REPUBLIC OF SIERRA LEONE
MINISTRY OF HEALTH AND SANITATION

National clinical guidelines for management of survivors of sexual and gender-based violence

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1. FOREWORD

Sexual Violence is an important public health and human rights concern in Sierra Leone, affecting women, girls, boys, and men alike. Although the physical consequences of SGBV are usually immediately apparent, the psychosocial consequences, are often far reaching. While there are many ongoing efforts to address Sexual and Gender Based Violence (SGBV) the problem, which is inherently linked to the status of women in the country and sub-region, persists.

The 11 -year brutal civil war in Sierra Leone, saw a rise in the cases of sexual violence inflicted on women and girls, and in recent times, the quarantine measures imposed by the Ebola Outbreak in 2014-2016 and the COVID-19 pandemic, have also increased the number of cases reported at police stations and health care facilities. In addition, the actual prevalence of GBV has proven difficult to measure due to the lack of robust data management systems, the difficulty faced by victims in reporting due to sociocultural taboos, and other systems failures.

Evidence has shown that Sexual Violence is an important risk factor contributing towards vulnerability to HIV and Hepatitis B infection especially amongst adolescents and women, who are often the victims. This calls for comprehensive measures to address issues of Sexual Violence and more importantly meet the diverse and often complex needs of the survivors, their caregivers and their families. Holistic care should highlight the fact that care could last for several months to several years after the initial incident. Comprehensive care for Sexual Violence ranges from medical treatment which includes management of physical injuries, provision of prophylactic treatment to reduce chances of contracting sexually transmitted infections including HIV, gonorrhea and syphilis, and provision of emergency contraception to reduce incidence of unwanted pregnancies. Comprehensive care also entails provision of psychosocial support through counseling to help survivors deal with trauma and depression; while legal assistance should be provided to ensure the survivor has access to justice, as well as including provision forensic verification requirements for the criminal justice system, if and when necessary.

These National Guidelines have been designed to give comprehensive information about management of sexual violence in Sierra Leone and focuses primarily on availing quality services that address the medical, psychosocial, and legal needs of a survivor of sexual assault. Although these needs are interrelated, attempt has been made to group the guidelines into chapters that can easily be accessed for easy reference.

The Guidelines recognize the fact that children, girls and boys alike, form a significant proportion of survivors of sexual violence and make special provisions which addresses their unique aspects, distinct from those of female and male adults. The Guidelines should be available in all health care facilities nationwide and it is our ardent hope that their implementation will methodically address the comprehensive needs of survivors of Sexual Violence in Sierra Leone.

Hon. Dr. Alpha Tejan Wurie (Ass. Prof.)
Minister for Health and Sanitation

2. ACKNOWLEDGEMENTS

Ensuring standardized health care delivery for all Sierra Leoneans

The Ministry of Health and Sanitation recognizes the medical and psychosocial impact of SGBV on its survivors. Formulating and implementing these comprehensive medical and psychological management guidelines are important in ensuring optimal care to survivors of sexual assault in Sierra Leone.

Special recognition is given to the Minister for Health and Sanitation for his continued support and leadership in ensuring standardized health care delivery for all Sierra Leoneans, and for SGBV survivors in particular. To the indefatigable technical team members who committed their valuable time and efforts towards the development of the guidelines for the clinical management of SGBV survivors, we are thankful for your continued commitment and dedication in ensuring that the voiceless in our society are given the care they rightfully deserve.

Special acknowledgements go to the MoHS team led by Dr. Francis Moses (reproductive health program manager), Dr. Patricia Ba (adolescent health program manager) under the overall leadership of Dr. Sartie Kenneh (director reproductive and child health). We are indebted to UNFPA for its continued technical and financial support in the production of vital national documents needed for standardized and evidence based health care delivery especially in reproductive, maternal and adolescent health. We are especially grateful to Dr. Kim Eva Dickson and Dr. Stephen Mupeta for their technical direction and leadership in the development of these guidelines.

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3. ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
COC	Combined oral contraceptive
DNA	Deoxyribonucleic acid
EC	Emergency contraception
FGMC	Female genital mutilation/cutting
FGM	Female genital mutilation
GBV	Gender-based violence
HIV	Human immuno-deficiency virus
MDGs	Millennium Development Goals
MoHS	Ministry of Health & Sanitation
PEP	Post-exposure prophylaxis
PRC	Post-rape care
PTSD	Post-traumatic stress disorder
QA	Quality Assurance
QI	Quality Improvement
SDP	Service Delivery Point
SGBV	Sexual and gender-based violence
SOA	Sexual Offences Act
STI	Sexually transmitted infection

4. EXECUTIVE SUMMARY

Sexual violence is a serious human rights violation and a public health problem in Sierra Leone and the world over. It has devastating effects on the lives of the survivors in terms of long-term consequences on their health and mental well-being. Survivors deserve to be supported, to be treated with dignity and respect and to see their offenders brought to justice. This requires a comprehensive set of policies, legislation and programmes to effectively respond to these needs.

Although various pieces of legislation and policies on sexual violence exist in Sierra Leone, there have not been any guidelines on services for survivors of sexual violence. This necessitated the development of these national clinical guidelines.

These guidelines have been designed to give general information about the management of sexual violence in Sierra Leone and are meant for use by qualified health care providers, focusing on the services that address all the needs of a sexual violence survivor, including medical, psychosocial and legal.

The guidelines also cater to the needs of children owing to the fact that in many of the health facilities in Sierra Leone, children comprise a significant percentage of the survivors of sexual violence. The guidelines single out all the aspects of child management that differ from those of adults and, where possible, integrates them into each section.

The guidance presents an overview of the global and national context of gender-based violence and the guiding principles for behaviour intervention and assistance, based on a rights-based, survivor-centred, do no harm approach.

It outlines the procedures relating to medical management of sexual violence including the first steps that need to be taken after meeting a survivor of sexual violence. It highlights ethical issues, history taking and required knowledge about management of health-related problems of sexual violence survivors. It discusses the resources, both human resources and logistical, that are needed at a clinical facility. History taking is presented in detailed steps, with special considerations for different groups including the elderly, male survivors and pregnant women.

Treatment protocols that are detailed in the guidance include HIV prevention, the prevention of unwanted pregnancy, hepatitis B and tetanus, and the management of sexually transmitted infections. Follow-up with survivors is discussed. The guidance cautions that since survivors may not choose to return, the first interaction with them may be the only one, so it has to be done with as much consideration and thoroughness as possible, in accordance with these recommendations.

Survivors of sexual violence have different reactions to the trauma they experienced; some immediate some short-term and some long-term. The amount and nature of psychological support and social support will therefore vary enormously. The guidance highlights the main psychological consequences of sexual violence, approaches to counselling and counselling procedures including ethical considerations. It also recognizes the need for self-care for the health care provider who is caring for the survivor, as this can be emotionally difficult for clinic staff.

Forensic management is also elaborately covered. It is absolutely essential in helping survivors access justice by ensuring availability of credible evidence that sexual violence indeed took place and help links the perpetrator to the crime. It includes information on appropriate collection and preservation of specimens, proper documentation and the maintenance of the chain of evidence.

Situations of conflict further exacerbate the vulnerability to gender-based violence. National accountability mechanisms are often weakened or absent, enabling a climate of impunity. The Minimum Initial Service Package for humanitarian settings seeks to address this through a series of high-impact interventions. Quality assurance and Quality Improvement which are a core component of any service delivery are also covered, as well as monitoring and evaluation of the data gathering and reporting on gender-based violence.

5. PURPOSE OF GUIDELINES

These guidelines describe best practices in the clinical management of survivors of sexual violence and are intended for use by qualified health care providers.

The document outlines the protocols for the management of survivors of sexual violence and can be used in developing curricula, in planning care services and in training health care providers.

The guidelines include detailed guidance on the clinical management of women, men and children who have experienced sexual violence. It explains how to provide first-line support to the survivors, take a detailed history of the incident and relevant information, perform a thorough physical examination, undertake investigations required, follow treatment protocols, record findings, collect forensic evidence and prepare the medical certificate. The guidelines also explain how to prepare the health centre for provision of gender-based violence (GBV) services and the required quality assurance (QA) and quality improvement (QI) systems.

6. THE GLOBAL AND NATIONAL BURDEN OF GENDER-BASED VIOLENCE

GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. GBV includes sexual violence (which these guidelines primarily address), physical violence, emotional violence and harmful practices, among others.

GBV or violence against women and girls, is a global pandemic that affects one in three women in their lifetime. The term GBV highlights the gender dimension of these types of acts: in other words, the relationship between male and female. It reveals the female's subordinate status in society and their increased vulnerability to violence. It is important to note, however, that men and boys may also be victims of GBV, especially sexual violence. The nature and extent of specific types of GBV vary across cultures, countries and regions. GBV includes sexual violence, including sexual exploitation/abuse and forced prostitution, domestic violence, trafficking, forced/early marriage, harmful practices such as female genital mutilation (FGM), honour killings, widow inheritance, and others.[1]

According to the World Health Organization (WHO) (2014), an estimated 35 per cent of women worldwide have experienced either physical and/or sexual intimate partner violence or non-partner sexual violence. Seven per cent have been sexually assaulted by someone other than a partner, and as many as 38 per cent of murders of women are committed by an intimate partner. In addition, 200 million women have experienced female genital mutilation /cutting ((FGM/C) (UNICEF, 2013).

GBV is devastating for survivors and their families, and also often entails significant social and economic costs. In some countries, violence against women is estimated to cost countries up to 3.7 per cent of their gross domestic product – more than double what most governments spend on education (World Bank, 2019).

One characteristic of GBV is that it knows no social or economic boundaries and affects women and girls of all socio-economic backgrounds: this issue needs to be addressed in both developing and developed countries.

Failure to address this issue also entails a significant cost for the future. Numerous studies (WHO, 2017; Watkins,1992) have shown that children growing up with violence are more likely to experience violence themselves or become perpetrators of violence.

Sexual violence affects the mental and physical health of individuals, and can also impact entire communities, leaving them devastated by violence, disease, broken families and unwanted children. Tragically, many cases are not reported as often women are too scared or embarrassed to report episodes of sexual assault due to concerns of stigma or fear of repercussion within their community.

1. Interagency Standing Committee on Gender Based Violence, as referenced in the Government of Sierra Leone National Referral Protocol on Gender Based Violence.

57 PERCENT

of Sierra Leonean women and girls aged 15 to 49 reported having faced physical or sexual violence

Women and girls in Sierra Leone face widespread and deeply rooted structural violence and marginalization. According to the Sierra Leone Demographic Health Survey (DHS) of 2013, 57 percent of Sierra Leonean women and girls aged 15 to 49 reported having faced physical or sexual violence. The Sierra Leone Police Annual General Crime Statistics Report (2019) recorded a total of 12,314 cases of offences against women and children at the regional level in six Police Regions in the country. The figure is comprised of 3,252 cases of sexual penetration, 145 cases of rape and 8,917 cases of domestic violence.

The National NGO Rainbo Initiative – in data gathered from its five centres providing free services to survivors of SGBV – recorded 3,897 cases of SGBV nationwide in 2019. It should be noted that the reports only contain records of cases which were reported to the police and centres and as such are likely an underestimation of the real numbers.[2]

Reducing violence against women and girls requires a community-based, multi-pronged approach, and sustained engagement with multiple stakeholders. The most effective initiatives address underlying risk factors for violence, including social norms regarding gender roles and the acceptability of violence.

Survivors of GBV require a comprehensive package of services which addresses their health, justice, security and social needs. These guidelines focus primarily on addressing the health needs of sexual assault survivors. While these guidelines address caring for both male and female survivors of assault, we use 'she' and 'her' throughout for ease of reading.

2. Included in the National Male Involvement Strategy for the Prevention of SGBV (2020)

7. DEFINITION OF TERMS

Child	A person under the age of 18
Consent	Agreement by choice and with the freedom and capacity to make that choice (Sexual Offences Act [SOA])
Designated persons	For purposes of the SOA, designated persons are medical practitioners under the various laws and acts of parliament.
Domestic violence	Any criminal offence arising out of physical, sexual, emotional or psychological, social, economic or financial abuse committed by a person against another person within a domestic relationship (adapted from the Domestic Violence Act 2007).
Gender-based violence	An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females

Genital organs	The whole or part of male or female reproductive parts and for the purposes of the act of sexual violence, includes the anus
Health care worker/ health provider	Professionals who provide health services including nurses, doctors, clinical officers and medical assistants, who have specific training in the field of health care delivery
Informed consent (medical)	Where the health care provider has disclosed all relevant information with regard to the proposed course of treatment to the patient so that the patient can then arrive at a choice as to whether or not to proceed with the same
Informed consent (legal):	Where a person has all relevant information regarding a certain course of action prior to agreeing to that action. For this consent to be legally valid the person has to be an adult of sound mind.
Medical certificate	A document that should be filled in by medical practitioners for purposes of medico-legal documentation following sexual violence
Penetration	Partial or complete insertion of the genital organs of a person or an object into the genital organs of another person
Rape	Physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using the penis, other body parts or an object, without consent
Sexual assault	Illegal sexual contact that usually involves force upon a person without consent or is inflicted upon a person who is incapable of giving consent (because of age or physical or mental incapacity) or who places the assailant in a position of trust or authority
Sexual penetration[3]	Any act which causes the penetration to any extent of the vagina, anus or mouth of a person by the penis or any other part of the body of another person, or by an object (SOA, 2012)
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work
Survivor (victim)	Preferred term for a person who has lived through an incident of GBV (according to the Government of Sierra Leone National Referral Protocol on Gender Based Violence)

3. Note that the terms 'rape' and 'sexual penetration' are often used interchangeably. In Sierra Leone, sexual penetration is used when a minor is involved.

8. LAWS AND POLICIES

The following section outlines the acts relevant to the clinical guidelines.

8.1 Domestic Violence Act, 2007

Enacted to suppress domestic violence, provide protection for the victims of domestic violence and to provide for other related matters. The Domestic Violence Act criminalizes domestic violence, addressing issues of sexual, physical, emotional, psychological and economic violence perpetrated against an individual in a domestic setting. The acts of violence covered under the act are commonly committed against women and children, and were lawful if reasonable, before the enactment of the law.

8.2 The Sexual Offences Act, 2012

Enacted to consolidate with amendments the law relating to sexual offences and The Sexual Offenses (Amendment) Act 2019.

The SOA applies to all sexual offenses committed on individuals and children and aims to strengthen and update the law on sexual offenses while improving the protection of individual from sexual offenders.
The amended Bill replaces sections in the SOA of 2012 to make provision for the increase of the maximum penalty for rape and sexual penetration of a child from 15 years to life imprisonment among others

8.3 Criminal Procedures Acts, 1965

In the Criminal Procedure Act, section 66 (1), 'Deposition of medical practitioner may be read as evidence' states: "The deposition of a medical practitioner or other medical witness, taken and attested by a Magistrate in the presence of the accused person, may be read as evidence, although the deponent is not called as a witness,"

The deposition of the medical practitioner is the medical practitioner's out-of-court testimony which is the medical certificate and this section states that once the medical certificate has been attested by a Magistrate in the presence of the perpetrator, it can then be used as evidence.

8.4 The Medical Practitioners and Dental Surgeons (Amendment) Act, 2008

The Medical Practitioners and Dental Surgeons (Amendment) Act, 2008, is an amendment of the Medical Practitioners and Dental Surgeons Degree, 1994. Section 39 states under Validity that, "no certificate or other document required by law to be signed by a medical practitioner or dental surgeon shall be valid unless it is signed by a registered medical practitioner or dental surgeon." This act clearly excludes all other health professionals from signing and endorsing the medical certificate that is the legal document of findings in a sexual violence case presented as evidence in court. The medical practitioner is therefore the 'expert witness' that gives evidence of fact in court.

Until the acts are amended, in Sierra Leone, only a medical practitioner can sign and endorse the medical certificate and appear in court giving evidence as an expert witness.

9. GENERAL GUIDANCE ON RESPONDING TO SURVIVORS OF SEXUAL ASSAULT

9.1 Role of health care providers in responding to survivors of sexual violence

As a health care provider, you are part of a team of people with the important role of providing compassionate, competent and confidential care to sexual assault survivors.

Compassion: Treating sexual assault survivors with compassion means creating a safe and supportive environment. You may not know which patients are sexual assault survivors, so it is important to treat everyone with kindness and respect. The job of a clinic worker is to provide care for people who come to us for assistance, and our job is to provide that care in a safe environment, providing compassion, concern for people as people for whatever they have experienced.

Competence: Competence means having the required skills and qualifications to do your job well. No matter what your job is, doing it in a competent and professional manner will help sexual assault survivors feel better about seeking care. For example, you can make sure that sexual assault survivors do not have to wait a long time to see a doctor. Avoid having survivors retell the incident many times to different people, as this stalls treatment and may force survivors to relive the trauma of the experience. Health care providers must know what they are doing and do it appropriately and carefully for people.

Privacy and confidentiality: Informed consent and safeguarding of confidentiality means the provision of health care, treatment and counselling should be private and confidential; information should be disclosed only with the consent of the women and must include the right to know what information has been collected about their health and having access to this information, including medical records (WHO, 2014).

Whatever happens in the clinic must never be discussed outside the clinic. You may overhear conversations about a patient or recognize a survivor seeking care. By discussing this outside the clinic you are betraying the patient's trust and may be putting her in danger.

Confidential care is essential for sexual assault, because it is a private matter and the responsibility is with the clinician to care for the client, not to share that information. The service should be provided in a room with both auditory and visual privacy as this gives confidence to the survivors to openly discuss their ordeal. Confidentiality is a big issue, in part because most clinics are crowded. The staff that work in those clinics know the community, maybe they are even from the same community. And a lot of the staff who work at the lower level cadres may not fully understand medical ethics, due to a lack of training, and therefore there is a possibility that they may divulge what they saw in the clinic when they go back home in the community. All clinic workers can improve patient care by showing compassion, demonstrating competence and ensuring confidentiality. By doing this, you, the clinic worker play an important role in reducing the harmful effects of sexual assault.

10. GUIDING PRINCIPLES AND APPROACHES

10.1 Basic principles and approaches

Below are the basic principles and approaches that should guide the behaviour, intervention and assistance of health care workers when responding to cases of sexual assault.

1 A rights-based approach

A rights-based approach includes the right to the highest attainable standard of health and the right to self-determination, which means women being entitled to make their own decisions including sexual and reproductive decisions and to refuse medical procedures and/or take legal action (WHO, 2014).

2 A survivor-centred approach

Similar to a rights-based approach, a survivor-centred approach means that all those who are engaged in programmes related to violence against women prioritize the rights, needs, and wishes of the survivor (endvawnow.org,2011).

3 Gender equality

Assuring gender equality in health means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy. It requires also being cognizant of inequalities in power relationships between women and men and between providers and patients (WHO, 2014).

4 Respect

Actions and response services of all actors will be guided by respect for the wishes, the rights and the dignity of the survivor (UNFPA, 2019).

5 Belief

As health workers we always believe a woman or girl. It is not our job to judge what happened; it is our job to help cope with the consequences. It is up to the police to investigate and the courts to decide.

6 Security and safety

The security and safety of the survivor are a priority at all times.

7 A do no harm approach

A do no harm approach involves taking all measures necessary to avoid exposing people to further harm as a result of the actions of service providers and humanitarian actors (adapted from UNFPA, 2019) decide.

10.2 Respecting a survivor's universal rights

Universal rights apply to everyone who seeks care at your clinic, including sexual violence survivors. At all times, a person seeking care should be treated with dignity and nondiscrimination and provided with the best health care possible. As a clinic worker, respecting these universal rights is not only essential to a survivor's healing, it is your responsibility.

Right to health care: Every survivor has a right to health care. Survivors of sexual assault have a right to high quality health care to help them heal physically and psychologically regardless of their ability to pay.

Right to non-discriminationEvery survivor has a right to non-discrimination. All survivors of sexual assault have the right to receive respectful and competent health care regardless of their race, sex, age, national or social origin, marital status, tribal identification, religion or socioeconomic status.

Right to information: Every survivor has a right to information in a language she understands. Survivors have a right to know about:

- their right to privacy, confidentiality, and self-determination;
- the details of the examination;
- treatment options available;
- the effects and side effects of prescribed medications;
- available referral services.

Right to privacy: Every survivor has a right to privacy.

- A survivor's privacy should be maintained by caring for her in a separate room where she cannot be overheard by those not involved in her care.
- She should not be required to move from room to room in the clinic.
- She should not have to interact with people other than those trained staff who are caring for her directly.

Right to confidentiality: Every survivor has a right to confidentiality.

- All medical and health information related to the survivor should be kept confidential, even from family members (unless the survivor is a child).
- Clinic workers may give information about the survivor only to those directly involved in her care. Any other release of information requires the survivor's permission.
- Clinic records of sexual assault survivors should be kept in a locked cabinet.

Right to self-determination: Every survivor has a right to self-determination.

- A survivor has the right to choose what kind of care she wants.
- A survivor may stop telling her story or stop the examination at any time.
- Clinic workers should not pressure a survivor to do anything she does not wish to do.

11. MEDICAL MANAGEMENT

11.1 Introduction

Medical management of sexual violence survivors is essential in mitigating against adverse effects of the violence. It is aimed at managing any life-threatening injuries and providing other post-rape services to reduce the chances of the survivor contracting any sexually related infections and pregnancy.

The management of any life-threatening injuries, and extreme distress should take precedence over all other aspects of post-rape care. However, the management of minor cuts and abrasions should not delay the delivery of other more time dependent treatments. Health care providers should be aware that Sierra Leone's laws entitle medical care to survivors of sexual violence as well as suspects, convicts or witnesses of sexual offences. Therefore, a perpetrator or alleged perpetrator seeking medical treatment should be accorded the necessary treatment and care as would a survivor.

These guidelines explain the processes taken at a health facility to care for GBV survivors, which includes how to receive the client at the health facility, provide crisis counselling, take history and conduct physical, genital and forensic examination, and adhere to ethical considerations. It also outlines how to collect and preserve forensic evidence, offer treatment for specific medical complications of sexual assault and provide counselling. It further gives useful guidelines on follow-up care and presenting medical evidence in court. There is a section specifically dedicated to special care required when attending to child survivors, pregnant women, men and elderly women.

11.2 Establishing clinical care services for survivors

Generally, a health care facility that already offers reproductive health services, such as family planning, antenatal care, normal delivery care or management of STIs, can offer care for survivors. The health care facility must make preparations to respond thoroughly and compassionately to survivors. The health administrators should ensure that health care providers (doctors, nurses, other paramedics and administrative staff) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, since most survivors are female. However, lack of trained female health care providers should not prevent the health care service facility from providing care.

All health care services for survivors should, preferably, be provided in one place (One-Stop-Centre) so that the survivor does not move from place to place. A One-Stop-Centre is a care facility designed to provide a comprehensive package of quality services (medical, psychosocial, legal, safety/protection) to survivors of SGBV under one roof and free of charge. The services are provided in a coordinated and survivor-centred way by a multidisciplinary team of qualified and well-orientated personnel. The team comprises health professionals, psychosocial counsellors, legal personnel and protection officers (police, who also are specifically trained to on how to handle survivors and how to undertake special investigations and appropriate record keeping).

Health care providers should provide the following information to members of the community:

- What services are available for survivors;
- Why survivors would benefit from seeking clinical care;
- Where to go for services;
- Why survivors should seek care immediately or as soon as possible after an incident. In the case of sexual and physical assault, without bathing or changing clothes;
- That survivors can trust the health provider to treat them with dignity, maintain their security, and respect their privacy and confidentiality;
- That the service is available 24 hours a day, 7 days a week.

These guidelines provide strategies for management of the possible medical consequences of GBV. The strategies include emergency contraception, testing and prevention of HIV and other sexually transmitted infections (STIs). The strategies should be provided with the following in mind:

- All health centre staff should be trained in the basic principles of responding to sexual assault;
- Medical staff who will care for survivors need to be identified and trained;
- A location for confidential examinations needs to be identified and stocked with needed materials;
- Translators and any partner organizations supporting survivors need to be identified and trained;
- A referral network for social support services must be established;
- All GBV cases should be treated as an emergency;
- Survivors should be included on the medical fees exemption list;
- Forensic evidence must be collected and preserved;
- Counselling, psychosocial care and support and follow up care need to be provided;
- Survivors must be attended to in a comprehensive, confidential and non-judgmental manner with a focus on the survivor and their needs;
- Providers should understand their own attitude and sensitivities, and socio-cultural context and their community's perspectives, practices and beliefs.

11.3 Assessing your clinic's resources

- It is essential that the clinic is well-organized and stocked with supplies to care for sexual assault survivors.
- Private examination areas are particularly important for maintaining confidentiality and helping the patient feel as comfortable as possible.

11.4 Essential clinic resources

A clinic needs to have the following essential resources:

- a private room for examining the survivor with both sound and visual privacy;
- good lighting;
- access to a latrine;
- stocked supply of appropriate drugs;
- stocked supply of administrative materials;
- forensic evidence supplies (if applicable).

(See Annex 7, Supplies for minimum care of sexually assaulted survivors.)

11.5 Organize staff and materials

All clinics are different, and it is important to know how yours operates and what you can do for a survivor of sexual assault. It is also important to know what your clinic is not able to do.

Even if your clinic does not meet the standards described in these guidelines, provide survivors with the best care you can.

All clinics should have:

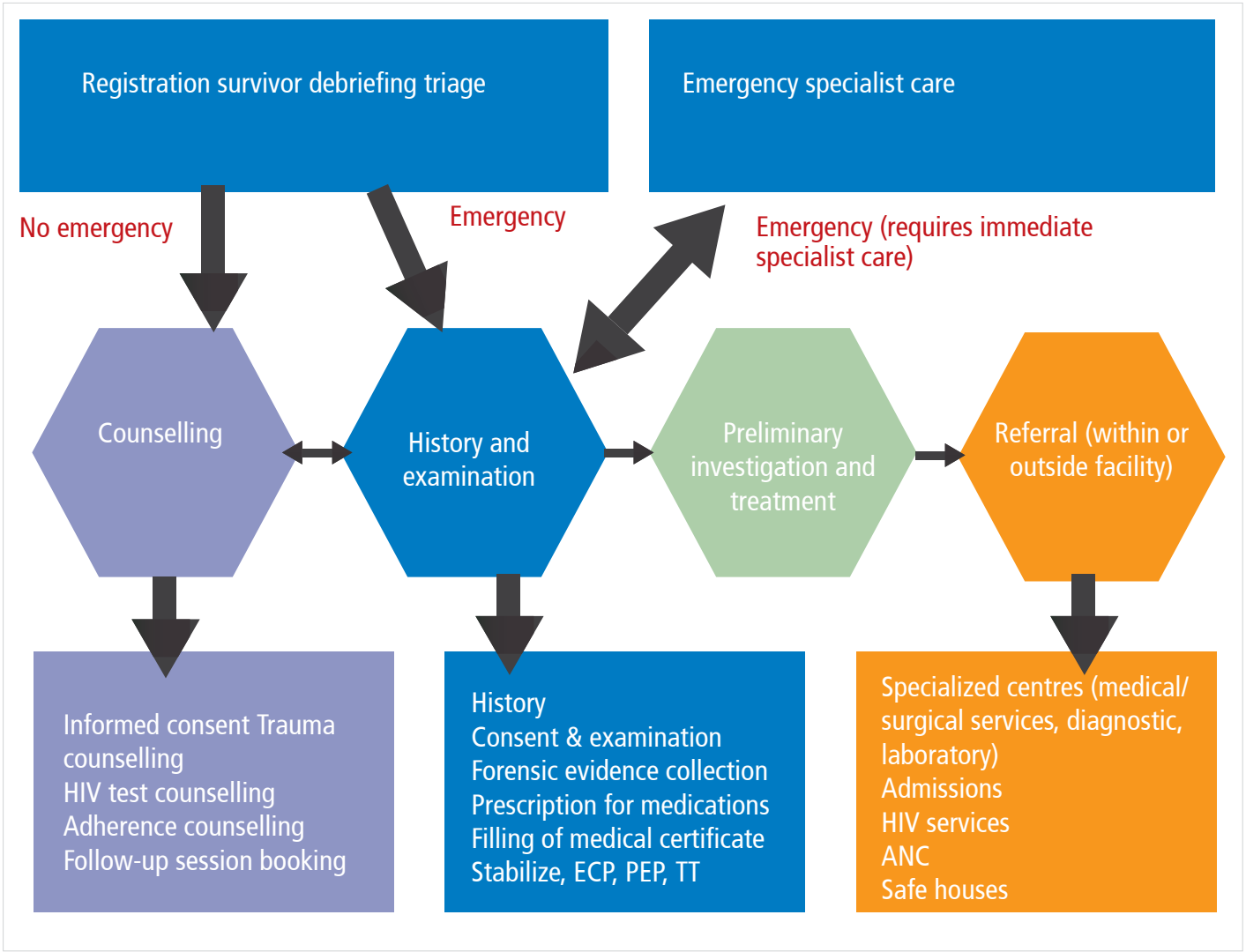
- a health care provider specifically trained to care for sexual assault survivors on-duty or on-call at all times;
- a protocol adapted to the local context and laws related to sexual assault;
- a plan for referring the survivor for mental health, legal and other support services.

