Clinical Management *of Rape Survivors*

Developing protocols for use with refugees and internally displaced persons

Revised edition

Clinical Management *of Rape Survivors*

Developing protocols for use with refugees and internally displaced persons

Revised edition

WHO Library Cataloguing-in-Publication Data

Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons -- Revised ed.

1. Rape 2. Refugees. 3. Survivors 4. Counseling 5.Clinical protocols 6.Guidelines
I.World Health Organization II.UNHCR

ISBN 92 4 159263 X
(NLM classification: WA 790)

© World Health Organization/United Nations High Commissioner for Refugees, 2004

All rights reserved. Publications of the World Health Organization can be obtained from Marketing and Dissemination, World Health Organization, 20 Avenue Appia, 1211 Geneva 27, Switzerland (tel: +41 22 791 2476; fax: +41 22 791 4857; email: bookorders@who.int).
Requests for permission to reproduce or translate WHO publications - whether for sale or for non-commercial distribution - should be addressed to Publications, at the above address (fax: +41 22 791 4806; email: permissions@who.int).

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization/United Nations High Commissioner for Refugees concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization/United Nations High Commissioner for Refugees in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by World Health Organization/United Nations High Commissioner for Refugees to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization/United Nations High Commissioner for Refugees be liable for damages arising from its use.

Printed in Italy

Free-of-charge copies of this document can be obtained from:

UNHCR - Technical Support Section
C.P. 2500, 1202 Geneva, Switzerland
Fax: +41-22-739 7366
E-mail: HQTS00@unhcr.ch
Web site: http://www.unhcr.ch

WHO - Department of Reproductive Health and Research
World Health Organization
20 Avenue Appia
1211 Geneva 27, Switzerland
Fax: +41 22 791 4189/4171
Email: rhrpublications@who.int
Web site:
http://www.who.int/reproductive-health/index.htm

UNFPA - Humanitarian Response Unit
11, Chemin des Anémones
1219 Châtelaine
Geneva, Switzerland
Fax: +41 22 917 8016
Web site:
http://www.unfpa.org/emergencies/

Clinical Management
of Rape Survivors

Contents

Preface v

Acknowledgements vii

Abbreviations and acronyms used in this guide viii

Introduction. 1

STEP 1 – Making preparations to offer medical care to rape survivors 5

STEP 2 – Preparing the survivor for the examination 9

STEP 3 – Taking the history 11

STEP 4 – Collecting forensic evidence. 13

STEP 5 – Performing the physical and genital examination 17

STEP 6 – Prescribing treatment 21

STEP 7 – Counselling the survivor 27

STEP 8 – Follow-up care of the survivor 31

Care for child survivors 32

ANNEX 1 – Additional resource materials 37

ANNEX 2 – Information needed to develop a local protocol 39

ANNEX 3 – Minimum care for rape survivors in low-resource settings 40

ANNEX 4 – Sample consent form 42

ANNEX 5 – Sample history and examination form 44

ANNEX 6 – Pictograms. 48

ANNEX 7 – Forensic evidence collection 52

ANNEX 8 - Medical certificates 55

ANNEX 9 – Protocols for prevention and treatment of STIs 59

ANNEX 10 – Protocols for post-exposure prophylaxis of HIV infection 61

ANNEX 11 – Protocols for emergency contraception 65

Preface

Sexual and gender-based violence, including rape, is a problem throughout the world, occurring in every society, country and region. Refugees and internally displaced people are particularly at risk of this violation of their human rights during every phase of an emergency situation. The systematic use of sexual violence as a method of warfare is well documented and constitutes a grave breach of international humanitarian law.

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 still needed to be done to prevent and respond to sexual and gender-based violence towards refugees. In a conference hosted by the office of the United Nations High Commissioner for Refugees, Geneva, 160 representatives of refugee, nongovernmental, governmental and intergovernmental organizations shared their experiences and lessons learned.

The first version of this document was an outcome of that conference. It 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 revised version, which is the result of collaboration between the International Committee of the Red Cross (Health Unit); the United Nations High Commissioner for Refugees (Technical Support Unit); the United Nations Population Fund (Humanitarian Response Unit); and the World Health Organization (Department of Reproductive Health and Research, Department of Injury and Violence Prevention, and Department of Gender, Women and Health). This version has also been updated to include the most recent technical information on the various aspects of care for people who have been raped.

Acknowledgements

The first edition of this guide was 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, Switzerland.

Special thanks go to all those who participated in the review and field-testing of this document:

Centers for Disease Control and Prevention (CDC), Atlanta, GA, USA;

Center for Health and Gender Equity (CHANGE), Takoma Park, MD, USA;

Département de Médecine Communautaire, Hôpital Cantonal Universitaire de Genève, Geneva, Switzerland;

International Centre for Reproductive Health, Ghent, Belgium;

International Committee of the Red Cross, Women and War Project and Health Unit, Geneva, Switzerland;

International Medical Corps, Los Angeles, CA, USA;

Ipas USA, Chapel Hill, NC, USA;

Médecins Sans Frontières, Belgium, The Netherlands, Spain, Switzerland;

Physicians for Human Rights, Boston, MA, USA;

Reproductive Health Response in Conflict Consortium (American Refugee Committee, CARE, Columbia University's Center for Population and Family Health, International Rescue Committee, Research and Training Institute of John Snow, Inc., Marie Stopes International, Women's Commission for Refugee Women and Children);

United Nations Population Fund, Humanitarian Response Unit, Geneva, Switzerland;

United Nations High Commissioner for Refugees, Technical Support Section, Geneva, Switzerland;

World Health Organization Headquarters Departments of Reproductive Health and Research, of Injury and Violence Prevention, of Gender, Women and Health, with the support of the Departments of

- Health Action in Crisis
- Essential Drugs and Medicines Policy,
- HIV/AIDS,
- Mental Health and Substance Dependence, and
- Immunization, Vaccines and Biologicals;

World Health Organization Regional Office for Africa;

World Health Organization Regional Office for South-East Asia.

A particular note of appreciation goes out to the following individuals who contributed to the finalization of this guide:

Dr Michael Dobson, John Radcliffe Hospital, Oxford, England;

Ms Françoise Duroc, Médecins Sans Frontières, Geneva, Switzerland;

Dr Coco Idenburg, formerly Family Support Clinic, Harare, Zimbabwe;

Dr Lorna J. Martin, Department of Forensic Medicine and Toxicology, Cape Town, South Africa;

Ms Tamara Pollack, UNICEF, New York, NY, USA;

Dr Nirmal Rimal, AMDA PHC Programme Bhutanese Refugees, Jhapa, Nepal;

Ms Pamela Shifman, UNICEF, New York, NY, USA;

Dr Santhan Surawongsin, Nopparat Rajathanee Hospital, Bangkok, Thailand.

Thanks are also due to the nongovernmental organizations and UNHCR staff in the United Republic of Tanzania, especially Marian Schilperoord, who organized the field-testing of this guide.

Abbreviations and acronyms used in this guide

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral
DNA	deoxyribonucleic acid
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
ICRC	International Committee of the Red Cross
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
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	voluntary counselling and testing (for HIV)
WHO	World Health Organization

Introduction

This guide describes best practices in the clinical management of people who have been raped in emergency situations. 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 in emergencies, taking into account available resources, materials, and 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 object. It does not include advice on standard care of wounds or injuries or on psychological counselling, although these may be needed as part of comprehensive care for someone who has been raped. Neither does it give guidance on procedures for referral of survivors to community support, police and legal services. Other reference materials exist that describe this kind of care or give advice on creating referral networks (see Annex 1); this guide is complementary to those materials. Users of the guide are encouraged to consult both UNHCR's *Sexual and gender-based violence against refugees, returnees and internally displaced persons: guidelines for prevention and response* and WHO's *Guidelines for medico-legal care for victims of sexual violence* (see Annex 1).

Note: It is not the responsibility of the health care provider 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 details of the history, the physical examination, and other relevant information, and, with the person's consent, to collect any forensic evidence that might be needed in a subsequent investigation.

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

- documentation of injuries,
- collection of forensic evidence,
- treatment of injuries,
- evaluation for sexually transmitted infections (STIs) and preventive care,
- evaluation for risk of pregnancy and prevention,
- psychosocial support, counselling and follow-up.

How to use this guide

This guide is intended for use by health care professionals who are working in emergency situations (with refugees or internally displaced persons -IDPs), or in other similar settings, and who wish 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 the following (not necessarily in this order):

1. Identify a team of professionals and community members who are involved or should be involved in caring for people who have been raped.
2. Convene meetings with health 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 laws, policies and procedures relating to rape (standard treatment protocols, legal procedures, laws relating to abortion, etc.). See Annex 2 for an example of a checklist for the development of a local protocol.
5. Develop a situation-specific health care protocol, using this guide as a reference document.
6. Train providers to use 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 treatment.
7. Counselling the survivor.
8. Follow-up care of the survivor.

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

Rape is a traumatic experience, both emotionally and physically. Survivors may have been raped by a number of people in a number of different situations; they may have been raped by soldiers, police, friends, boyfriends, husbands, fathers, uncles or other family members; they may have been raped while collecting firewood, using the latrine, in their beds or 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 once or a number of times over a period of months. Survivors may be women or men, girls or boys; but they are most often women and girls, and the perpetrators are most often men.

