, but should be considered in children and adolescents who were sexually active prior to the incident or who have been abused over a long period of time or in young children with HIV positive mothers. The absence of a test does not prevent the child from being given PEP, but a positive test means that the child is not a candidate for PEP and should be referred for HIV treatment services.

The side effects of PEP may be difficult for children to tolerate and time must be taken to ensure that they understand as much as possible the need to take the medication as directed for a full 28 days.

Sample regimens for post-exposure prophylaxis of HIV in children[6]

Treatment	**Form**	**Dosage**	**28 day supply**
Children < 2 yrs old (5 – 9 kg)			
Zidovudine (AZT) **and**	10 mg/ml	7.5 ml twice a day	420 ml (i.e. five bottles of 100 ml or three bottles of 200 ml) **plus**
Lamivudine (3TC)	10 mg/ml	2.5 ml twice a day	140 ml (i.e. two bottles of 100 ml or one bottle of 200 ml)
Children 10 – 19 kg			
Zidovudine (AZT) **and**	100 mg capsule	one capsule three times a day	90 capsules **plus**
Lamivudine (3TC)	150 mg tablet	½ tablet twice a day	30 tablets
Children 20 – 39 kg			
Zidovudine (AZT) **and**	100 mg capsule	two capsules twice a day	120 capsules **plus**
Lamivudine (3TC)	150 mg tablet	one tablet twice a day	60 tablets
Children and adolescents 40 kg or more – Treat according to adult protocol			

Follow-up

The follow-up care schedule is the same as for adults. The child should be seen one week after the first visit to evaluate adherence to treatment, side effects, signs and symptoms of infection, and mental and emotional status. If a vaginal infection persists after prophylaxis or treatment, consider the possibility of the presence of a foreign body or continuing sexual abuse.

[6] As with any drug treatment, follow local guidelines if the exist and are adequate.

Many children will exhibit dramatic behavior change after a sexual assault, including loss of previously acquired developmental skills. The health care provider should be sensitive to these changes and reassure the child and family that these reactions can be normal and will usually pass with time and emotional support.

The following signs of trauma are common in children who have experienced sexual violence (ages given are a rough guide only):

Baby / Small child (0 to 5 years)

- Increased crying
- Always frightened / sad
- Clings to caregivers
- Nightmares / does not sleep
- Hyperactive / Inactive
- Failure to grow

Children (6 to 12 years)

- Increased crying
- Always frightened / sad
- Aggressive or sexualized play
- Afraid of going to sleep in the dark
- Wets the bed
- Refuses to talk or to eat
- Runs away from home
- Complains of headaches / stomach aches

Adolescents (13 to 19 years)

- Withdrawal / won't talk about feelings
- Makes plans for revenge
- Runs away from home
- Nightmares
- Self-harming
- Eating disorders
- Substance abuse
- Depression / suicidal thoughts

Referral

Referrals for counseling and other support services are an essential responsibility of health care staff. The survivor and her family will have psychosocial, legal or safety issues that the health care provider cannot help with. The health provider should offer referrals for these services. Sources of referral should be identified and mechanisms established as part of the process of setting up health services.

Part III. COLLECTING FORENSIC EVIDENCE

The main purpose of the examination of a sexual assault survivor is to determine what medical care should be provided. Forensic evidence may also be collected to help the survivor pursue legal redress if she wishes and it is feasible. The survivor may choose not to have evidence collected. Respect her choice.

Only qualified and trained health workers should collect evidence and only after review of the pertinent local laws and procedures. In some countries only registered doctors are allowed to testify in court. You should be familiar with local guidelines on forensic examinations, including whether specific forensic post–rape kits are available.

BEFORE COLLECTING FORENSIC EVIDENCE ASK YOURSELF

- Can this be processed? Can it be stored safely?
- Are the police or local authorities able to perform the tests?

Do not collect evidence that cannot be processed or that will not be used.

Documenting injuries and collecting samples, such as blood, hair, saliva and semen, within 72 hours of the incident may help to support the survivor's story and identify the aggressor(s). If the survivor presents more than 72 hours after the assault, the amount and type of evidence that can be collected will be diminished. The survivor needs to understand that evidence collection can only be done during the initial exam. Once it is collected she can decide how to use it or if it should be destroyed, but if it is not collected during the first exam, there will be no other opportunity.