11.6 Reception and intake of survivors at the health facility

All staff in health facilities from reception staff to health care providers, dealing with survivors, should be sensitized and trained in the management of GBV cases. They should always show compassion, observe confidentiality and uphold the professional code of conduct. Reception personnel must be sensitive and responsive to the physical and emotional trauma, shame or fear the survivor may be experiencing or have experienced. They should:

- remain calm and record the survivor's particular's in detail in a respectful manner;
- soon after, escort the survivor to the facility's dedicated space for GBV care;
- if the survivor has a severe or life-threatening condition, refer for emergency treatment immediately;
- provide emergency treatment and prophylaxis such as emergency contraception and PEP if trained and authorized persons are available;
- preserve (and not contaminate) forensic and any other medical evidence in the process of referring survivor for emergency treatment;
- ensure that the survivor doesn't have to move from one part of the facility to another but rather where possible relevant staff should be called to meet the survivor in the established space for care of GBV survivors.

Figure 1: Health facility services flow chart



In the event of an emergency, stabilize the patient by controlling bleeding from the genitals, anus and/or general body injuries and stabilizing fractures if necessary. Provide wound care and pain relief. HBsAg rapid/diagnostic test should be done before administering Hepatitis B Virus vaccine. In children and early adolescents, childhood immunization history must be taken in detail. The pentavalent vaccine, which is part of the National Expanded Programme on Immunization since 2007, confers protection against hepatitis B infection.

All medical personnel must be aware that:

- No police or medical report is required to provide health care services to survivors.
- No fees will be requested from survivors for any service provided.
- Children can receive treatment in any health facility and do not need to be referred to children's hospitals.
- Receiving personnel should ask the survivor if they have already reported to the police.
- If survivor **has already reported** to the police, ensure that she/he has been given Police Medical Report form.
- If survivor **has not reported** to the police, help survivor contact the nearest police station. The police officers will meet the survivor at the health facility.
- Each facility should keep a directory of available places of safety, police contact persons, legal services, etc.
- The provider must enquire if the survivor has received medical services at any other facility.

11.7 First-line support

First-line support provides practical care and responds to the survivors' emotional, physical, safety and support needs, without re-traumatizing them or intruding on their privacy. Often, first-line support is the most critical care that health workers can provide. Even if this is all the health worker can do, it will have significantly helped the client. First-line support has helped people who have been through various upsetting or stressful events, including women and girls subjected to violence.

Remember: This may be your only opportunity to help the survivor of violence.

First-line support may be the most important care that you can provide, and it may be all that she needs. The support involved caring for emotional and practical needs. Its goals include:

- identifying her needs and concerns;
- listening and validating her concerns and experiences;
- helping her to feel connected to other, calm, and hopeful;
- empowering her to feel able to help herself and to ask for help;
- exploring her options;
- respecting her wishes;
- helping her to find social, physical and emotions support;
- enhancing safety.

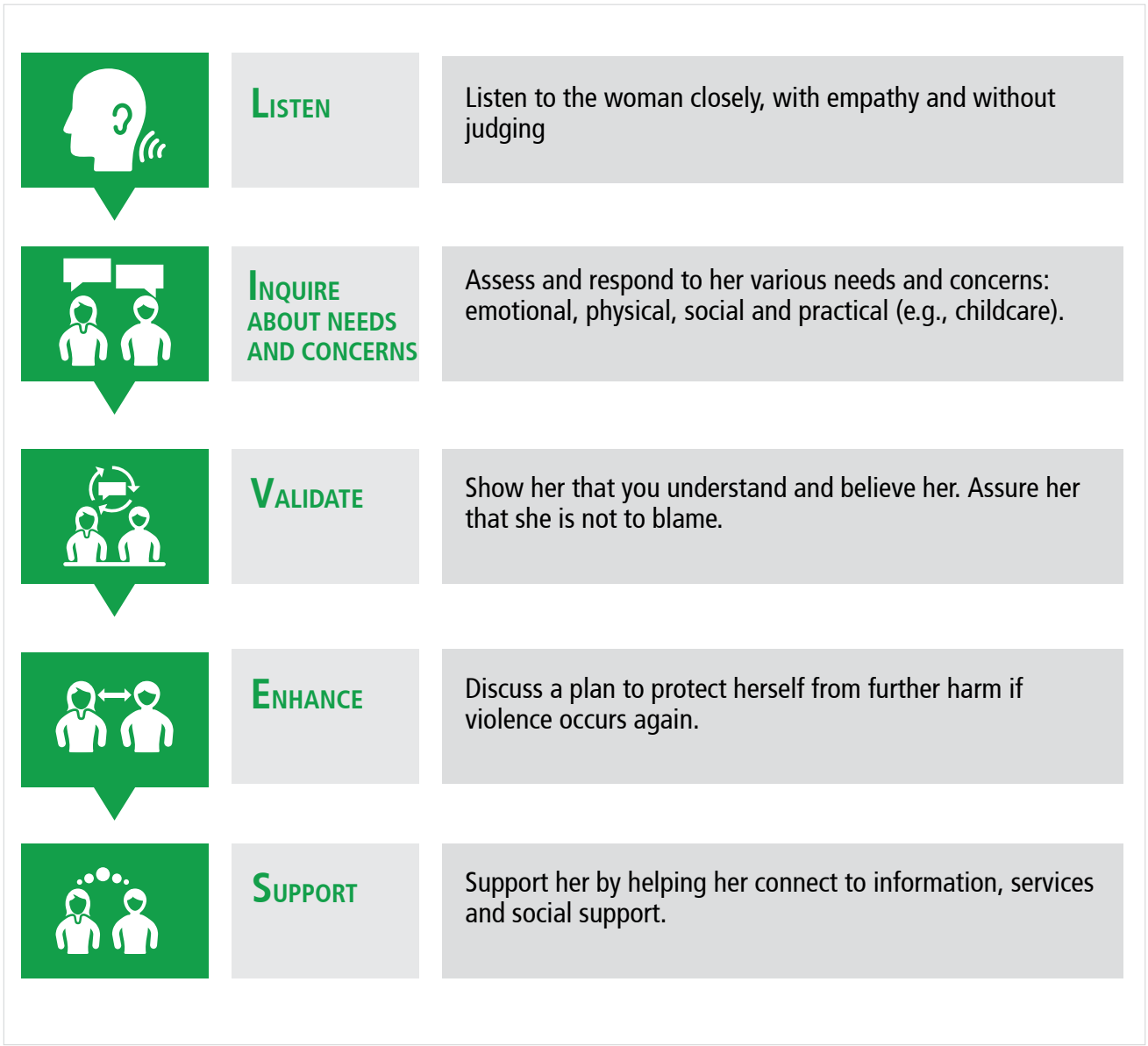
Remember: When you help her deal with her practical needs, it helps with her emotional needs. When you help with her emotional needs, you strengthen her ability to deal with practical needs.

You do not need to:

- solve her problems;
- convince her to leave a violent relationship;
- convince her to go to any other services, such as police or the courts;
- ask detailed questions that force her to relive painful events;
- ask her to analyse what happened or why;
- pressure her to tell you her feelings and reactions to an event.
- These actions could do more harm than good.

First-line support involves five simple tasks. It responds to both emotional and practical needs at the same time. The 'LIVES' graphic is a useful way to remember these five tasks that protect women's lives (see Figure 2).

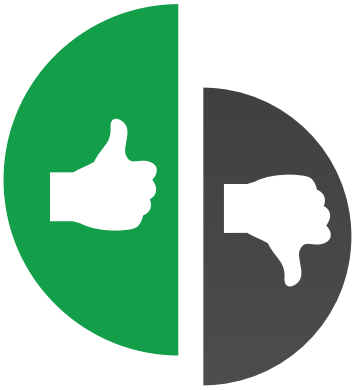
Figure 2: LIVES



ACTIVE LISTENING DO'S AND DON'TS

DO

- Allow for silence. Give her time to think.
- Stay focused on her experience and on offering her support.
- Acknowledge what she wants and respect her wishes.



DONT'S

- Do not try to finish her thoughts for her.
- Do not tell her someone else's story or talk about your own troubles.
- Do not think and act as if you must solve her problems for her.

11.8 Obtaining consent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent is obtained by ensuring that the survivor fills the consent form (see Annex 2). It is crucial that survivors understand the options open to them and are given sufficient information to enable them to make informed decisions about their care.

Ensure that a safe and respectful environment is created for the survivor and empower the survivor, allowing him/her to control the course of the evaluation. The following items should be discussed in order to obtain consent for examination from the survivor:

1. Explain all aspects of the consultation process to the survivor.
2. Request permission to examine the survivor.
3. Ask if she wants a parent, guardian, person of trust and/or the police to be present.
4. Request for permission to submit medical report to the police if appropriate.
5. Where indicated in special circumstances, under forensic expertise obtain written consent.

Particular emphasis should be placed on the matter of the release of information to other parties, including the police. Examining a person without their consent could result in the health care provider in question being charged with violence or trespass of the survivor's privacy. The results of an examination conducted without consent cannot be used in legal proceedings. Consent for children, unconscious and mentally ill survivors can be given by their caregiver.

Table 1: Informed consent/ assent guidelines for children

Age (years)	Child	Caregiver	If no caregiver or not in child's best interest	Means
0–5	-	Informed consent	Other trusted adult's or case-worker's informed consent	Written consent
6–11	Informed as-sent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, written consent
12–14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, written consent
15–18	Informed consent	Obtain informed consent with child's ermission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

11.9 History taking and examination

History taking

General guidelines

- If the interview is conducted in the treatment room, cover the medical instruments until use.
- Before taking the history, review any documents or paperwork brought by the survivor to the health centre.
- Explain what you are going to do.
- Try to create a climate of trust.
- Let the survivor tell her story the way she wants to.
- Questioning should be done gently and at the survivor's own pace.
- Sufficient time should be allotted to collect all needed information without rushing.
- Do not ask questions that have already been asked and documented by other people involved in the case.
- Avoid any distraction or interruption during history taking.

A sample history and examination form is included in Annex 3.

General information

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

Description of the incident

Ask the survivor to describe what happened. Allow the survivor to speak at his/her own pace. Do not interrupt to ask for details; follow up with clarification questions after he/she finishes telling his/her story. Explain that he/she does not have to tell you anything he/she does not feel comfortable with.

In the incident history, it is important that the description of the incident is detailed including WHO did it, WHAT orifice was used, WHERE it happened, WHEN it happened and HOW it happened.

WHO, was it a stranger or someone they know? The number of perpetrators? Most sexual assaults are by people they know or who are in a position of trust; close relatives, teachers, religious leaders, employers, landlords, neighbours, etc. Ask them the name, age or address of the perpetrator if known.

WHAT was used? Penis (erect or not), digit or an object. Ask if the object was seen and what type of an object it was. Which orifice was used? Vagina, anus or the mouth.

Was physical force used, was the survivor punched, kicked, slapped, grabbed, beaten, dragged or tied?
Was a weapon used? What weapon was used?

Were a condom and lubricants used by the perpetrator?
Did the survivor assault the perpetrator in self-defense, and what was done?

WHERE it happened is the exact location where the incident took place.
WHEN it happened is the exact date and time of the incident
HOW is the circumstances around which the incident happened.

It is important to find out if there were any witnesses.

A detailed history of the incident guides the health worker during the physical examination to identify and record injuries. Explain this to the survivor and reassure her of confidentiality if she is reluctant to give detailed information.

Current signs and symptoms

Note pain, bleeding, discharge or any other symptoms.

Medical history

This includes the menstrual and obstetric history to evaluate for possible pregnancy.
If the incident occurred recently, determine whether the survivor has bathed, urinated, vomited, defecated, brushed their teeth, rinsed their mouth, or used a tampon or pad. This may affect the collection of forensic evidence.

Existing health problems

This includes history of FGM (type), allergies, current medication, vaccination and HIV status. This helps determine the best treatment to provide, counselling needed and follow-up health care.

Identification of survivors who fear to report GBV cases

Some situations may present themselves as obvious abuse, and the survivor may openly state that her perpetrator caused the injuries. Some survivors, however, will keep the true cause of the injuries secret.
Reasons for secrecy include the following:

- fear that he/she will not be believed;
- fear of injury from the perpetrator;
- being threatened by the perpetrator not to reveal the true cause;
- fear that the perpetrator will be informed that a report has been made;
- fear for his/her children if they are with the perpetrator;
- fear of support being withdrawn as a result of reporting (especially where the perpetrator is a known person or relative).

Identifying abuse

It is the responsibility of the health care provider to identify abuse where the survivor tries to conceal it. During history taking, the health care provider should take note of inconsistencies in the survivor's story and the indicators of abuse.

Abuse would have occurred if the survivor or accompanying person expresses the following:

- Survivor is tense, fearful and apprehensive;
- Survivor looks to companion for direction;
- Survivor is unable to make decisions alone and/or leaves decisions totally to his/her companion, even those regarding physical needs and health;
- Survivor is overly concerned about the perpetrator and/or children and has little or no concern for his/her own health needs;
- Survivor minimizes the seriousness of the injury or how it occurred;
- Accompanying person interrupts or constantly explains his/her version of the survivor's injuries;
- Accompanying person hovers over the survivor and is reluctant to leave her/him alone, even for examinations;
- Accompanying person is pushy or demanding of the survivor or medical staff for information;
- Accompanying person appears more concerned about himself/herself than the health of the survivor.

Indicators of physical abuse

- Injuries, some of which may be visible such as bruising, cuts, burns, choke marks, black or swollen eyelids;
- Any injuries, with no – or questionable – explanation as to how they occurred;
- Unattended injuries that may be apparent such as old untreated fractures;
- Serious bleeding injuries, especially to the face, head, and internal organs.

Note: Breasts, chest and abdomen are often target areas, especially if the woman is pregnant.

Indicators of psychological abuse

- Severe crying spells or feelings of isolation or inability to cope;
- Depression, at times accompanied by suicidal thoughts;
- Reports of acute anxiety attacks;
- Intermittent or continual presence of stress reactions such as tension, hyperactivity, headaches, insomnia, pain in the back, chest or stomach which often have no clear physiological cause;
- Intermittent or continual presence of fear, anxiety, depression, hopelessness;
- Inconsistency between cognitive and emotional levels;
- Presence of any or all of above indicators with statements that the situation is alright and/or hopefulness that the situation will improve.

Potential questions for the assessment of abuse

- Does someone criticize or insult your thoughts or actions?
- Does someone ever follow you, check your whereabouts, or call you regularly to make sure you are at home or work?
- Do you stop saying or doing what you believe because you are fearful of your perpetrator's reaction?
- During arguments, are you ever afraid of what he/she might do?
- Has your perpetrator ever physically held or restrained you from going somewhere or doing something he/she objected to?
- During arguments are you ever hit, slapped, punched or pushed?

Probe in a sensitive manner if you suspect abuse

- Ask the survivor if they are afraid to talk about the abuse.
- Assure the survivor that the information shared will not be passed on to the perpetrator.
- Let the survivor know that the information remains confidential.
- Let the survivor know that you may have to act if you are concerned that they may cause self-harm or harm someone else or if they are in danger from the perpetrator or anyone else and that action involves keeping them in a safe place and not disclosing information to the perpetrator.
- Ask the survivor if they think what they are experiencing is abuse.

Head-to-toe physical examination

The primary objective of the examination is to evaluate the nature, extent and severity of the injuries sustained and to determine what medical care should be provided to the survivor. A systematic head-to-toe physical examination of the survivor should be conducted according to the medical examination form (see sample form in Annex 3).

If the survivor wants to pursue legal action, a medical certificate on findings from the examination and forensic evidence collected during the examination can be produced. If the health care provider suspects abuse at any point of the assessment, they should request the accompanying person to remain or move to the waiting room while the survivor gives the history and gets examined. If the accompanying person insists on being present, assure them that they will be called immediately should they be required. Firmly, but calmly, advise them that it is standard procedure to examine the survivor alone. If they become difficult let them know that you may have to contact relevant authorities.

Preparing the survivor for overall clinical evaluation

A survivor could have experienced trauma and may be in an agitated or depressed state. She/he may experience fear, guilt, shame and anger, or any combination of these, or may be in pain. The health care provider must prepare the survivor for the examination and ensure they conduct the examination in a compassionate, systematic and competent manner.

- Introduce yourself.
- Ensure that a trained health care provider, preferably of the same sex, examines the survivor and, where not possible, a trusted same sex companion should accompany the survivor throughout the examination.
- Explain what is going to happen during each step of interviewing, history taking and the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- Reassure the survivor that they are in control of the pace, timing and components of the whole process of care.
- Reassure the survivor that the examination findings will be kept confidential.
- Ask if they have any questions.
- Ask them if they would like the presence of a specific person during the whole process for support.
- Limit the number of people allowed in the room during interviews, history taking and examination to the minimum necessary.
- A police officer should not be present when the survivor is undressed unless the survivor requests so.

General guidelines

- Make sure the equipment and supplies are prepared.
- Always look at the survivor first, before you touch her, and note her appearance and mental state.
- 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 assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications might be:
  - extensive trauma (to genital region, head, chest or abdomen);
  - asymmetric swelling of joints (septic arthritis);
  - neurological deficits, respiratory distress.

  The treatment of these complications is not covered here.
- Obtain voluntary informed consent for the examination and to obtain the required samples for forensic examination (see sample consent form in Annex 2).

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 and 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, which may be a result of being slapped.
- There are three steps in the examination:
  1. examine;
  2. describe;
  3. draw.

Examine: Examine systematically from head to toe.

Describe: Describe the findings and carefully note all findings on the medical examination form. Record the type (ecchymosis/bruise, abrasion, laceration, incision wound, petechiae), size, colour, shape or form, exact location of the wounds or injuries and associated tenderness, bleeding or discharge.

Draw: Draw all the findings in the pictograms (see sample in Annex 4). The pictograms can be used as evidence in court.

- Take note of the survivor's mental and emotional state (e.g., withdrawn, crying, calm).
- Take samples of any foreign material on the survivor's body or clothes (blood, saliva, semen, fingernail cuttings or scrapings, swabs of bite marks, etc.) according to the local evidence collection protocol.
- Take a sample of the survivor's own blood, if indicated.

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 of the rape, or presents with complaints, do a full physical examination as above. In all cases:

- note size and colour of any bruises and scars;
- note any evidence of possible complications of the rape (deafness, fractures, abscesses, etc.);
- note the survivor's mental state (normal, withdrawn, depressed, suicidal).

The medical examination has four components

1- GENERAL EXAMINATION;
2- PHYSICAL EXAMINATION;
3- GENITAL EXAMINATION;
4- ANAL EXAMINATION.

--------1. GENERAL EXAMINATION----------

The general examination starts as soon as the survivor walks into the centre.

Note the appearance of the survivor (e.g., clothing, hair, disabilities). The survivor may look drowsy or falling asleep, and this may be due to alcohol or may be high on non-prescription drugs like cannabis.

Describe her mental state:

Demeanour: She may be crying, calm, anxious, cooperative, upset, quiet, laughing, rude, tearful, hysterical or behaving inappropriately.
A manic depressive may have pressure of speech.
Also remember that in the rape trauma syndrome, they may go into shock and may initially seem fine and then have a delayed reaction.

Breath: Determine what you can smell. Alcohol, cigarette, cannabis or ketones smelt in diabetes and starvation.

Gait: It can be a staggering gait or a limp. Alcohol can alter the gait. In children the gait may be affected by the genital injuries with or without infection.

Skin condition: Scabies and fungal infections are common. You may also be able to see old scars from beatings. These are an indication of abuse and or poor hygiene.

Signs of alcohol intoxication

1. Tremors;
2. Gait;
3. Breath;
4. General appearance and behaviour
   - Aggressive;
   - Jittery.
5. Speech: slurred and slow;
6. Eyes: injection of the conjunctiva (blood shot eyes); this is also seen with cannabis.
   - Pupil size is small and constricted and this is also seen in heroin users;
   - Pupils are dilated with cocaine and LSD;
   - Nystagmus is also seen with cannabis.
7. Clothing;
8. Check coordination
   - finger/nose test;
   - heel/shin test;
   - straight line test;
   - stand on one leg test;
   - pick up object test;
   - hand flapping test.

These tests are all performed slowly and with deliberate concentration.

Survivor's vital signs

The pulse, blood pressure, height, weight, temperature and respiratory rate are determined. These are useful to reveal severe medical problems like head injuries, bleeding or intoxication.

Note the pubertal age. All these elements are very useful when writing the medical report. The initial assessment may reveal severe medical complications that need to be treated urgently and for which the patient will have to be admitted to hospital. Such complications might be:

- extensive trauma;
- asymmetric swelling of joints;
- neurological deficits;
- respiratory distress.

--------2. PHYSICAL EXAMINATION----------

Examine the survivor's body systematically starting from the head and moving to the feet, from the front to the back.

HEAD: Look and feel for lacerations, missing clumps of hair with associated bruising and swellings if the hair was pulled out. Feel for swellings and tenderness of the scalp.
Is there hair dye: Write down the colour and type of hair (short, curly, or straight). Does the survivor have a weave-on hair style?
Look at the pinna of the ear to see if she had been punched or slapped of the side of the face. There will be bruising on the head behind the pinna.

EAR/EARLOBE: Look inside the ear, the tympanic membrane could be ruptured due to a heavy slap or blow.

FACE:

Eyes: Look for - nystagmus;
- blood shot eyes;
- haemorrhage;
- petechiae.

Describe the eyelids, whether they are swollen, tender or injured. In attempted strangulation, due to hypoxia, you see petechaie on the mucosa of the inner eyelids and palate.

Nose: Are there injuries with associated swellings, epistaxis (nasal bleeding) and deviation of the nose bridge which may indicate a fractured nasal bone? If punched with a fist wearing a ring, may cause bruising and laceration.

Nostrils: Look for fresh bleeding or old dried blood.

Lips: Are the lips bruised, lacerated, swollen or tender?

Inner mouth: The inner mouth mucosa may be lacerated and there may be bleeding from pressure wounds or from the teeth from a blow to the cheeks. Are there any missing tooth or teeth?

Tongue: Is it lacerated and or bleeding?

Palate: Is there petechial haemorrhage? This usually resolves within three or four days and a maximum of seven days.

Cheeks: There may be prints of the fingers if slapped across the face. Look for grip marks along the jaws and bite marks.

NECK: Look for 'love bites' which are suction or multiple petechaie marks on the skin and may look like a bruise. In hand strangulation you may not see anything, or you may see scratch marks which are defence marks or teeth marks with bruising and bite marks. Photographs may be taken for dental identification. In soft tissue strangulation there may be reddening. With a rope or cord tightly applied, there may be abrasions, bruises or redness.

UPPER LIMBS: The most important features to look for are grip marks.

HANDS: Look for loss of nail or nail extensions, and for defence marks.

BREASTS/CHEST: Look for bite marks and bruising.

ABDOMEN: Injuries are not common in or on the abdomen.

BACK: If the survivor was dragged or punched, look for bruises and/or abrasions and punch marks.

LEGS: Scratch marks are more common seen.

INNER THIGH: Fingertip bruising from forcing the thighs apart may be seen.

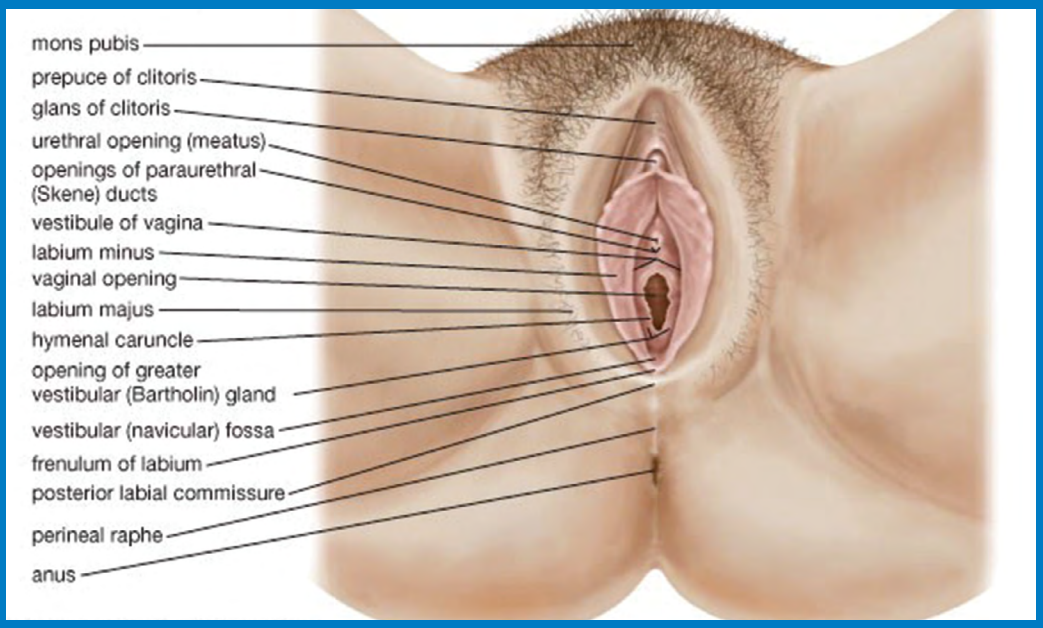
--------3. GENITAL EXAMINATION----------

General observation

Look for obvious bleeding, vaginal discharge and odour.
Systematically examine the genitalia in the gynaecological position.
Even when the genitalia are examined immediately after the rape, there is identifiable damage in less than 50 per cent of cases.