Survivors may react in any number of ways to such a trauma; whether their trauma reaction is long-lasting or not depends, in part, on how they are treated when they seek help. By seeking medical treatment, survivors are acknowledging that physical and/or emotional damage has occurred. They most likely have 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, by centring this care around the survivor and her needs, and by being aware of the setting-specific circumstances that may affect the care provided.

Center for Health and Gender Equity (CHANGE)

Human rights and medical care for survivors of rape

Rape is a form of sexual violence, a public health problem and a human rights violation. Rape in war is internationally recognized as a war crime and a crime against humanity, but is also characterized as a form of torture and, in certain circumstances, as genocide. All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Governments have a legal obligation to take all appropriate measures to prevent sexual violence and to ensure that quality health services equipped to respond to sexual violence are available and accessible to all.

Health care providers should respect the human rights of people who have been raped.

- **Right to health:** Survivors of rape and other forms of sexual abuse have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the abuse, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way "revictimize" rape survivors.
- **Right to human dignity:** Persons who have been raped should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients' privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.
- **Right to non-discrimination:** Laws, policies, and practices related to access to services should not discriminate against a person who has been raped on any grounds, including race, sex, colour, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.
- **Right to self-determination:** Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment (e.g. emergency contraception and pregnancy termination, if the law allows) are personal ones that can only be made by the survivors herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.
- **Right to information:** Information should be provided to each client in an individualized way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, adoption). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.
- **Right to privacy:** Conditions should be created to ensure privacy for people who have been sexually abused. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment.
- **Right to confidentiality**: All medical and health status information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose

information about the health of the survivor only to people who need to be involved in the medical examination and treatment, or with the express consent of the survivor. In cases where a charge has been laid with the police or other authorities, the relevant information from the examination will need to be conveyed (see Annex 4).

Health care providers, in collaboration with workers in other sectors, may play a role in the broader community, by identifying and advocating for interventions to prevent rape and other forms of sexual violence, and to promote and protect the rights of survivors. Lack of recognition of rape as a health issue, and non-enforcement of legislation against rape, prevent any real progress towards gender equality.

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 health 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 benefit from seeking medical care;
- *where* to go for services;
- that rape survivors should come for care immediately or as soon as possible 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 privacy and confidentiality;
- *when* services are available; this should preferably be 24 hours a day, 7 days a week.

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, accredited 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 legal requirements with regard to reporting?
- What are the national laws regarding management of the possible medical consequences of rape (e.g. emergency contraception, abortion, testing and prevention of human immunodeficiency virus (HIV) infection)?

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 equipment 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? Is emergency contraception available?

- What possibilities are there for referral of the survivor to a secondary health care facility (counselling services, surgery, paediatrics, or gynaecology/obstetrics services)?

Where should care be provided?

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

Who should provide care?

All staff in health facilities dealing with rape survivors, from reception staff to health care professionals, should be sensitized and trained. 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 aspects, on collection and preservation of forensic evidence, and on counselling/psychological support options;
- care should be provided in comprehensive, confidential and non-judgemental 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 the next page 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 and 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 3 for the minimum care that can and should be made available to survivors even in the lowest-resource settings.

Remember: the survivor's autonomy and right to make her own decisions should be respected at all times.

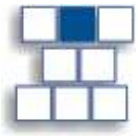
Checklist of needs for clinical management of rape survivors

1 Protocol	Available?
▸ Written medical protocol in language of provider*	
2 Personnel	**Available**
▸ Trained (local) health care professionals (on call 24 hours/day)*	
▸ For female survivors, a female health care 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**
▸ Room (private, quiet, accessible, with access to a toilet or latrine)*	
▸ Examination table*	
▸ Light, 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**
▸ "Rape Kit" for collection of forensic evidence, could include:	
✓ Speculum* (preferably plastic, disposable, only adult sizes)	
✓ Comb for collecting foreign matter in pubic hair	
✓ Syringes/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 needs for clinical management of rape survivors

► Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	
► Resuscitation equipment*	
► 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 contraceptive pills and/or copper-bearing intrauterine device (IUD)*	
► Tetanus toxoid, tetanus immunoglobulin	
► 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 records confidential*	

** 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

A person who has been raped has experienced trauma and may be in an agitated or depressed state. She often feels fear, guilt, shame and anger, or any combination of these. The health worker must prepare her and obtain her informed consent for the examination, and carry out the examination in a compassionate, systematic and complete fashion.

To prepare the survivor for the examination:

- Introduce yourself.
- 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 unless she decides to bring charges (see Annex 4).
- Ask her if she has any questions.
- Ask if she wants to have a specific person present for support. Try to ask her this when she is alone.
- Review the consent form (see Annex 4) with the survivor. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form. 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.
- Do the examination as soon as possible.
- Do not force or pressure the survivor to do anything against her will. Explain that she can refuse steps of the examination at any time as it progresses.

STEP 3 – Taking the history

General guidelines

- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any documents or paperwork brought by the survivor to the health centre.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Let the survivor tell her story the way she wants to.
- Questioning should be done gently and at the survivor's own pace. Avoid questions that suggest blame, such as "what were you doing there alone?"
- Take sufficient time 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 the history-taking.
- Explain what you are going to do at every step.

A sample history and examination form is included in Annex 5. The main elements of the relevant history are described below.

General information

- Name, address, sex, date of birth (or age in years).
- Date and time of the examination and the names and function 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 her 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.
- Survivors may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health worker understands exactly what happened in order to check for possible injuries and to assess the risk of pregnancy and STI or HIV. Explain this to the survivor, and reassure her of confidentiality if she is reluctant to give detailed information. The form in Annex 5 specifies the details needed.

History

- If the incident occurred recently, determine whether the survivor has bathed, urinated, defecated, vomited, used a vaginal douche or changed her clothes since the incident. This may affect what forensic evidence can be collected.
- Information on existing health problems, allergies, use of medication, and vaccination and HIV status will help you to determine the most appropriate treatment to provide, necessary counselling, and follow-up health care.
- Evaluate for possible pregnancy; ask for details of contraceptive use and date of last menstrual period.

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 checklist suggests useful questions to ask the survivor if a pregnancy test is not possible.

Checklist for 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 7 days?	
	4	Have you had a miscarriage or abortion in the past 7 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 ruled out or 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, 1999 (www.sane-sart.com)

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 of a rape survivor is to determine what medical care should be provided. Forensic evidence may also be collected to help the survivor pursue legal redress where this is possible.

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

Important to know before you develop your protocol

Different countries and locations have different legal requirements and different facilities (laboratories, refrigeration, etc.) for performing tests on forensic materials. National and local resources and policies determine if and what evidence should be collected and by whom. Only qualified and trained health workers should collect evidence. **Do not collect evidence that cannot be processed or that will not be used.**

In some countries, the medical examiner may be legally obliged to give an opinion on the physical findings. Find out what the responsibility 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

A forensic examination aims to collect evidence that may help prove or disprove a connection between individuals and/or between individuals and objects or places.

Forensic evidence may be used to support a survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and possibly to identify the attacker. Proper collection and storage of forensic evidence can be key to a survivor's success in pursuing legal redress. Careful consideration should be given to the existing mechanisms of legal redress and the local capacity to analyse specimens when determining whether or not to offer a forensic examination to a survivor. The requirements and capacity of the local criminal justice system and the capacity of local laboratories to analyse evidence should be considered.

Annex 7 provides more detailed information on conducting a forensic examination and on proper sample collection and storage techniques.

Collect evidence as soon as possible after the incident

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.

Whenever possible, forensic evidence should be collected during the medical examination so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic.

Documenting the case

- Record the interview and your findings at the examination in a clear, complete, objective, non-judgemental way.
- It is not the health care provider's responsibility to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- Completely assess and document the physical and emotional state of the survivor.
- Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds (see Table 1). Record your findings on pictograms (see Annex 6). Health workers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible (see Table 1), without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.
- Record precisely, in the survivor's own words, important statements made by her, such as reports of 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.
- Make note of any sample collected as evidence.

Table 1: Describing features of physical injuries

FEATURE	NOTES
Classification	Use accepted terminology wherever possible, i.e. abrasion, contusion, laceration, incised wound, gun shot.
Site	Record the anatomical position of the wound(s).
Size	Measure the dimensions of the wound(s).
Shape	Describe the shape of the wound(s) (e.g. linear, curved, irregular).
Surrounds	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen).
Colour	Observation of colour is particularly relevant when describing bruises.
Course	Comment on the apparent direction of the force applied (e.g. in abrasions).
Contents	Note the presence of any foreign material in the wound (e.g. dirt, glass).
Age	Comment on any evidence of healing. (Note that it is impossible accurately to identify the age of an injury, and great caution is required when commenting on this aspect.)
Borders	The characteristics of the edges of the wound(s) may provide a clue as to the weapon used.
Depth	Give an indication of the depth of the wound(s); this may have to be an estimate.

Adapted from *Guidelines for medico-legal care for victims of sexual violence,* Geneva, WHO, 2003.

