

Clinical Management *of Survivors of Rape*

A guide to the development of protocols for use in
refugee and internally displaced person situations

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

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This guide is to be field-tested. Users are invited to submit comments to WHO at the address below.

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Preface

Sexual and gender-based violence is a worldwide problem. Refugees and internally displaced people are particularly at risk of this violation of their human rights during every phase of the refugee cycle. Rape – one of the most extreme forms of sexual violence – occurs in every society, country and region. Rape as a weapon of war is well documented, as is rape of refugees.

Over the past five years, humanitarian agencies have been working to put in place systems to respond to sexual and gender-based violence as well as to support community-based efforts to prevent such violence. In March 2001, the international humanitarian community came together to document what had been done and what is still needed to prevent and respond to sexual and gender-based violence towards refugees. Hosted by the United Nations High Commissioner for

Refugees, 160 representatives of refugee, nongovernmental, governmental and intergovernmental organizations met in Geneva to share experiences and lessons learned. This document is an outcome of that conference. It was produced under the leadership of the World Health Organization's Department of Reproductive Health and Research, with support from the International Committee of the Red Cross and the United Nations High Commissioner for Refugees.

A draft of this guide was distributed in a variety of settings around the world and field-tested at several sites. Feedback from these field-tests has been included in the current revision. This version will be circulated more widely and its use in the field evaluated over a period of one to two years before being revised. Comments on its use will be welcome.

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- ▶ Emergency and Humanitarian Action,
- ▶ Essential Drugs and Medicines Policy,
- ▶ Gender and Women's Health,
- ▶ HIV/AIDS,
- ▶ Injuries and Violence Prevention,
- ▶ Mental Health and Substance Dependence, and
- ▶ Vaccines and Biologicals;
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Thanks are also due to the nongovernmental organizations and UNHCR staff in the United Republic of Tanzania, especially Marianne Schilperoord, who organized the field-testing of this guide.

Abbreviations and acronyms used in this guide

ARV	antiretroviral
DT	diphtheria and tetanus toxoids
DTP	diphtheria and tetanus toxoids and pertussis vaccine
ECP	emergency contraceptive pills
ELISA	enzyme-linked immunosorbent assay
HBV	hepatitis B virus
HIV	human immunodeficiency virus
IDP	internally displaced person
IUD	intrauterine device
PEP	post-exposure prophylaxis
RPR	rapid plasma reagin
STI	sexually transmitted infection
Td	tetanus toxoid and reduced diphtheria toxoid
TIG	tetanus immunoglobulin
TT	tetanus toxoid
UNHCR	United Nations High Commissioner for Refugees
VCT	voluntary counselling and testing
WHO	World Health Organization

Introduction

This guide describes best practices in clinical management of people who have been raped. It is intended for adaptation to each situation, taking into account national policies and practices, and availability of materials and drugs.

This guide is intended for use by qualified health care providers (health coordinators, medical doctors, clinical officers, midwives and nurses) in developing protocols for the management of rape survivors, based on available resources, materials, drugs, and national policies and procedures. It can also be used in planning care services and in training health care providers.

The document includes detailed guidance on the clinical management of women, men and children who have been raped. It explains how to perform a thorough physical examination, record the findings and give medical care to someone who has been penetrated in the vagina, anus or mouth by a penis or other objects. It does not include advice on standard care of wounds or injuries or on psychological counselling, although these may be needed. Neither does the guide give guidance on referral procedures to community support, police and legal services. Other reference materials exist that describe this kind of care or give advice on creating referral networks; this guide is complementary to those materials.

Note: It is not the health care provider's responsibility to determine whether a person has been raped. That is a legal determination. The health care provider's responsibility is to provide appropriate care, to record the history and other relevant information and, with the person's consent, to collect any forensic evidence that might be needed in a subsequent investigation.

While it is recognized that men and boys can also be raped, most individuals who are raped are women or girls; feminine

pronouns are therefore used in the guide to refer to rape survivors, except where the context dictates otherwise.

The essential components of medical care after a rape are:

- collection of forensic evidence,
- evaluation for sexually transmitted infections and preventive care,
- evaluation for risk of pregnancy and prevention,
- care of injuries,
- counselling and follow-up.

How to use this guide

This document is meant to be used by health care professionals who are working with refugees or internally displaced persons (IDPs), or in other similar settings to develop specific protocols for medical care of rape survivors. In order to do this a number of actions have to be taken. Suggested actions include (not necessarily in the following order):

- 1 Identify a team of professionals and community members who are involved in caring for people who have been raped.
- 2 Convene meetings with medical staff and community members.
- 3 Create a referral network between the different sectors involved in caring for rape survivors (community, health, security, protection).
- 4 Identify the available resources (drugs, materials, laboratory facilities) and the relevant national policies and procedures relating to rape (standard treatment protocols, legal procedures, laws relating to abortion, etc.). See Annex 1 for an example of a checklist for the development of a local protocol.

- 5 Develop a situation-specific medical care protocol, using this guide as a reference document.
- 6 Train providers on use of the protocol, including what must be documented during an examination for legal purposes.



Steps covered in this guide

- 1 Making preparations to offer medical care to rape survivors.
- 2 Preparing the survivor for the examination.
- 3 Taking the history.
- 4 Collecting forensic evidence.
- 5 Performing the physical and genital examination.
- 6 Prescribing treatments.
- 7 Counselling the survivor.
- 8 Follow-up care of the survivor.

Special considerations needed when caring for children, men, and pregnant and elderly women are also described.

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

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

Center for Health and Gender Equity (CHANGE)



STEP 1 – Making preparations to offer medical care to rape survivors

The health care service must make preparations to respond thoroughly and compassionately to people who have been raped. The health coordinator should ensure that health care providers (doctors, medical assistants, nurses, etc.) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the service providing care for survivors of rape.

In setting up a service, the following questions and issues need to be addressed, and standard procedures developed.

What should the community be aware of?

Members of the community should know:

- what services are available for people who have been raped;
- why rape survivors would want to seek medical care;
- where to go for services;
- that rape survivors should come immediately after the incident without bathing or changing clothes;
- that rape survivors can trust the service to treat them with dignity, maintain their security, and respect their confidentiality;
- that there is 24-hour access to services.

What are the host country's laws and policies?

- Which health care provider should provide what type of care? If the person wishes to report the rape officially to the authorities, the country's laws may require that a certified or licensed medical doctor provide the care and complete the official documentation.
- What are the legal requirements with regard to forensic evidence?
- What are the national laws regarding management of the possible medical consequences of rape (e.g. emergency contraception, abortion, testing and preventive treatment for human immunodeficiency virus (HIV))?

What resources and capacities are available?

- What laboratory facilities are available for forensic testing (DNA analysis, acid phosphatase) or screening for disease (STIs, HIV)? What counselling services are available?
- Are there rape management protocols and "rape kits" for documenting and collecting forensic evidence?
- Is there a national STI treatment protocol, a post-exposure prophylaxis (PEP) protocol and a vaccination schedule? Which vaccines are available?
- What possibilities are there for referral of the survivor to a secondary health care facility (psychiatry, surgery, paediatrics, or gynaecology/obstetrics)?

Where should care be provided?

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

Who should provide care?

All staff in health facilities dealing with rape survivors, from reception staff to health care professionals, should be trained in their care. They should always be compassionate and respect confidentiality.

How should care be provided?

Care should be provided:

- according to a protocol that has been specifically developed for the situation. Protocols should include guidance on medical, psychosocial and ethical (responsibilities of the provider) aspects, and on counselling options;
- in a compassionate manner;
- with a focus on the survivor and her needs;
- with an understanding of the provider's own attitudes and sensitivities, the sociocultural context, and the community's perspectives, practices and beliefs.

What is needed?

- All health care for rape survivors should be provided in one place within the health care facility so that the person does not have to move from place to place.
- Services should be available 24 hours a day, 7 days a week.
- All available supplies from the checklist on page 5 and 6 should be prepared and kept in a special box or place, so that they are readily available.

How to coordinate with others?

- Interagency and intersectoral coordination should be established to ensure comprehensive care for survivors of sexual violence.
- Be sure to include representatives of social/community services, protection, the police or legal justice system, and security. Depending on the services available in the particular setting, others may need to be included.
- As a multisectoral team, establish referral networks, communication systems, coordination mechanisms, and follow-up strategies.