Make note of any samples collected as evidence.

1. SAMPLES THAT CAN BE COLLECTED AS EVIDENCE

- Injury evidence: physical and/or genital trauma can be proof of force and should be documented and recorded on pictograms.
- Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (for example, if replacement clothing is not available) describe its condition.
- Foreign material (for example, soil, leaves or grass) on clothes or body or in hair may corroborate the survivor's story and should be saved in an envelope or folded sheet of paper. The survivor can undress on two layers of flip chart paper and the upper layer can then be folded up to collect whatever debris has fallen from her body.
- Hair: foreign hairs may be found on the survivor's clothes or body. Pubic and head hair from the survivor may be plucked or cut for comparison. The survivor’s pubic hair can be combed for foreign hairs or other material.
- Sperm and seminal fluid: swabs may be taken from the vagina, anus, thighs or oral cavity if ejaculation or penetration took place in these locations. A trained health care provider or laboratory worker can examine wet–mount slides under a

microscope for the presence of sperm or the samples can be used for prostatic acid phosphatase analysis.
- DNA analysis, where available, can be done on material found on the survivor's body or at the location of the assault, which might be soiled with blood, sperm, saliva or other material from the assailant (e.g., clothing, sanitary pads, handkerchiefs, condoms). In this case, blood from the survivor must be drawn to allow her DNA to be distinguished from any other DNA.
- Blood or urine may be collected for toxicology testing (for example, if the survivor was drugged).

2. MAINTAINING THE CHAIN OF EVIDENCE

It is important to maintain the chain of evidence at all times, to ensure that the evidence will be admissible in court. This means that the evidence is collected, labeled, stored and transported properly. Documentation must include a signature of everyone who has possession of the evidence at any time, from the individual who collects it to the one who takes it to the courtroom.

If it is not possible to take the samples immediately to a laboratory, precautions must be taken:
- All clothing, cloths, swabs, gauze and other objects to be analyzed need to be well dried at room temperature and packed in paper (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 five days. To keep the samples longer they need to be stored in a freezer. Follow the instructions of the local laboratory.
- All samples should be clearly labeled with a confidential identifying code (not the name or initials of the survivor), date, time, type of sample (what it is, from where it was taken) and the collectors name, and put in a container.
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your name across the tape. Evidence should be released to the authorities only if the survivor decides to proceed with a legal case and only to the extent that it relates to the case (see Appendix 5: Sample consent for release of information).

CONFIDENTIAL
Consent for Treatment

<u>This form should be read to the client or guardian in her/his first language. Clearly explain to the client what the procedure for the medical examination involves and allow she/he to chose any or none of the options listed.</u>

I, ……., give my permission for an IRC medical doctor or midwife to perform the following (tick all that apply):

	Yes	No
Conduct a medical examination	☐	☐
Conduct a pelvic examination	☐	☐
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs.	☐	☐
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.	☐	☐

I understand that I can refuse any aspect of the examination I don't wish to undergo.

Client/ Guardian Signature:……..

Staff Signature:……

Date:……

Medical History and Examination Form – Sexual Violence

1. GENERAL INFORMATION

First Name	Last Name	
Address		
Sex	Date of birth (dd/mm/yy)	Age
Date / time of examination /	In the presence of	

In case of a child include: name of school, name of parents 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 on body**	
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)				
	Yes	**No**	**Not sure**	**Location (oral, vaginal, anal, other)**
Ejaculation				
Condom used				

If the survivor is a child, also ask: Has this happened before? When was the first time? How long has it been happening? Who did it? Is the person still a threat? Also ask about bleeding from the vagina or the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, any other sign or symptom.

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defecate?			Wash or bath?		
Brush teeth?			Use tampon or pad?		

Contraception use					
Pill		IUD		Sterilisation	
Injectable		Condom		Other	

Menstrual/obstetric history	
Last menstrual period (dd/mm/yy)	Menstruation at time of event Yes ☐ No ☐
Evidence of pregnancy Yes ☐ No ☐	Number of weeks pregnant _____ weeks
Obstetric history	

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date (dd/mm/yy)	Name of individual:

Existing health problems
History of female genital mutilation, type
Allergies
Current medication

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Known		Unknown	

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)			
Mental state (calm, crying, anxious, cooperative, depressed, other)			
Weight:	Height:	Pubertal stage (pre-pubertal, pubertal, mature):	
Pulse rate:	Blood pressure:	Respiratory rate:	Temperature:

Physical findings
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.