Samples that can be collected as evidence

- Injury evidence: physical and/or genital trauma can be proof of force and should be documented (see Table 1) and recorded on pictograms.
- Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g. if replacement clothing is not available) describe its condition.
- Foreign material (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: swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis.
- DNA analysis, where available, can be done on material found on the survivor's body or at the location of the rape, which might be soiled with blood, sperm, saliva or other 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 any foreign DNA found.
- Blood or urine may be collected for toxicology testing (e.g. if the survivor was drugged).

Forensic evidence should be collected during the medical examination and should be stored in a confidential and secure manner. The consent of the survivor must be obtained before evidence is collected.
Work systematically according to the medical examination form (see Annex 5). Explain everything you do and why you are doing it. Evidence should only be released to the authorities if the survivor decides to proceed with a case.

The medical certificate[3]

Medical care of a survivor of rape includes preparing a medical certificate. This is a legal requirement in most countries. It is the responsibility of the health care provider who examines the survivor to make sure such a certificate is completed.

The medical certificate is a confidential medical document that the doctor must hand over to the survivor. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story.

Depending on the setting, the survivor may use the certificate up to 20 years after the event to seek justice or compensation. The health care provider should keep one copy locked away with the survivor's file, in order to be able to certify the authenticity of the document supplied by the survivor before a court, if requested. The survivor has the sole right to decide whether and when to use this document.

3 Adapted from *Medical care for rape survivors*, MSF, December 2002

The medical certificate may be handed over to legal services or to organizations with a protection mandate only with the explicit agreement of the survivor.

See Annex 8 for examples of medical certificates. These should be adapted to each setting in consultation with a legal expert.

A medical certificate must include:

- the name and signature of the examiner;*
- the name of the survivor;*
- the exact date and time of the examination;*
- the survivor's narrative of the rape, in her own words;
- the findings of the clinical examination;
- the nature of the samples taken;
- a conclusion.

* *If the certificate is more than one page, these elements should be included on every page of the document.*

If the certificate is shared with human rights organizations for advocacy purposes, without the consent of the survivor, her name must be removed from every page.

STEP 5 – Performing the physical and genital examination

The primary objective of the physical 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 5).

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 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 include:
  - 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 4).
- Record all your findings and observations as clearly and completely as possible on a standard examination form (see Annex 5).

Part A: Survivor presents within 72 hours of the incident

Physical examination

- Never ask the survivor to undress or uncover completely. 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. Start the examination with vital signs and hands and wrists rather than the head, since this is more reassuring for the survivor. Do not forget to look in the eyes, nose, and mouth (inner aspects of lips, gums and palate, in and behind the ears, and on

the neck. Check for signs of pregnancy. 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 head, or torn eardrums, which may be a result of being slapped (see Table 1 in Step 4). If the survivor reports being throttled, look in the eyes for petechial haemorrhages. Examine the body area that was in contact with the surface on which the rape occurred to see if there are injuries.
- Note all your findings carefully on the examination form and the body figure pictograms (see Annex 6), 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, and semen), fingernail cuttings or scrapings, swabs of bite marks, etc., according to the local evidence collection protocol.

Examination of the genital area, anus and rectum

Even when female genitalia are examined immediately after a rape, there is identifiable damage in less than 50% of cases. Carry out a genital examination as indicated below. **Collect evidence as you go along, according to the local evidence collection protocol** (see Annex 7). Note the location of any tears, abrasions and bruises on the pictogram and the examination form.

- Systematically inspect, in the following order, 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 or childbirth.
  - 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", page 32).
  - 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.
- For the anal examination the patient may have to be in a different position than for the genital examination. Write down her position during each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital 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 bleeding from rectal tears.
  - If indicated by the history, collect samples from the rectum according to the local evidence collection protocol.
- 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", page 32):
  - 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.
- 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. If there is bleeding, pain or suspected presence of a foreign object, refer the patient to a hospital.

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.

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 reduced vaginal lubrication and a thinner and more friable vaginal wall. Use a thin speculum for genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

Special considerations for men

- For the genital examination:
  - Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus and anus.
  - Note if the survivor has been 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 surgical 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.

Laboratory testing

Only the samples mentioned in Step 4 need to be collected for laboratory testing. If indicated by the history or the findings on examination, further samples 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 for possible culture.
- Do a pregnancy test, if indicated and available (see Step 3).
- Other diagnostic tests, such as X-ray and ultrasound examinations, 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:

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

Examination of the genital area

If the assault occurred more than 72 hours but less than a week ago, note any healing injuries to genitalia and/or recent scars.

If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal discharge or ulcers), there is little indication to do a pelvic examination.

Even when one might not expect to find injuries, the survivor might feel that she has been injured. A careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the patient and might be the main reason she is seeking care.

Laboratory screening

Do a pregnancy test, if indicated and available (see Step 3). If laboratory facilities are available, samples may be taken from the vagina and anus for STI screening for treatment purposes. Screening might cover:

- rapid plasma reagin (RPR) test for syphilis or any point-of-care rapid test;
- Gram stain and culture for gonorrhoea;
- culture or enzyme-linked immunosorbent assay (ELISA) for Chlamydia or any point-of-care rapid test;
- wet mount for trichomoniasis;
- HIV test (only on a voluntary basis and after counselling).

STEP 6 – Prescribing treatment

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. Male survivors require the same vaccinations and STI treatment as female survivors.

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 given antibiotics to treat gonorrhoea, chlamydial infection and syphilis (see Annex 9). 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 shortest courses available in the local protocol, which are easy to take. For instance: 400 mg of cefixime plus 1 g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and syphilis.
- Be aware that women who are pregnant should not take certain antibiotics, and modify the treatment accordingly (see Annex 9).
- Examples of WHO-recommended STI treatment regimens are given in Annex 9.
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

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 (PEP) in preventing transmission of HIV after rape. However, on the basis of experience with prophylaxis after occupational exposure and prevention of mother-to-child transmission, it is believed that starting PEP as soon as possible (and, in any case, within 72 hours after the rape) is beneficial. PEP for rape survivors is available in some national health settings and it can be ordered with inter-agency emergency medical kits. Before you start your service, make sure the staff are aware of the indications for PEP and how to counsel survivors on this issue or make a list of names and addresses of providers for referrals.

- PEP should be offered to survivors according to the health care provider's assessment of risk, which should be based on what happened during the attack (i.e. whether there was penetration, the number of attackers, injuries sustained, etc.) and HIV prevalence in the region. Risk of HIV transmission increases in the following cases: if there was more than one assailant; if the survivor has torn or damaged skin; if the assault was an anal assault; if the assailant is known to be HIV-positive or an injecting drug user. **If the HIV status of the assailants is not known, assume they are HIV-positive, particularly in countries with high prevalence.**
- PEP usually consists of 2 or 3 antiretroviral (ARV) drugs given for 28 days (see Annex 10 for examples). There are some problems and issues surrounding the prescription of PEP, including the challenge of counselling the survivor on HIV issues during such a difficult time. If you wish to know more about PEP, see the resource materials listed in Annex 1.
- If it is not possible for the person to receive PEP in your setting, refer her as soon as possible (within 72 hours of the rape) to a service centre where PEP can be supplied. If she presents after 72 hours, provide information on voluntary counselling and testing (VCT) services available in your area.
- PEP can start on the same day as emergency contraception and preventive STI regimens, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Prevent pregnancy

- Taking emergency contraceptive pills (ECPs) within 120 hours (5 days) of unprotected intercourse will reduce the chance of a pregnancy by between 56% and 93%, depending on the regimen and the timing of taking the medication.
- **Progestogen-only pills are the recommended ECP regimen.** They are more effective than the combined estrogen-progestogen regimen and have fewer side-effects (see Annex 11).
- 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 an established pregnancy and thus WHO does not consider them a method of abortion.[4]
- The use of emergency contraception is a personal choice that can only be made by the woman herself. Women should be offered objective counselling on this method so as to reach an informed decision. A health worker who is willing to prescribe ECPs should always be available to prescribe them to rape survivors who wish to use them.
- If the survivor is a child who has reached menarche, discuss 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 for STIs and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

4 *Emergency contraception: a guide for service delivery*. Geneva, World Health Organization, 1998 (WHO/FRH/FPP/98.19).

Provide wound care

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

Prevent tetanus

Good to know before you develop your protocol

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

TT - tetanus toxoid

DTP - triple antigen: diphtheria and tetanus 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 - tetanus immunoglobulin

- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
- Use Table 2 to decide whether to administer tetanus toxoid (which gives active protection) and tetanus 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 different sites of administration.
- Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

Table 2: Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds[5]

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 sexual intercourse. 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 may be given at the same time as tetanus vaccine.

Provide mental health care

- Social and psychological support, including 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, community counsellors, and support groups. At this stage, do not push the survivor to share personal experiences beyond what she wants to share. However, the survivor may benefit from counselling at a later time, and all survivors should be offered a referral to the community focal point for sexual and gender-based violence, if one exists.
- If the survivor has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e. without an organic cause), explain to her that these sensations are common in people who are very scared after having gone through a frightening experience, and that they are not due to disease or injury.[6] The symptoms reflect the strong emotions she is experiencing, and will go away over time as the emotion decreases.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of the symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose may be repeated for a few days with daily assessments.