See Annex 8 for the minimum care that can and should be made available to survivors in the lowest-resource settings.

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

Checklist of supplies for clinical management of rape survivors

1 Protocol	Available
<ul style="list-style-type: none"> ▶ Written medical protocol translated in language of provider* 	
2 Personnel	Available
<ul style="list-style-type: none"> ▶ Trained (local) health care professionals (on call 24 hours/day)* ▶ For female survivors, a female health provider speaking the same language is optimal. IF this is not possible a female health worker (or companion) should be in the room during the examination* 	
3 Furniture/Setting	Available
<ul style="list-style-type: none"> ▶ Room (private, quiet, accessible, access to a toilet or latrine)* ▶ Examination table* ▶ Lighting, preferably fixed (a torch may be threatening for children)* ▶ Magnifying glass (or colposcope) ▶ Access to an autoclave to sterilise equipment* ▶ Access to laboratory facilities/microscope/trained technician ▶ Weighing scales and height chart for children 	
4 Supplies	Available
<ul style="list-style-type: none"> ▶ "Rape Kit" for collection of forensic evidence, could include: <ul style="list-style-type: none"> ✓ Speculum* (preferably plastic, disposable, only adult sizes) ✓ Comb for collecting foreign matter in pubic hair ✓ Syringes/needles (butterfly for children)/tubes for collecting blood ✓ Glass slides for preparing wet and/or dry mounts (for sperm) ✓ Cotton tipped swabs/applicators/gauze compresses for collecting samples ✓ Laboratory containers for transporting swabs ✓ Paper sheet for collecting debris as the survivor undresses ✓ Tape measure for measuring the size of bruises, lacerations, etc*. ✓ Paper bags for collection of evidence* ✓ Paper tape for sealing and labelling containers/bags* 	

Checklist of supplies for clinical management of rape survivors

▶ Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	
▶ Resuscitation equipment for anaphylactic reactions*	
▶ Sterile medical instruments (kit) for repair of tears, and suture material*	
▶ Needles, syringes*	
▶ Cover (gown, cloth, sheet) to cover the survivor during the examination*	
▶ Spare items of clothing to replace those that are torn or taken for evidence	
▶ Sanitary supplies (pads or local cloths)*	
▶ Pregnancy tests	
▶ Pregnancy calculator disk to determine the age of a pregnancy	
5 Drugs	Available
▶ For treatment of STIs as per country protocol*	
▶ For post-exposure prophylaxis of HIV transmission (PEP)	
▶ Emergency contraception pills and/or intrauterine device (IUD)*	
▶ Tetanus toxoid, tetanus immuno-globulin	
▶ Hepatitis B vaccine	
▶ For pain relief* (e.g. paracetamol)	
▶ Anxiolytic (e.g. diazepam)	
▶ Sedative for children (e.g. diazepam)	
▶ Local anaesthetic for suturing*	
▶ Antibiotics for wound care*	
6 Administrative Supplies	Available
▶ Medical chart with pictograms*	
▶ Forms for recording post-rape care	
▶ Consent forms*	
▶ Information pamphlets for post-rape care (for survivor)*	
▶ Safe, locked filing space to keep confidential records*	

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor.



STEP 2 – Preparing the survivor for the examination

The person who survives rape has experienced trauma and may be in an agitated or depressed state. She often feels fear, guilt, shame and anger. The health worker must prepare her for the examination, and must carry out the examination in the most compassionate, systematic and complete fashion.

To prepare the survivor for the examination:

- Ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination.
- Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- Reassure the survivor that she is in control of the pace, timing and components of the examination.
- Reassure the survivor that the examination findings will be kept confidential.
- Ask her if she has any questions.
- Ask if she wants to have a specific person present for support.
- Review the consent form (see Annex 2) with the survivor. Make sure she understands everything in it, and explain that she can delete anything she does not wish to consent to. Once you are sure she understands the form completely, ask her to sign it. If she cannot write, obtain a thumb print together with the signature of a witness.
- Limit the number of people allowed in the room during the examination to the minimum necessary.
- Undertake the examination as soon as possible.
- Do not force or pressure the survivor to do anything against her will.



STEP 3 – Taking the history

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.
- 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.
- Explain what you are going to do.
- Try to create a climate of trust.

A sample history and examination form is included in Annex 3. The main elements of the relevant history are described below.

General information

- Name, address, sex, date of birth (or age in years).
- Note the date and time of the examination 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 her own pace. Do not interrupt to ask for details; follow up with clarification questions after she finishes telling her story. Explain that she does not have to tell you anything she does not feel comfortable with.
- It is important that the health worker understands the details of exactly what happened in order to check for possible injuries. Explain this to the survivor, and reassure her of confidentiality if she is reluctant to give detailed information. The form in Annex 3 specifies the details needed.

History

- If the incident occurred recently, determine whether the survivor has bathed, urinated, vomited, etc. since the incident. This may affect the collection of forensic evidence.
- Information on existing health problems, allergies, use of medication, and vaccination and HIV status will help you to determine the best treatment to provide, counselling needed, and follow-up health care.
- Evaluate for possible pregnancy, ask for details of contraceptive use, last menstrual period, etc.

In developed country settings, some 2% of survivors of rape have been found to be pregnant at the time of the rape.¹ Some were not aware of their pregnancy. Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination. The following guide may be useful if you do not have access to pregnancy tests.

A guide for confirming pre-existing pregnancy (adapted from an FHI protocol ²)		
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?	
	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? (check with specific questions)	

If the survivor answers **NO** to all the 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 arrive at an informed choice (see Step 7)

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

1 Sexual assault nurse examiner (SANE) development and operation guide. Washington, DC, United States Department of Justice, Office of Justice Programs, Office for Victims of Crime (www.sane-sart.com/SaneGuide/toc.asp).

2 Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet*, 1999, 354(9178).



STEP 4 – Collecting forensic evidence

The main purpose of the examination is to determine what medical care should be provided. However, forensic evidence may also be collected to help the survivor pursue legal redress.

The survivor may choose not to have evidence collected. Respect her choice.

Good to know before you develop your protocol

Different countries and locations have different legal requirements and different facilities (laboratories, refrigeration, etc.) for performing tests. National and local resources and policies determine what evidence should be collected. Do not collect evidence that cannot be processed.

In some countries, the medical doctor may be legally obliged to give an opinion on the physical findings. Find out what the role of the health care provider is in reporting medical findings in a court of law. Ask a legal expert to write a short briefing about the local court proceedings in cases of rape and what to expect to be asked when giving testimony in court.

Reasons for collecting evidence

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

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

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

Documenting the case

- Record the interview and your findings at the examination in a clear, complete, objective, non-judgemental way.
- Completely assess and document the physical and emotional state of the survivor.
- Record precisely important statements made by her, such as threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.
- Note down exactly which samples you take.

Samples that can be collected as evidence

- Injury evidence: physical and/or genital trauma is proof of force and should be documented.
- Clothing: torn or stained clothing is useful to prove force was used.

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

Forensic evidence should be collected during the medical examination. It is necessary to obtain the consent of the survivor for the collection of evidence. Work systematically according to the medical examination form (see Annex 3). Explain everything you do and why you are doing it.

Inspection of the body

- Examine the survivor's clothing under a good light source before she undresses. Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, foreign hairs). Ask the person to undress while standing on a sheet of paper to collect any debris that falls. Do not ask her to uncover fully. Examine the upper half of her body first, then the lower half,

or provide a gown for her to cover herself. Collect torn and stained items of clothing, **only** if you can give her replacement clothes.

- Document all injuries (see Step 5).
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit her) or semen on the skin, with the aid of a cotton-tipped swab lightly moistened with sterile water.
- The survivor's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity, for direct examination for sperm, and for DNA and acid phosphatase analysis.
- Take a blood and urine sample if indicated.

Inspection of the anus, perineum and vulva

Inspect and collect samples for DNA analysis from the skin around the anus, perineum and vulva using cotton-tipped swabs moistened with sterile water.

Examination of the vagina and rectum

Depending on the site of penetration, examine the vagina and/or the rectum.

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis).
- Collect some of the fluid in the posterior fornix for examination for sperm.
- Take specimens of the posterior fornix and the endocervical canal for DNA analysis, using cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina. These can be analysed for acid phosphatase.

- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

Direct examination for sperm

Put a drop of the fluid collected on a slide, if necessary with a drop of normal saline (wet-mount), and examine it for sperm under a microscope. Note the mobility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.

Screening for STIs

Tests for sexually transmitted infections are usually not used as forensic evidence. A pre-existing STI could be used against the survivor in court.

In some settings screening for gonorrhoea, chlamydia, syphilis and HIV is done for children who have a history of sexual abuse (see “Care for child survivors”, pages 25-27).

Maintaining the chain of evidence

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

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

- All clothing, cloth, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper (not plastic) bags. Samples can be tested for DNA many years after the incident, provided the material is well dried.
- Blood and urine samples can be stored in the refrigerator for 5 days. To keep the samples longer they need to be stored in a freezer. Follow the instructions of the local laboratory.
- All samples should be clearly labelled with a confidential identifying code (not the name or initials of the survivor), date, time and type of sample (what it is, from where it was taken), and put in a container
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your initials across the tape.

In the adapted protocol, clearly write down the laboratory’s instructions for collection, storage and transport of samples.

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

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

Reporting medical findings in a court of law

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

In cases of rape, the prosecutor (not the health care provider) must prove three things:³

- 1 Some penetration, however slight, of the vagina or anus by a penis or other object, or penetration of the mouth by a penis.
- 2 That penetration occurred without the consent of the person.
- 3 The identity of the perpetrator.

In most settings the health care provider is expected to give evidence as a factual witness (that means reiterating the findings as he or she recorded them), not as an expert witness.

Meet with the prosecutor prior to the court session to prepare your testimony and obtain information about the significant issues involved in the case.

Conduct yourself professionally and confidently in the courtroom:

- Dress appropriately.
- Speak clearly and slowly, and make eye contact with whomever you are speaking to.
- Avoid using medical terms.
- Answer questions as thoroughly and professionally as possible.
- If you do not know the answer to a question, say so. Do not make an answer up and do not testify about matters that are outside your area of expertise.
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions.

The notes written during the initial interview and examination are the mainstay of the findings to be reported. It is difficult to remember things that are not written down. This underscores the need to record all statements, procedures and actions in sufficient detail, accurately, completely and legibly. This is the best preparation for an appearance in court.

3 Brown, W.A. Obstacles to women accessing forensic medical exams in cases of sexual violence. Unpublished background paper to the Consultation on the Health Sector Response to Sexual Violence, WHO Headquarters, Departments of Injuries and Violence Prevention and Gender and Women's Health, Geneva, June 2001.



STEP 5 – Performing the physical and genital examination

The primary objective of the examination is to determine what medical care should be provided to the survivor. Work systematically according to the medical examination form (see sample form in Annex 3).

What is included in the physical examination will depend on how soon after the rape the survivor presents to the health service. Follow the steps in Part A if she presents within 72 hours of the incident; Part B is applicable to survivors who present more than 72 hours after the incident. The general guidelines below apply in both cases.

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).

Part A: Survivor presents within 72 hours of the incident

Physical examination

- Never ask her to fully undress or uncover. Examine the upper half of her body first, then the lower half; or give her a gown to cover herself.
- Minutely and systematically examine the patient's body, starting at the head. Do not forget to look in the eyes, nose, 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.

- Note all your findings carefully on the examination form and the body figure pictograms (see sample in Annex 4), taking care to record the type, size, colour and form of any bruises, lacerations, ecchymoses and petechiae.
- Take note of the survivor's mental and emotional state (withdrawn, crying, calm, etc.).
- 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.

Examination of the genital area

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

- Systematically inspect the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen:
 - ▶ Note any scars from previous female genital mutilation.
 - ▶ Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
 - ▶ Look for any sign of infection, such as ulcers, vaginal discharge or warts.
 - ▶ Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and

adolescents (see "Care for child survivors", pages 25-27).

- ▶ Take samples according to your local evidence collection protocol. If collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva, in order to avoid contamination.
- If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline (**do not use a speculum when examining children**; see "Care for child survivors", pages 25-27):
 - ▶ Under good lighting inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
 - ▶ Take swabs and collect vaginal secretions according to the local evidence collection protocol.
- If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.

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

Examination of anus and rectum

- For the anal examination the patient may have to change position. Write down her position during the examination (supine for genital examination; supine, prone, knee-chest or lateral recumbent for anal examination).
- Note the shape and dilatation of the anus. Note any fissures around the anus, the presence of faecal matter on the perianal skin, and possible bleeding from rectal tears.

- If indicated by the history, collect samples from the rectum according to the local evidence collection protocol.
- If indicated, do a rectovaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge. Note the sphincter tone.
- 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).

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 sexually transmitted infections 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 Step 3).
- Other diagnostic tests, such as X-ray and ultrasound examination, may be useful in diagnosing fractures and abdominal trauma.

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

Physical examination

It is rare to find any physical evidence more than one week after an assault. If the survivor presents within a week of the rape, or presents with complaints, do a full physical examination as above. In all cases:

Examination of the genital area

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

Laboratory screening

Screen for STIs if possible. Follow the instructions of the local laboratory. Screening might cover:

- rapid plasma reagin (RPR) test for syphilis;
- Gram stain and culture for gonorrhoea;
- culture or enzyme-linked immunoassay (ELISA) for chlamydia;
- screening for HIV (but only on a voluntary basis and after counselling).



STEP 6 – Prescribing treatments

Treatment will depend on how soon after the incident the survivor presents to the health service. Follow the steps in Part A if she presents within 72 hours of the incident; Part B is applicable to survivors who present more than 72 hours after the incident.

Part A: Survivor presents within 72 hours of the incident

Prevent sexually transmitted infections

Good to know before you develop your protocol

Neisseria gonorrhoeae, the bacterium that causes gonorrhoea, is widely resistant to several antibiotics. Many countries have local STI treatment protocols based on local resistance patterns. Find out the local STI treatment protocol in your setting and use it when treating survivors.

- Survivors of rape should be treated with antibiotics to prevent gonorrhoea, chlamydial infection and syphilis. If you know that other STIs are prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.
- Give the woman the shortest courses available in the local protocol, which are easy to take. For instance: 2 g of azithromycin orally plus one injection of 2.4 million IU of benzathine

benzylpenicillin will be sufficient treatment for gonorrhoea, chlamydial infection and syphilis.

- Be aware that women who are pregnant should not take certain antibiotics, and modify the treatment accordingly.
- Examples of WHO-recommended STI treatment regimens are given in Annex 5.

Prevent HIV transmission

Good to know before you develop your protocol

As of the date of publication of this document, there are no conclusive data on the effectiveness of post-exposure prophylaxis in preventing transmission of HIV after rape. However, PEP is available in some settings for rape survivors. Before you start your service, find out if PEP is available in your setting and make a list of names and addresses of providers for referrals.

- If PEP is available, it usually consists of 1, 2 or 3 antiretroviral (ARV) drugs given for 28 days (see Annex 6 for examples). There are many problems and issues surrounding the prescription of PEP, not the least of which is the difficulty of counselling the survivor on HIV issues at a time like this. If you wish to know more about PEP, see the resource materials listed in Annex 9.
- If it is possible for the person to receive PEP in your setting, refer her as soon as possible (within 72 hours of the rape) to the relevant centre. If she presents after this time, provide information on voluntary counselling and testing (VCT) services available in your area.

Prevent pregnancy

- Taking emergency contraceptive pills (ECP) within 72 hours of unprotected intercourse will reduce the chance of a pregnancy by between 74% and 85%, depending on the regimen chosen and the time of starting the course (see Annex 7).
- Emergency contraceptive pills work by interrupting a woman's reproductive cycle – by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. ECPs do not interrupt or damage a pregnancy and thus WHO does not consider them a method of abortion.⁴
- Some people believe that ECPs are abortifacients. Health workers who believe this may feel unable to provide this treatment. Women should be offered objective counselling on this treatment so as to reach an informed decision.
- A health worker who is willing to prescribe ECPs should always be available to prescribe the treatment to rape survivors who wish to use it. If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian who can help her to understand and take the regimen as required.

- If an early pregnancy is detected at this stage, either with a pregnancy test or from the history and examination (see Steps 3 and 5), make clear to the woman that it cannot be the result of the rape.
- There is no known contraindication to giving ECPs at the same time as antibiotics.