Head and face	*Mouth and nose*
Eyes and ears	*Neck*
Chest	*Back*
Abdomen	*Buttocks*
Arms and hands	*Legs and feet*

5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	*Introitus and hymen*	Anus
Vagina/penis	Cervix	*Bimanual/rectovaginal examination*
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 laboratory	Result

7. EVIDENCE TAKEN

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

8. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and Comments
STI prevention/treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Other			

9. 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 to Yes ☐ No ☐	Has someone to accompany her/him Yes ☐ No ☐
Counselling provided:	
Referrals	
Follow-up required Date of next visit	

Name of health worker conducting examination/interview: _____

Title: _____ ***Signature:*** _____ ***Date:*** _____

MEDICAL CERTIFICATE

I, the undersigned: (NAME, first name) -

title: (Indicate the function) -

on this date and time: (day-month-year, time) -

certify having examined at his/her request Mr, Mrs, Miss: (NAME, first name)

- -

date of birth: (day, month, year)- -

address: (exact address of the person examined)

- -

- -

She/He declared that she/he was the victim of a sexual attack on:

(time, day, month, year) -

- - - - -

at: (place)- -

by: (known or unknown person) -

Ms, Mrs, Miss, Mr ___________________________________ **presents the following signs:**

General examination (behaviour, prostrate, excited, calm, afraid, mute, crying, etc.)

Physical examination: (detailed description of lesions, the site, extent, pre-existing or recent, severity)

Genital examination: (signs of recent or previous intercourse, bruises, abrasions, tears, etc.)

Anal examination:

Other examinations carried out and samples taken:

Evaluation of the risk of pregnancy:

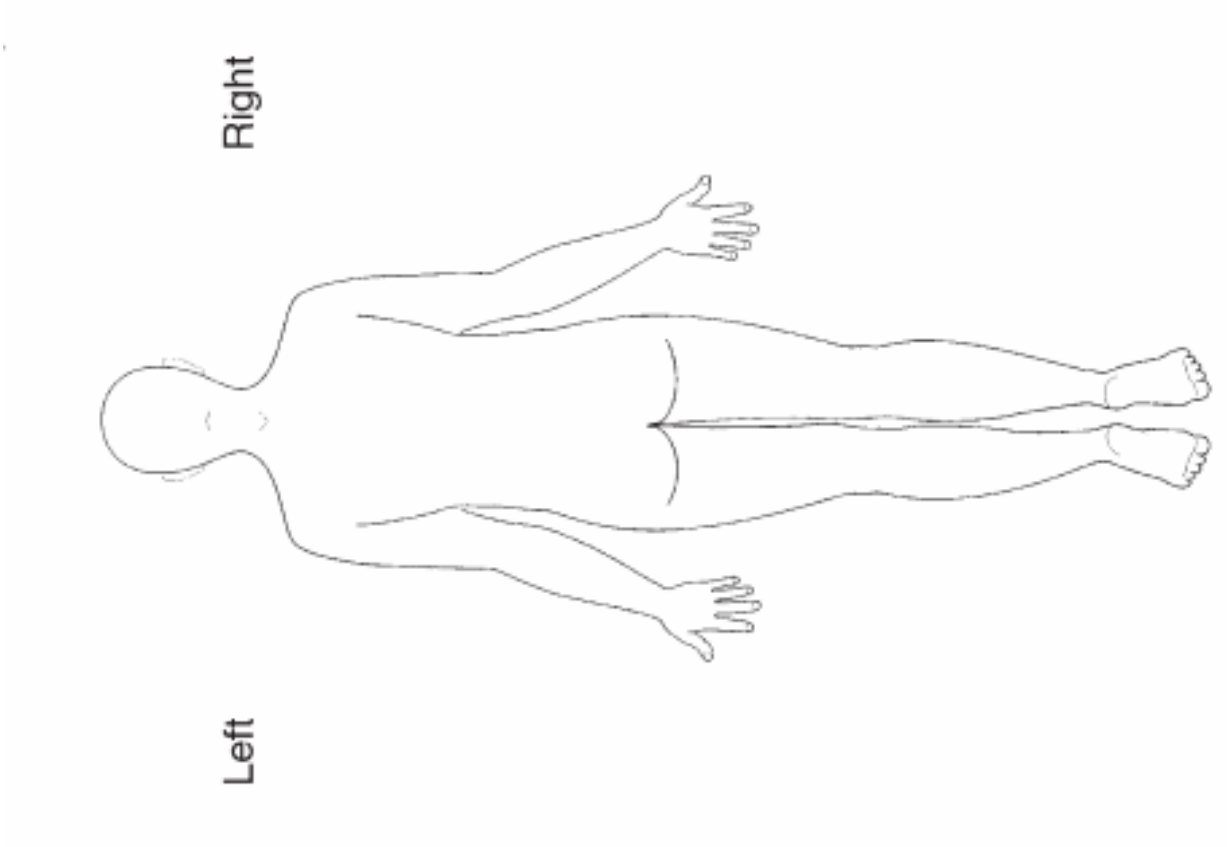
The absence of lesions should not lead to the conclusion that no sexual attack took place.