6 Resnick H, Acierno R, Holmes M, Kilpatrick DG, Jager N. Prevention of post-rape psychopathology: preliminary findings of a controlled acute rape treatment study. *Journal of anxiety disorders,* 1999, 13(4):359-70.

- **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivors.**

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

Sexually transmitted infections

If laboratory screening for STIs reveals an infection, or if the person has symptoms of an STI, follow local protocols for treatment.

HIV transmission

In some settings, testing for HIV can be done as early as six weeks after a rape. Generally, however, 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 between 72 hours (3 days) and 120 hours (5 days) after the rape, taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72 hours, but it is still moderately effective within 120 hours after unprotected intercourse (see Annex 11). There are no data on effectiveness of emergency contraception after 120 hours.
- 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. If an IUD is inserted, make sure to give full STI treatment to prevent infections of the upper genital tract (for recommendations see Annex 9).

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 tetanus immunoglobulin if this is available (see "Prevent tetanus" in Part A).

Hepatitis B

Hepatitis B has an incubation period of 2-3 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, community counsellors, and support groups. All survivors should be offered a referral to the community focal point for sexual and gender-based violence, if one exists.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case, and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose of diazepam may be repeated for a few days with daily assessments.
- **Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivors.**
- Many symptoms will disappear over time without medication, especially during the first few months. However, if the assault occurred less than 2 to 3 months ago and the survivor complains of sustained, severe subjective distress lasting at least 2 weeks, which is not improved by psychological counselling and support (see Step 7), and if she asks repeatedly for more intense treatment and you cannot refer her, consider a trial of imipramine, amitriptyline or similar antidepressant medicine, up to 75-150 mg at bedtime. Start by giving 25 mg and, if needed, work up to higher doses over a week or so until there is a response. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the person gets out of bed in the morning. The duration of the treatment will vary with the medication chosen and the response.
- If the assault occurred more than 2 to 3 months ago and psychological counselling and support (see Step 7) are not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares, or constant fear, and you cannot refer her, consider a trial of antidepressant medication (see the bullet above).

STEP 7 – Counselling the survivor

Survivors seen at a health facility immediately after the rape are likely to be extremely distressed and may not remember advice given at this time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and 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 problems

- Medical care for survivors of rape includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to the community focal point for sexual and gender-based violence, if one exists. A coordinated integrated referral system should be put in place as soon as possible (see Step 1 and the UNHCR guidelines[7]).
- The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, it is a sign that she trusts you. Your compassionate response to her disclosure can have a positive impact on her recovery.
- Provide basic, non-intrusive practical care. Listen but do not force her to talk about the event, and ensure that her basic needs are met. Because it may cause greater psychological problems, do not push survivors to share their personal experiences beyond what they would naturally share.
- Ask the survivor if she has a ***safe place*** to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. Enlist the assistance of the counselling services, community services provider, and law enforcement authorities, including police or security officer as appropriate (see Step 1). If the survivor has dependants to take care of, and is unable to carry out day-to-day activities as a result of her trauma, provisions must also be made for her dependants and their safety.
- Survivors are at increased risk of a range of symptoms, including:
  - feelings of guilt and shame;
  - uncontrollable emotions, such as fear, anger, anxiety;
  - nightmares;
  - suicidal thoughts or attempts;
  - numbness;
  - substance abuse;
  - sexual dysfunction;
  - medically unexplained somatic complaints;
  - social withdrawal.

7 *Sexual and gender-based violence against refugees, returnees and internally displaced persons: guidelines for prevention and response.* Geneva, UNHCR, 2003.

- Tell the survivor that she has experienced a serious physical and emotional event. Advise her about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to experience strong negative emotions or numbness after rape.
- Advise the survivor that she needs emotional support. Encourage her - but **do not force** her - to confide in someone she trusts and to ask for this emotional support, perhaps from a trusted family member or friend. Encourage active participation in family and community activities.
- Involuntary orgasm can occur during rape, which often leaves the survivor feeling guilty. Reassure the survivor that, if this has occurred, it was a physiological reaction and was beyond her control.
- In most cultures, there is a tendency to blame the survivor in cases of rape. If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her 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. Do not make moral judgements of the survivor.

Special considerations for men

- Male survivors of rape are even less likely than women to report the incident, 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.

Pregnancy

- Emergency contraceptive pills cannot prevent pregnancy resulting from sexual acts that take place after the treatment. If the survivor wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her and prescribe this to start on the first day of her next period or refer her to the family planning clinic.
- 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 adoption or foster care services in your area. Find out what services are available and give this information to the survivor.
  - In many countries the law allows termination of a pregnancy resulting from rape. Furthermore, local interpretation of abortion laws in relation to the mental and physical health of the woman may allow termination of the pregnancy if it is the result of rape. 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 where legal, if they so choose.
  - Advise survivors to seek support from someone they trust - perhaps a religious leader, family member, friend or community worker.
- Women who are pregnant at the time of a rape are especially vulnerable physically and psychologically. 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. Their infants may be at higher risk for abandonment so follow-up care is also important.

HIV/STIs

Both men and women may be concerned about the possibility of becoming infected with HIV as a result of rape. While the risk of acquiring HIV through a single sexual exposure is small, these concerns are well founded in settings where HIV and/or STIs prevalence are high. 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.
- The survivor should be advised to use a condom with all partners for a period of 6 months (or until STI/HIV status has been determined).
- 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.

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, where legal, 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 an unwanted pregnancy may undergo an unsafe abortion. 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.

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.

The follow-up visits for survivors who receive post-exposure prophylaxis for HIV and those who do not differ slightly.

Follow-up visits for survivors who do not receive post-exposure prophylaxis

Two-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 3, 6, and 7).
- Check that survivor has taken the full course of any medication given for STIs.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV (see Steps 6 and 7).
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Three-month follow-up visit

- Evaluate for STIs, and treat as appropriate.
- Assess pregnancy status, if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Follow-up visits of survivors who receive post-exposure prophylaxis

One-week follow-up visit

- Evaluate post-exposure prophylaxis (side-effects and adherence).
- If not supplied at the first visit, provide the additional three-week supply of post-exposure prophylactic medication.
- Check that survivor has taken the full course of any medication given for STIs.
- Evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV (see Steps 6 and 7).
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Six-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 3, 6, and 7).
- If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate, and provide advice on voluntary counselling and testing for HIV (see Steps 6 and 7).
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Three-month follow-up visit

- Evaluate for STIs, and treat as appropriate.

- Assess pregnancy status, if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on follow-up voluntary counselling and testing for HIV for those who had a negative test during the first week.
- Offer voluntary counselling and testing for HIV to survivors that were not tested before.
- Evaluate mental and emotional status; refer or treat as needed (see Step 7).

Care for child survivors

Good to know before you develop your protocol

- If it is obligatory to report cases of child[8] abuse in your setting, obtain a sample of the national child abuse management protocol and information on customary police and court procedures. Evaluate each case individually — in some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.
- Find out about specific laws in your setting that determine who can give consent for minors and who can go to court as an expert witness.
- Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that health care staff receive special training in examining children who may have been abused.

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 include:

- 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 a breathing rate of more than 60 breaths/minute.

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

Create a safe environment

- Take special care in determining who is present during the interview and examination (remember that it is

8 The United Nations Convention on the Rights of the Child (1989) defines a child as any individual below the age of eighteen years.

possible that a family member is the perpetrator of the abuse). 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.

- 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 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?"
- Avoid asking leading or suggestive questions.
- Assure the child it is okay to respond to any questions with "I don't know".
- Be patient; go at the child's pace; do not 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.
- For girls, depending on age, ask about menstrual and obstetric history.

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 go to?);
- how the rape/abuse was discovered;
- who did it, and whether he or she is still a threat;
- if this has happened before, how many times and the date of the last incident;
- whether there have been any physical complaints (e.g. bleeding, dysuria, discharge, difficulty walking, etc.);
- whether any siblings are at risk.

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 cannot relax because he or she has **pain**. If this is a possibility, give paracetamol or other simple painkillers, and wait for them 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 in the same order as an examination 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.
- 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.
- Do **not** carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size).
- 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.
- All children, boys and girls, should have an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Do **not** carry out a digital examination to assess anal sphincter tone.

Laboratory testing

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations:[9]

- the child presents with signs or symptoms of STI;
- the suspected offender is known to have an STI or is at high risk of STI;
- there is a high prevalence of STI in the community;
- the child or parent requests testing.

In some settings, screening for gonorrhoea and chlamydia, syphilis and HIV is done for all children who may have been raped. The presence of any one of these infections may be diagnostic of rape (if the infection is not likely to have been acquired perinatally or through blood transfusion).[10] Follow your local protocol.

9 From *Guidelines for the management of sexually transmitted infections,* revised version. Geneva, World Health Organization, 2003 (WHO/RHR/01.10).

10 American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. *Pediatrics*, 1999,103:186-91.

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 physical treatment is vital, the examination may be performed with the child under sedation, using one of the following drugs:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg;

  or

- promethazine hydrochloride, 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 1-2 hours for full effect. In the meantime allow the child to rest in a quiet environment.

Treatment

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

Routine prevention of STIs is not usually recommended for children. However, in low-resource settings with a high prevalence of sexually transmitted infections, presumptive treatment for STIs should be part of the protocol (see Annex 9 for sample regimens).