Forensic evidence is collected during the genital examination. Special consideration should be given in the genital examination of a woman who has undergone FGM (see Annex 5).

Figure 3. Female external genitalia



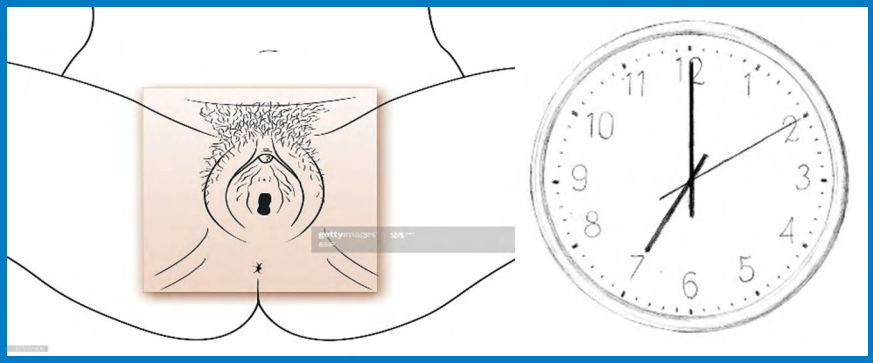
LABIA MAJORA - Injuries are not commonly seen in the labia majora, but bruising, swellings, lacerations and abrasions can occur.

LABIA MINORA – Injuries in the labia minora are more likely with digital or object penetration, rather than with penile penetration. Lacerations, bruising, swellings or bleeding can occur.
The labia minora and vaginal opening can be visualized by gently parting and pulling the labia majora downwards and outwards.

VAGINA – Injuries are not common, but discharge, bleeding, tears or lacerations or bruising can occur.

The face of the clock is used to describe the hymenal or introitus injuries with the 12 o'clock up to the Mons Pubis and the 6 o'clock to the anal end.

Figure 4. Drawing



HYMEN – Fresh hymen tears are commonly seen in the posterior region between the 5 – 7 o'clock positions as seen on the face of a clock, particularly in the midline at the 6 o'clock position. This is due to the downward pressure of the penis on the posterior wall during intercourse.
Hymen tears may be partial or full thickness tears with or without bleeding and this is seen commonly in children and adolescents. A hymen with bruising and no tear is possible if the orifice is large enough and there is good lubrication.

SPECULUM EXAMINATION:

A well-lubricated speculum is used to see vaginal and cervical injuries and these are seen commonly in post-menopausal women with atrophic vaginitis (dry vagina) and in a violent sexual assault particularly in children. Ensure that an appropriate size of speculum is used to avoid causing additional trauma to the survivor.

BIMANUAL PALPATION:
Bimanual palpation is done to establish pregnancy, in abdominal trauma or in a case with an infection.

URETHRA – Urethral injuries are not common but you can see redness and oedema particularly after digital penetration.

POSTERIOR FOURCHETTE – This is the most common site for injuries. Redness, swelling, abrasions, lacerations and bleeding can be seen.

CERVIX – Injuries in the cervix are rare. Petechiae due to penile contact from forced entry may be seen. Lacerations may be due to objects.

INTERNAL GENITAL EXAMINATION
An internal genital examination is done:

1. if there has been a vaginal penetration;
2. to collect forensic specimens;
3. on adults only; it is not done in children.

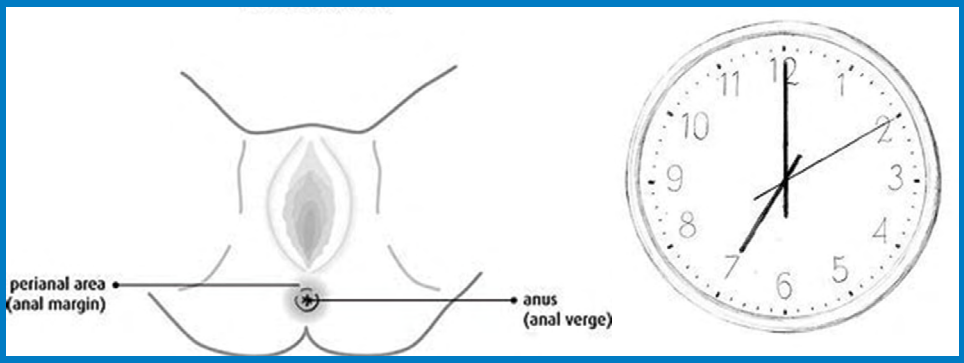
--------4. ANAL EXAMINATION----------

Survivor's position – knee-chest or laterally on the side.
Forensic evidence is collected at the same time the anal examination is being done.

EXAMINE

- Note the shape and dilatation of the anus.
- Note any fissures or tears around the anus.
- Note the presence of faecal matter on the skin around the anus and for possible tears and bleeding.
- Note the sphincter tone.
- Note the presence of scar tissue.
- Anal dilatation or reductions in anal tone are recognized sequelae following penile penetration of the anus over a period of time.
- Penile penetration of the anus can also occur without leaving injuries especially if good lubrication was used.
- Anal injuries can include bruising, lacerations, swelling and bleeding.
- The location of anal injuries is also made in relation to the face of a clock.

Figure 5. The perianal area



DRAW:

Draw all the findings in the pictogram.
The pictogram may be used as evidence in court forming part of the injury evidence.

11.10 Special considerations

Special considerations for children

General

A parent or legal guardian should sign the consent form for examination of the child and collection of forensic evidence, unless he or she is the suspected offender. In this case, a representative from the police, the community support services or the court may sign the form. Adolescent minors may be able to give consent themselves. The child should never be examined against his or her will, whatever the age, unless the examination is necessary for medical care.

The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications might be:

- convulsions;
- persistent vomiting;
- stridor in a calm child;
- lethargy or unconsciousness;
- inability to drink or breastfeed.

In children younger than three months, look also for:

- fever;
- low body temperature;
- bulging fontanelle;
- grunting, chest indrawing, and breathing rate of more than 60 breaths/minute.

The child will need to be referred for treatment of these complications.

Create a safe and trusting environment

- Introduce yourself to the child. Sit at eye level and maintain eye contact.
- Assure the child that he or she is not in any trouble.
- Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favourite activities.
- Take special care in determining who should be present during the interview and examination (remember that it is possible that a family member is the perpetrator). It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who he or she would like to be present, and respect his or her wishes.

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 or her train of thought.
- Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.

The pattern of sexual abuse of children is generally different from that of adults. 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;
- whether there has been any bleeding;
- whether the child has had difficulty walking.

Prepare the child for examination

As for adult examinations, there should be a support person or trained health worker whom the child trusts in the examination room with you.

- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- With adequate preparation, most children will be able to relax and participate in the examination.
- It is possible that the child has pain and cannot relax for that reason. If this is a possibility, 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 examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase 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 and 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 as follows:

- Note the child's weight, height and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the parent's lap. Older children should be offered the choice of sitting on a chair or on the parent's lap or lying on the bed.
- Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as perpetrators often use it.
- 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 sensitive indicators of penetration.
- Digital examination (assessing the size of the vaginal orifice by the number of fingers that can be inserted) should not be carried out.
- Look for vaginal discharge. In prepubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine prepubertal 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 prepubertal child is usually done under general anaesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- Conduct an anal examination in both boys and girls.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Digital examination to assess anal sphincter tone should not be done.

General approach:

- Ensure privacy.
- Approach the child with extreme sensitivity and recognize their vulnerability.
- Identify yourself as a helping person.
- Try to establish a neutral environment and rapport with the child before beginning the interview.
- Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently from adults, making interpretation of questions and answers a sensitive matter.
- Ask the child if she or he knows why she or he has come to see you.
- Ask the child to describe what happened or is happening to them in their own words (where applicable). Play therapy can be used where necessary.
- Always ask open-ended questions and avoid leading questions. Only use direct questioning when open-ended questions have been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity
- Prepare the child for examination by explaining the procedure and showing equipment; this helps to diminish fears and anxiety.
- Encourage the child to ask questions about the examination.
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination.
- Stop the examination if the child indicates discomfort or withdraws permission to continue.
- Consider interviewing the child and the caregiver of the child separately.

Special considerations for male survivors

Male-specific history:

- Any pain or discomfort experienced in the penis, scrotum or anus;
- Any urethral or anal discharge;
- Difficulty or pain on passing urine or stool.

Counselling

- Male survivors of rape are even less likely than women to report because of the extreme embarrassment that they typically experience. While 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, it was a physiological reaction and was beyond his control.

Genital examination

- Examine the 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.
- If the urine contains large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

Treatment

Men need the same STI preventive treatment and vaccinations as described below in Section 12, Treatment protocols, Step 3.

Special considerations for pregnant women

Women who are pregnant at the time of a rape are physically and psychologically especially vulnerable. In particular, they are susceptible to miscarriage, hypertension of pregnancy and premature delivery.
Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy (see Annex 7).

Special considerations for elderly women

Elderly women who have been vaginally raped are at increased risk of vaginal tears and injury, and transmission of STI 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. Use a thin speculum for genital examination. If collecting evidence or screening for STIs is the only indication for the examination, consider inserting swabs only without using a speculum.

Special considerations for circumcised women

The health consequences of female genital cutting
Female genital cutting (FGC) has no health benefits for girls and women. There are, however, numerous adverse short and long-term consequences, indicated in Table 2.

Table 2. Adverse consequences of female genital cutting

Short-term consequences	Long-term consequences
• Severe pain and shock • Infection • Urine retention • Injury to adjacent tissues and organs (which can be severe, depending on the extent to which the girl or woman subject to the procedure struggles) • Immediate fatal hemorrhage	• Extensive damage of the external reproductive system • Uterus, vaginal and pelvic infections • Cysts and neuromas • Increased risk of vesico-vaginal fistula • Complications in pregnancy and childbirth, including obstructed labor • Psychological damage resulting from traumareame • Sexual dysfunction and painful sexual relations • Difficulties in menstruation

- FGC or circumcision carries long-term risks and is never medically indicated.
- Health personnel should never be involved in FGC.
- If a previously circumcised (infibulated) patient has vaginal tears, it is better not to re-stitch the vaginal opening.
- Immediate repair following trauma carries a higher risk of infection. Suturing a dirty wound, increases the risk of an infection.
- Repairs, when done, should always leave genitalia in as natural a state as possible.

11.11 Investigations for clinical management

Laboratory testing

No additional samples need to be collected for laboratory testing, other than those collected for evidence, unless indicated by the history or the findings on examination. Samples for testing for STIs may be collected for medical purposes.

- If the survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and possibly for culture.
- Do a pregnancy test, if indicated and available (see Section 12, Treatment protocols, Step 2).
- Do the HIV test if indicated and available.
- Other diagnostic tests, such as X-rays and ultrasound examination, may be useful in diagnosing fractures, confirming a pregnancy, confirming a missed, incomplete or complete abortion and abdominal trauma.

11.12 Treatment protocols

Step 1. Prevention of HIV transmission
Step 2. Prevention of unwanted pregnancy
Step 3. Prevention/treatment of STIs
Step 4. Prevention of hepatitis B
Step 5. Prevention of tetanus

Step 1. Prevention of HIV transmission

Introduction

Rape or sexual penetration presents a higher risk of HIV transmission than consensual sexual intercourse because the intercourse is violent and entails traumatic lesions of the genital mucous membranes.

The risk of transmission increases in these circumstances:

- if there is anal and vaginal penetration;
- if there is oral penetration with ejaculation and history of biting with bleeding;
- if there is the presence of blood;
- if the perpetrator or survivor is infected with STIs;
- if there are wounds or injuries in the vagina or mouth of the survivor;
- if there was ejaculation;
- cases of gang rape.

HIV prevention after sexual violence requires the administration of Post-exposure prophylaxis (PEP) for HIV. This is a combination of anti-retroviral (ARV) drugs for 28 days after the exposure to HIV, started within 72 hours of sexual violence. An HIV test is not required before PEP is started even though it has to be offered to the survivor if available. PEP reduces the risk of sero-conversion post-rape by 79 per cent, but it is not 100 per cent effective.

Timing of PEP

PEP must be started as soon as possible after the possible exposure to HIV since the efficacy decreases with the length of time from exposure to the first dose. People presenting later than 72 hours after sexual violence should be offered other aspects of post rape care including HIV testing, except PEP.

HIV test

An HIV test should be recommended to the survivor where available.

The benefits of having an HIV test:

- Legally, a documented sero-conversion has impact in court;
- The survivor can be started on art early if positive;
- The survivor "decides" if she wants to know her HIV status.

The demerits of having an HIV test:

- Risk of finding out a seropositivity at a bad time (i.e., while coping with "rape trauma");
- No art available in some settings.

If the survivor wants to have an HIV test, the following is advised:

- Ensure pre and post-test counselling;
- Follow up the test six months later;
- If HIV positive, PEP is stopped and the survivor is counselled to start family planning to avoid mother-to-child transmission and use condoms.

PEP protocols

This guideline recommends the use of triple therapy i.e., three ARV drugs, as per the National ART Guidelines on HIV Prevention, Diagnosis, Treatment and Care.

Table 3: Choice of ARVs for PEP in adults and children

	Recommended	Alternative
Children (≤10 years)	AZT + 3TC + LPV/r OR ABC+3TC+ LPV/r	ABC + 3TC + DTG
Adult and adolescent	TDF + 3TC + ATV/r	TDF +3TC +DTG

Note: *AZT (Zidovudine), 3TC (Lamivudine), LPV/r (Lopinavir/Ritonavir), TDF (Tenofovir), ABC (Abacavir), DTG (Dolutegravir)

Dosing of all drugs is the same as in ART and the course should be continued for **28 days.**

PEP can start on the same day as emergency contraception and preventive STI regimens, although the doses should be spread out and taken with food to reduce side effects such as nausea.

There are no teratogenic effects, however there are some side effects which are shown in Table 4.

Table 4: Side effects of ARVs

Drug	Possible side effects
Tenofovir	Renal toxicity and bone mineral loss
Zidovudine	Anaemia, gastrointestinal side effects, and proximal muscle weakness
Abacavir	Skin rash, cough, fever, headache, as-thenia, diarrhoea
Lamivudine	Gastrointestinal side effects, anaemia
Lopinavir/ ritonavir	Gastrointestinal side effects
Dolutegravir	Hepatotoxicity, hypersensitivity reac-tions

The side effects are often slight and transient: **Don't stop treatment if they appear!**

Enhanced adherence counselling is important for patients due to side effects of the medications. There are usually a lot of problems with compliance so survivors must be followed up closely.

In the follow-up of the treatment:

- A blood count is recommended if there is suspicion of blood problems.
- Monitor signs that indicate HIV sero-conversion, such as: acute fever, lymphadenopathy, cutaneous eruptions, pharyngitis (non-specific), and ulcers of the mouth. These are symptoms in 50-70 per cent of cases of HIV primary infection and they appear three to six weeks after exposure.

Step 2. Prevention of unwanted pregnancy

Introduction

A woman who has been sexually assaulted is likely to worry about getting pregnant from the sexual assault.

Emergency contraception

Emergency contraception (EC) is a contraceptive method used by women after unprotected sexual intercourse to prevent an unwanted pregnancy. The use of EC is a personal choice that can only be made by the woman herself. Women should be offered objective counselling on this method so as to reach an informed decision. A health worker who is willing to prescribe EC pills (ECP) should always be available to prescribe them to rape survivors who wish to use them.

If the survivor is a child who has reached menarche, discuss EC with her and her parent or guardian, who can help her understand and take the regimen as required.

There are two methods of EC:

1. oral emergency contraceptive pills (oral ECP);
2. copper-releasing intrauterine device (IUD).

Oral ECP is the preferred option in post-rape cases.

Prescribing EC for a rape survivor

EC is given if there was vaginal penetration or ejaculation.

There are two scenarios:

1.The survivor presents within 72 hours:

A pregnancy test is done:

- If test is positive: counselling is done. The pregnancy is not a result of the rape.
- If test is negative: ECP is given.

2.The survivor presents after 72 hours:

A pregnancy test is done:

• If test is positive: counselling is done. Perpetrator may be the father.
• If test is negative: IUD is provided if day four or five. Test is repeated afterwards.

Oral ECP

ECP is sometimes referred to as the 'morning after' or post-coital pill. Taking ECPs within 120 hours (five days) of unprotected intercourse will reduce the chance of a pregnancy by between 56 and 93 per cent, depending on the regimen and the timing of taking the medication. The earlier it is taken after unprotected sex, the more effective it is.

ECPs work by interrupting a woman's reproductive cycle, by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. The ECPs do not interrupt or damage an existing pregnancy and thus are not considered a method of abortion.

EC should be given to all females who have experienced menarche except those on menses, pregnant or on reliable contraceptive methods.

There are two types of ECPs:

1. Oral contraceptives containing only progesterone (levonorgestrel or norgestrel);

2. Combined oral contraceptives (COC) containing oestrogen (ethinyl oestrogen) and progesterone (levonorgestrel), also known as the Yuzpe method.

Progestogen-only pills are the recommended ECP regimen. They are more effective than the combined estrogen-progestogen regimen and have fewer side effects.

Table 5: Emergency contraceptive protocol

Regime	Formulation (per pill)	Common brand name	First dose (tablet)	Second dose 12 hours later (tablet)
Levonorgestrel only	1.5mg	I-Pill Revoke	1	N/A
	750µg	NorLevo	2	N/A
	30µg	Microlut	25	25
	37.5µg	Ovrette	20	20
Combined	EE50µg + LNG250µg OR EE50µg+NG500µg	Eugynon Fertilan Neogynon	2	2
	EE30µg+LGN150µg EE30µg+NG3	Microgynon	4	4

Note: EE = ethinyl estradiol; LGN= Levonorgestrel.

Most women will have a normal menstruation within 21 days after the treatment. Menstruation may be up to a week early or a few days late. If the survivor has not had a period within 21 days after the treatment, she should return to have a pregnancy test done or to discuss the options in case of pregnancy.

There is no known contraindication to giving ECPs at the same time as antibiotics for STIs and PEP, although the doses should be spread out and taken with food to reduce side effects, such as nausea.

The side effects of ECPs are:

Nausea:

- Occurs in 50 per cent of women using COCs and 20 per cent of women using progestin-only pills;
- Does not usually last more than 24 hours;
- Taking pills with food/milk or at bedtime may help reduce nausea.

Vomiting:

- Occurs in 20 per cent of women using COCs and 5 per cent of women using progestin-only pills;
- Repeat the dose if vomiting occurs within two hours of taking the pills;
- If vomiting is severe, the repeat dose may be administered vaginally.

Irregular uterine bleeding:

- Spotting may occur in some women;
- Menstrual periods typically arrive on time or slightly early;
- If menstruation is delayed by more than a week, a pregnancy test should be performed.

Other side effects:

- Breast tenderness, headache, dizziness, fatigue. These effects do not usually last more than 24 hours.

ECPs are very safe:

- The hormonal dose is small and does not appear to alter blood clotting mechanisms with its short exposure.
- No foetal malformations or congenital defects are associated with use.
- They don't appear to increase the possibility that a pregnancy following will be ectopic.
- No deaths or serious medical complications have been reported in the last 20 years.

If a pregnancy is already established, the ECP is not effective. If a woman does not know if she is pregnant, ECP may be taken, as there is no evidence to suggest harm to the women or to an existing pregnancy.

Intrauterine device

Insertion of a copper-bearing IUD is an effective method of EC within seven days after a rape.

The copper IUD prevents more than 99 per cent of possible pregnancies. It creates a hostile uterine environment for the sperm, making fertilization and subsequent implantation less likely.

There are two conditions of a rape survivor that warrant additional considerations prior to insertion:

- Risk of STIs;
- Traumatic insertion.

The side effects are:

- Cramping;
- Heavy blood flow, spotting, bleeding;
- Other signs: fever or chills, pelvic pain or tenderness, IUD threads cannot be felt.

The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception if she wishes to do so.

Step 3. Prevention and treatment of sexually transmitted infections

STIs are very common globally. The most widely known are gonorrhoea, syphilis, chlamydia and HIV, but there are more than 20 others.

In Sierra Leone 15-20 per cent of the total number of medical consultations are related to STIs. Given the high prevalence in the population, there is a high probability that perpetrators of rape are infected with an STI and this therefore places survivors at high risk of having contracted an STI during a sexual assault. If the survivor had an STI when she was assaulted, it is easier for HIV to pass from an HIV-positive perpetrator to the survivor.

The consequences and complications of STIs are enormous. These are not only medical consequences but there may be psychological, emotional, social and economic consequences as well.One of the main concerns of a survivor is the treatment of STIs. In some cases of domestic abuse, there is also child sexual abuse and some mothers blame themselves for their children being infected with an STI.

Transmission of STIs

The main mode of transmission of STIs is through unprotected penetrative sexual intercourse. Sexual transmission may include penis-to-vagina, penis-to-mouth, penis-to-anus, mouth-to-vagina, and mouth-to-anus contact. Other possible modes of transmission include: mother-to-child transmission; during pregnancy (HIV and syphilis); at delivery (HIV, gonorrhoea, and chlamydia) or after birth (HIV); or by transfusions or other contact with blood or blood products (syphilis, HIV).

Management of STIs

Management of STIs involves two possible courses of action:

1.If the survivor presents within 72 hours of the incident, she should be treated with antibiotics to prevent gonorhoea, chlamydia infection and syphilis. If other STIs are prevalent in the area (such as trichomoniasis or chancroid), provide preventive treatment for these infections as well.

2.If the survivor presents more than 72 hours after the incident, an evaluation of symptoms of an STI will be done and the survivor will be treated according to the syndromic approach.

Prevention of STIs

If the survivor presents within 72 hours of the incident medications should be given to prevent gonorrhoea, chlamydia infection, trichonomiasis and syphilis using the recommended treatments presented in Table 6.

Table 6 : STI treatment for adults

STI	1st Line	2nd line	Alternate	In pregnancy
Gonorrhea	Ceftriaxone 250 mg IM as a single dose AND Azithromycin 1g orally as a single dose	Cefixime 400 mg orally as a single dose AND Azithromycin 1g orally as a single dose	Single therapy can be used if there is recent local resistance data confirming susceptibility to the micro-organism Ceftriaxone 250mg IM as a single dose **OR** Cefixime 400mg orally as a single dose **OR** Spectinomycin 2g IM as a single dose	Same as Recommended, 2nd Line and Alternate options
Chlamydia	Azithromycin 1g orally as a single dose	Doxycycline 100 mg orally twice a day for 7 days	Erythromycin 500 mg orally four times daily for 7 days **OR** Tetracycline 500 mg orally four times daily for 7 days **OR** Ofloxacin 200-400mg orally twice daily for 7 days	Azithromycin 1g orally as a single dose **OR** Erythromycin 500 mg orally four times daily for 7 days ***Doxycycline is contraindicated**

Table 6 : STI treatment for adults (continued)

STI	1st Line	2nd line	Alternate	In pregnancy
Syphillis	Benzathine Penicillin G 2.4 million units IM as a single dose (Inject Benzathine 5ml in each buttock)	Procaine Penicillin G 1.2mu IM 10-14 days Penicillin-allergic patients may be treated with: Doxycycline 100mg twice daily for 14 days **OR** Ceftriaxone 1g IM once daily for 10-14 days **OR** Azithromycin 2g as a single dose		Same as Recommended and 2nd Line options. In pregnant women who are allergic to penicillin: Give erythromycin base/ stearate 500 mg orally QID for 14 days
Trichomoniasis	Metronidazole 2g orally in a single dose	Tinidazole 2g orally in a single dose	Metronidazole 500mg orally twice daily for 7 days	Same as recommended option if infection is confirmed by microscopy. *If no microscopy, avoid in first trimester
Candidiasis	Clotrimazole 500mg pessary as a single dose with Clotrimazole 1% cream for pruritis/ excoriations **OR** Clotrimazole 100mg pessary once daily for 6 days	Clotrimazole 1% cream 5 g intravaginally daily for 7–14 days **OR** Miconazole 100 mg vaginal suppository, one suppository daily for 7 days	Clotrimazole 2% cream 5 g intravaginally daily for 3 days **OR** Miconazole 200 mg vaginal suppository, one suppository for 3 days	Only topical azole therapies, applied for 7 days are recommended for use by pregnant women

Table 7: STI treatment for children

Weight	1st line	Alternative treatment
5-12 kg	Cefixime 8mg/kg stat **PLUS** Azithromycin 20mg/kg stat	
12-25 kg	Cefixime 200mg stat **PLUS** Azithromycin 500mg stat	
25-45 kg	Cefixime 400mg stat **PLUS** Azithromycin 2g stat	
Prophylaxis for trichomoniasis in children Tinidazole 50mg/ kg (max 2g), Stat OR Metronidazole 30mg/kg/day in 3 doses 7 days		

Treatment of STIs

When the survivor presents more than 72 hours after the incident, check if the person has symptoms of an STI, and treat according to the syndromic case management approach.

- Cefixime stat dose;
- Azithromycin stat dose (Erythromycin in pregnant women);
- Metronidazole stat dose/ x 7 days (Avoid in1st Trimester);
- Nystatin insertion x 14 days.

Using flow charts for syndromic case management
See Annex 6 for national guidelines for the management of STIs including syndromic case management.

Step 4. Prevention of hepatitis B

- Hepatitis B is a viral hepatitis and transmission occurs in three ways:
  - Sexual;
  - Through infected blood and other body fluids;
  - Mother-to-child transmission.
- The risk of contamination of hepatitis B is 200 times greater than the risk of HIV contamination.
- There is no information on the incidence of hepatitis B infection following rape. However, hepatitis B Virus (HBV) is present in semen and vaginal fluid and is efficiently transmitted through sexual intercourse.
- If possible, survivors of rape should receive hepatitis B vaccine within 14 days of the incident.
- The incubation period is 4–30 weeks (two to three months on average).
- The signs of acute infection are: fever, tiredness, nausea and gastrointestinal disorders followed a few days later by jaundice accompanied by dark urine and clay coloured stool.
- The survivor can be a carrier before any clinical signs appears. There are chronic carriers also.
- There are some fulminant forms where the patient dies (1–3 per cent of cases).
- There are some chronic forms (0.2–10 per cent) that become cirrhosis.
- Vaccination is given on day 0, day one and at six months.
- The suspension for the injection is presented in a single-dose syringe.

- The doses are given through IM injection in the anterolateral part of the thigh or in the deltoid muscle (outer part of the upper arm) as follows:
  - Adult - 20 micrograms
  - Child - 5-10 micrograms

Step 5. Prevention and treatment of tetanus

Tetanus has an incubation period of 3 to 21 days but can last many months.

Signs of tetanus infection signs are as follows:

- Trismus with spasms of the masseters preventing the normal opening of the mouth. Therefore, mastication becomes difficult and the trismus becomes intractable. The spasm spreads to the pharynx (dysphagia "difficulty in swallowing") and the face (rictus sardonicus "sad face").
- Within two days, permanent painful spasms appear: rigidity in the vertebral muscles leads to the opisthotonos and extends to other muscles with typical exaggerated curvature of the spine, abducted arms and extended leg position.

If all these signs appear, refer the survivor to the hospital.

Tetanus prophylaxis should be given in cases of breaks in the skin or mucous membranes unless the survivor has been fully vaccinated previously. Based on Table 8 below, decide whether or not to administer tetanus toxoid (TT), which gives active protection and anti-tetanus-globulin (TIG), if available, which gives passive protection.