Certificate prepared on this day and handed over to the person concerned as proof of evidence.

Signature of the clinician: -

Date: -

Location:- -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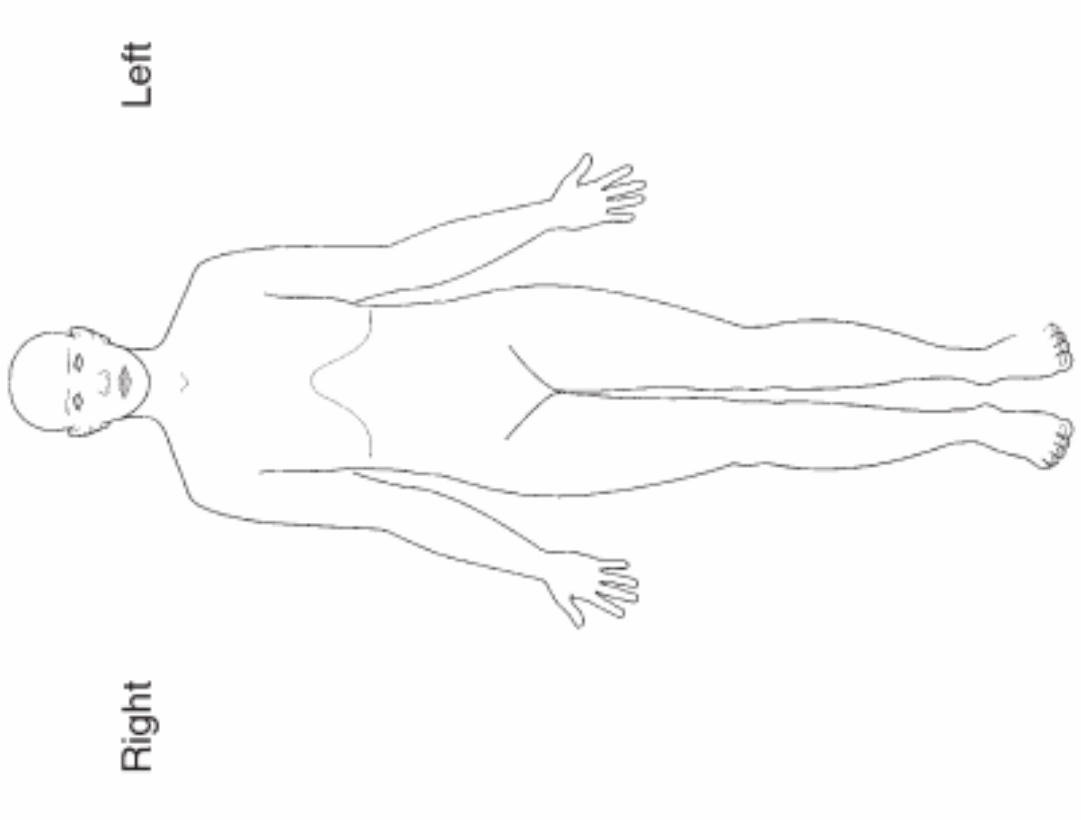
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CONFIDENTIAL
Consent for Release of Information

<u>This form should be read to the client or guardian in her/his first language. It should be clearly explained to the client that she/he can choose any or none of the options listed.</u>

I, ……., give my permission for IRC Health staff to share information about the incident I have reported to them.