Recommended dosages for post-exposure prophylaxis to prevent HIV transmission in children are given in Annex 10.

Follow-up

Follow-up care is the same as for adults. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse.

Annex 1 • Additional resource materials

General information

Sexual and gender-based violence against refugees, returnees and internally displaced persons: guidelines for prevention and response. Geneva, UNHCR, 2003 (http://www.unhcr.ch/ or http://www.rhrc.org/resources/gbv/).

Guidelines for medico-legal care for victims of sexual violence. Geneva, WHO, 2003 (http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/).

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, 1999 (www.sane-sart.com).

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/WHR on integrating gender-based violence into sexual and reproductive health published in New-York, from 2000 to 2002, International Planned Parenthood Federation, (http://www.ippfwhr.org/publications/publication_detail_e.asp?PubID=10).

Information on mental health

Mental health of refugees. Geneva, WHO, 1996 (http://whqlibdoc.who.int/hq/1996/a49374.pdf).

Mental health in emergencies: psychological and social aspects of health of populations exposed to extreme stressors. Geneva, WHO, 2003.
(http://www.who.int/mental_health/prevention/mnhemergencies/en/).

Information on sexually transmitted diseases

Guidelines for the management of sexually transmitted diseases, revised version. Geneva, WHO, 2003 (WHO/RHR/01.10) (http://www.who.int/reproductive-health/publications).

Information on emergency contraception

Emergency contraceptive pills: medical and service delivery guidelines, second edition. Washington DC, International Consortium for Emergency Contraception, 2004
(http://www.cecinfo.org).

Selected practice recommendations for contraceptive use, second edition. Geneva, WHO, 2004 (http://www.who.int/reproductive-health/family_planning/index.html).

Information on post-exposure prophylaxis of HIV infection

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 post exposure prophylaxis. *Morbidity and mortality weekly report,* 2001, 50(RR-11), Appendix C, 45-52 (http://www.cdc.gov/hiv/treatment.htm#prophylaxis).

HIV post-exposure prophylaxis following non-occupational exposure including sexual assault, updated July 2004. New York, State Department of Health AIDS Institute (http://hivguidelines.org/public_html/center/clinical-guidelines/pep_guidelines/pep_guidelines.htm).

Detailed information on the abortion policies of countries

Abortion policies: a global review. New York, UN Department of Economic and Social Affairs, Population Division, 2002 (http://www.un.org/esa/population/publications/abortion).

Safe abortion: technical and policy guidance for health systems. Geneva, WHO, 2003 (http://www.who.int/reproductive-health/publications/safe_abortion/safe_abortion.html).

Information on protection

IASC Task Force. Activities of the Inter-Agency Standing Committee Task Force on Protection from Sexual Exploitation and Abuse. June 2004 (http://ochaonline.un.org/webpage.asp?Page=1139).

Information on rights

Convention on the Rights of the Child. New York, United Nations, 1989 (http://www.unhchr.ch/html/menu2/6/crc/treaties/crc.htm).

Convention on the Elimination of All Forms of Discrimination against Women. New York, United Nations, 1979 (http://www.un.org/womenwatch/daw/cedaw/cedaw.htm).

Annex 2 • 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
Medical laws and legal procedures	
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
Forensic evidence	
Which medical practitioner can give medical evidence in court (e.g. doctor, nurse, other)	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
Medical protocols	
National STI protocol	Ministry of Health
Vaccine availability and vaccination schedules	Ministry of Health
Location of voluntary HIV counselling and testing services	National AIDS Control Programme, Ministry of Health
Confirmatory HIV testing strategy and laboratory services	UNHCR, National AIDS Control Programme, Ministry of Health, Regional Medical Officer
Possibilities/protocols/referral for post-exposure prophylaxis of HIV infection	National AIDS Control Programme, Ministry of Health
Clinical referral possibilities (e.g. psychiatry, surgery, paediatrics, gynaecology/obstetrics)	Referral hospital at regional level

Annex 3 • 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	
✓ Set of replacement clothes	
✓ Tape measure for measuring the size of bruises, lacerations, etc.	
► Supplies for universal precautions	
► Resuscitation equipment for anaphylactic reactions	
► Sterile medical instruments (kit) for repair of tears, and suture material	
► Needles, syringes	
► Gown, cloth, or 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 4 • Sample consent form

Notes on completing the consent form

Consent for an examination is a central issue in medico-legal practice. Consent is often called "informed consent" because it is expected that the patient (or his/her parent(s) or guardian) will receive information on all the relevant issues, to help the patient make a decision about what is best for her/him at the time.

It is important to make sure that the patient understands that her consent or lack of consent to any aspect of the exam will not affect her access to treatment and care.

The health care provider must provide information in a language that is readily understood by the patient or his/her parent/guardian to ensure that he/she understands:

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.
- What the physical examination will involve.
- What the pelvic examination will involve.
- That the physical examination, including pelvic examination, will be conducted in privacy and in a dignified manner.
- That during part of the physical exam, the patient will lie on an examination couch.
- That the health care provider will need to touch her for the physical and pelvic examinations.
- That a genito-anal examination will require the patient to lie in a position where her genitals can be adequately seen with the correct lighting.
- That specimen collection (where needed) involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva. That clothing may be collected. And that not all of the results of the forensic analysis may be made available to the patient and why.
- That she can refuse any aspect of the examination she does not wish to undergo.
- That she will be asked to sign a form which indicates that she has been provided with the information and which documents what procedures she has agreed to.

Inform the patient that if, and only if, she decides to pursue legal action, the information told to the health worker during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice with her consent.

Sample consent form

Name of facility -

Note to the health worker:

After providing the relevant information to the patient as explained on page 42 (notes on completing the consent form), read the entire form to the patient (or his/her parent/guardian), explaining that she can choose to refuse 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
Conduct a medical examination	☐	☐
Conduct pelvic examination	☐	☐
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided.	☐	☐

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

Signature: -

Date: -

Witness: -

Annex 5 • Sample history and examination form

CONFIDENTIAL CODE:

Medical History and Examination Form – Sexual Violence

1. GENERAL INFORMATION

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

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

2. THE INCIDENT

Date of incident:	**Time of incident:**
Description of incident (survivor's description)	

Physical violence	**Yes**	**No**	**Describe type and location on body**
Type (beating, biting, pulling hair, etc.)			
Use of restraints			
Use of weapon(s)			
Drugs/alcohol involved			

Penetration	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal, type of object)**
Penis				
Finger				
Other (describe)				

	Yes	**No**	**Not sure**	**Location (oral, vaginal, anal, other)**
Ejaculation				
Condom used				

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

3. MEDICAL HISTORY

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

Contraception use					
Pill		IUD		Sterilisation	
Injectable		Condom		Other	

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

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

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

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				

HIV/AIDS status	Known	Unknown

4. MEDICAL EXAMINATION

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

Physical findings

Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae, marks, etc. Document type, size, colour, form and other particulars. Be descriptive, do not interpret the findings.

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

5. GENITAL AND ANAL EXAMINATION

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

Position of patient (supine, prone, knee-chest, lateral, mother's lap)

For genital examination:	For anal examination:

6. INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result

7. EVIDENCE TAKEN

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

8. TREATMENTS PRESCRIBED

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

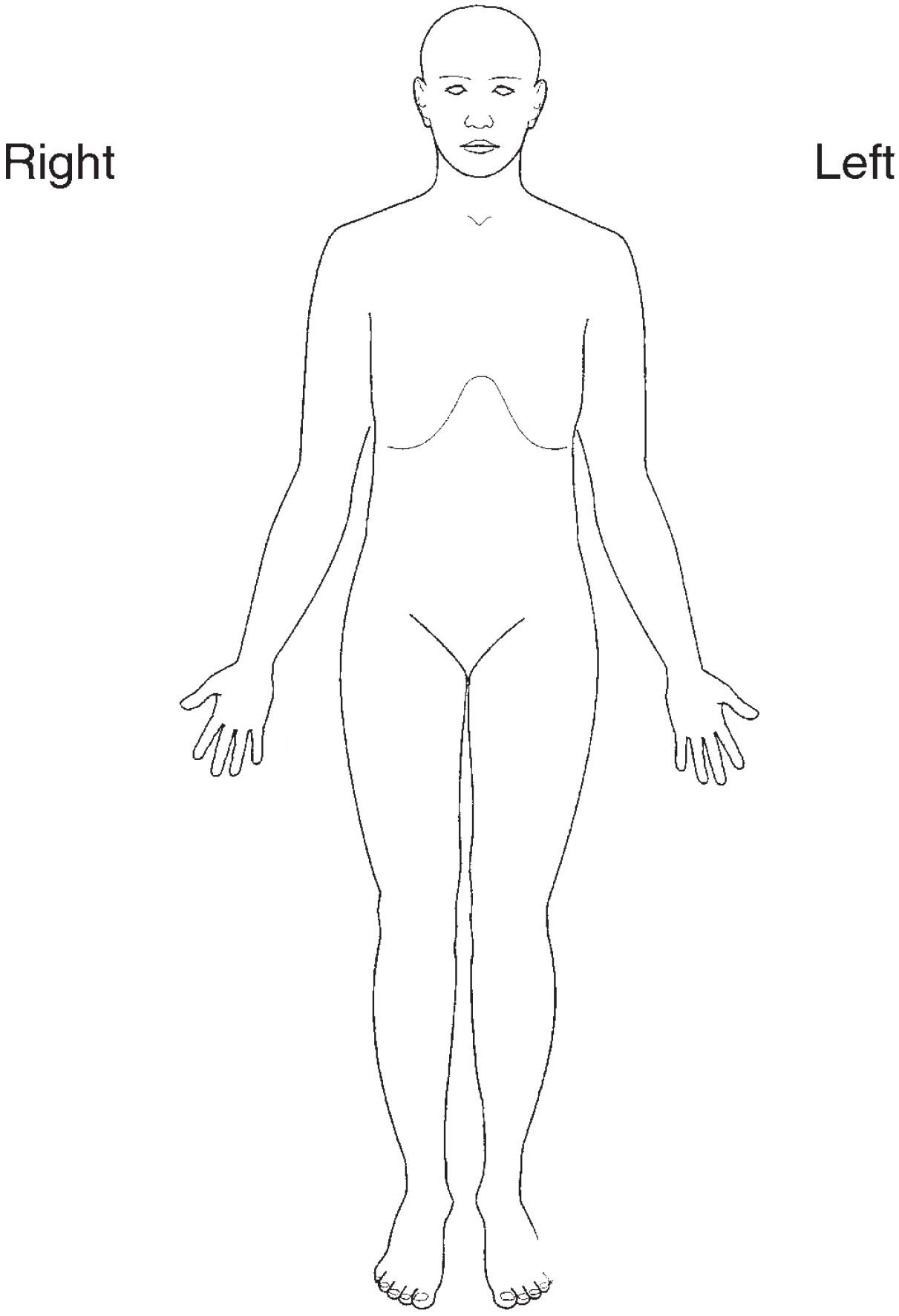
9. COUNSELLING, REFERRALS, FOLLOW-UP

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

Name of health worker conducting examination/interview: _____

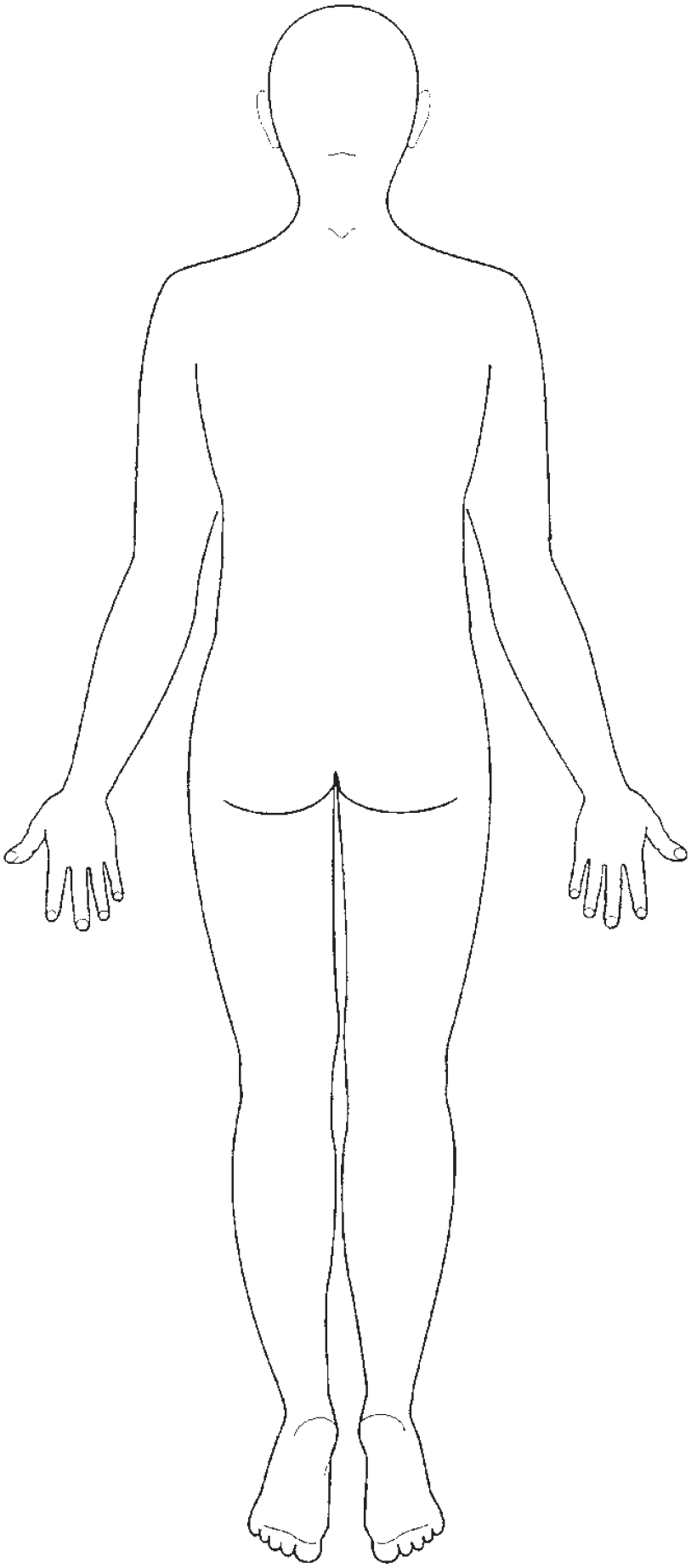
Title: _____ ***Signature:*** _____ ***Date:*** _____