Provide wound care

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

⁴ Emergency contraception: a guide for service delivery. Geneva, World Health Organization, 1998 (document no. WHO/FRH/FPP/98.19).

Prevent tetanus

Good to know before you develop your protocol

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

TT – tetanus toxoid

DTP – triple antigen: diphtheria and tetanus toxoids and pertussis vaccine

DT – double antigen: diphtheria and tetanus toxoids; given to children up to 6 years of age

Td – double antigen: tetanus toxoid and reduced diphtheria toxoid; given to individuals aged 7 years and over

TIG – antitetanus immunoglobulin

- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
- On the basis of the table below, decide whether to administer tetanus toxoid, which gives active protection, and antitetanus immunoglobulin, if available, which gives passive protection.
- If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and separate sites of administration.
- Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

Guide for administration of tetanus toxoid and tetanus immunoglobulin in cases of wounds⁵

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	Yes
3 or more	No, unless last dose >10 years ago	No	No, unless last dose >5 years ago	No

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

5 Adapted from: Benenson, A.S. Control of communicable diseases manual. Washington DC, American Public Health Association, 1995.

Prevent hepatitis B

Good to know before you develop your protocol

- Find out the prevalence of hepatitis B in your setting, as well as the vaccination schedules in the survivor's country of origin and in the host country.
 - Several hepatitis B vaccines are available, each with different recommended dosages and schedules. Check the dosage and vaccination schedule for the product that is available in your setting.
- Whether you can provide post-exposure prophylaxis against hepatitis B will depend on the setting you are working in. The vaccine may not be available as it is relatively expensive and requires refrigeration.
 - There is no information on the incidence of hepatitis B virus (HBV) infection following rape. However, HBV is present in semen and vaginal fluid and is efficiently transmitted by sex. If possible, survivors of rape should receive hepatitis B vaccine within 14 days of the incident.
 - In countries where the infant immunization programmes routinely use hepatitis B vaccine, a survivor may already have been fully vaccinated. If the vaccination record card confirms this, no additional doses of hepatitis B vaccine need be given.
 - The usual vaccination schedule is at 0, 1 and 6 months. However, this may differ for different products and settings. Give the vaccine by intramuscular injection in the deltoid muscle (adults) or the anterolateral thigh (infants and children). Do not inject into the buttock, because this is less effective.
 - The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It can be given at the same time as tetanus vaccine.

Provide mental health care

- Social support and psychological counselling (see Step 7) are essential components of medical care for the rape survivor. Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust, the community counsellor, and support groups. All rape survivors should be referred to the community focal point for sexual and gender-based violence.
- Occasionally a survivor may have severe symptoms of post-traumatic stress disorder. These symptoms can include anxiety, nightmares, inability to sleep, and constant crying.
- In exceptional cases, if the level of anxiety is such that it is disrupting the survivor's everyday life, give one 10 mg tablet of diazepam, to be taken at bedtime. In this case she should be referred to a specially trained health professional and her symptoms reassessed the next day.

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

Sexually transmitted infections

If laboratory screening for STIs has revealed an infection, or if the person has symptoms of an STI, treat according to the syndromic approach. Follow local protocols.

HIV transmission

While in some settings testing for HIV can be done as early as six weeks after a rape, it is recommended that the survivor is referred for voluntary counselling and testing (VCT) after 3-6 months, in order to avoid the need for repeated testing. Check the VCT services available in your setting and their protocols.

Pregnancy

- If the survivor is pregnant, try to ascertain if she could have become pregnant at the time of the rape. If she is, or may be, pregnant as a result of the rape, counsel her on the possibilities available to her in your setting. (See Step 3, Step 7, and Step 8).
- If the survivor presents within five days of the rape, insertion of a copper-bearing IUD is an effective method of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies). The IUD can be removed at the time of the woman's next menstrual period or left in place for future contraception. Women should be offered counselling on this service so as to reach an informed decision. A skilled provider should counsel the patient and insert the IUD.

Bruises, wounds and scars

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

Tetanus

Tetanus usually has an incubation period of 3 to 21 days, but it can be many months. Refer the survivor to the appropriate level of care if you see signs of a tetanus infection. If she has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident. If there remain major, dirty, unhealed wounds, consider giving antitoxin if this is available (see "Prevent tetanus" in Part A).

Hepatitis B

Hepatitis B has an incubation period of two to three months on average. If you see signs of an acute infection, refer the person if possible or provide counselling. If the person has not been vaccinated and it is appropriate in your setting, vaccinate, no matter how long it is since the incident.

Mental health

- Social support and psychological counselling (see Step 7) are essential components of medical care for the rape survivor. Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust, the community counsellor, and support groups. All rape survivors should be referred to the community focal point for sexual and gender-based violence.
- Occasionally a survivor may have severe symptoms of post-traumatic stress disorder. These symptoms can include anxiety, nightmares, inability to sleep, and constant crying.
- In exceptional cases, if the level of anxiety is such that it is disrupting the survivor's everyday life, give one 10 mg tablet of diazepam, to be taken at bedtime. In this case she should be referred to a specially trained health professional and her symptoms reassessed the next day.



STEP 7 – Counselling the survivor

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

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

Psychological and emotional trauma

- Medical care for survivors of rape includes care and referral for psychological trauma.
- The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, she has demonstrated that she trusts you.
- Rape causes psychological and emotional trauma as well as physical injury. Survivors may experience a range of post-traumatic symptoms, including:
 - ▶ self-blame;
 - ▶ uncontrollable emotions, such as fear, anger, guilt, shame, anxiety;
 - ▶ mood swings;
 - ▶ nightmares and sleeping disorders;
 - ▶ eating disorders;
 - ▶ suicidal thoughts or suicide attempts.
- Tell the survivor that she has experienced a serious physical and emotional trauma. Advise her about the post-traumatic symptoms (emotional and physical) that she may experience.
- In most cultures, there is a tendency to blame the survivor in cases of rape. Assure the survivor that she did **not** deserve to be raped, that the incident was **not** her fault, and that it was **not** caused by her behaviour or manner of dressing.
- Advise the survivor that part of the care she needs is emotional support. Encourage her to confide in someone she trusts and to ask for this emotional support, perhaps from a family member or friend.
- Refer the survivor to a counselling service for psychosocial assistance.
- Ask the survivor if she has a safe place to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no **safe place** to go to now, efforts should be made to find her a safe place. Enlist the assistance of the counselling services, community services provider, police or security officer (see Step 1).
- In some cases, the survivor is seriously traumatized and experiences severe emotional or psychological dysfunction, becoming unable to carry out day-to-day activities. Referral for psychological evaluation and more in-depth counselling may be needed. Find out what services are available in your area.

Pregnancy

- Emergency contraceptive pills cannot prevent pregnancy resulting from sexual acts that take place after the treatment. If the survivor wishes to use an additional hormonal method of contraception, she should start this on the first day of her next period. Condom use for a period of 6 months should be recommended to protect against transmission of STIs and HIV infection.
- Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of the rape. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:
 - ▶ There may be services for adoption and/or foster care in your area. Find out what services are available and give this information to the survivor.
 - ▶ In many countries the law allows termination of pregnancy resulting from rape. Furthermore, local interpretation of abortion laws in relation to mental and physical health may include indications for rape survivors as well. Find out whether this is the case in your setting. Determine where safe abortion services are available so that you can refer survivors to this service if they so choose.
 - ▶ Advise survivors to seek support from someone they trust – perhaps a religious leader, family member, friend or community worker.

HIV

Both men and women may be concerned about the possibility of becoming HIV-positive as a result of rape. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded. Compassionate and careful counselling around this issue is essential. The health care worker may also discuss the risk of transmission of HIV or STI to partners following a rape.

- The survivor may be referred to an HIV/AIDS counselling service if available.
- Condom use with all partners for a period of 6 months (or depending on the result of HIV screening tests) should be recommended.
- Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation.

Other

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

Follow-up care at the health facility

- Tell the survivor that she can return to the health service at any time if she has questions or other health problems. Encourage her to return in two weeks for follow-up evaluation of STI and pregnancy (see Step 8).
- Give clear advice on any follow up needed for wound care or vaccinations.



STEP 8 – Follow-up care of the survivor

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.