Table 8: Tetanus toxoid

History of tetanus immunization (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	No
3 or more	No, unless last dose > 10 years	No	No, unless last dose >5 years	No

When the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different injection sites.

Dosage

Tetanus toxoid:

- 0.5 ml per injection. Administer by IM injection in the mid-lateral part of the thigh or in the deltoid muscle.
- A second dose after four weeks, followed by a booster dose after one year, then every 10 years.

Tetanus immuno-globulin (TIG):

- 250UI in a single dose. Administer by IM injection. The dose should be doubled if the injury occurred more than 24 hours before, if the wound is major and/or infected or if the adult weighs over 90 kg.

For children following the national Expanded Programme on Immunization Protocols:

TIG:
- Children more than seven years: 250UI, IM
- Children less than seven years: 4UI/Kg, IM

DPT:
- 0.5 ml per injection
- Dose 1: Given at the first visit to the centre
- Dose 2: Four weeks after the first dose
- Dose 3: Four weeks after the second dose
- Booster: Every 10 years.

For **adolescents,** the tetanus vaccination remains the same as for adults.

11.13 Management of physical injuries

Patients with severe, life-threatening conditions should be referred for emergency treatment immediately. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated in situ by the examining health care worker or other nursing staff. Any wounds should be cleaned and treated as necessary.

General wound care

- Clean any tears, cuts and abrasions and remove dirt, faeces and dead or damaged tissue.
- Decide if any wounds 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. If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.
- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.

Genital wound care

- Clean abrasions and superficial lacerations with antiseptic and either dress or paint with tincture of iodine, including minor injuries to the vulva and perineum.
- If stitching is required, stitch under local anaesthesia. If the survivor's level of anxiety does not permit it, consider sedation or general anaesthesia.
- High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anaesthesia by a gynaecologist or other qualified personnel and repaired accordingly.
- In cases of confirmed or suspected perforation, laparatomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon
- Provide analgesics to relieve the survivor of physical pain.

The following medications may be indicated: antibiotics to prevent wounds from becoming infected; a tetanus booster or vaccination (according to local protocols); and medications for the relief of pain, anxiety or insomnia.

11.14 Follow-up care

It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit, as this may be the only visit.

Reasons for follow-up visits include:

- To check the effectivity of treatment. Check that survivor has taken the full course of any medication given for STIs;
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate and provide advice on condom use;
- To look for pregnancy symptoms after ECP and do a pregnancy test if signs and symptoms of pregnancy are found and provide counselling and referral for abortion services if legal;
- To test for syphilis if prophylaxis was not given;
- To evaluate for psychological impact and offer psychological help;
- To check the wounds;
- For those receiving PEP, evaluate for side effects and adherence;
- To provide Voluntary Counselling Confidential Test for HIV;
- To propose legal procedures.

Frequency of follow-up visits:

Follow-up visits can be made based on need, more frequent or less and can continue for as long as they are needed by the survivor.

Follow-up visits for survivors who do not receive PEP are at 0, 14 days and 3 months.

Follow-up visits of survivors who receive PEP are at 0, 2 weeks, 6 weeks and 3 months.

12. MENTAL HEALTH CARE: PSYCHOLOGICAL SUPPORT AND REFERRALS

12.1 Introduction

Survivors of sexual violence react differently to the ordeal. Some survivors experience immediate psychological distress, others short-term and/or long-term psychological problems. The amount and length of social support and/or psychological counselling required by survivors of sexual violence varies enormously, depending on the degree of psychological trauma suffered and the survivor's individual coping skills and abilities. This chapter highlights the procedures of psycho-social care for survivors of sexual violence including ethical consideration. Efforts are made to address the distinct psycho-social needs of adult male and females and children – a boys and girls – and persons with disabilities.

It is recommended that all counsellors providing trauma counselling to survivors of sexual violence are trauma counsellors and should also have basic professional training (e.g., nurses, clinical officers, doctors, psychological counsellors, social workers, psychiatrists).

12.2 Survivor-centred approach to counselling

The counsellor should apply the principles of 'doing good' and not 'doing harm' in counselling a survivor.

When providing services to survivors of sexual violence, counsellors should adhere to the following fundamental principles of counselling:

- Autonomy: The right of patients to make decisions on their own behalf (or in the case of patients under 18 years of age, individuals acting for the child, i.e., parents or guardians). All steps taken in providing services are based on the informed consent of the survivor.
- Beneficence: The duty or obligation to act in the best interests of the survivor.
- Non-maleficence: The duty or obligation to avoid harm to the survivor. Justice or fairness: doing and giving what is rightfully due to the survivor.

These principles have practical implications for the manner in which services are provided, namely:

- awareness of the needs and wishes of the survivor;
- displaying sensitivity and compassion;
- maintaining objectivity (WHO, 2003). (See Annex 8).

12.3 Counselling different groups

Caring for the male adult survivor

When counselling male survivors of sexual violence, counsellors need to be aware that men have the same physical and psychological responses to sexual violence as women. Men experience rape trauma syndrome (RTS) in much the same way as women. However, men are likely to be particularly concerned about their masculinity, their sexuality, the opinions of other people (i.e., afraid that others will think they are homosexual) and the fact that they were unable to prevent the rape.

Caring for the child survivor affected by sexual violence

The dynamics of child sexual abuse differ from those of adult sexual abuse. In particular, children rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour (WHO, 2003). The counsellor should make an effort to believe in and trust the child, create rapport, let the child speak at her/his own pace and listen carefully with understanding. The counsellor needs to be familiar with the protocol on counselling children.

Caring for persons with disabilities affected by sexual violence

Counsellors need to be aware that people with developmental disabilities who have been sexually violated have challenges to work through or talk about their traumatic experiences in a treatment or therapeutic setting. Guardians may also need assistance as caretakers of the abused. Counsellors should not have prejudices about people with disabilities. For example, the benefit of psychotherapy for people with mental retardation as well as the impact of the abuse should not be questioned. Counsellors should debrief the guardian and/or family members and make appropriate referrals.

12.4 Caring for yourself and your staff

Working with survivors of sexual assault can be emotionally difficult for clinic staff. You yourself may be a survivor of sexual assault. Feelings of distress, anxiety, guilt, frustration, concern, confusion and exhaustion are real and important. If you are feeling this way, do not try to ignore these emotions or work through them alone; instead, discuss them with your supervisor or someone you trust. You too can use the counselling services available to patients. And if you are a supervisor, be sensitive to the needs of your staff.

In order for us to be able to continue working in an efficient and satisfactory manner, we need to be aware of the things that are potentially harmful to us. Therefore, it is very important to protect ourselves and to develop tools to care for ourselves and our colleagues.

How can I look after my well-being at work?

It is important to understand the possible risk factors and look at implementing strategies that support your well-being at work and in your personal life. If you are able to maintain your well-being you will be more effective in your work and in your personal life and relationships. The following are some things you can do to help yourself.

- Limit your work hours to no more than 8 or 10 hours a day.
- Take frequent brief breaks from work to clear your head and think about different things. For example, go for a walk, grab a cup of tea and chat with a colleague.
- Maintain a good diet, eating healthy foods and keeping up your fluid intake.
- Exercise. Sometimes a mere 30-minute session of exercise can be very helpful in maintaining a clear head and a positive outlook.
- Stay connected to your friends and family.
- Talk about your emotions, and process difficult situations and client work with your supervisor or trusted colleague.
- Do some meditation, yoga or other mindfulness activity, that assists you to focus on your inner self.
- Seek counselling if you need to further process your experiences with clients and its impact on you.

Signs you may require extra support

- Difficulty in communicating your thoughts or remembering directions from your manager;
- Difficulty in making decisions and limited attention span;
- Being uncharacteristically argumentative, easily frustrated, feeling general irritation, loss of objectivity, refusal to follow reasonable directions from your manager;
- Unnecessary risk taking, increased use of alcohol or other drugs;
- Increased headaches and other physical symptoms;
- Inability to sleep — intrusive thoughts;
- Inability to switch off from work;
- Poor professional boundaries.

General techniques of self-care

Setting and maintaining boundaries involves knowing at a psychological level where you stop and where another person begins. It refers also to knowing the difference between what your emotions are and what belongs to someone else. While this sounds quite simple, it can be quite easy to take on the emotions, thoughts and worries of others. Learning how to set and maintain boundaries involves reflective practice,

Self-nurturing strategies involves knowing how to look after yourself emotionally. It will mean different things to different people and can include things like, exercise, engaging in hobbies, spending time with people you find supportive or good company, avoiding excessive use of alcohol and having a good diet,

Self-awareness involves having a good understanding of what one is feeling and why. This understanding is developed over time by attending to one's thoughts and feelings, interpreting and becoming familiar with them. You might ask yourself: Why am I feeling this way? This is the first step in acknowledging there is a problem and gaining clarity about how you can take steps to deal with it.

Reflective practice refers to the process of thinking about your work with the view to understanding and evaluating both the work and your responses to it. There are many different frameworks for reflective practice. The following questions offer a process that may assist in undertaking reflective practice:

- What are my thoughts about this work?
- What happened – what was the sequence of events?
- What were the main issues? What would my supervisor have suggested?
- What would I suggest to someone who asked my opinion about this?
- What would I have done differently?
- Where does this leave me now? How do I feel about the work? How do I feel now? Are these feelings related to work? If so, how?

Professional supervision refers to the process by which a worker (supervisee) meets regularly with a more senior member of their profession (supervisor) on a regular basis. The aims of supervision may vary and are dependent upon the specific agreement between supervisee and supervisor, but can include:

- ensuring that clients are receiving appropriate and adequate support;
- assisting in the development of broad or specific clinical skills;
- assisting in the development of self-management skills as they relate to work, for example, prioritizing work, responses to work, time management;
- assisting in understanding and managing organizational issues;
- identifying personal issues that the supervisee may need to work on in a different forum.

Sleep strategies play an important role in physical and mental well-being. The following strategies may assist:

- Use a sleep ritual so that the body can gradually unwind such as a bath, shower or gentle stretching.
- Be aware of your 'sleep windows' and following your body's natural rhythm.
- Keep a regular sleep-wake schedule by getting up at the same time every morning.
- Engage in relaxation exercises.

13. TAKING LEGAL ACTION

13.1 Forensic management of sexual violence

Introduction

Forensic management is essential in helping survivors of sexual violence access justice through judicial processes. Proper management of evidence helps in presenting credible evidence to the court to prove that sexual violence indeed occurred and link the perpetrator to the crime. This chapter elaborates on the procedures of forensic management while highlighting the processes of collecting, handling and preserving evidence.

Definition of key terms

Forensic examination	A medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion.
Medical practitioners	A practitioner registered in accordance with section 6 of the 'Medical Practitioners and Dentists Act'.
Designated persons	This includes a nurse registered under section 12(1) of the 'Nurses Act' or clinical officer registered under section 7 of the 'Clinical Officers (training, registration and licensing) Act'..
Evidence	The means by which disputed facts are proved to be true or untrue in any trial in a court of law or an agency that functions like a court.
Forensic evidence	The evidence collected during a medical examination. The role of forensic evidence in criminal investigation includes the following: i) to link or delink the perpetrator to the crime. (Aside from sexual violence, it includes deliberate HIV/ AIDS infection, which constitutes another crime on its own); (ii) to ascertain that sexual violence occurred; (iii) to help in collection of data on perpetrators of sexual violence. In most cases, forensic evidence is the only thing that can link the perpetrator to the crime, e.g., where the incident is reported a long time after it has happened or where the survivor was pregnant.
Physical evidence	This refers to any object, material or substance found in connection with an investigation that helps establish the identity of the offender, the circumstances of the crime or any other fact deemed to be important to the process.
Physical evidence	may include: used condoms, cigarette butts, ropes, masking tape etc. Physical evidence can be collected from the survivor as well as the environment (crime scene location).
Crime scene	This constitutes either a person, place or an object capable of yielding physical evidence which has the potential of assisting in apprehending or exonerating the suspect. No one should interfere with a crime scene by changing or tampering with any of the objects. One should leave everything as it was. A survivor is considered a crime scene as a lot of evidence can be collected from him/her. For example suspects hair found on the survivor. There are five stages in crime scene management: (i) identification; (ii) protection; (iii) search; (iv) record; (v) retrieval.

Types of evidence

There are two types of evidence that need to be collected:

Table 9: Type of specimen that can be collected as forensic evidence

Specimen	Source of specimen
Injury evidence	Physical and/or genital trauma can be proof of force and should be adequately documented and recorded on pictograms in the PRC forms.
Clothing	Torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g., if replacement clothing is not available) describe its condition.
Foreign material	Examples include soil, leaves and grass on clothes or body or in hair; this may corroborate the survivor's story.
Sperm and seminal fluid	Swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis.
Blood or urine	May be collected for toxicology testing (e.g., if the survivor was drugged).
DNA analysis	Where available, can be done on material found on the survivor's body or at the location of the rape, which might be soiled with blood, sperm, saliva or other biological material from the assailant (e.g., clothing, condoms etc.) as well as on swab samples from semen stains, and the orifices involved, and on fingernail cuttings and scrapings. In this case, blood from the survivor must be drawn to allow her DNA to be distinguished from any foreign DNA found.

1. Evidence to confirm that sexual violence has occurred, e.g., evidence of penetration (torn hymen), if obtained by force there might be bruises, tears and cuts around the vaginal area and the clothing may be stained.

Locard's exchange principle states that every contact leaves a trace. "Wherever he steps, whatever he touches, whatever he leaves, even unconsciously, will serve as a silent witness against him. Not only his fingerprints or his footsteps, but his hair, the fibre from his clothes, the glass he breaks, the tool mark he leaves, the paint he scratches, the blood or semen he deposits or collects."

2. Evidence to link the alleged assailant to the violence, e.g., perpetrator's torn clothes, used condoms, grass and blood stains, scratches and bite marks on the perpetrator, and eyewitness testimony such as that from people who last saw the perpetrator walking away with the survivor (this is because circumstantial evidence can help the court adduce the guilt of the accused).

Exhibit management

The following practices must be followed when handling an exhibit:

- Protect the exhibit from weather and contamination;
- Use clean instruments and containers;
- Wear protective devices e.g., gloves when appropriate;
- Package, transport and store exhibit safely and securely;
- Take special care with fragile and perishable exhibits;
- Call on an expert if you lack adequate training to handle a particular type of exhibit.

Collection and handling of specimen

When collecting specimen for forensic analysis, the following principles should strictly be adhered to:

Avoid contamination: Ensure that specimens are not contaminated by other materials. Store each exhibit separately. Wear gloves at all times to ensure that the exhibit is not contaminated and also for your own protection.

Collect early: Try to collect forensic specimens as soon as possible. Specimens should be collected within 24 hours of the violence; after 72 hours, yields are reduced considerably. Collect the same before requiring the victim to bathe.

Handle appropriately: Ensure that specimens are packed, stored and transported correctly. As a general rule, the fluids (e.g., urine) should be refrigerated; anything else should be kept dry. In some instances, blood can be dried on gauze and stored as such. Biological evidence material (e.g., body fluids, soiled clothes) should be packaged in paper envelopes or bags after drying, avoiding plastic bags.

Label accurately: All specimens must be clearly labelled with the survivor's name and date of birth, the health care provider name, the type of specimen, and the date and time of collection.

Ensure security: Specimens should be packed to ensure that they are secure and tamper-proof. Only authorized people should be entrusted with specimens.

Maintain continuity: Once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded. An exhibit register should be maintained at each facility. It is not a good practice for the survivor to move any samples taken from them from one facility to another for any analysis.

Note:

- All tests and results should be recorded in a laboratory register (date, name, registration number, age, sex, investigations done, results and a place for anyone who takes specimen to sign in order to maintain a chain of custody of evidence). The laboratory register should be kept well locked away and only accessible to authorized health facility personnel as a measure towards preserving confidentiality and to avoid tampering with the results.

- The above tests may be carried out on the survivor and also on the perpetrator.

- With regard to the perpetrator, the court order that certain specific samples be collected.

Document collection

It is good practice to compile an itemized list in the survivor's medical notes or reports of all specimens collected and details of when, and to whom, they were transferred.

Handling exhibits

- Exhibits should not be exposed to direct light and sunshine. If wet, exhibits must be dried under shade or dark rooms;
- Exhibits should be marked properly and signed for immediately upon receipt and stored;
- All exhibits including documents filled (e.g., PRC, P3) must be kept in places that guarantee safety and confidentiality.

Chain of evidence

This refers to the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the community, health facility and finally to the police. Also refers to a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation).

Documentation and reporting

In general, most effort should be expended on documenting evidence that can corroborate the survivor's evidence in a court of law. Such evidence includes:

- Evidence that sexual intercourse (penetration) has taken place – engorgement of the genital and maybe increased epithelial cells in the urine and broken hymen. If the hymen is not broken it does not mean that penetration didn't take place.
- Evidence that ejaculation has taken place – presence of semen around the genitalia. Semen inside the vagina is evidence that ejaculation did take place inside the vagina – hence the importance of a high vaginal swab. It is important to know that ejaculation doesn't always have to take place.
- Evidence that force was used – torn clothes including undergarments, bruised genitalia. Significant levels of epithelial cells in the urine.
- Evidence linking the suspect with the sexual offence. This will mainly be police work but the health care provider will collect the various specimens as detailed in the forensic chapter of these guidelines.

13.2 The medical certificate

Before going to court, at the time of initial examination, the doctor completes the medical certificate that reiterates the findings of the medical examination.

The medical certificate is a legal document that serves as proof.

The medical certificate is a medical document filled when attending to the survivor. The form allows space for history taking, documentation and examination. It has all relevant details that were taken at the first contact of the survivor in the health facility. The medical certificate strengthens the development of a chain of custody of evidence by having a duplicate that can be used for legal purposes and showing what specimens were collected, where they were sent and who signed for them. The certificate is filled by a medical doctor.

Note:

When the medical certificate is filled and signed completely:

- The original form is to be given to the police for custody. This is the form that is produced in court as evidence and may sometimes be the only evidence available in the court of law.

- The duplicate form remains with the hospital.
It is NOT the health worker's (doctor's) role or responsibility to prove if it was a rape or not, this is the responsibility of the prosecutor. The health worker (doctor) simply reports the facts discovered during the examination.

Rape is a legal term, not a medical term; whether a crime has been committed is to be determined by the courts.

Do not put anything in the medical certificate that you do not have in your notes.

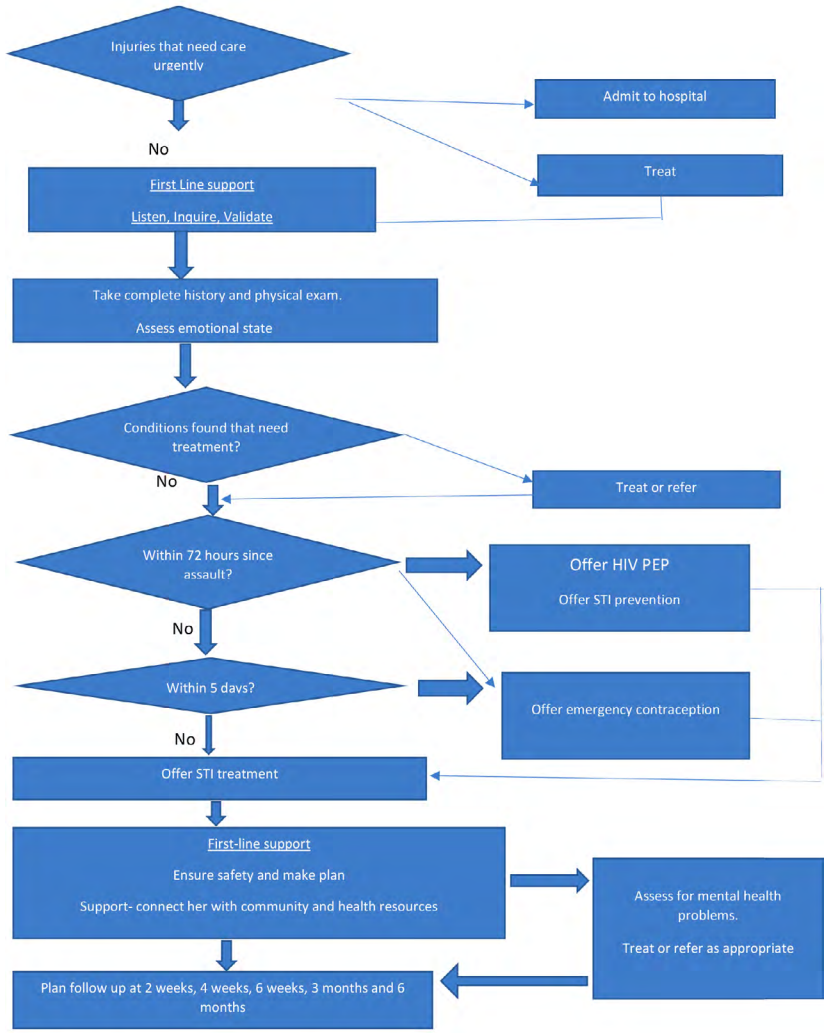
Write your report in an impartial way and avoid emotive language as much as possible. Do not use the terms: "I believe" or "I feel."

Avoid subjective descriptions as much as possible, avoid the use of 'very', 'always', 'never'.

14. CLINICAL PATHWAY OF TREATMENT OF SURVIVORS OF SEXUAL ASSAULT

The Clinical Pathway for the Treatment of Survivors of Sexual Assault is a graphic representation of the treatment paths available to survivors who present with different symptoms at various times following the assault. This pathway (see Figure 6) shows the steps that all providers should follow in the management of sexual assault survivors.

Figure 6: Clinical pathway for the treatment of survivors of sexual assault



14.1 Referral network

Terminology used in referrals for GBV services

Referral: A procedure by which a service provider sends a survivor of violence to the most appropriate service point where the survivor can receive the required service, because they cannot, at their level (expertise, experience or responsibility level) respond to the survivor's needs.

Follow up: Contacting the survivor at a later, specified date to check on their progress since the last appointment.

Referral system: A system that facilitates good coordination (organization, preparation, adequate and timely support) and good collaboration between actors and service providers.

Counter referral: The response or return action or the feedback that the referral service providers gives the referring agency/ institution about the services that are provided to the survivor. It is initiated by the structure receiving the referred client.

A referral network is important as we work with other partners because rape and all other forms of sexual assault are community issues that need the input of other actors. When the clinic cannot provide everything a survivor needs, the clinic's referral network should be used. The clinic should be able to refer the survivor to the following:

- Higher level care facility with surgical capacity;
- A safe home or women's centre where sexual survivors can safely stay;
- Antenatal care;
- Psychosocial counselling services;
- Adoption and abortion (if legal) services;
- Legal support services;
- Agencies, clinics, or groups specific to that community.

Good communication with referral facilities is important, so that you can contact them and prepare them to care for the survivor and get feedback on how best to prepare survivors for the referral. Transportation to take a survivor to another facility should be readily available. Ensure you know the contact numbers for the ambulance systems and the hotlines to assist the survivors.

Every clinic is different. Some will have many resources, most will have very few. As a clinic worker, it is important that you are proactive. Do the best with what you have to make sure a survivor receives the best possible care in your clinic.

14.2 Types of referrals for GBV services

Referrals within the health facility

Survivor is referred from one Service Delivery Point to the next for provision of the appropriate prevention or response services within the same health facility.

(See Table 10, health facility flow chart.)

Referrals within the health facility

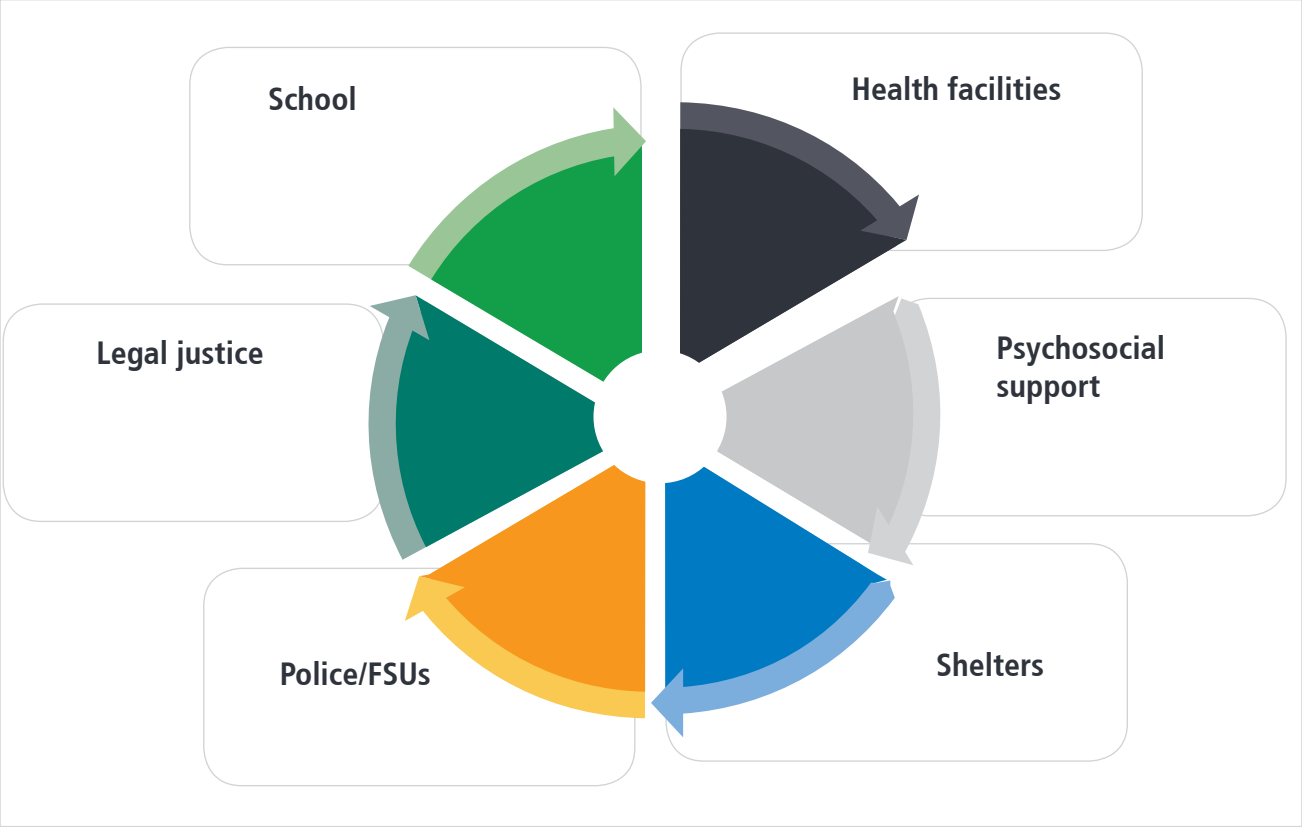
Survivor is referred outside the health facility for additional services that she may require from other service provider e.g., police (FSU), psychological, shelters, legal etc.

(See Figure 7, referral network flowchart.)