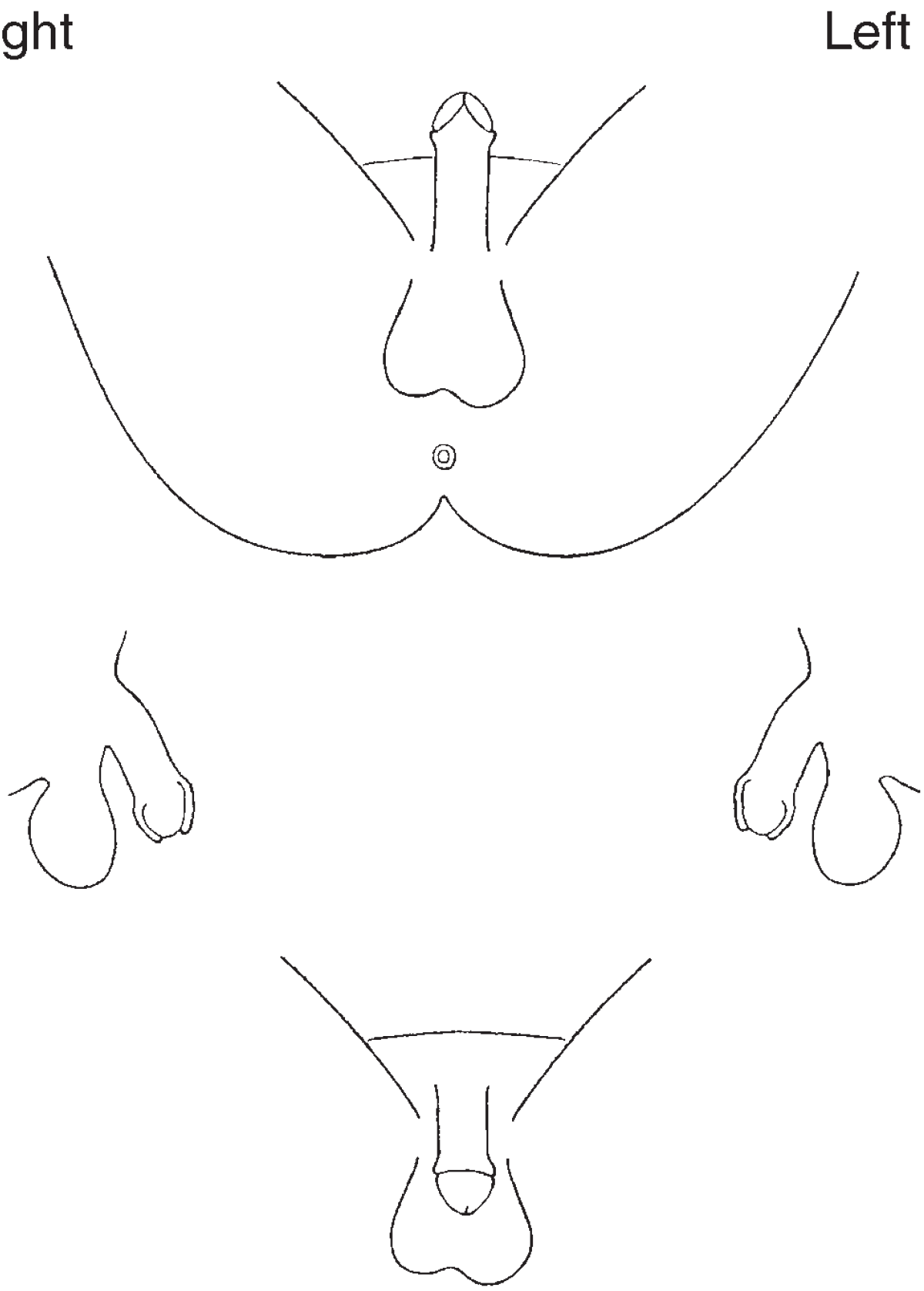
Annex 6 • Pictograms

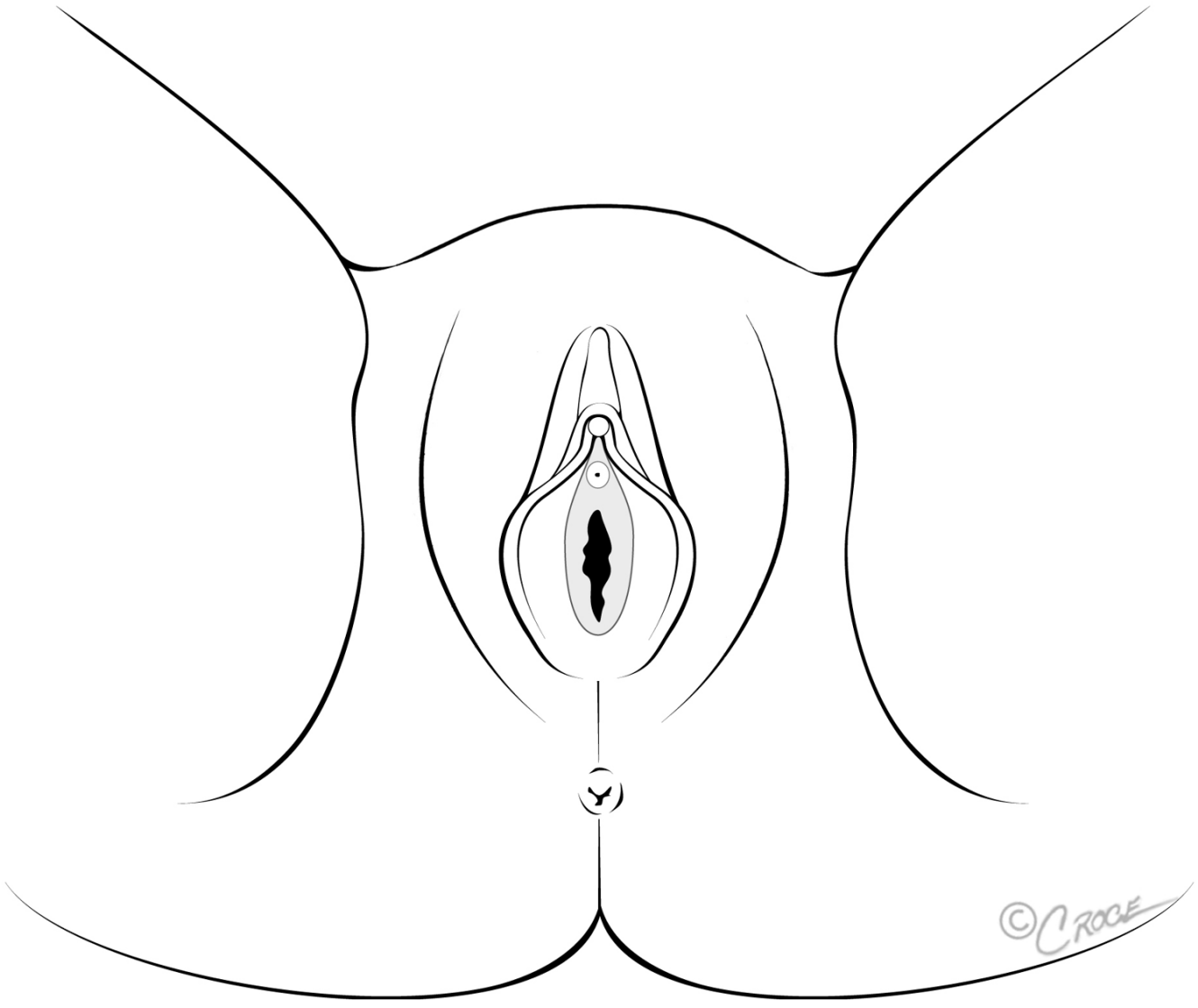


Left

Right




Right
Left


©CROCE

Annex 7 • Forensic evidence collection

As stated on page 13, the capacity of laboratories to analyse forensic evidence differs considerably. This annex describes the different types of forensic evidence that can be collected and outlines procedures for doing so. Health workers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence. Do not collect evidence that cannot be processed.

Inspection of the body

- Examine the survivor's clothing under a good light 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 in as much detail as possible (see Step 4).
- 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 sterile cotton-tipped swab, lightly moistened with sterile water if the skin is dry.
- 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. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.
- Take blood and/or urine for toxicology testing if indicated (e.g. if the survivor was drugged) .

Inspection of the anus, perineum and vulva

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

Examination of the vagina and rectum

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

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis).
- Using a cotton-tipped swab, collect fluid from the posterior fornix for 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.
- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina for acid phosphatase analysis.
- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

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 keep track of the location of the evidence.

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

- All clothing, cloths, swabs, gauze and other objects to be 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 be released to the authorities only if the survivor decides to proceed with a legal case.

The survivor may consent to have evidence collected but not to have it released to the authorities at the time of the examination. In this case, advise her that the evidence will be kept in a secure locked space in the health centre for one month and then 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:[11]

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.

11 Brown WA. Obstacles to women accessing forensic medical exams in cases of sexual violence. Unpublished background paper for the WHO Consultation on the Health Sector Response to Sexual Violence, Geneva, June 2001.

Conduct yourself professionally and confidently in the courtroom:

- Dress appropriately.
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whoever you are speaking to.
- Use precise medical terminology.
- 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.

Annex 8 • Medical certificates

MEDICAL CERTIFICATE for a child

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

title: (Indicate the function) -

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

certify having examined at the request of: -

(name of father, mother, legal representative)

child: (NAME, first name) -

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

address: (exact address of the parents or place of residence of the child)

- -

- -

During the meeting, the child told me: (repeat the child's own words as closely as possible)

During the meeting, (name of the person accompanying the child) **stated:**

This child presents the following signs:

General examination: (child's behaviour: prostrate, excited, calm, fearful, mute, crying, etc.)

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

During the genital examination: (signs of recent or previous defloration, bruises, tears, etc.)

During the anal examination:

Other examinations carried out and samples taken:

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

Certificate prepared on this day and handed over to (Name, first name of father, mother, legal representative) **as proof of evidence.**

Signature of the clinician

MEDICAL CERTIFICATE for an adult

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

title: (Indicate the function) -

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

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

- -

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

address: (exact address of the person examined)

- -

- -

She/He declared that she/he was the victim of a sexual attack on: (time, day, month, year) - - - - - -

- -

at: (place)- -

by: (known or unknown person) -

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

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

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

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

Anal examination:

Other examinations carried out and samples taken:

Evaluation of the risk of pregnancy:

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

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

Signature of the clinician

Annex 9 • Protocols for prevention and treatment of STIs

Based on WHO-recommended STI treatments for adults (may also be used for prophylaxis)

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	**ciprofloxacin**	500 mg orally, single dose *(contraindicated in pregnancy)*
		or
	cefixime	400 mg orally, single dose
		or
	ceftriaxone	125 mg intramuscularly, single dose
Chlamydial infection	**azithromycin**	1 g orally, in a single dose *(not recommended in pregnancy)*
		or
	doxycycline	100 mg orally, twice daily for 7 days *(contraindicated in pregnancy)*
Chlamydial infection in pregnant woman	**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 *(give as two injections in separate sites)*
Syphilis, patient allergic to penicillin	**doxycycline**	100 mg orally, twice daily for 14 days *(contraindicated in pregnancy)* *(Note: this antibiotic is also active against chlamydia)*
Syphilis in pregnant women allergic to penicillin	**erythromycin**	500 mg orally, 4 times daily for 14 days *(Note: this antibiotic is also active against chlamydia)*
Trichomoniasis	**metronidazole**	2 g orally, in a single dose or as two divided doses at a 12-hour interval *(contraindicated in the first trimester of pregnancy)*

***Note: benzathine benzylpenicillin** may be omitted if the prophylactic treatment regimen includes **azithromycin** 1 g orally, in a single dose, which is effective against incubating syphilis.*

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:

- cefixime 400 mg orally + azithromycin 1 g orally, single dose
  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 STI treatments for children and adolescents (may also be used for presumptive treatment)

Note: *These are examples of presumptive 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	8 mg/kg of body weight orally, single dose
	≥ 45 kg		Treat according to adult protocol
Chlamydial infection	< 45 kg	**azithromycin**	20 mg/kg orally, single dose
			or
		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		Treat according to adult protocol
Syphilis		* **benzathine benzyl penicillin**	50 000 IU/kg intramuscularly (up to a maximum of 2.4 million IU), single dose
Syphilis, patient allergic to penicillin		**Erythromycin**	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, 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

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

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

Annex 10 • Protocols for post-exposure prophylaxis of HIV infection

The following are examples of post-exposure prophylaxis (PEP) protocols used for preventing HIV infection after rape. These examples do not outline all the care that may be needed. If it is not possible in your programme to provide PEP, refer the survivor as soon as possible (within 72 hours) to a clinic where this service can be provided.