If the survivor is started on post-exposure prophylaxis with antiretroviral drugs, the follow-up schedule may be different from the one below. Discuss this with the PEP provider.

Two-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 3, 6, 7).
- Evaluate for STIs, treat as appropriate, provide advice on voluntary counselling and testing for HIV (see Steps 6, 7).
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Six-month follow-up visit

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

If the woman is pregnant as a result of the rape

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

Care for child survivors

Good to know before you develop your protocol

- If it is obligatory to report cases of child abuse in your setting, obtain a sample of the national child abuse management protocol and information on customary police and court procedures.
- Find out about specific laws in your setting that determine who can give consent for minors.
- In settings where the health worker is expected to go to court as an expert witness, he or she should receive special training in examining children who have been abused.
- Health care providers should be knowledgeable about child development and growth as well as normal child anatomy.

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 3 months, look also for:

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

The treatment of these complications is not covered here in detail.

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 mother's lap. Older children should be offered the choice of sitting on a chair or on the mother'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 assailants 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.

Laboratory testing

In some settings, screening for gonorrhoea and chlamydia (by culture), syphilis and HIV is done for all children presenting with a history of rape. The presence of these infections may be diagnostic of rape (if the infection is not likely to have been acquired perinatally or through blood transfusion).⁶ Follow your local protocol.

If the child is highly agitated

In rare cases, a child cannot be examined because he or she is highly agitated. **Only** if the child cannot be calmed down and treatment is vital, the examination may be performed with the child under sedation, using **one** of the following drugs:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg;
- or**
- promethazine hydrochloride, syrup, by mouth;
 - ▶ 2-5 years: 15-20 mg
 - ▶ 5-10 years: 20-25 mg

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

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

Treatment

Routine prevention of STIs is not usually recommended for children if screening can be done. However, in low-resource settings with a high prevalence of sexually transmitted diseases, presumptive STI treatment may be part of the protocol (see Annex 5 for sample regimens).

Follow-up

Follow-up care is the same as for adults. If a vaginal infection does not clear, consider the possibility of the presence of a foreign body, or continuing sexual abuse.

⁶ American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. *Pediatrics*, 1999,103:186-191.

Special considerations for men

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 in Step 6.

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.

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 the 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.

Annex 1 • Information needed to develop a local protocol

Checklist developed for refugee camps in the United Republic of Tanzania

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

Information needed	Where the information was found
<i>Medical laws and legal procedures</i>	
Abortion laws	Ministry of Health
Emergency contraception regulations	Ministry of Health
Foster placement and adoption laws and procedures	Ministry of Community Development, Women Affairs and Children
Crime reporting requirements and obligations, for adult or child survivors	Ministry of Justice
Police and other forms required	Ministry of Home Affairs
<i>Forensic evidence</i>	
Which medical practitioner can give medical evidence in court (e.g. doctor, nurse, etc)	Ministry of Justice
Training for medical staff in forensic examination (of adult or child survivors)	Ministry of Health
Evidence allowed/used in court for adult and child rape cases that can be collected by medical staff	Ministry of Justice
Forensic evidence tests possible in country (e.g. DNA, acid phosphatase)	Forensic laboratory in capital
How to collect, store and send evidence samples	Forensic laboratory in capital; laboratory at regional level
Existing "rape kits" or protocols for evidence collection	Referral hospital at regional level or in capital
<i>Medical protocols</i>	
National STI protocol	Ministry of Health
Vaccination availability and schedules	Ministry of Health
Location of voluntary HIV counselling and testing services	National AIDS Control Program, Ministry of Health
Confirmatory HIV testing strategy and laboratory services	UNHCR, National AIDS Control Program, Ministry of Health, Regional Medical Officer
Possibilities/protocols/referral of post-exposure prophylaxis of HIV infection	National AIDS Control Program, Ministry of Health
Clinical referral possibilities (e.g. psychiatry, surgery, paediatrics, gynaecology/obstetrics)	Referral hospital at regional level

Annex 2 • Sample consent form

Name of facility - - - - -

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

I, - - - - - , (print name of survivor)

authorize the above-named health facility to perform the following (tick the appropriate boxes):

- | | Yes | No |
|--|--------------------------|--------------------------|
| 30 Conduct a medical examination , including pelvic examination | <input type="checkbox"/> | <input type="checkbox"/> |
| Collect evidence , such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs | <input type="checkbox"/> | <input type="checkbox"/> |
| Provide evidence and medical information to the police and/or courts concerning my case ; this information will be limited to the results of this examination and any relevant follow-up care provided. | <input type="checkbox"/> | <input type="checkbox"/> |

Signature: - - - - -

Date: - - - - -

Witness: - - - - -

Annex 3 • Sample history and examination form

Sample form, page 1 of 4

CONFIDENTIAL

CODE:

Medical History and Examination Form – Post-Sexual Violence

1. GENERAL INFORMATION

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

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

2. THE INCIDENT

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

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If use of restraints, drugs/alcohol involved and if the survivor is a child, also ask: Has this happened before, for how long, who is the perpetrator, is (s)he still a threat, etc. Also ask about bleeding from the vagina or the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, etc.

3. MEDICAL HISTORY

After the incident, did the survivor		Yes	No			Yes	No		
Vomit				Rinse mouth					
Urinate				Change clothing					
Defecate				Wash/bathe					
Brush teeth				Use tampon/pad					
Contraception use									
Pill				IUD					
Injection				Other (specify)					
Menstrual history									
Last menstrual period				Menstruation at time of event				Yes <input type="checkbox"/>	No <input type="checkbox"/>
Evidence of pregnancy				Yes <input type="checkbox"/>	No <input type="checkbox"/>	Number of weeks pregnant		_____ weeks	
History of consenting intercourse (only if samples have been taken for DNA analysis)									
Last consenting intercourse within a week prior to the assault			Date:			Name of individual:			
Existing health problems									
<i>History of female genital cutting, type</i>									
<i>Allergies</i>									
<i>Current medication</i>									
Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments					
Tetanus									
Hepatitis B									
HIV/AIDS status	Know		Negative		Unknown				

4. Medical examination

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

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5. GENITAL AND ANAL EXAMINATION

<i>Vulva/scrotum</i>	<i>Introitus and hymen</i>	<i>Anus</i>
<i>Vagina/penis</i>	<i>Cervix</i>	<i>Bimanual/rectovaginal examination</i>
<i>Position of patient (supine, prone, knee-chest, lateral, mother's lap)</i>		
For genital examination:		For anal examination:

6. INVESTIGATIONS DONE

Type and location	Examined/sent to lab	Result

7. EVIDENCE TAKEN

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

8. TREATMENTS PRESCRIBED

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

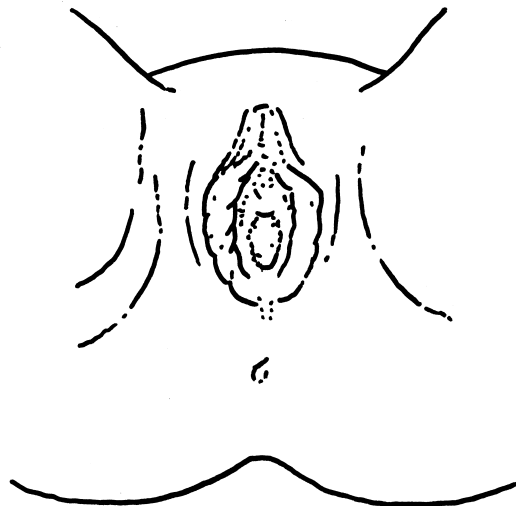
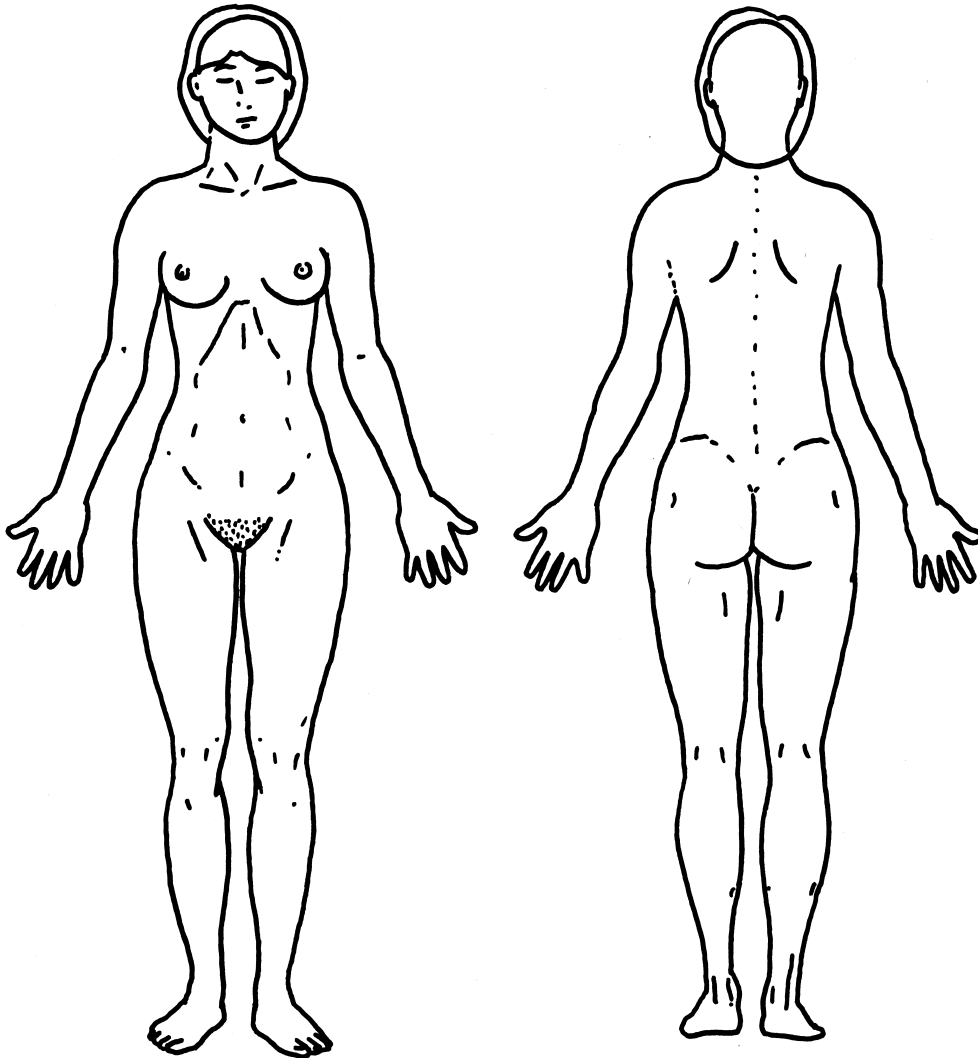
9. COUNSELLING, REFERRALS, FOLLOW-UP

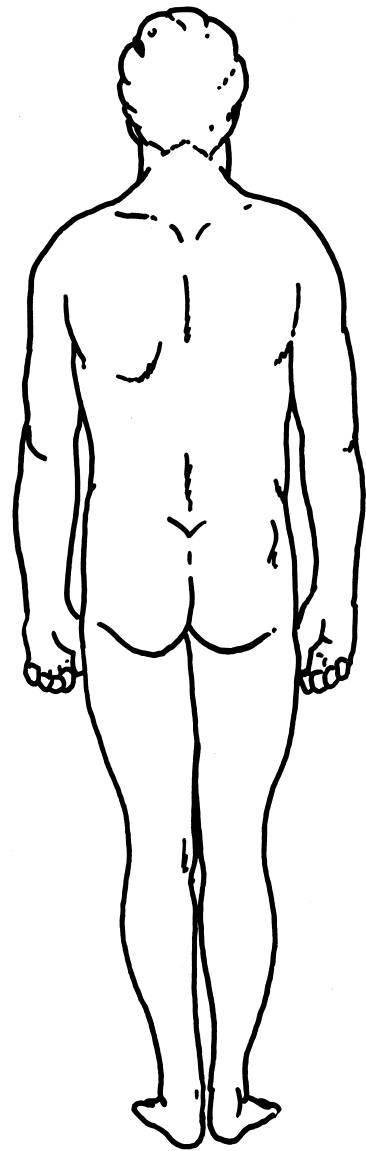
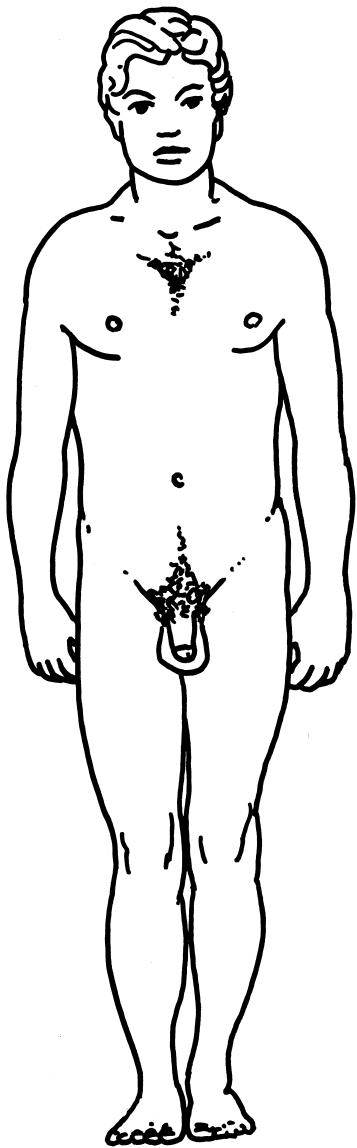
General psychological status	
Survivor plans to report to police OR has already made report Yes <input type="checkbox"/> No <input type="checkbox"/>	
Survivor has a safe place to go Yes <input type="checkbox"/> No <input type="checkbox"/>	Has someone to accompany her/him Yes <input type="checkbox"/> No <input type="checkbox"/>
Counselling provided:	
Referrals	
Follow-up required	
Date of next visit	

Name of health worker conducting examination/interview: _____

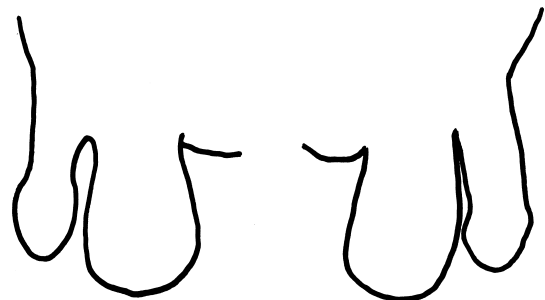
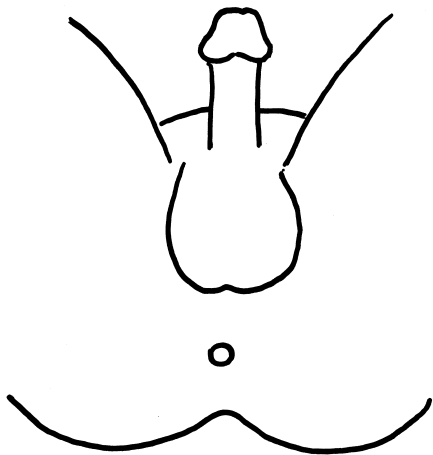
Title: _____ **Signature:** _____ **Date:** _____