Table 10: Roles of receiving and referring units

Role of referring unit (health facility)	Role of receiving unit
Maintains an updated referral directory with contact details of referral services	Receives client
Identifies client	Provides service
Provides ongoing treatment	Documents service
Refers client for services not provided onsite	Refers clients to other needed services
Follows up with client and receiving organization	
Documents referral activity	
Conducts quality assurance	

Figure 7: Referrals outside the health facility



15. HUMANITARIAN ISSUES

Age and gender are vulnerabilities that predispose women and girls to exploitation and abuse. In early stages of conflict, these gender vulnerabilities are further increased due to:

- the breakdown of law and order;
- the absence of systems that would respond to distress signals;
- the lack of adequate services that would minimize the effects of sexual violence.

In the stabilized phases of conflict, these vulnerabilities are augmented by:

- the continual reproductive roles of women and girls such as fetching firewood and/or water in unsecure areas which predispose them to the dangers of being sexually violated;
- the possible abuse of power by the security and humanitarian workers who demand sexual favours in return of goods and services;
- harmful cultural practices such as forceful early marriage of the girls in order to meet the lack of resources in the family.

During armed conflict, women and girls are particularly vulnerable to all forms of sexual violence. Vulnerability to exploitation and abuse by virtue of their age and gender is further increased by conflict and the prevailing humanitarian and security conditions. This chapter highlights the vulnerability factors to sexual violence in conflict situations. It further highlights interventions required in addressing the needs of sexual violence survivors in such situations.

Multi-causal nature of sexual violence in humanitarian crisis

Today's armed conflicts mostly occur within state borders and typically drag on for years, even decades. Multi-causal in nature, these crises are typically "highly politicized" and "frequently associated with non-conventional warfare". National accountability mechanisms are characteristically absent or severely weakened, which consequently gives rise to a climate of impunity for perpetrating all sorts of crimes. These conflicts tend to affect the civilian sphere, regardless of growing international emphasis on the protection of civilians in conflict situations.

Minimum Initial Service Package for reproductive health in humanitarian settings

Addressing GBV is one of the six components recognized in the Minimum Initial Service Package (MISP) for reproductive health in humanitarian settings. In view of the proven benefits of addressing life-threatening reproductive health problems in humanitarian situations, reproductive health and relief organizations globally developed the Minimum Initial Service Package, which is a package of high impact interventions. It comprises prevention and management of sexual violence; HIV prevention; family planning services, provision of comprehensive reproductive health services, including equipment and supplies and a required referral system for obstetric emergencies which may be integrated within the primary health care system. Therefore, immediately disaster occurs, measures to prevent and manage GBV, including management of sexual violence should be put in place.

16. QUALITY ASSURANCE AND QUALITY IMPROVEMENT

Quality assurance (QA) and quality control should be an essential part of all the post-rape service. The objectives of QA interventions are:

- to ensure optimal quality of care and support services for survivors;
- to establish the relationships between identified problems and quality of care issues and their impact on the provision of care;
- to recommend corrective action and regularly monitor the effect of the interventions.

Offering mentoring and supervision to support providers' performance

Regular follow-up, mentoring and supervision by health services managers are important for sustaining good performance of trained health care providers. Training alone is unlikely to sustain changes in health-care providers' practices. Returning to their workplace after training, health care providers are likely to have many questions. Many may reflect on their personal experiences of violence or having seen violence among family members. Mentoring and supervision provide support and motivation to health care providers to offer good care, and can help them apply what they have learned in training to their daily practice as well as to deal with their own experiences with violence. It can also help health care providers address challenging clinical cases and improve their clinical and communication skills while avoiding vicarious trauma and burnout.

Regular follow-up is a key component of quality assurance. It can help health care providers set goals for their practice and identify areas for improvement (WHO, 2017). Having a supervisor and/or mentor also boosts staff morale and motivation to continue offering good health care to women subjected to violence. Mentors and supervisors should have attended trainings on violence against women.

17. MONITORING AND REPORTING

Collecting information on GBV is a fundamental part of GBV monitoring and evaluation. Key ethical and safety issues are typically associated with the planning, collection and use of information on GBV. Due to the sensitive nature of the subject, health care workers must be trained and well-versed in the principles, standards and practices essential for ethical GBV monitoring and evaluation. The Gender-Based Violence Information Management System is a shared system which enables service providers to effectively and safely collect, store, analyse and share data related to the reported incidents of SGBV. When the system works well it has been shown to be effective in providing data which allows partners to track trends and plan action to address issues.

Barriers to GBV reporting include socio-cultural taboos and stigma. Since most acts of GBV are perpetrated by someone the victim knows, it is often underreported as families choose to settle the issues behind closed doors. These obstacles to formal reporting will underestimate the magnitude of SGBV, as well as affect the response strategy of service providers. Fostering partnerships between existing community structures and service providers working on SGBV as well as strengthening coordination and referral pathways across these groups will ensure a tighter network of services and care for survivors.

Table 11: Sources for obtaining GBV-related information

Type of information	Source
The prevalence of GBV	• Demographic Health Survey • Quantitative and qualitative studies
GBV context (attitudes, norms, legal context)	• Qualitative data from non-governmental organizations • Local women's organizations and key informants • Demographic Health Survey • Quantitative and qualitative studies • Policy and legal context data • Participatory data collection activities
Source of services available for GBV survivors	• Qualitative data from NGOs • Local women's organizations and key informants • Resource mapping activities

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19. ANNEXES

Annex 1.

CONFIDENTIAL

INTAKE AND INITIAL ASSESSMENT FORM

Instructions	**1**- This form must be filled out by a case staff, social worker or other authorized person providing services to the survivor.
	2- Note that questions followed by an asterisk* must remain on the intake form. These questions are a part of a minimum essential dataset on SGBV.
	3- Unless otherwise specified, always mark only one response field for each question.

Before beginning the interview, please be sure to remind your survivor that all information given will be kept confidential, and that they may choose to decline to answer any of the following questions.

1-Administrative Information

Incident ID*	**Survivor code***	**RI Staff Identify #***
Date of interview (day/month/year) * _____(day) _____(month) _____ (year)	**Date of Last incident** (day/month/year) * _____(day) _____(month) _____ (year)	
Center Code:	☐ 1OSC ☐ 4OSC ☐ 2OSC ☐ 5OSC ☐ 3OSC ☐ 6 OSC	

☐ **Reported by the survivor or reported by survivor's escort and survivor is present at reporting***

(This incident will be entered into the Incident Recorder)

☐ **Reported by someone other than the survivor and survivor is not present at reporting**

(This incident will not be entered into the Incident Recorder)

2-Survivor Information

Date of birth: (If Available): _____**(Day)** _____**(Month)** _____**Year. Age:** ____**mths/yrs** **Prove of age:** ☐ **Birth Certificate** ☐ **School results** ☐ **ID card** ☐**other** (.....)	**Sex*** ☐ Female ☐ Male
District of origin* ☐Western Area ☐Western Rural ☐ Port Loko ☐ Tonkolili ☐ Bo ☐ Bombali ☐Kono ☐ Bonthe ☐ Kenema ☐ Karene ☐ Pujehun ☐ Kambia ☐Kailahun ☐ Tonkolili ☐ Koinadugu ☐ Falaba Others: _____	

Current civil / marital status* ☐ Single ☐ Divorced / Separated ☐ Married / Cohabitating ☐ Widowed ☐ Not applicable

Number of children ☐

Occupation

☐ Attendant ☐ Trader ☐ Security Personnel ☐ Home worker ☐ Other Employment: _____

☐ Student (any person attending an educational institution)

☐ Unemployed (Includes farmers, miner s and housewives).

Appearance on arrival and vulnerability *

☐ Weak ☐ Slum dweller ☐ Confused ☐ single parent ☐ With Fracture ☐ Homeless/Street child ☐ Unconscious ☐ Person with Disability (PWD)

Basic Evidence Collected on arrival

☐ Torn clothes ☐ Knife ☐ Torn pant ☐ other (specify) _____ ☐ Blood on clothes

What type of disability?

☐ Mental disability (deaf & dumb, mental disorder)

☐ Physical disability (Polio, amputee, wheel-chair user, visually impaired)

☐ Mental & Physical disability

Is the survivor an unaccompanied minor, separated child, or other vulnerable child? * ☐ No ☐ Yes

☐ Unaccompanied Minor ☐ Separated Child ☐Other Vulnerable Child

Sub-Section for Child Survivors (less than 18 years old)

If the survivor is a child (less than 18yrs) does she/he live alone? ☐ No ☐ Yes

If 'No', please describe any relevant details about the survivor's living situation.

3-Details of the Incident	
Account of the incident / Description of the incident (summarize the details of the incident in survivor's words)	
1. What happened?	
2. Where did it happen?	
3. Who did it and do you know any reason(s) to why he did this?	
4. How did you feel?	
5. Who was around?	
6. What happened after the incident?	
7. How were you supported before coming to the One Stop Centre?	
Summary	

Time of day that incident took place*	**Incident location / Where the incident take place*ↄ**		
☐ Morning (sunrise to noon)	☐ School	☐ Latrine	☐ Bush-Forest
☐ Afternoon (noon to sunset)	☐ Road	☐ Survivor's Home	☐ Entertainment Centre
☐ Evening/night (sunset to sunrise)	☐ Streamside	☐ Perpetrator's Home	☐ Unfinished House
☐ Unknown/Not Applicable	☐ Beach	(if not the same as the client's home)	☐ Guest House- Hotel
	☐ Farm - Garden	☐ Perpetrator's Friend's Home	☐ Other :_____
	☐ Market		

3-Details of the Incident *Continued*

Type of incident violence*

(Please refer to the GBVIMS GBV Classification Tool and select only ONE)

☐ Rape (includes gang rape, marital rape)

☐ Sexual Assault (includes attempted rape and all sexual violence/abuse without penetration, and female genital mutilation/cutting)

☐ Physical Assault (includes hitting, slapping, kicking, shoving, etc. that are not sexual in nature)

☐ Forced Marriage (includes early marriage)

☐ Denial of Resources, Opportunities or Services

☐ Psychological / Emotional Abuse

☐ Non-GBV *Note: Non-GBV incidents will not be entered into the incident recorder.* (Specify): _____

Did the reported incident involve penetration?
If yes → classify the incident as "Rape".

If no → proceed to the next incident type on the list.

Did the reported incident involve unwanted sexual contact?
If yes → classify the incident as "Sexual Assault".

If no → proceed to the next incident type on the list.

Did the reported incident involve physical assault?
If yes → classify the incident as "Physical Assault".

If no → proceed to the next incident type on the list.

Was the incident an act of forced marriage?
If yes → classify the incident as "Forced Marriage".

If no → proceed to the next incident type on the list.

Did the reported incident involve the denial of resources, opportunities or services?
If yes → classify the incident as "Denial of Resources, Opportunities or Services".

If no → proceed to the next incident type on the list.

Did the reported incident involve psychological/emotional abuse?
If yes → classify the incident as "Psychological / Emotional Abuse".

If no → proceed to the next incident type on the list.

Is the reported incident a case of GBV?
If yes → Start over at number 1 and try again to reclassify the incident (If you have tried to classify the incident multiple times, ask your supervisor to help you classify this incident).
If no → classify the incident as "Non-GBV"

Was this incident a harmful traditional practice? * ☐ No ☐ Early Marriage ☐ FGM ☐ Forced Confession	**Was money, goods, benefits, and / or services exchanged in relation to this incident? *** ☐ N o ☐ Yes

Type of abduction at time of the incident *

☐ None ☐ Forced Conscription ☐ Trafficked ☐ Other Abduction / Kidnapping

Has the survivor reported this incident anywhere else? *

(If yes, select the type of service provider and write the name of the org / agency where the survivor reported); (**Select all that apply**).

☐ No

☐PHU/Health/Medical Services_____

☐ Psychosocial/Counseling Services_____

☐ FSU/Police/Other Security Actor_____

☐ Legal Assistance Services_____

☐ Livelihoods Program_____

☐ Safe House/Shelter_____

☐ Community Action Group/ Community Volunteer _____

☐ Other (specify) _____

Has the survivor faced any previous incident(s) of SGBV perpetrated against him/her? * ☐ No ☐ Yes

If yes, include a brief description:

_____

_____

4-Alleged Perpetrator Information

Number of alleged perpetrator(s) * ☐ 1 ☐ 2 ☐ 3 ☐ More than 3 ☐ Unknown

Sex of alleged perpetrator(s) * ☐ Male ☐ Female ☐ Both female and male perpetrators

Nationality of alleged perpetrator

☐ Sierra Leone ☐ Liberia ☐ Ghana ☐ Nigeria ☐ Mali ☐ Ivory Coast ☐ Unknown

☐ Guinea ☐ Lebanon ☐ China ☐ India ☐ Other (specify):

Has this survivor had any previous incidents of GBV by this perpetrator? * ☐ Yes ☐ No

4-Alleged Perpetrator Information *Continued*

How old is the alleged perpetrators(s)* (Can be estimated but please be specific) ☐ **or Unknown** ☐

Name(s) of Perpetrator(s): 1)_____ **2)** _____ **3)** _____

Alleged perpetrator relationship with survivor * (Select the **first** ONE that applies)

☐ Intimate partner / Former partner
☐ Primary caregiver
☐ Family member other than spouse or caregiver
☐ Co-tenant / Housemaid / Landlord
☐ Service Provider
☐ Teacher / School official
☐ Schoolmate
☐ Family Friend / Neighbor
☐ Other resident community member
☐ Other
☐ No relation
☐ Unknown

Main occupation of alleged perpetrator *ↄ Please select and be specific to name the institution

☐ Police	☐ Trader / Business Owner	☐ UN Staff ( )	☐ Community Volunteer
☐ State Military	☐ Security guard	☐ NGO Staff ( )	☐ Driver/Bike Rider
☐ Health Worker	☐ Community Leader	☐ Mechanic	☐ under age
☐ Teacher / Lecturer	☐ Student	☐ CBO Staff	☐ Unemployed
☐ Farmer	☐ Religious Leader	☐ Miner	☐ Unknown
☐ Civil Servant			

5-Planned Action / Action Taken *Continued*

Did you refer the survivor to psychosocial services? * ☐ No ☐ Yes

If 'No', why not? *

☐ Service provided by your agency

☐ Services already received from another agency

☐ Service not applicable

☐ Referral declined by survivor

☐ Service unavailable

If 'Yes', did you provide the survivor with psychosocial services? *

☐ No ☐ Yes

Date reported or future appointment date and time:

_____ **(day)** _____**(month)** _____**(year)**

Provider and location: _____

Notes (including action taken or recommended action to be taken):

_____

Does the survivor want to pursue legal action? * ☐ Yes ☐ No ☐ Undecided at Time of Report

Did you refer the survivor to legal assistance services?*

☐ No ☐ Yes

If 'No', why not? *

☐ Service provided by your agency

☐ Services already received from another agency

☐ Service not applicable

☐ Referral declined by survivor

☐ Service unavailable

Date reported or future appointment date and time:

_____ **(day)** _____**(month)** _____**(year);** _____ **(Time)**

Provider and location: _____

Notes (including action taken or recommended action to be taken):

_____

_____

Did you refer the survivor to the FSU/police or other type of security actor? *

☐ No ☐ Yes

If 'No', why not? *

Date reported or future appointment date and time:

_____ **(day)** _____**(month)** _____**(year);** _____**(Time)**

Did you refer the survivor to the FSU/police or other type of security actor? * ☐ No ☐ Yes **If 'No', why not?** * ☐ Service provided by your agency ☐ Services already received from another agency ☐ Service not applicable ☐ Referral declined by survivor ☐ Service unavailable	**Date reported or future appointment date and time:** _____ **(day)** _____**(month)** _____**(year);** _____**(Time)** **Provider and location:** _____ **Notes (including action taken or recommended action to be taken):** _____ _____ _____
Did you refer the survivor to a livelihoods program? * ☐ No ☐ Yes **If 'No', why not?** * ☐ Service provided by your agency ☐ Services already received from another agency ☐ Service not applicable ☐ Referral declined by survivor ☐ Service unavailable	**Date reported or future appointment date and time:** _____ **(day)** _____**(month)** _____**(year);** _____**(Time)** **Provider and location:** _____ **Notes (including action taken or recommended action to be taken):** _____ _____
Did the survivor give his/her consent to share his/her non-identifiable information for reporting purposes? * ☐ No ☐ Yes	

6 - Assessment Points

Describe the emotional state of the survivor at the beginning of the interview	Describe the emotional state of survivor at the end of the interview

6 - Assessment Points *Continued*

Will the survivor be safe when she or he leaves? ☐ No ☐ Yes

If no, give reason:

What actions were taken to ensure survivor's safety?

Who will give the survivor emotional support?

Other relevant information

If raped, have you explained the possible consequences of rape to the survivor (if appropriate)? ☐ No ☐ Yes

Have you explained the possible consequences of rape to the survivor's parent/caregiver (if unable to explain to survivor)? ☐ No ☐ Yes

Annex 2: Sample Consent Form

CONFIDENTIAL

CONSENT FOR EXAMAMINATION

Note to the Centre staff:
This form should be read to the survivor or guardian in her/his first language. Clearly explain to the survivor what the procedure for the medical examination involves and allow her/him to chose any or none of the options listed. The survivor can change his/her mind at any time and a new form can be completed.

I, _____, give my permission for _____ to
(Print name of survivor) (Medical provider's name and title)

perform the following (select one option for each, do not leave blank):

1. A medical examination:	**Yes** ☐	**No** ☐
2. A pelvic examination:	**Yes** ☐	**No** ☐
3. A speculum exam (if medically necessary):	**Yes** ☐	**No** ☐
4. Collection of evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails:	**Yes** ☐	**No** ☐
5. Blood draw:	**Yes** ☐	**No** ☐

I understand that I can refuse any aspect of the examination I do not wish to undergo.

Survivor's Signature: _____

Guardian Signature (if the survivor is a minor): _____

Staff ID/Code: _____ Date: _____

Annex 3: Sample History and Examination Form

CONFIDENTIAL

Health Service Provider Data Collection Form

1. General Information

Was the incident reported by the survivor or reported by survivor's escort and received services at time of report? * ☐Yes ☐No				
Staff Code*	**Date / Time of Exam*** DD / MM/ YYYY 00:00	**Present during the exam** *(note role or relationship, not names)*	**Age**	**Sex** ☐ Male ☐ Female

2. Incident Information

Description of Incident *(Only necessary if incident description varies from that given during counseling session, or additional details are needed for medical purposes)*			
Date / Time of Incident (estimate if unknown) DD / MM/ YYYY 00:00 HRS			
Physical Violence Involved? *	☐ Yes ☐ No	**Describe:**	
Use of Restraints?	☐ Yes ☐ No	**Describe:**	

Use of Weapon(s)?	☐ Yes ☐ No	**Describe:**
Drugs/Alcohol Involved?	☐ Yes ☐ No	**Describe:**

Penetration Involved? * *(Mark all that apply)*					
	No	**Vagina**	**Anus**	**Other Orifice**	**Describe**
Penis					
Finger					
Other					

3. Current Signs and Symptoms *(Note pain, bleeding, discharge from vagina or rectum, or any other symptoms)*

4. Medical History & Examination

	Yes	**No**	**Unknown**
Known allergies?			
Chronic conditions?			

Other Relevant Information

Last Menstrual Period: _____ **Signs of pregnancy? *** ☐ No ☐ Yes (# of Weeks:_____)	**Current contraception used? *** ☐ None ☐Pill ☐ IUD ☐ Condoms ☐Injectable contraceptive ☐Other ☐ Implant
After the incident, did the survivor (mark all that apply) ☐ Brush teeth ☐ Change clothes ☐ Vomit ☐ Defecate ☐ Use tampon or pad ☐ Urinate ☐ Rinse mouth ☐ Wash or bath ☐ None	
Weight	**Height**
HIV/AIDS status* ☐Positive ☐Negative ☐Unknown	

Physical Exam			
Head and Face			**Mouth and Nose**
Eyes and Ears			**Neck**
Chest			**Back**
Abdomen			**Buttocks**
Arms and Hands			**Legs and Feet**

Genital Exam			
Genital examination done?	☐ Yes - External Exam ☐ Yes - Speculum Exam ☐ No - Patient Declined ☐ No - Not Applicable ☐ No - Not Available	☐ Yes ☐ No - Patient Declined ☐ No - Not Applicable ☐ No - Not Available	**Anal examination done ?**
Position of patient…(supine, prone, knee-chest, lateral, if child - in adult's lap)			
For genital examination			**For anal examination**
Vulva / Scrotum			**Vagina/ Penis**
Introitus and Hymen			**Cervix**
Anus			**Bimanual/ Recto-vaginal Exam**

5. Investigations Done

Tests Done	No - Survivor Declined	No - Not Available	No - Not Applicable	Yes - Negative	Yes - Positive	Yes – No results
Pregnancy Test*						
VCCT Counseling*						
HIV Test*						
Gonorrhea Test*						
Chlamydia Test*						
Syphilis Test*						
Trichomoniasis Test*						
Hepatitis B Test*						

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

Treatments Prescribed

STI Prevention*	*Notes:*
☐ Yes ☐ No – Survivor declined ☐ No – Not applicable ☐ No – Not available	
STI Treatment*	*Notes:*
☐ Yes ☐ No – Patient declined ☐ No – Not applicable ☐ No – Not available	
Emergency Contraception*	*Notes:*
☐ Yes ☐ No – Patient declined ☐ No – Not applicable ☐ No – Not available	

Wound Treatment*	*Notes:*
☐ Yes ☐ No – Patient declined ☐ No – Not applicable ☐ No – Not available	

Tetanus Prophylaxis*	*Notes:*
☐ Yes ☐ No – Patient declined ☐ No – Not applicable ☐ No – Not available	

Hepatitis B Vaccination*	*Notes:*
☐ Yes ☐ No – Survivor declined ☐ No – Not applicable ☐ No – Not available	

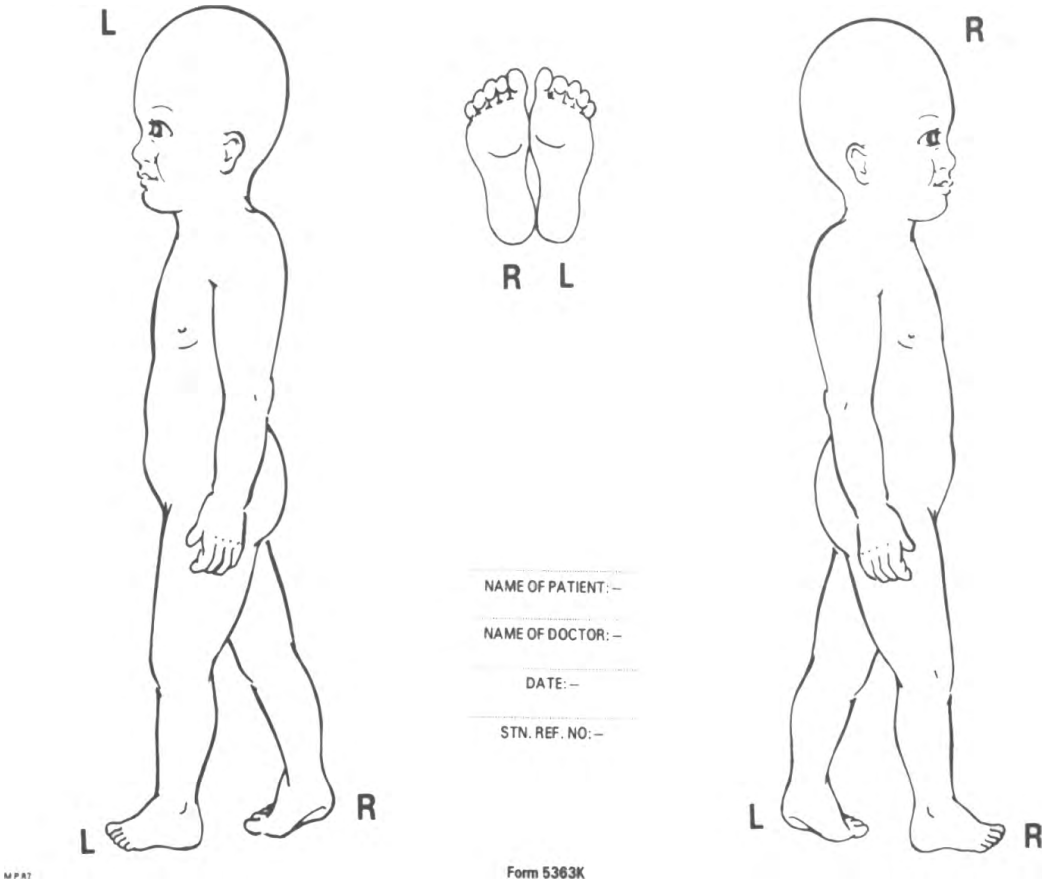
HIV Prophylaxis (PEP) *	*Notes:*
☐ Yes ☐ No – survivor declined ☐ No – Not applicable ☐ No – Not available	

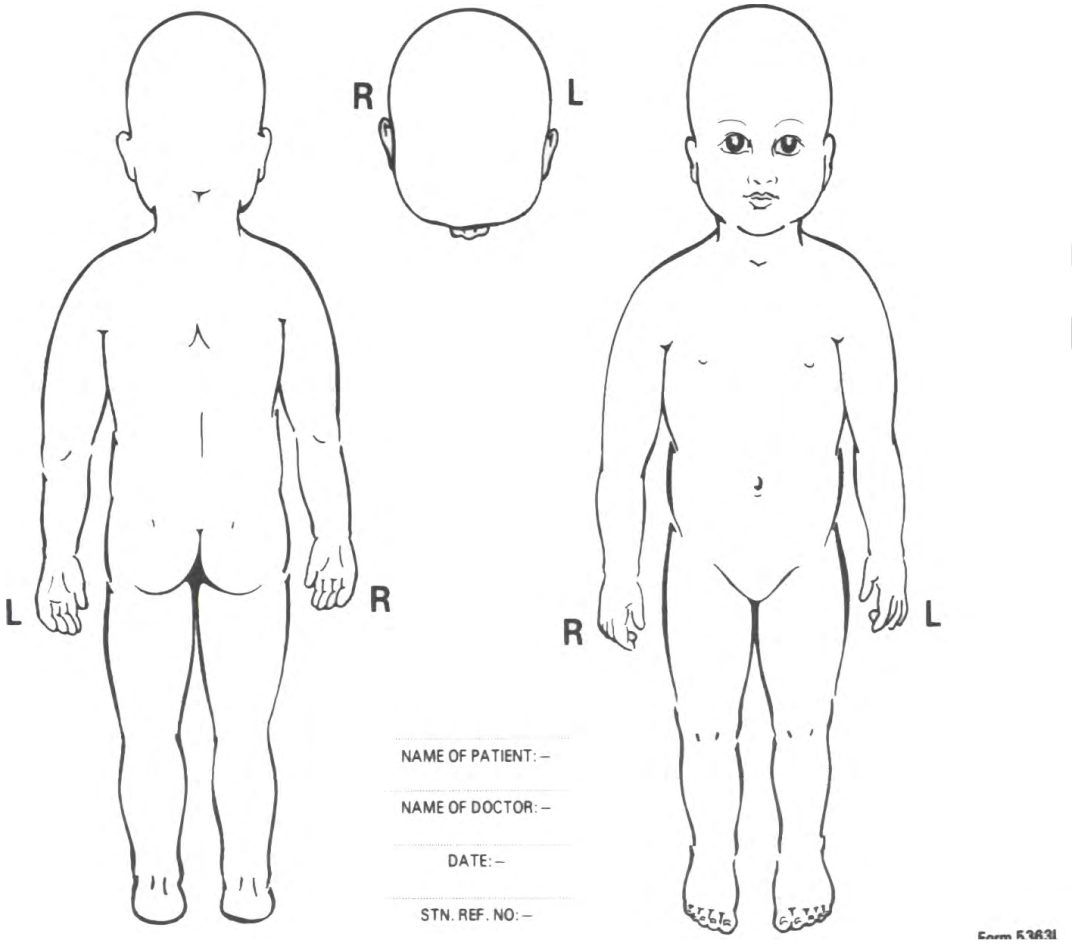
7. Planned Action / Action Taken: Any action / activity regarding this report.