I understand that the purpose of sharing information is so I can receive the best possible protection, care and assistance. I understand that shared information will be treated with confidentiality and respect, and shared only as needed to provide the assistance I request.

I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me.

I agree that the information can be released to the following:

Tick all that apply

☐ Police (name and jurisdiction):……...

☐ Health Worker (name and agency):……

☐ Legal Representative (name):……...……

☐ Other (please specify):……

……

……..

Client/ Guardian Signature:
…….

Staff Signature:…….

Date:……

Considerations when adapting the protocol to local conditions

Medical laws and legal procedures

- Abortion laws.
- Emergency contraception regulations.
- Foster placement and adoption laws and procedures in the case of a pregnancy.
- Legal age of maturity and rules regulating medical care for children.
- Crime reporting requirements and obligations, for adult or child survivors.
- Police and other forms.
- Who may complete the forms and/or testify if needed.

Forensic evidence

- Which medical practitioner can give medical evidence in court (e.g. doctor, nurse, other).
- Training for medical staff in forensic examination (of adult or child survivors).
- Evidence allowed/used in court for adult and child sexual assault cases that can be collected by medical staff.
- Forensic evidence tests possible in country (e.g. DNA, acid phosphatase).
- How to collect, store and send evidence samples.
- Existing "rape kits" or protocols for evidence collection.

Medical protocols

- National STI protocol.
- Vaccine availability and vaccination schedules.
- Availability and location of voluntary HIV counseling and testing services.
- Possibilities/protocols/referral for post–exposure prophylaxis of HIV infection.
- Clinical referral possibilities (e.g. psychiatry, surgery, pediatrics, gynecology/obstetrics).

Resources for training health staff

Clinical management of rape survivors: Developing protocols for use with refugees and IDPs. *Geneva, Switzerland: WHO; 2001. Available online.* (www.rhrc.org/resources)

This guide is designed to assist qualified health care providers (medical coordinators, 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.

Advancing commitments: Sexual and reproductive health presentation tools. *Family Care International.* (www.familycareintl.org)

A set of user–friendly multi–media tools designed for use in presentations on a range of sexual and reproductive health and rights topics.

BASTA! Summer 2000. *International Planned Parenthood Federation Western Hemisphere Region; 2000. Available online.* (www.ippfwhr.org) In English and Spanish.

Includes instructions on how to create a referral network; presents a basic introduction to health staff sensitization and training; discusses issues in implementing systematic screening; offers ideas on what health care providers and institutions can do to address GBV without funding; and provides a sample management checklist form.

Sexual Assault Nurse Examiner (SANE): Development and operation guide. *Minneapolis, MN: US Department of Justice; 2001. Available online* (www.ojp.usdoj.gov/ovc/publications/welcome.html)

This document provides an effective model for sexual assault medical evidentiary exams and offers a multidisciplinary, victim centered way of responding to sexual assault victims by outlining specific steps to replicate "best practices".

Caring for women with circumcision: A technical manual for health care providers. N. Toubia. *New York, NY: RAINBO; 1999.* (www.rainbo.org/)

This manual includes information on the anatomy and histology of the female external genitalia; countries where FC/FGM is practiced and its context; health complications resulting from FC/FGM; obstetrical care of circumcised women; laws pertaining to FC/FGM; and advice on how to communicate sensitively with circumcised women. This book also contains seven case studies. The cost is US$17.95.

A practical approach to gender–based violence: A program guide for health care providers & managers. (www.unfpa.org/upload/lib_pub_file/99_filename_gender.pdf)

The manual offers guidance on how RH facilities can begin their own GBV projects.

UNICEF Training of Trainers on Gender–Based Violence Focusing on Sexual Exploitation and Abuse. http://www.reliefweb.int/library/documents/2003/unicef-tot-25sep.pdf

This manual is a guide to help you facilitate a five day workshop the goals of which are to: 1) help participants understand the experiences of women and children who have survived sexual violence; 2) prepare participants to respond to both the immediate and long term consequences of sexual violence.