Annex 4 • Pictograms



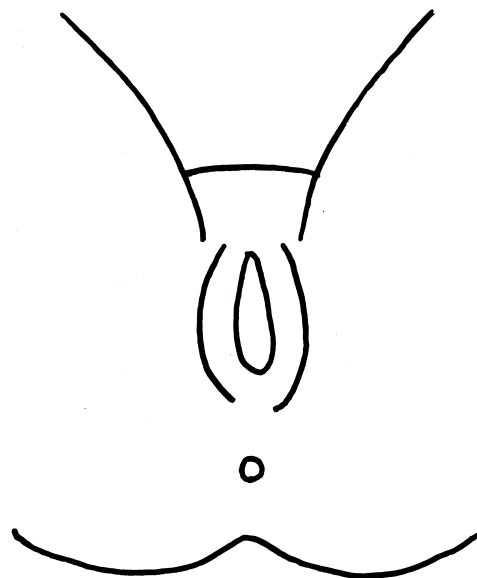
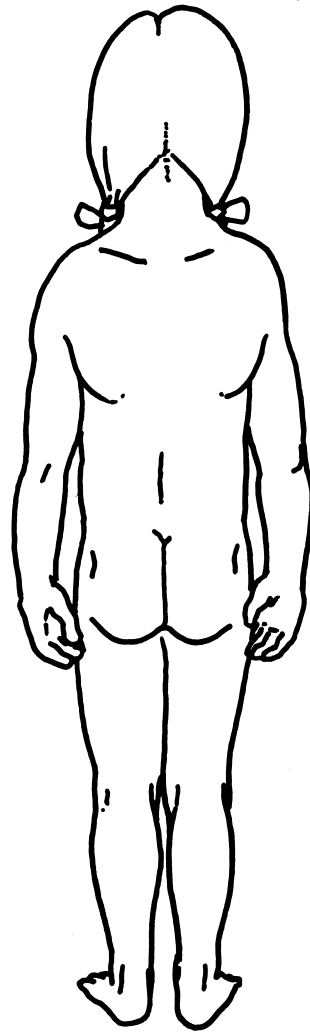
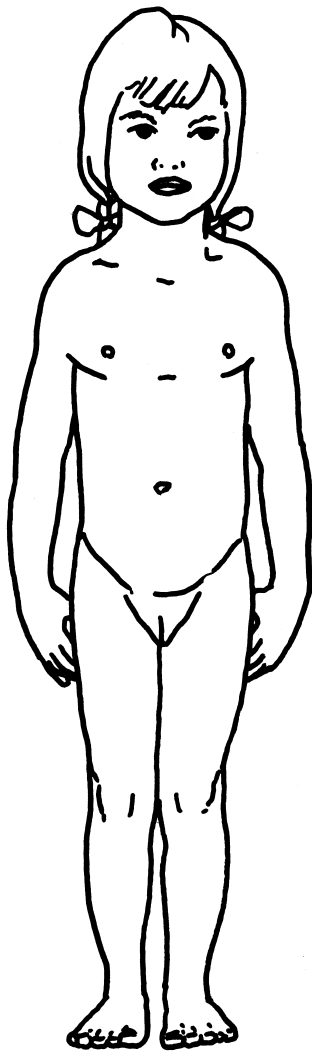


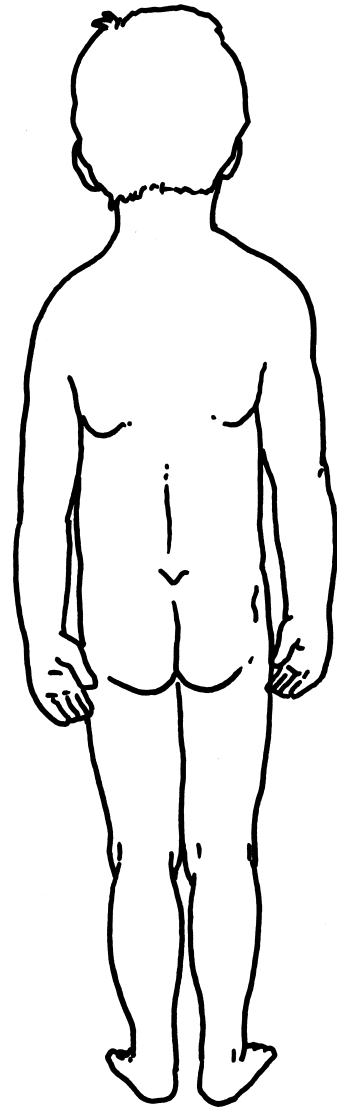
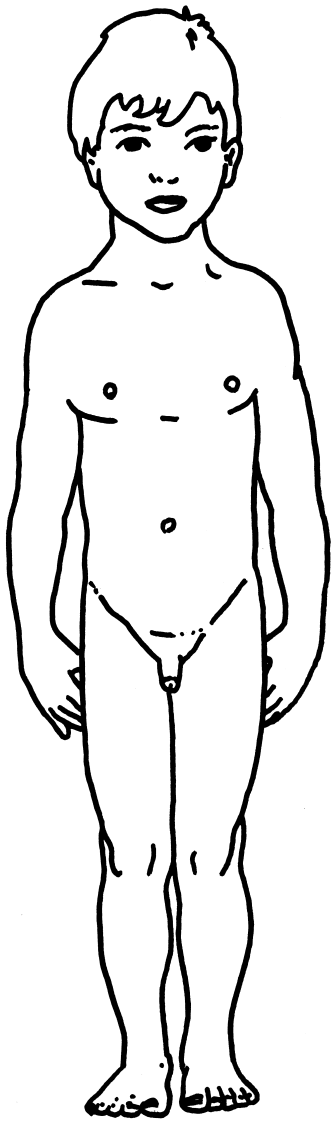
36



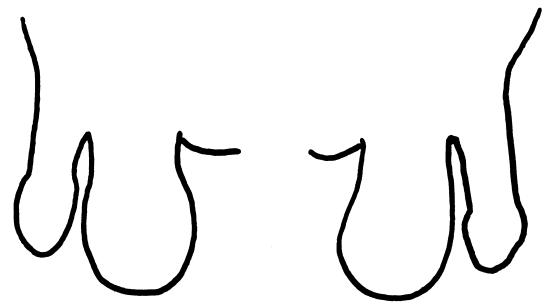
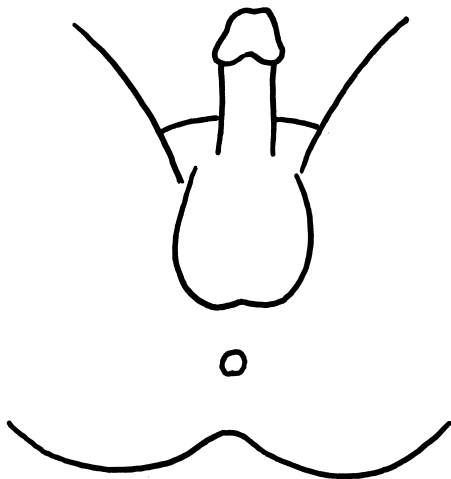
Left

Right





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Left

Right

Annex 5 • Protocols for treatment of STIs

WHO-recommended treatments for adults

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

STI	Treatment	
Gonorrhoea	azithromycin	2 g orally (not recommended in pregnancy) <i>(Note: in this case you do not have to give further treatment for chlamydial infection)</i> or
	ciprofloxacin	500 mg orally, single dose (<i>contraindicated in pregnancy</i>) or
	cefixime	400 mg orally, single dose or
	ceftriaxone	125 mg intramuscularly, single dose
Chlamydial infection	doxycycline	100 mg orally, twice daily for 7 days (<i>contraindicated in pregnancy</i>) or
	azithromycin	1 g orally, in a single dose <i>(not recommended in pregnancy)</i>
<i>Chlamydial infection in pregnant woman</i>	erythromycin	500 mg orally, 4 times daily for 7 days or
	amoxicillin	500 mg orally, 3 times daily for 7 days
Syphilis	benzathine benzylpenicillin	2.4 million IU, intramuscularly, once only <i>(give as two injections in separate sites.)</i>
<i>Syphilis, patient allergic to penicillin</i>	doxycycline	100 mg orally twice daily for 15 days (<i>contraindicated in pregnancy</i>) or
	tetracycline	500 mg orally, 4 times daily for 15 days (<i>contraindicated in pregnancy</i>) <i>(Note: both these antibiotics are also active against chlamydia)</i>
<i>Syphilis in pregnant women allergic to penicillin</i>	erythromycin	500 mg orally, 4 times daily for 15 days <i>(Note: this antibiotic is also active against chlamydia)</i>
Trichomonas	metronidazole	2 g orally, in a single dose or as two divided doses at a 12-hour interval <i>(contraindicated in the first trimester of pregnancy)</i>

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

Example

Presumptive treatment for gonorrhoea, syphilis and chlamydial infection for a woman who is not pregnant and not allergic to penicillin

- azithromycin 2g orally + benzathine benzylpenicillin 2.4 million IU intramuscularly,

or

- ciprofloxacin 500 mg orally + benzathine benzylpenicillin 2.4 million IU intramuscularly + doxycycline 100 mg orally, twice daily for 7 days

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

WHO-recommended treatments for children and adolescents

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

STI	Weight or age	Treatment	
Gonorrhoea	< 45 kg	ceftriaxone	125 mg intramuscularly, single dose
		or	
		spectinomycin	40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose
		or (if > 6 months)	
		cefixime	8mg/kg of body weight orally, single dose
	< 45 kg	Treat according to adult protocol	
Chlamydial infection	< 45 kg	erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	≥ 45 kg but < 12 years	erythromycin	500 mg orally, 4 times daily for 7 days
		or	
		azithromycin	1 g orally, single dose
	≥ 12 years	doxycycline	100 mg orally, twice daily for 7 days
		or	
		azithromycin	1 g orally, single dose
		or	
		erythromycin	500 mg orally, 4 times daily for 7 days
Syphilis		benzathine penicillin	50 000 IU/kg IM (up to a maximum of 2.4 million IU), single dose
Syphilis, patient allergic to penicillin		Erythromycin or doxycycline in the dosages recommended for chlamydial infection for 14 days	
Trichomoniasis	< 12 years	metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	≥ 12 years	Treat according to adult protocol	

Based on: *Tailoring clinical management practices to meet the special needs of adolescents: sexually transmitted infections*. Geneva, World Health Organization (document WHO/CAH 2002, WHO/HIV/AIDS 2002.03), in print.