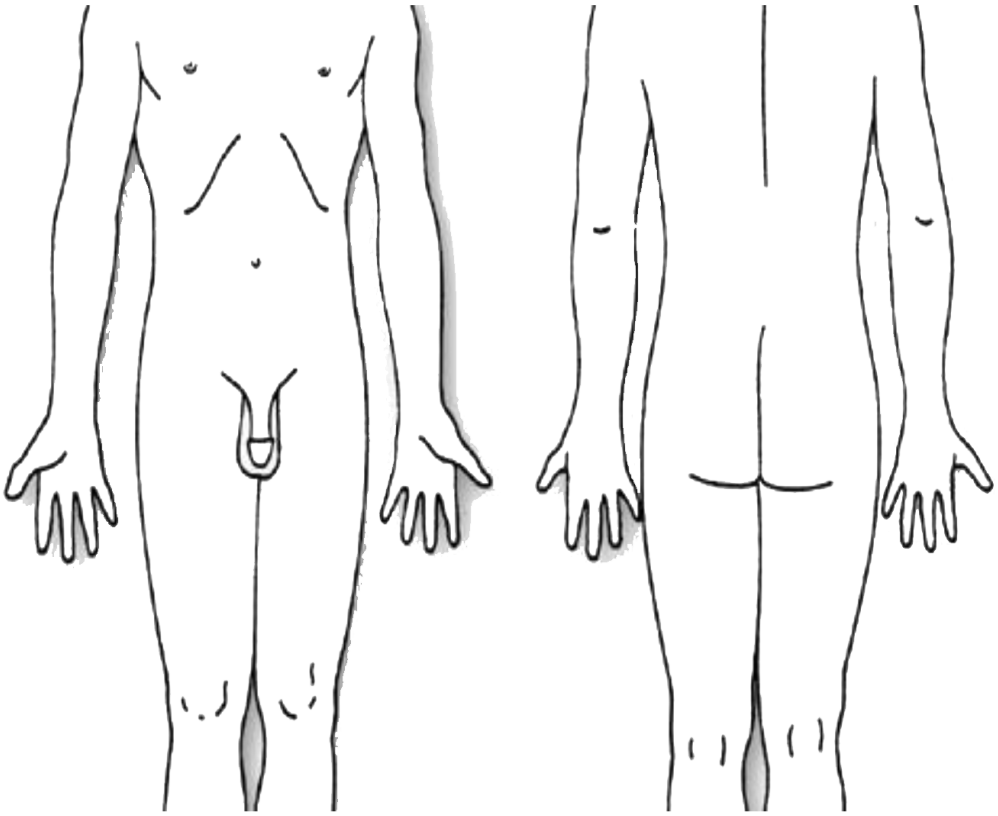
Did you refer patient for higher level medical services? *	☐Yes (Indicate for which of the following reasons): ☐ Antenatal Care ☐ Vaccination ☐ Family Planning ☐ Closer Facility ☐ Surgery ☐ VCCT Follow-up ☐ Other Advanced Treatment
	☐ No (Indicate for which of the following reasons): ☐ Services already received ☐ Patient declined ☐ Service not applicable ☐ Service unavailable

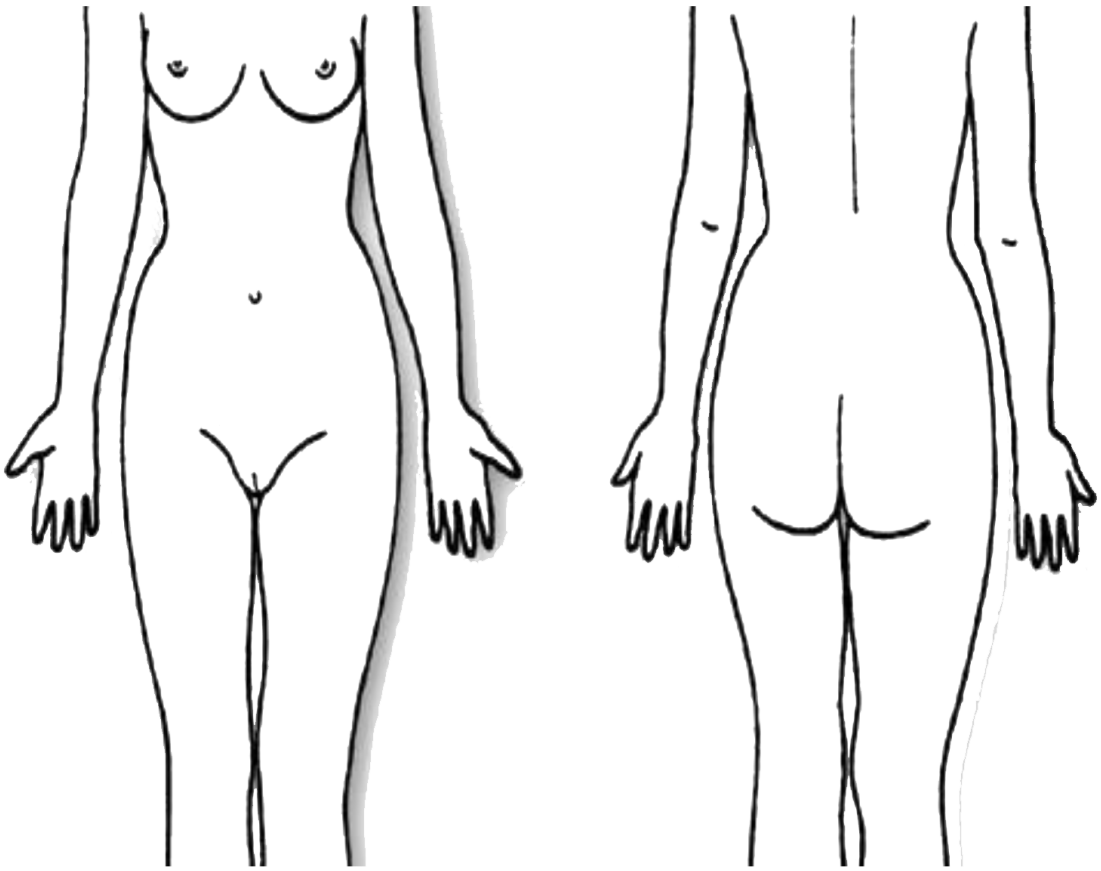
Did the patient request a medical certificate?*	**Was a medical certificate provided for the patient?***	**Was a follow-up visit scheduled?**	**Was the medical examination process explained prior to beginning the procedure?**
☐Yes ☐No	☐ Yes ☐No	☐Yes ☐No	☐Yes ☐No

Annex 4: Pictograms

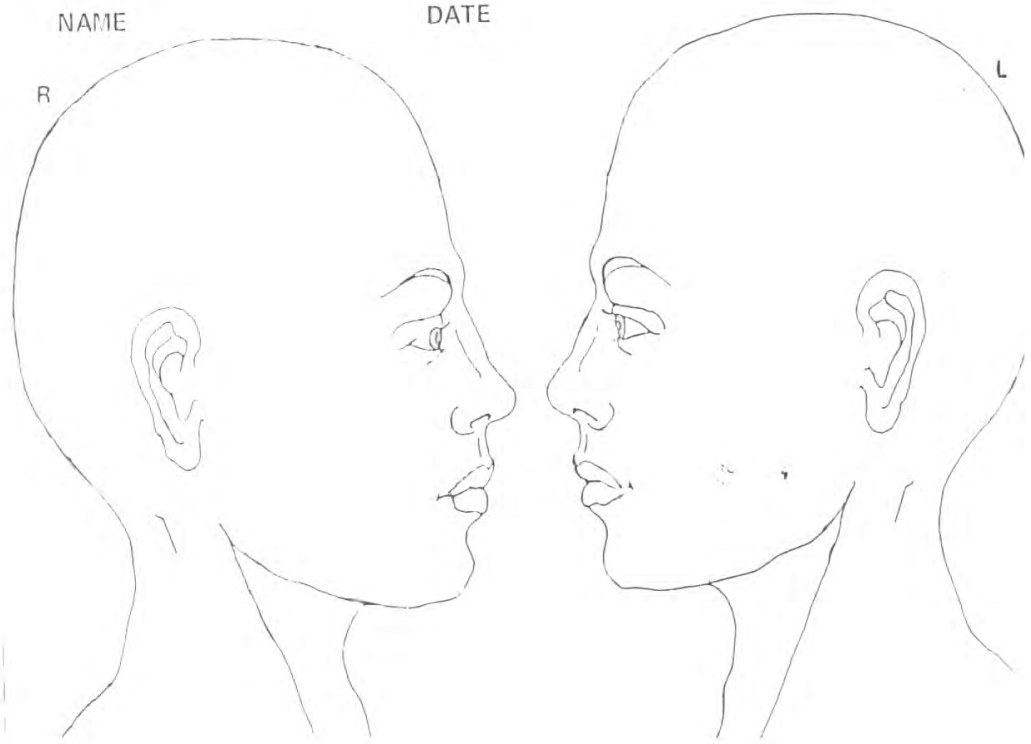








NAME DATE



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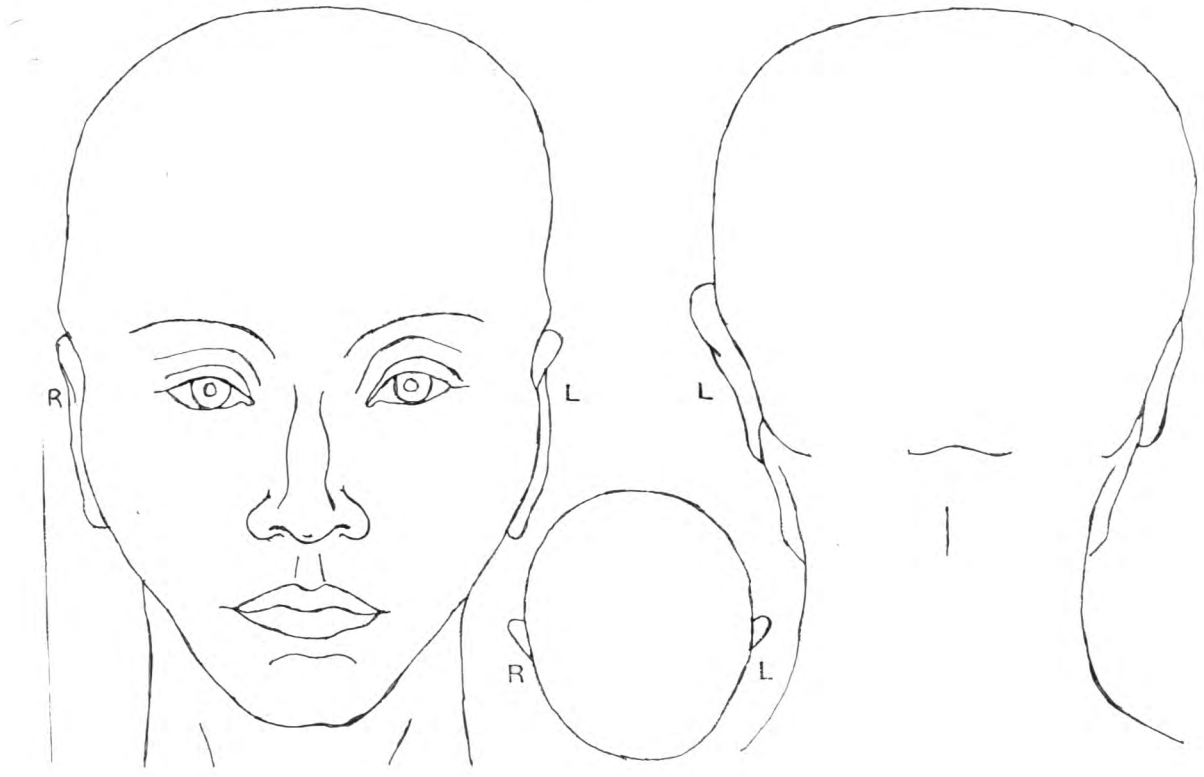

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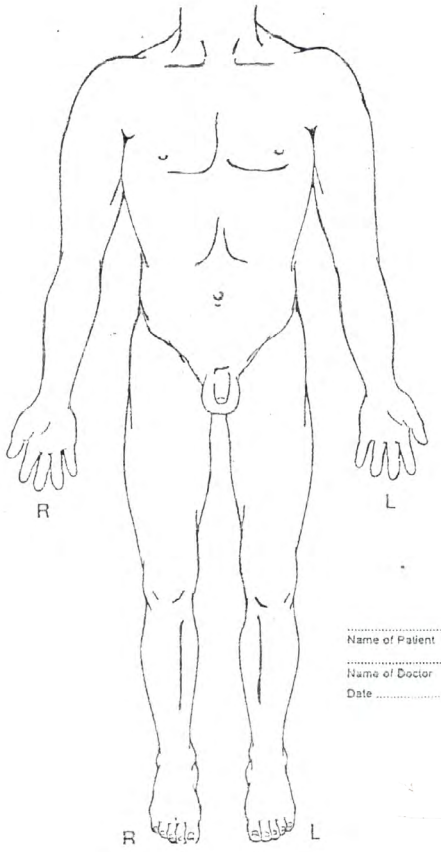
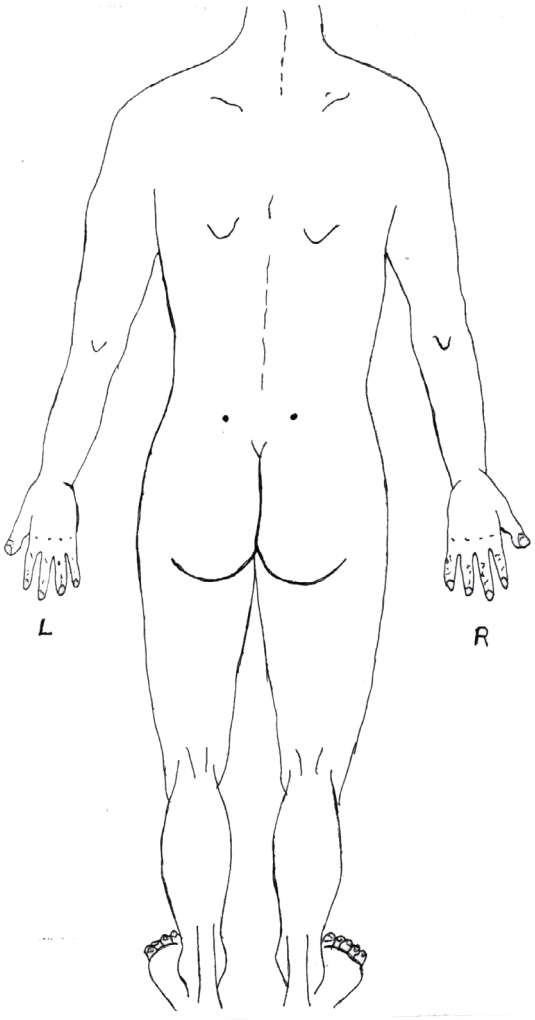


Name of Patient .....

Name of Doctor .....

Date .....

NAME: DOCTOR: DATE:



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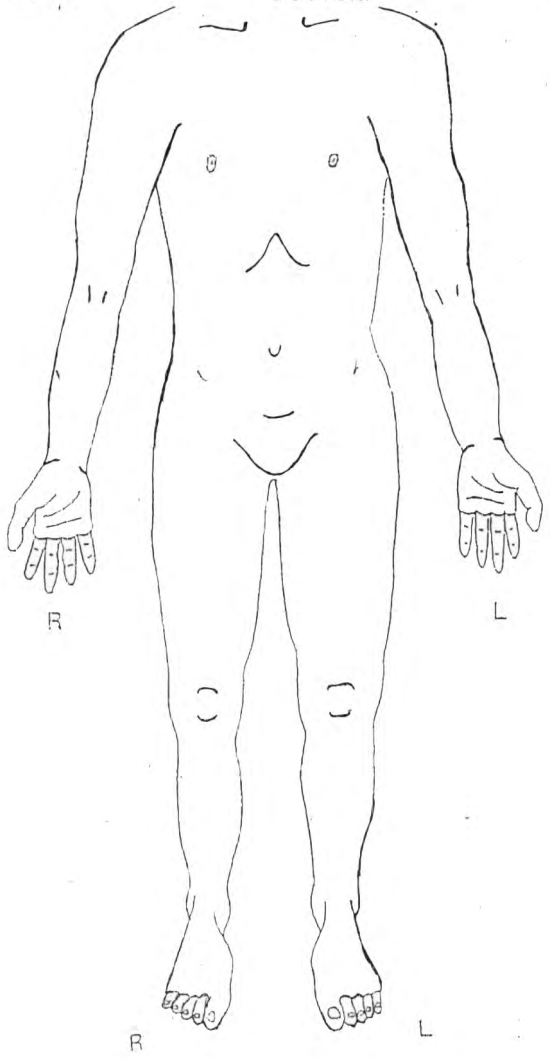

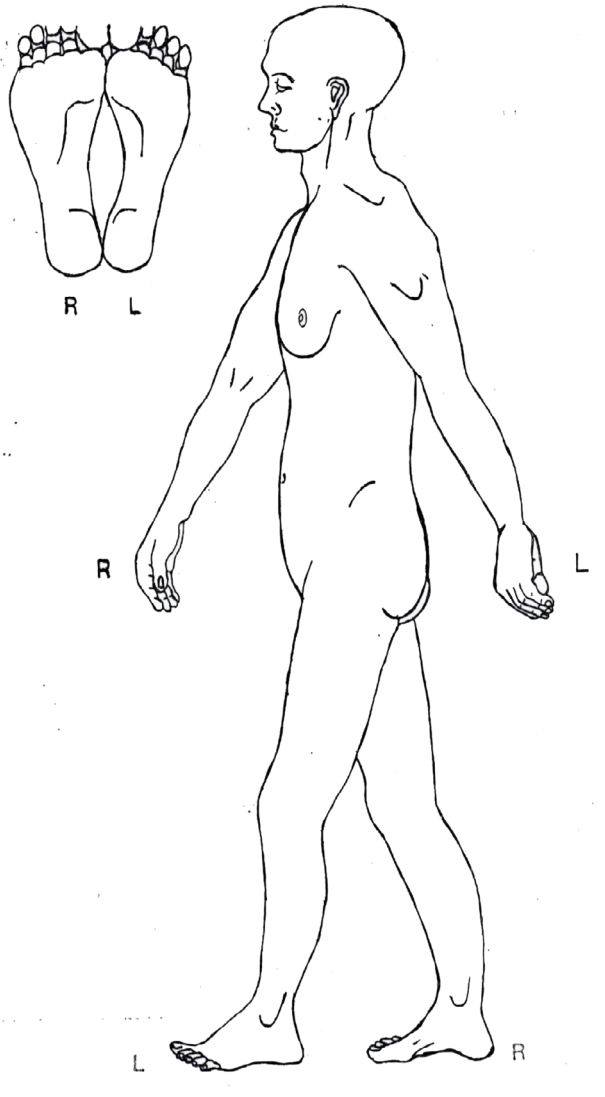

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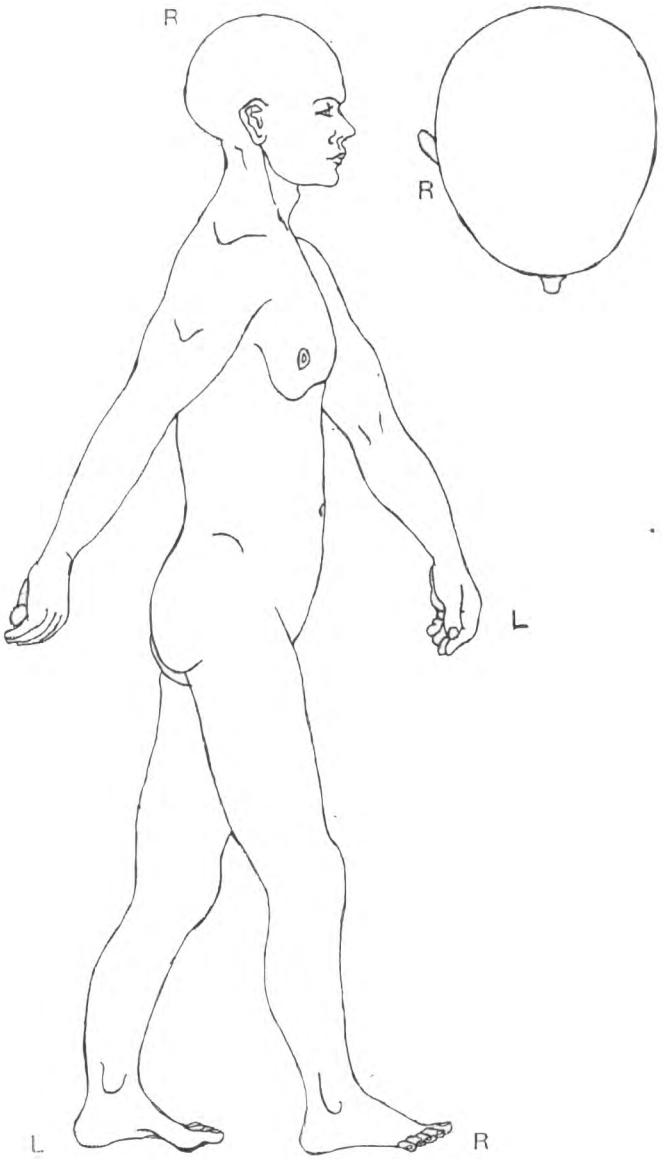

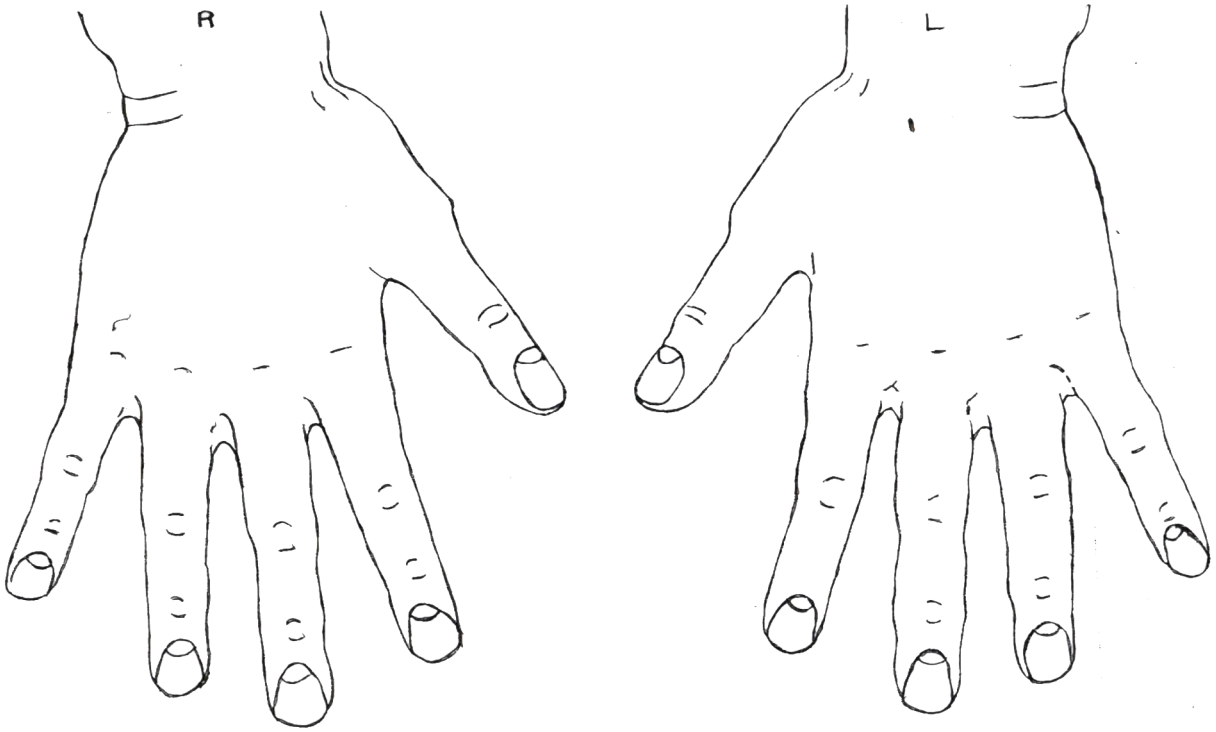

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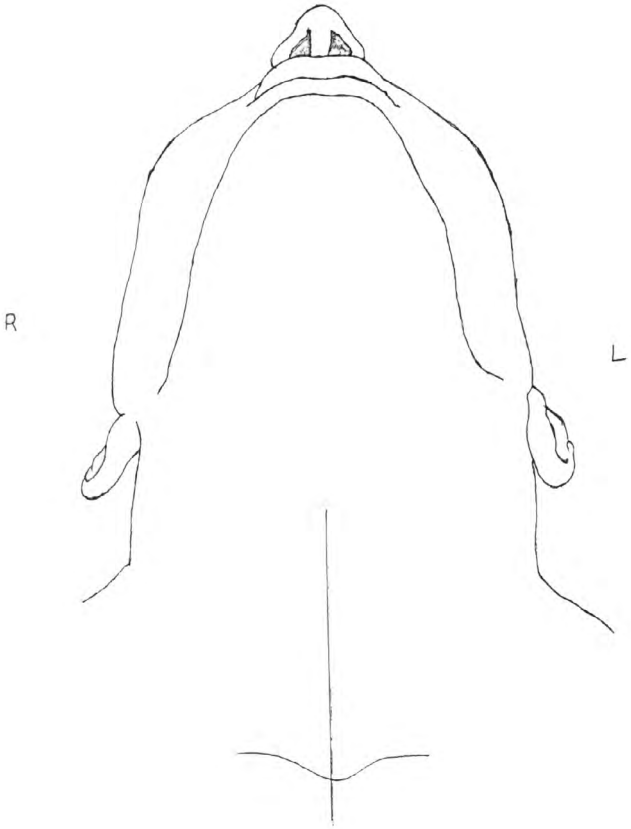
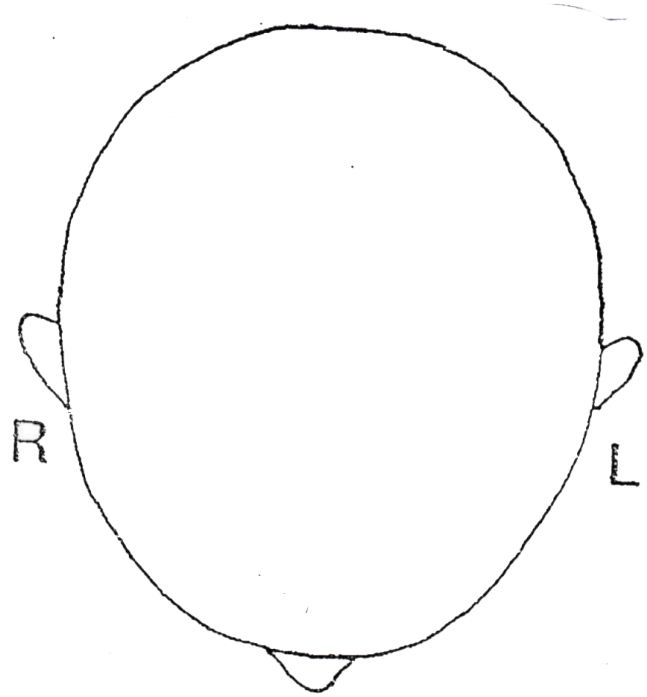
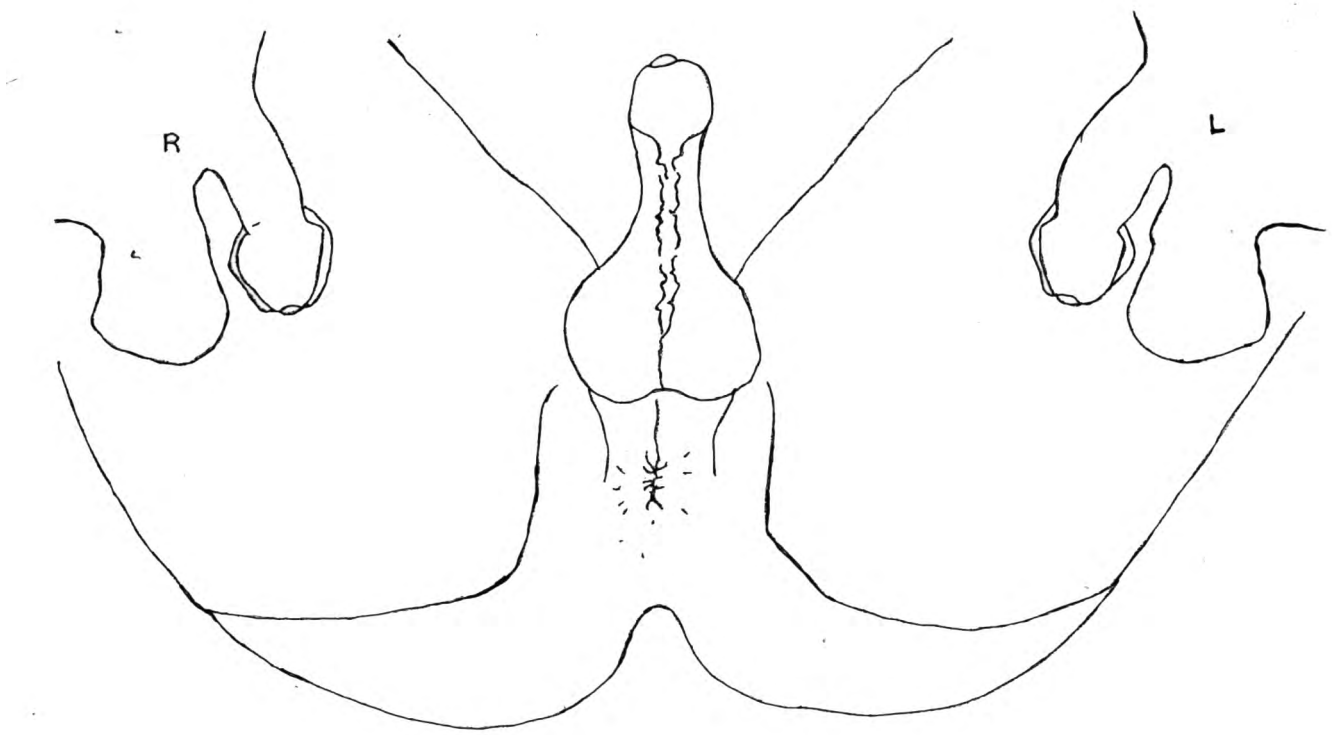
NAME: DOCTOR: DATE:







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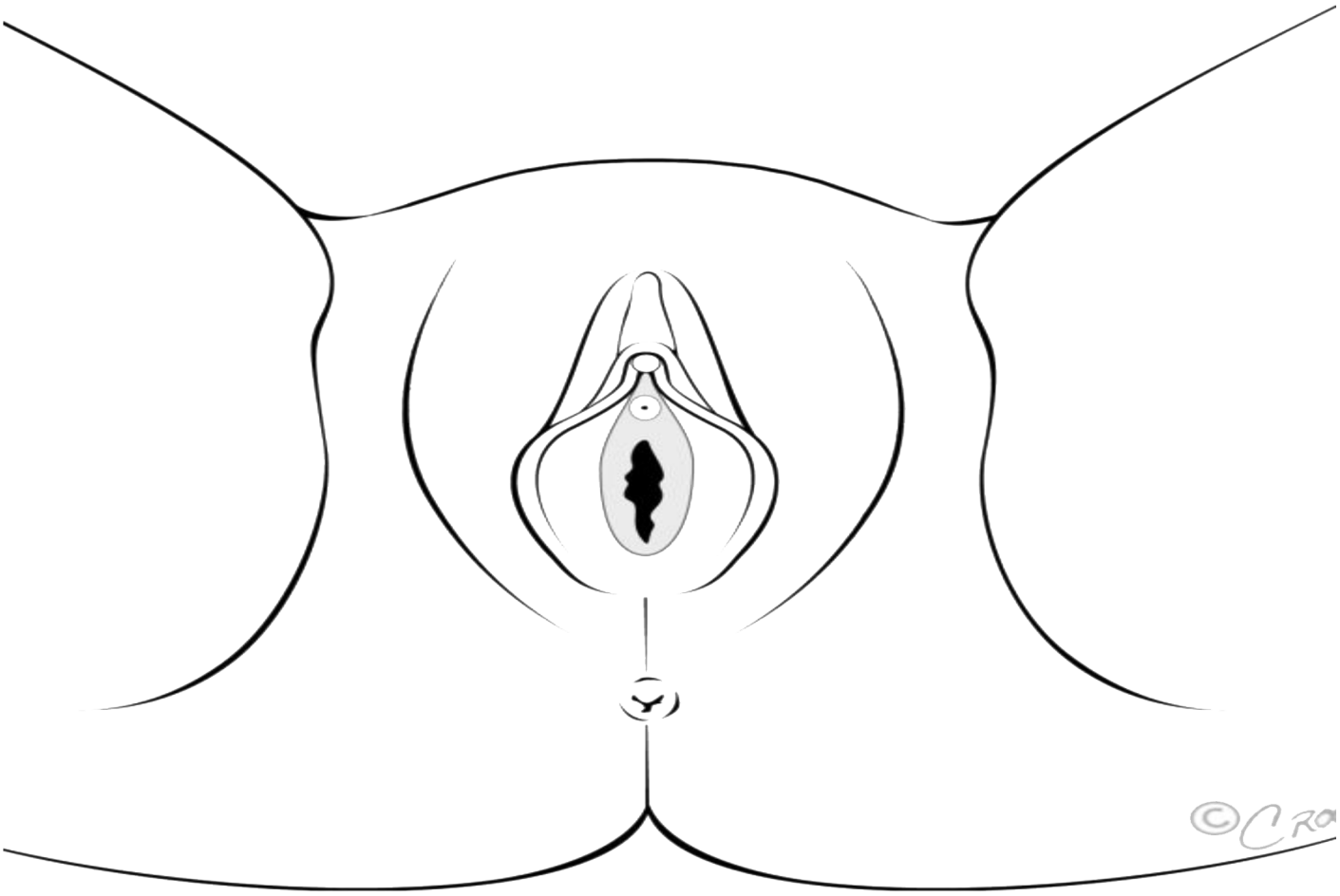
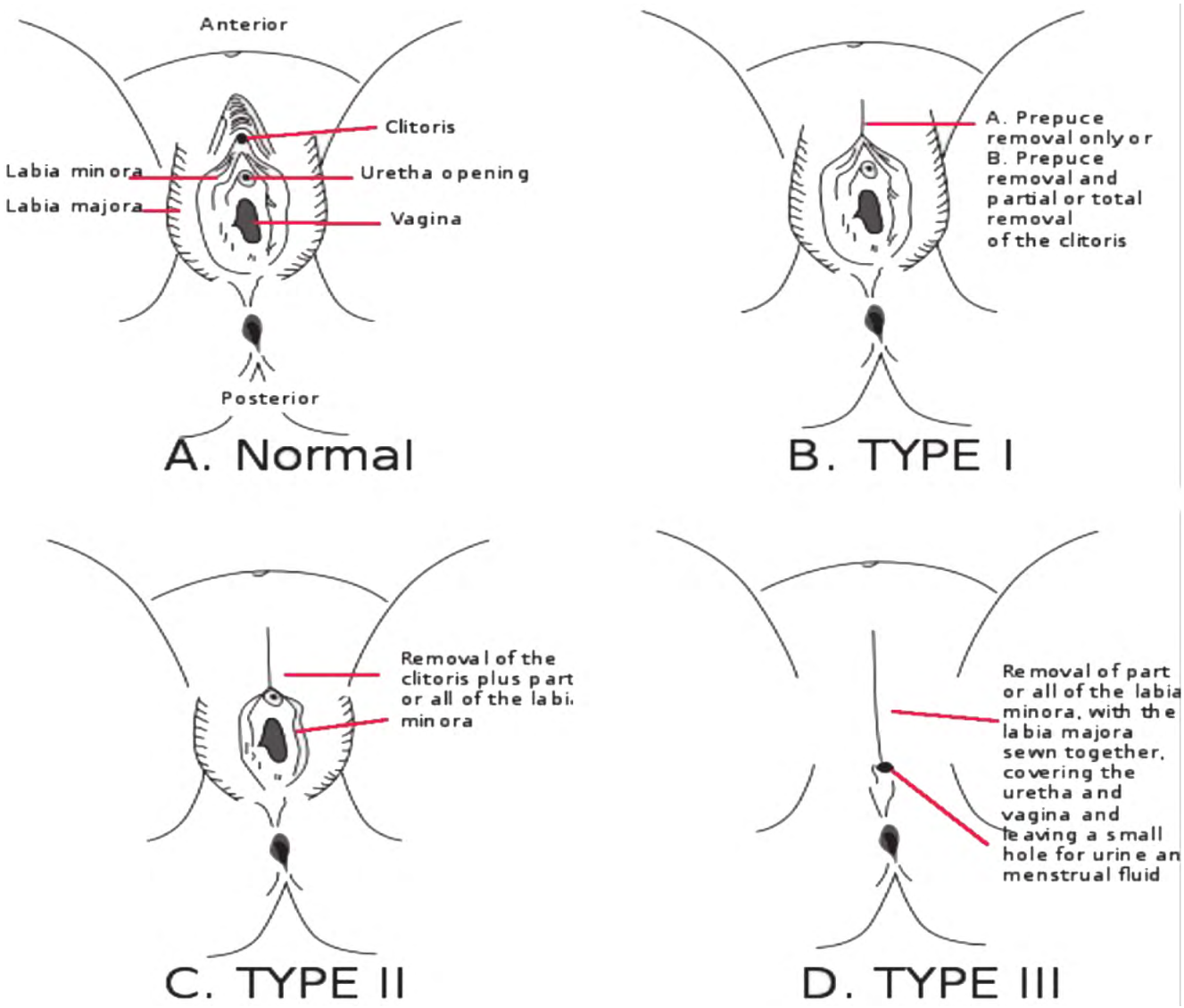
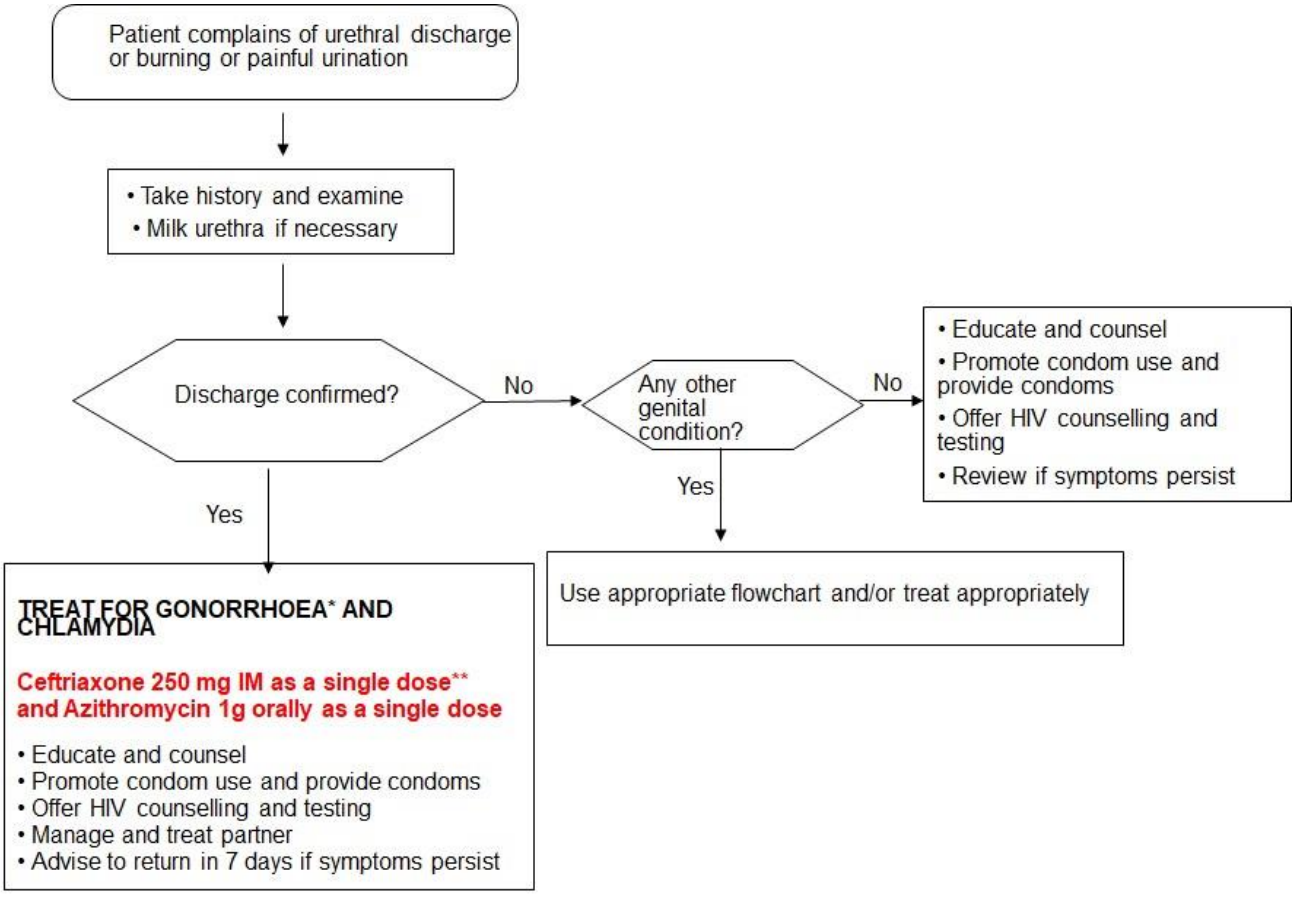


Annex 5: Type of FGM



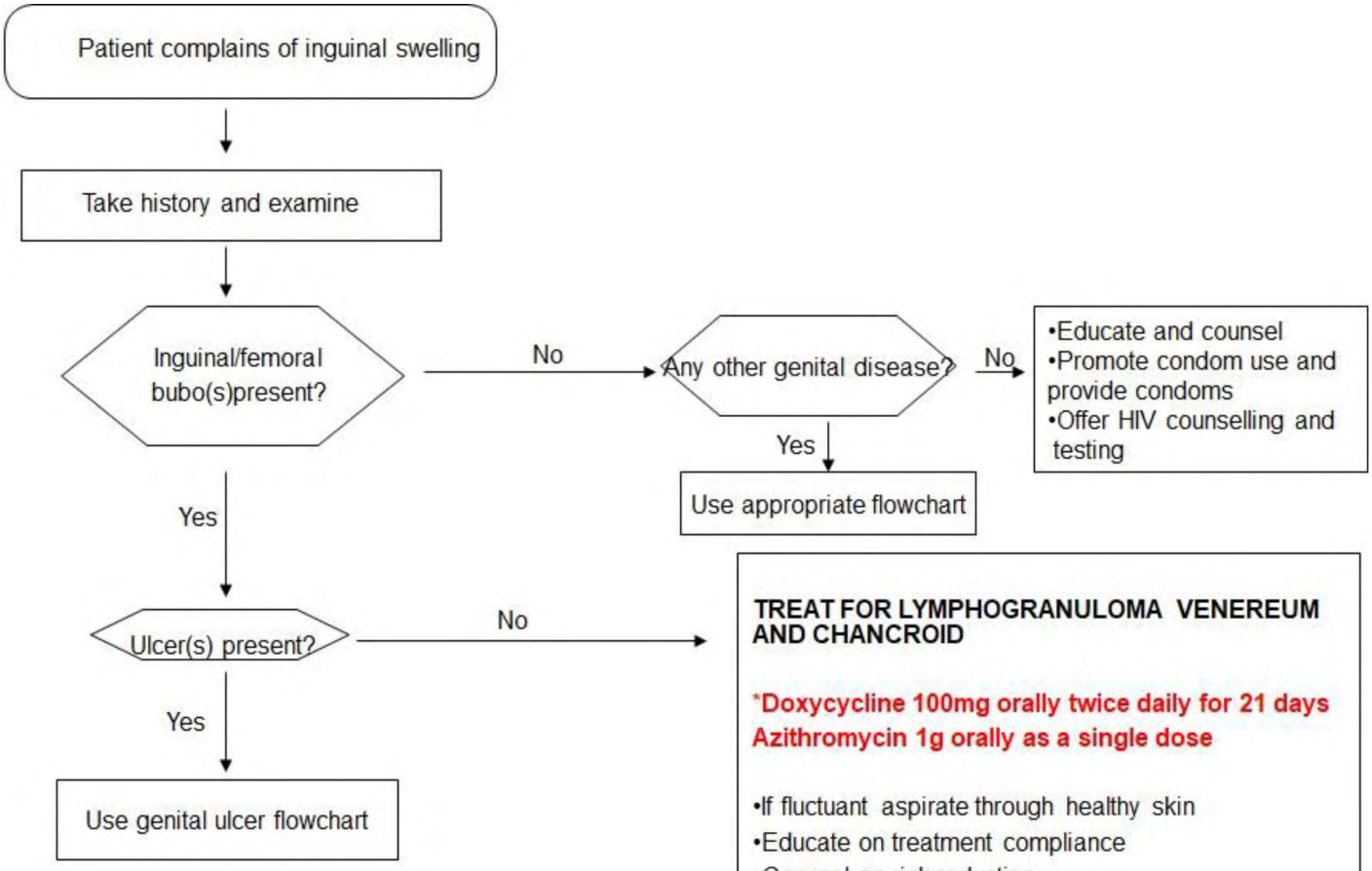
Annex 6: Flow charts for syndromic STI management

6.1 Urethral Discharge



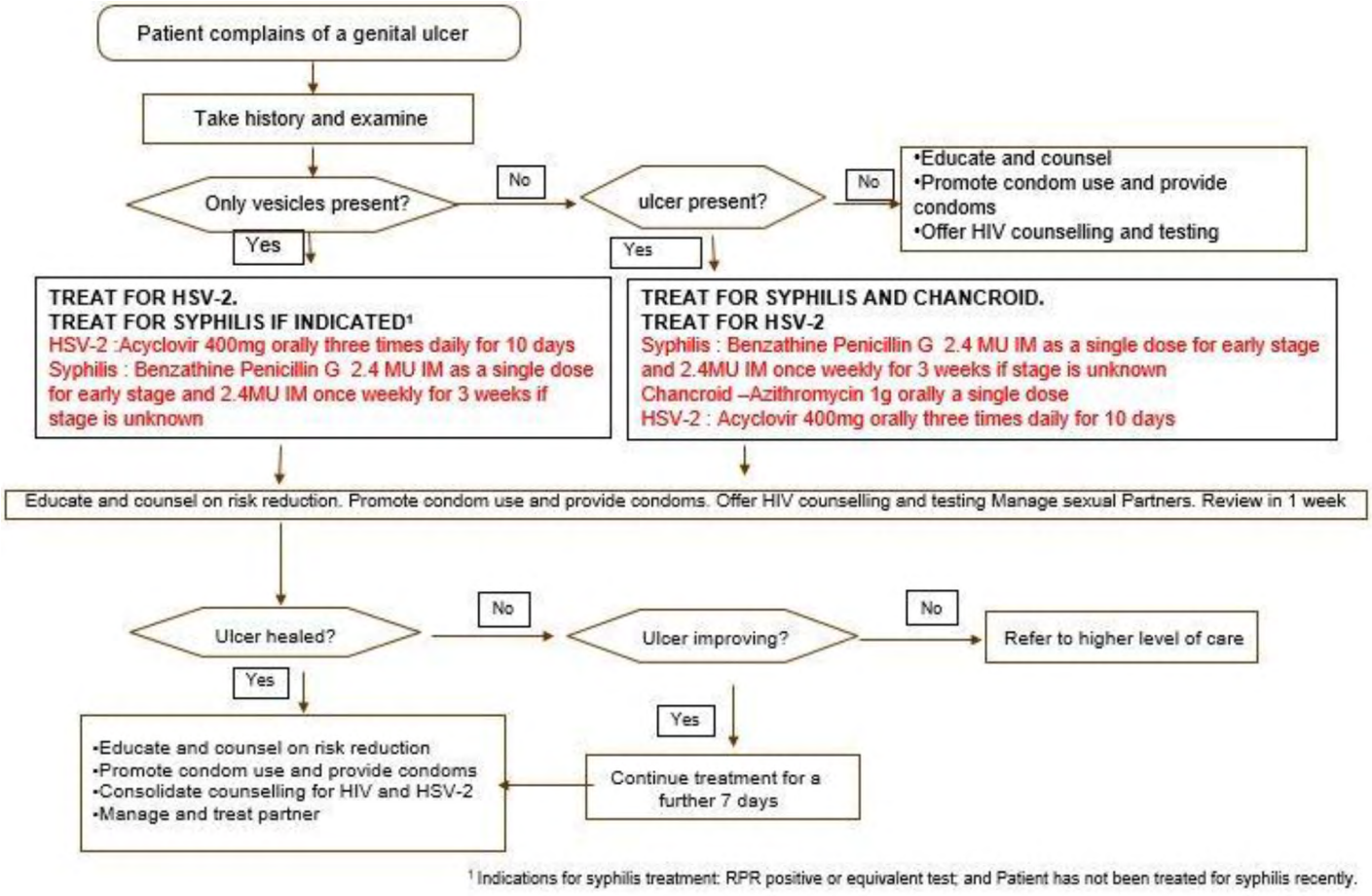
*If microscopy is available, do Gram stain smear of urethral exudates. If no intra-cellular Gram-negative diplococci are seen, treatment for chlamydial infection only may be considered. ** Preferred regimen reflected. See other regimen in the Treatment Options table

6.2 Inguinal bubo syndromic management flow chart



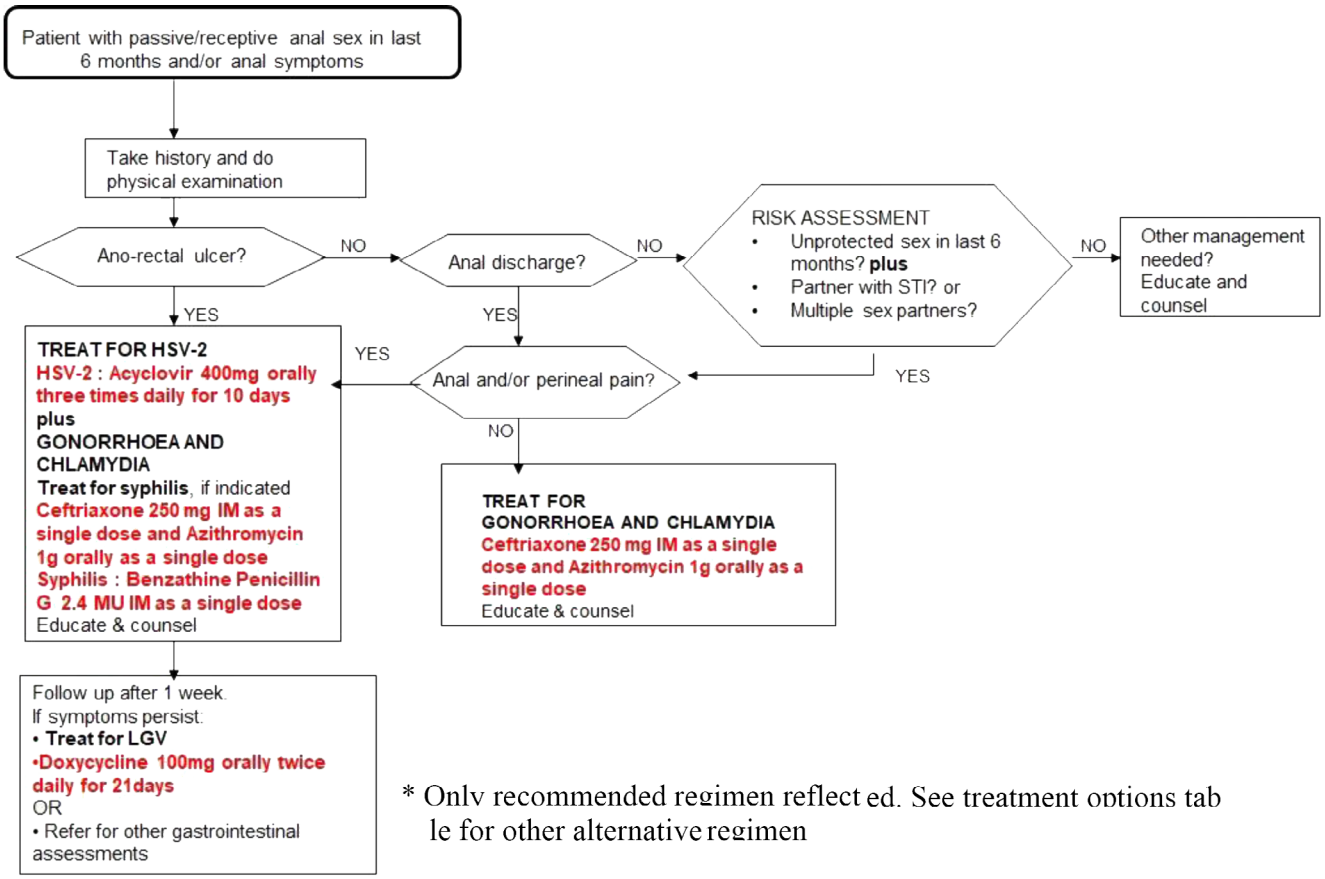
* Only preferred regimen reflected. See Treatment options table for other alternative regimen

6.3 Genital ulcer syndromic management flow chart



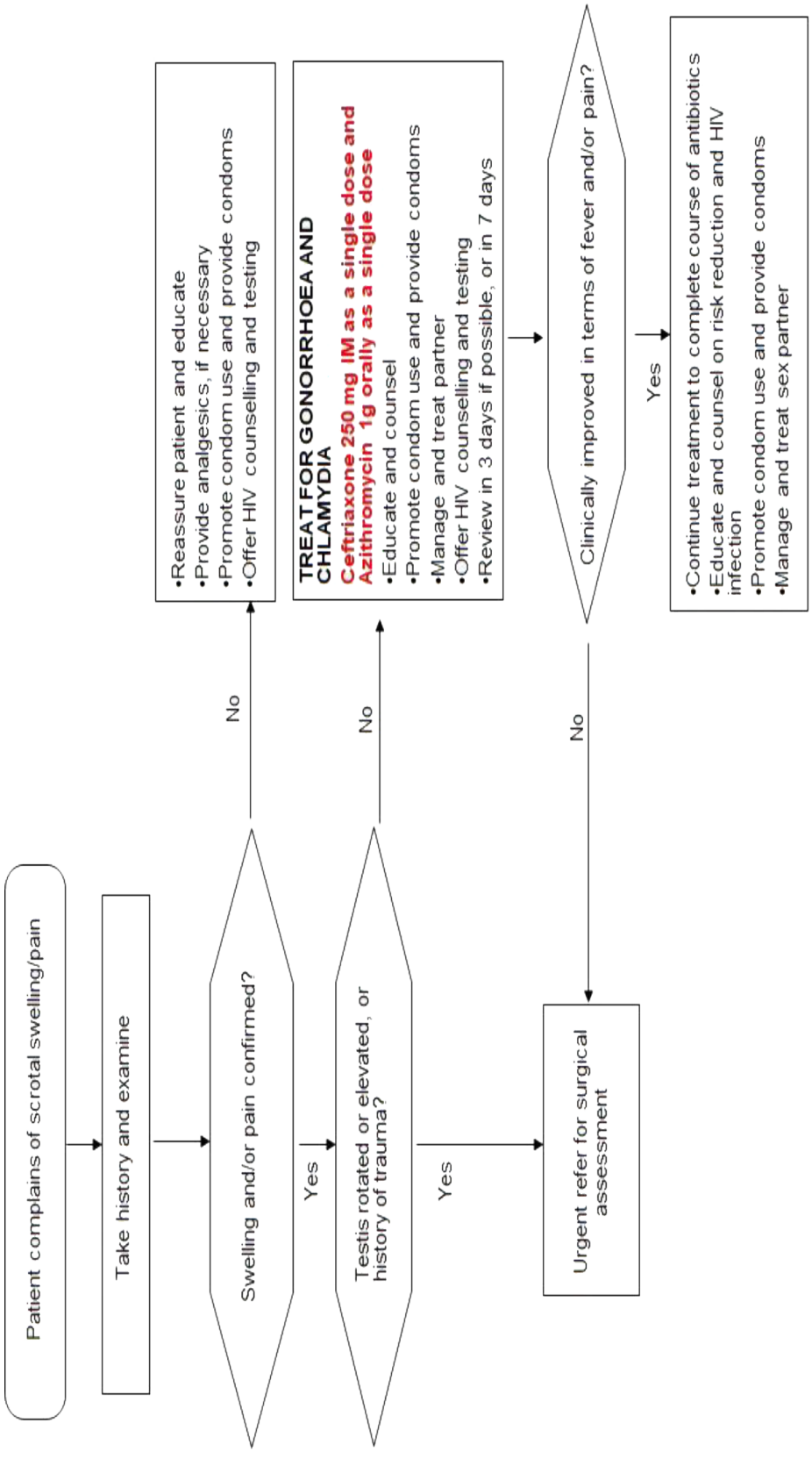
[1] Indications for syphilis treatment: RPR positive or equivalent test; and Patient has not been treated for syphilis recently.