Good to know before you start

In settings where ARV drugs are widely available for treatment of AIDS, it is more likely that HIV virus will be resistant to one of these drugs. In this case you need to use three drugs in your PEP protocol. Find out if ARV drugs are widely available and which drugs are used to treat AIDS patients. Also find out if there is a national PEP protocol and use this in your service.

There are currently no conclusive data on the effectiveness of post-exposure prophylaxis (PEP) in preventing transmission of HIV after rape. However, based on experience with PEP for occupational exposure and mother-to-child transmission, experts believe that starting PEP as soon as possible (but only within 48-72 hours after the rape) is beneficial. PEP for rape survivors is available in some national health settings. Before you start your service, make sure staff is aware of the indications for PEP and how to counsel survivors on this issue or make a list of names and addresses of providers for referrals. WHO does not yet have an official policy or specific recommendations on PEP regimens. Expert opinion on the best regimens to use in different settings is divided. A consultation will be convened by WHO in 2005 to recommend appropriate regimens.

Post-exposure prophylaxis using two antiretroviral drugs

- Use this regimen in settings where triple-ARV AIDS treatment is not widely available.
- This preventive treatment consists of two ARV drugs, to be taken twice a day for 28 days. The drugs are zidovudine (ZDV or AZT) and lamivudine (3TC). These drugs are available combined in one tablet called Combivir.
- Gastrointestinal side-effects may occur in up to 50% of people taking ZDV/3TC, but they are relatively minor. Appropriate counselling will help people take the full treatment. There are no contraindications to starting PEP on the same day as emergency contraception and STI prophylaxis, although the doses should be spread out, and if possible taken with food, to reduce side-effects, such as nausea.
- All survivors should be offered voluntary counselling and HIV testing. HIV testing is not mandatory. Survivors who cannot or do not want to undergo HIV testing and who are not already known to be HIV -positive, should be offered PEP if indicated. A short PEP treatment is not expected to do harm in someone of unknown HIV status who is actually HIV-positive. **Administration of PEP must never be made conditional on the person agreeing to have an HIV test.**
- Survivors who are known or found to be HIV-positive should not be offered PEP. While it is not likely to do harm, there is no expected benefit. Such people should be appropriately counselled and referred to special programmes for people living with HIV/AIDS (PLHA), such as home-based care, supplementary feeding, and treatment of opportunistic infections.

- Counselling for HIV testing may be particularly difficult with a person who has just gone through the ordeal of sexual assault. The survivor may not be ready for the additional stress of HIV-testing and receiving the result. If the survivor does not want to be tested immediately, PEP can be initiated and HIV-testing can be addressed again at the one-week follow-up visit.
- Pregnancy is not a contraindication to PEP, and it should be prescribed to pregnant women in the same manner as to non-pregnant women. Women who are less than 12 weeks pregnant should be informed that the possible effects of the drug on the fetus are not known. (Ensure that pregnant women are referred for appropriate antenatal care.)
- The following points should be covered when counselling the survivor on PEP:
  - The level of risk of HIV transmission during rape is not exactly known, but the risk exists, particularly in settings where HIV prevalence is high.
  - It is preferable to know the survivor's HIV status prior to starting antiretrovirals, so the best possible recommendation can be made for her.
  - The survivor is free to choose whether or not to have immediate HIV-testing. If she prefers, the decision can be delayed until the one-week follow-up visit.
  - The efficacy of PEP in preventing seroconversion after rape is not known, but there is evidence from research on prevention of mother-to-child transmission and prophylaxis after occupational exposure to indicate that PEP is very likely to be effective in reducing the risk of transmission of HIV after rape.
  - Explain the common side-effects of the drugs, such as feelings of tiredness, nausea and flu-like symptoms. Reassure her that these side-effects are temporary and do not cause long-term harm. Most side-effects can be relieved with ordinary analgesics, such as paracetamol.
  - Provide the survivor with a patient information leaflet, adapted and translated in the local language.
- Routine blood testing, with full blood count and liver enzymes, is not recommended for patients on zidovudine and lamivudine. Blood tests should be performed only if indicated by the survivor's clinical condition.
- Survivors may be given a one-week's supply of PEP at the first visit, with the remainder of the drugs (another 3-weeks' supply) given at the one-week follow-up visit. **For survivors who cannot return for a one-week assessment for logistic or economic reasons, a full supply should be given at the first visit.**

Adolescents > 40 kg and adults, including pregnant and lactating women

Treatment	Prescribe	28 days supply
Combined tablet containing zidovudine (300 mg) and lamivudine (150 mg) **or** zidovudine (ZDV/AZT) 300 mg tablet **plus** lamivudine (3TC) 150 mg tablet	1 tablet twice a day **or** 1 tablet twice a day **plus** 1 tablet twice a day	60 tablets **or** 60 tablets **plus** 60 tablets

Children*

Weight or age	Treatment	Prescribe	28 days supply
< 2 years or 5 – 9 kg	zidovudine (ZDV/AZT) syrup** 10 mg/ml **plus** lamivudine (3TC) syrup** 10 mg/ml	7.5 ml twice a day **plus** 2.5 ml twice a day	= 420 ml (i.e.5 bottles of 100 ml or 3 bottles of 200 ml) **plus** = 140 ml (i.e. 2 bottles of 100 ml or 1bottle of 200 ml)
10 - 19 kg	zidovudine (ZDV/AZT) 100 mg capsule **plus** lamivudine (3TC) 150 mg tablet	1 capsule three times a day **plus** 1/2 tablet twice a day	90 capsules **plus** 30 tablets
20 - 39 kg	zidovudine (ZVD/AZT) 100 mg capsule **plus** lamivudine (3TC) 150 mg tablet	2 capsules twice a day **plus** 1 tablet twice a day	120 capsules **plus** 60 tablets

* From: *Medical care for rape survivor. MSF draft guideline, December 2002.*

*** A bottle of syrup should be discarded 15 days after being opened.*

Post-exposure prophylaxis using three antiretroviral drugs

Some experts recommend a third drug (protease inhibitor) to be added to the PEP protocol of ZDV and 3TC where possible, particularly in settings where there is widespread access to ARVs, to prevent transmission of HIV resistant to one of the drugs. Adherence to the triple regimen may be more difficult than to the two-drug regimen.

One recommended regimen[12] is:

zidovudine (300 mg) and lamivudine (150 mg) combined tablet; one tablet two times per day

plus

indinavir, 800 mg three times per day

Side-effects are common with indinavir. Any of the following may occur: nausea, vomiting, diarrhoea, loss of appetite, stomach pain, headache, rash, kidney stones with blood in the urine, muscle pains, general malaise, fever, jaundice, raised blood sugar and haemolytic anaemia. The patient should drink lots of water (at least 2 litres per day)

Because of the potential side-effects of indinavir, the survivor should be referred to a doctor experienced in HIV treatment. Nelfinavir and lopinavir/ritonavir are also other protease inhibitor options that can be considered.

Note: Nevirapine is **not** recommended for use as post-exposure prophylaxis.[13]

12 *World Health Organization Health and Medical Service. Post Exposure Preventive Treatment Starter Kits.* WHO Geneva, November 2004

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

Annex 11 • Protocols for emergency contraception

Emergency contraceptive pills

- There are two emergency contraceptive pill regimens that can be used:

1 **the levonorgestrel-only regimen:** 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen; it is more effective and has fewer side-effects), or

2 **the combined estrogen-progestogen regimen** (Yuzpe): two doses of 100 micrograms ethinylestradiol plus 0.5 mg of levonorgestrel taken 12 hours apart.

- Treatment with either regimen should be started as soon as possible after the rape because research has shown that efficacy declines with time. Both regimens are effective when used up to 72 hours after the rape, and continue to be moderately effective if started between 72 hours and 120 hours (5 days) after. Longer delays have not been investigated.
- The levonorgestrel-only regimen can be taken as a single dose of 1.5 mg of levonorgestrel as soon as convenient, ideally not later than 120 hours after the rape. With the combined estrogen-progestogen regimen, a first dose should be taken as soon as convenient, but not later than 120 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 (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 that take place after their use. 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. If they work, menstruation will occur around the time she would normally expect it. It may be up to a week early or a few days late. If she has not had a period within a week after it was expected, she should return to have a pregnancy test and/or to discuss the options in case of pregnancy. Explain to her that spotting or slight bleeding is common with the levonorgestrel regimen and that it is nothing to worry about. This should not be confused with a normal menstruation.
- *Side-effects.* The levonorgestrel regimen has been shown to cause significantly less nausea and vomiting than the Yuzpe regimen. If vomiting occurs within 2 hours of taking a dose, repeat the dose. In cases of severe vomiting, ECPs can be administered vaginally.
- *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	Pill composition[a] *(per dose)*	Common brand names	First dose *(number of tablets)*	Second dose 12 hours later *(number of tablets)*
Levonorgestrel only	750 µg	Levonelle, NorLevo, Plan B, Postinor-2, Vikela	2	0
	30 µg	Microlut, Microval, Norgeston	50	0
	37.5 µg	Ovrette	40	0
Combined	EE 50 µg + LNG 250 µg or EE 50 µg + NG 500 µg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, 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,* second edition. Washington, DC, 2004).

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

- If the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle), 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. If an IUD is inserted, make sure to give full STI treatment, as recommended in Annex 9.
- The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

ISBN 92 4 159263 X