Annex 6 • Protocols for post-exposure prophylaxis of HIV infection

The following are examples of post-exposure prophylaxis (PEP) protocols used in some settings for preventing HIV infection after rape. There may be other examples. These examples do not outline all the care that may be needed. If it is possible in your setting to provide PEP, refer the survivor as soon as possible (within 72 hours) to the relevant centre.

Example 1

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

Treatment regimen (28 days)

Zidovudine (AZT), 300 mg twice a day

- Survivors are given a one-week supply of the drug **and** an appointment to return for reassessment in one week.
- Survivors are seen at one week for evaluation and to obtain the results of their blood tests. They are given the remainder of their 28-day course of zidovudine.
- The next visits are at 6 weeks and 3 months after the rape. HIV testing is performed at both these visits.
- Routine testing, with full blood count and liver enzymes is not recommended for patients on zidovudine. Any blood tests are performed only if indicated by the survivor's clinical condition.

Example 2

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

Treatment regimen (28 days)

Zidovudine, 300 mg twice a day or 200 mg 3 times per day, **and**

lamivudine, 150 mg twice a day

Alternative regimen (28 days)

Didanosine, 200 mg twice a day, **and**

stavudine, 40 mg twice a day

Consider adding:*

nelfinavir, 750 mg three times a day, **or** indinavir, 800 mg three times a day

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

** In the rare case where the assailant is known to be infected with HIV that is resistant to reverse transcriptase inhibitors, it is recommended to add a protease inhibitor, such as nelfinavir or indinavir. An HIV specialist should be consulted to determine the appropriate regimen.*

Note: Nevirapine is **not** recommended for use as post-exposure prophylaxis after rape.¹

1 Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. *Morbidity and mortality weekly report*, 2001, 50(RR-11), Appendix C.

Annex 7 • Protocols for emergency contraception

Emergency contraceptive pills

- There are two emergency contraceptive pill (ECP) regimens that can be used: the levonorgestrel-only regimen (this is the recommended regimen) or the combined estrogen-progesterone regimen (Yuzpe).
- In both regimens, a first dose should be taken as soon as convenient, but not later than 72 hours after the rape, and a second dose 12 hours later. There are products that are specially packaged for emergency contraception, but at present they are registered only in a limited number of countries. If pre-packaged ECPs are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills which are available for family planning purposes (see the table below for guidance).
- Counsel the survivor about how to take the pills, what side-effects may occur, and the effect the pills may have on her next period. ECPs do not prevent pregnancy from sexual acts after treatment. If needed, provide her with condoms for use in the immediate future.
- Make it clear to the survivor that there is a small risk that the pills will not work. Most patients 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 she has not had a period within 21 days after the treatment, she should return to have a pregnancy test or to discuss the options in case of pregnancy.
- Side effects: especially if the Yuzpe regime is used, nausea can occur. If vomiting occurs within 2 hours of taking a dose, repeat the dose.
- Precautions: ECPs will not be effective in the case of a confirmed pregnancy. ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

Regimen	Formulation ^a (per pill)	Common brand names	First dose (number of tablets)	Second dose 12 hours later (number of tablets)
Levonorgestrel only	750 µg	Levonelle-2, NorLevo, Plan B, Postinor, Postinor-2, Vikela	1	1
	30 µg	Microlut, Microval, Norgeston	25	25
	37.5 µg	Ovrette	20	20
Combined	EE 50 µg + LNG 250 µg or EE 50 µg + NG 500	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovrán, Tetragynon/PC-4, Preven, E-Gen-C, Neo-Primovlar 4	2	2
	EE 30 µg + LNG 150 µg or EE 30 µg + NG 300 µg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4	4

^a EE = ethinylestradiol; LNG = levonorgestrel; NG = norgestrel.

(Adapted from: Consortium for Emergency Contraception, *Emergency contraceptive pills, medical and service delivery guidelines*. Seattle, WA, 2000).

Use of an intrauterine device (IUD) as an emergency contraceptive

- If the survivor presents within five days after the rape, insertion of a copper-bearing IUD is an effective method of emergency contraception. It will prevent more than 99% of expected subsequent pregnancies.
- Women should be offered counselling on this service so as to reach an informed decision.
- A skilled provider should counsel the patient and insert the IUD.
- The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Annex 8 • Minimum care for rape survivors in low-resource settings

Checklist of supplies

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

Collecting minimum forensic evidence

Evidence should only be collected and released to the authorities with the survivor's consent (see Step 4).

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

Minimum examination

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

Minimum treatment

Give compassionate and confidential treatment as follows (see Step 6):

- treatment and referral for life threatening complications;
- treatment or preventive treatment for STIs;
- emergency contraception;
- care of wounds;
- supportive counselling;
- referral to social support and psychosocial counselling services.

Annex 9 • Additional resource materials

General information

Sexual assault nurse examiner (SANE) development and operation guide. Washington, DC, United States Department of Justice, Office of Justice Programs, Office for Victims of Crime (<http://www.sane-sart.com/SaneGuide/toc.asp>).

Reproductive health in refugee situations: an inter-agency field manual. Geneva, UNHCR, 1999 (<http://www.who.int/reproductive-health/publications> or <http://www.rhrc.org/fieldtools> or <http://www.unhcr.ch/>).

Basta!: A newsletter from IPPF/WHO on integrating gender-based violence into sexual and reproductive health. International Planned Parenthood Federation (<http://www.ippfwho.org/whatwedo/basta.html>).

- 46 Sexual violence against refugees: guidelines on prevention and response. Geneva, UNHCR, 1995 (<http://www.unhcr.ch/>).

Mental health of refugees. Geneva, World Health Organization, 1996 (<http://www.unhcr.ch/>).

Information on sexually transmitted diseases

Guidelines for the management of sexually transmitted diseases. Geneva, World Health Organization, 2001 (document number WHO/RHR/01.10) (<http://www.who.int/reproductive-health/publications>).

Information on emergency contraception

Emergency contraception: a guide for service delivery. Geneva, World Health Organization, 1998 (document no. WHO/FRH/FPP/98.19) (<http://www.who.int/reproductive-health/publications>).

Information on post-exposure prophylaxis (PEP) of HIV infection

Management of possible sexual, injecting-drug-use, or other nonoccupational exposure to HIV, including considerations related to antiretroviral therapy: Public Health Service Statement. Morbidity and mortality weekly report, 1998, 47(RR17):1-14 (<http://www.cdc.gov/hiv/treatment.htm#prophylaxis>).

PHS report summarises current scientific knowledge on the use of post-exposure antiretroviral therapy for non-occupational exposures. Atlanta, GA, Centers for Disease Control and Prevention, 1998 (<http://www.cdc.gov/hiv/pubs/facts/petfact.htm>).

Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for postexposure prophylaxis. Morbidity and mortality weekly report, 2001, 50(RR-11), Appendix C, 45-52 (<http://www.cdc.gov/hiv/treatment.htm#prophylaxis>).

Detailed information on the abortion policies of countries

Abortion policies: a global review. New York, UN Department of Economic and Social Affairs, Population Division, 2001 (<http://www.un.org/esa/population/publications/abortion/profiles.htm>).