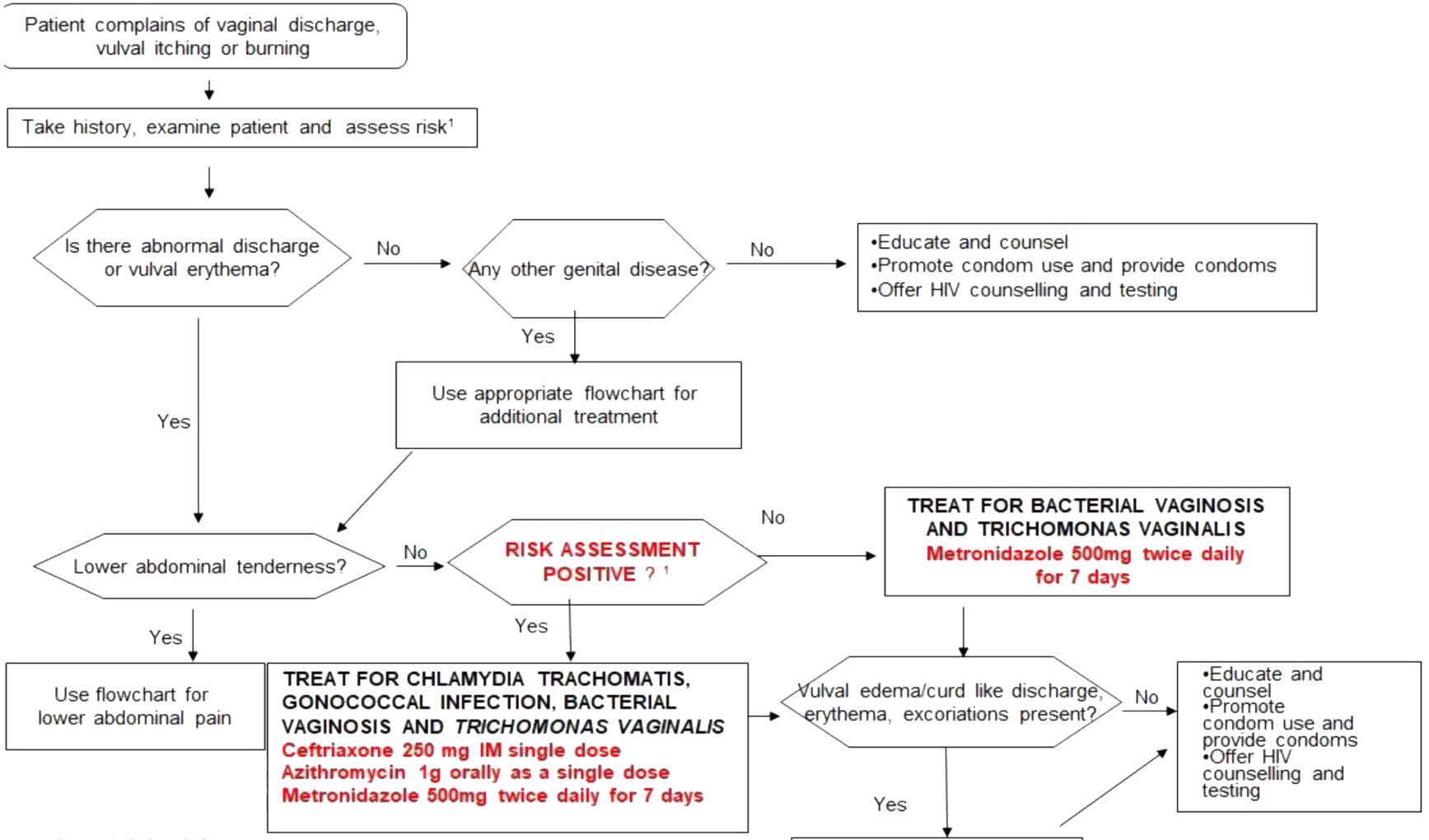
6.4 Anorectal ulcer syndromic management flow chart



* Only recommended regimen reflected. See treatment options table for other alternative regimen

6.5 Scrotal swelling syndromic management flow chart

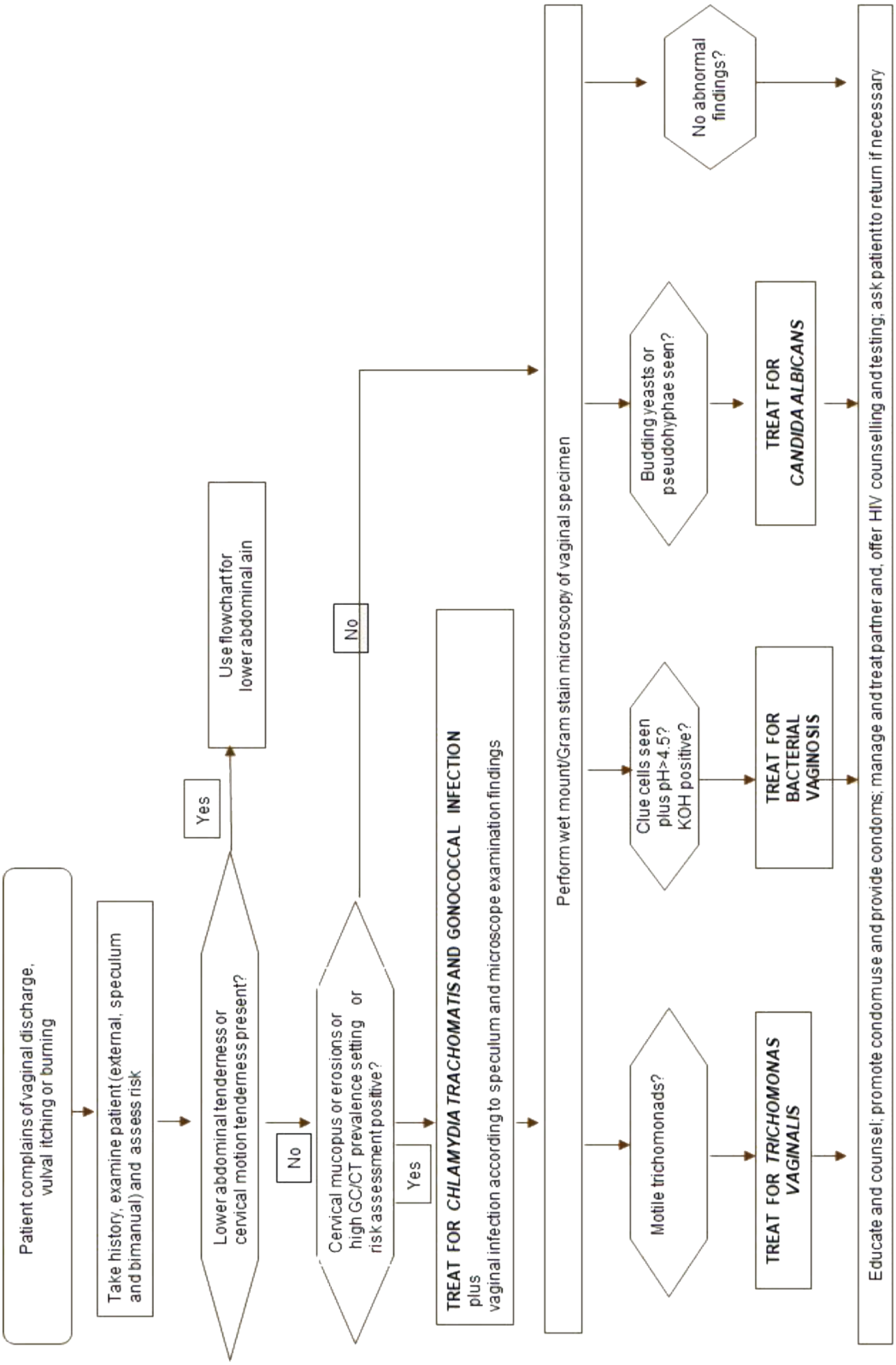




RISK ASSESSMENT

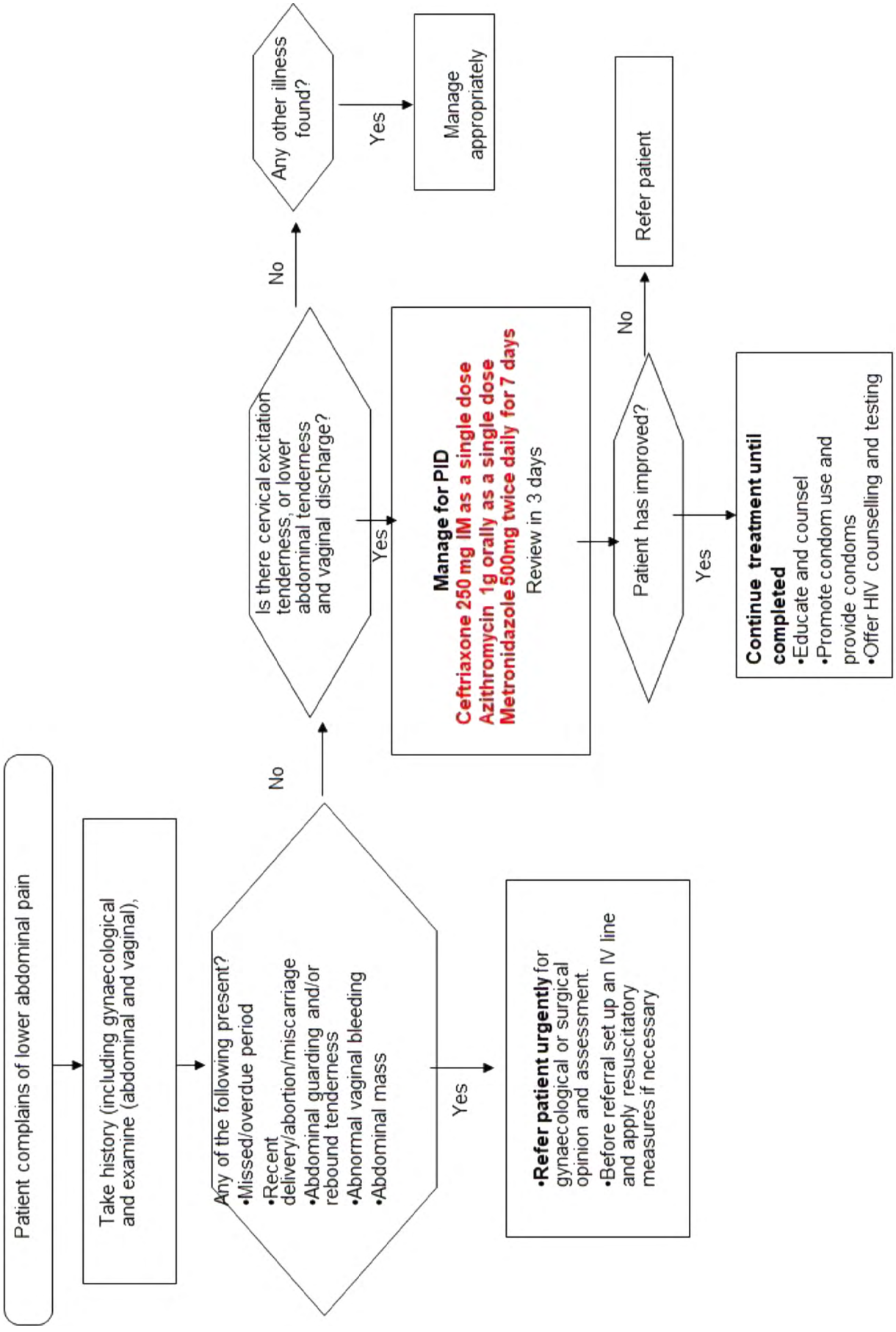
1. Unprotected sex with more than one sexual partner in the past six months
2. Engages in sex work
3. Sex partner has urethral discharge or swollen testicles
4. Victim of rape

6.6 b. Vaginal discharge (microscope, speculum, bimanual) flow chart



* Only preferred regimen reflected. See treatment Option table for other a alternative regimen

6.7 Lower Abdominal Pain



Annex 7: Confirming pre-existing pregnancy

If the survivor is pregnant, try to ascertain if she could have become pregnant at the time of the rape. If she is pregnant or may be pregnant as a result of the rape, counsel her on possibilities available.

The following guide may be useful.

A guide for confirming pre-existing pregnancy

No		Yes
	1. Have you given birth in the past 4 weeks?	
	2.Are you less than 6 months postpartum and fully breastfeeding and free from menstrual bleeding since you had your child/children?	
	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 menstrual period (apart from the incident)?	
	6. Have you been using a reliable contraceptive method consistently and correctly?	

If the survivor answered **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 make an informed choice about what to do.

If the survivor answers **NO** to all questions, ask about and look for signs and symptoms of pregnancy. If pregnancy cannot be confirmed, provide her with information on emergency contraception to help her make an informed choice about what to do.

Annex 8: Survivor-centred attitudes and behaviors

SURVIVOR-CENTRED ATTITUDES	SURVIVOR-CENTRED TIPS
Provide a safe space for emotional expression. If the interview comes to a halt with shouting or expressions of rage, for example, point out the behaviour and ask how you can help the survivor feel more comfortable.	• "I see this is difficult for you, would you like to take a break?" • "Anger is normal, what can we do to release this feeling?"
"Provide empathy and support by reflecting back to the person what she/he is doing (e.g., crying, expressing anger) and ask how you can help.	• "I see you are angry. You have a right to be angry. Please tell me what I can do to help you feel better." • "I see you are crying. We can wait until you are ready to talk. Is there anything that I can do to help you?"
Avoid specialized medical or legal language. Be careful to avoid using words that the survivor may not understand or that may increase anxiety.	• "Let me explain what happens now…" • "Do you have any questions? Would you like me to go over the next steps we talked about to check that we both understand what happens after this?"
Do not rush to fill silence with words. Some survivors need to sit quietly and process the event. After a few moments, acknowledge the silence.	• "I can see this is not easy to put into words." • "Sometimes it feels easier not to talk." • "Sometimes it may feel better to be silent."
Acknowledge that you are a stranger, a new person in her/his life.	• "I know we have just met, it may be uncomfortable for you to tell me about what happened to you, but I am here for you, to listen to you and make sure you are okay."
Reassure the survivor that you will be patient and that she or he does not need to hurry through her/his story.	• We can take as long as you need." • "I'll wait." • "That's okay, take your time."
Clearly acknowledge that the survivor is not at fault and ensure that your attitude is supportive, not blaming.	• "What happened was not your fault."

Annex 9: Supplies for minimum care of sexual assault survivor

Infrastructure	Protocols	Medical supplies
Out-patient department/consultation rooms private, quiet accessible examination room	Displayed SOP flow charts, forensic charts	Local anaesthesia
Examination table	Client flow chart displayed at out-patient department and other waiting bays/strategic points at the facility	Suture packs
Proper lighting	Consent forms	Drug kit in place: 1st PEP dose, ECP, STI treatment, analgesics
Functional refrigerator	Referral to next service delivery point	Lab tests: HIV, PDT, HB, HEP B and C, high vaginal swab
Access to autoclave/sterilized equipment	Laboratory: displayed SOP flow charts, forensic charts	Sanitary supplies
Assembled PRC kits		Gloves
Cloth or sheet to cover the survivor during examination		Personal Protective Equipment
PRC form available, accurately and completely filled		
Lockable cabinets: for storage of data, tools, commodities and evidence		

Annex 10: Contents of a rape kit

Item	Use	Items to assemble from facility	To buy one-off	To buy routinely
Powder-free gloves (clean gloves)	To avoid contamination	√		
Sterile gloves	For sterile procedures such as collecting High Vaginal Swab	√		
Six stick swabs	To take the High Vaginal Swab and/or anal swabs from the survivor	√		
Masking tape	To seal the brown envelopes in which the specimens have been stored			√
Brown envelopes	To collect samples and for proper storage of collected specimens			√
Tape Measure	To measure the physical injuries found on the survivor, if any		√	
Needles & syringes	To collect blood samples	√		
Urine bottles	To collect urine samples	√		
Vacutainer tubes	To collect blood samples	√		
Speculum	To collect specimens from the vaginal cavity	√		
Labels	To label the brown envelopes with the details of the specimens stored inside			√
Pregnancy testing kit	To test for pregnancy	√		
Seal lock bags	For proper storage of collected specimens			√
Green towels	One for wiping hands during the sterile procedure One for placing beneath the patient's buttocks			√

Annex 11: Medical certificates

MEDICAL CERTIFICATE for a child

I, the undersigned: (NAME, first and last names)____
____

Title: (indicate the function)
____
____

On this date and time: (day-month-year, time) ____ (day) _____(Month) ______(Year)_____(Time)

At the request of:(name, surname of father, mother, legal representative)

____
____
____

The child called (name, surname)
____
____
____

Born (day, month, year): ________ (day) _________ (Month) _________ (Year)

Living at (precise address):
____
____

Referred by:
____
____

In the interview, the children told me that :
____
____
____
____
____
____
____
____
____
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____
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A. GENERAL OBSERVATION:

____
____
____
____
____
____
____
____
____
____

B. PHYSICAL INJURIES:

____
____
____
____
____
____
____
____

C. **GENITAL FINDINGS:**

D. **ANAL FINDINGS:**

E. **FORENSIC EVIDENCE TAKEN:**

In the interview *(name of the person accompanying the children)* ***has declared that****:*

Note: *The absence of injuries does not mean that a sexual assault did not occur.*

SIGNATURE:

_____

Date: _____

Referred by:

_____

_____

She/he declares to have been sexually assaulted at (hour, day, month, year)

_____**at**

(place)_____**by**_____

_____

_____

_____

_____

_____

_____

_____

MEDICAL CERTIFICATE

For Adult

STATEMENT OF DR:

_____

_____

Address_____

_____

_____

Date_____

Tel

_____

I certify that I have examined on this

____(day) ____(month)

_____(Year)_____(Time)

at the request of (name, surname)

_____

_____

born (day, month, year)

_____

_____

living at (precise address)

_____

_____

A. GENERAL OBSERVATIONS:

B. PHYSICAL INJURIES:

C. GENITAL FINDINGS:

D. ANAL FINDINGS:

E. FORENSIC EVIDENCE TAKEN:

_____
_____
_____
_____
_____

F. **EVALUATION OF PREGNANCY RISK:**

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Note: *The absence of injuries does not mean that a sexual assault did not occur.*

SIGNATURE:

_____
_____ **Date:** _____

ANNEX 12: Sexual violence Community Awareness Info Pack

What is rape?

Rape is sex (sexual intercourse) that is obtained by use of force, coercion, intimidation or any kind or threat. It includes penetration of the vagina, the anus or any other body orifice. Rape happens to persons when they do not give consent to have sex.

Rape happens to women and girls as well as men and boys

In Sierra Leone, sex with children below 18 years is called defilement and is a criminal offence.

Rape is often done by people we know and may at times be close to us.

Rape is about violence and the abuse of power by a person. It is not about love.

What should I do if I am raped?

Get to a safe place and go the nearest health facility within 72 hours. Note: The national, Provincial and District Hospitals provide Post Rape Care Services.

At the hospital you will get:

1. medical evaluation and attention for your injuries;

2. counselling support for yourself and your family;

3. treatments to prevent infection with HIV, pregnancy and other STIs;

4. referral for other services you may require.

What should I NOT do if I am raped?

Do not wash yourself no matter how much you want to before you visit a hospital and are examined by a medical officer.

Do not destroy or wash your clothing. Wrap them in a non-polythene bag or in plain cotton clothes. Do not put them in a plastic bag. This may destroy the evidence.

Take them to the hospital with you and let the doctor examine them.

After rape you may experience feelings of shame, guilt and blame. Remember: It is the person that raped you who is wrong. What has happened is NOT your fault.

What happens at the hospital?

• A health care provider will examine your whole body for marks, bruises and wounds. The examination may be uncomfortable, embarrassing and sometimes painful, but it is necessary.

• The health care provider will ask questions about the rape experience. You will need to answer all questions asked frankly.

• The health care provider will record this information in detail in a form already available at the hospital. The health care provider will need to sign this.

• if possible take a family member or a friend with you to support you. Remember: Keep the medical notes and any documents that the doctor writes in a safe place. You may require them at a later date.

What treatment do I need if I have been raped?

Treatment of your physical injuries (if there are any) is most important. Drugs that could reduce chances of infection with HIV after rape are available.

• These anti-retroviral (ARV) drugs are referred to as PEP (Post Exposure Prophylaxis).

• PEP must be started soonest possible after rape and certainly with 72 hours.

• PEP is taken for a period of 28 days.

• PEP is prescribed and managed by a qualified medical officer.

• To the laboratory for necessary blood tests.

What tests do I need to take if I am raped?
Tests that need to be done right away include the following:

A vaginal swab or an anal swab in case of sodomy. This will attempt to show sperm in your vagina/anus. This can be used as evidence. However, the absence of sperm does not mean you were not raped.

A pregnancy test – to make sure you are not already pregnant. If a pregnancy test cannot be done, you should get emergency contraception.

If you suspect that you may already be pregnant it is alright to take emergency contraception since it does not interfere with established pregnancies.

Test for sexually transmitted infections
These tests are not really necessary if drugs to reduce the possibility of STI infections are provided.

• PEP will benefit you ONLY if you were HIV-negative before being raped.

• Taking PEP when you are HIV-positive is not useful and increases your body resistance to any future ARV treatment.

• A HIV test is therefore necessary to determine whether or not you can take PEP.

Drugs to prevent pregnancy (emergency contraception)

These drugs are also available in pharmacies. The most commonly used drug is called postinor.

• If this is not affordable or available, ask your pharmacist to give you a combination for emergency contraception from normal oral contraceptive pills.

- Drugs to reduce the possibility of infection with sexually transmitted diseases (STIs).

• For counselling at the VCT site for support and preparation to undertake a HIV test.

HIV test

Why do I need a HIV test?

PEP drugs reduce the chances of HIV transmission. PEP drugs do not cure HIV. PEP is only useful to someone who is HIV negative. It is important to establish HIV status for PEP to be provided. You can get PEP for three days before taking an HIV test as you decide whether you wish to proceed with it.

It is important to remember that:

• You will get counselling to support you through your trauma and in making your decision to take a HIV test.

• PEP may have some uncomfortable side effects. You may need to discuss these with your clinician/doctor. Do not stop PEP without consultation with your clinician

The **HIV test** and necessary blood test will be undertaken in a laboratory.

Remember: it is entirely an individual's choice to be tested for HIV and is only necessary in hospitals and clinics where PEP is available.

If I was raped and did not take PEP does it mean I have HIV?

Many people who have been raped do not get HIV.

What if I choose to report to the police?

At the police station, you will report and a record will be made in the occurrence book (OB). You will get a client number.

You will be asked questions about the incident. The police will cross-examine what you say in detail and may sometimes ask questions that are difficult for you. It may be uncomfortable or even painful, but necessary. You must speak the absolute truth of the situation.

If you have not been to the hospital, it is important that you go there immediately after reporting. Other procedures such as writing a statement or obtaining a medical certificate can be undertaken after you have received initial treatment.

You may be asked to record a statement and sign it. Do not sign this statement until you are happy and comfortable with what has been written in it.

What are my likely reactions to rape?

There are reactions commonly referred to as rape trauma syndrome (RTS):

• Shock can make you cry, laugh, shake or stay very calm.

• Guilt and shame – you may feel and think that you could have done things differently to avoid or stop the rape. You may feel that others are faulting you.

• Fear – this may immobilize and dysfunction you and can be triggered by different things – a word, a film, a book, a smell etc.

Counselling support can help your fear go away.

What are my rights as a survivor of sexual violence?

You have a right to:

• choose when, where, how and with whom to have sex;

• engage in consensual sex in all situations at all times;

• have your choice respected and protected by society and the law;

• willingly decide to lay a charge of rape with the police;

• access termination of pregnancy and post-abortion care in the event of pregnancy from rape;

• obtain legal representation.