



Protocol/Guideline of

# CLINICAL MANAGEMENT OF SEXUAL ASSAULT SURVIVORS

MINISTRY OF HEALTH (MOH) IRAQ | 2016



# **Clinical Management of Sexual Assault Survivors**

Iraq Ministry of Health

## Abbreviations and Acronyms

<b>3ZT</b>	Lamuvudine
<b>AIDS</b>	Acquired Immunodeficiency Syndrome
<b>ARV</b>	Antiretroviral
<b>AZT</b>	Ziduvudine
<b>CMR</b>	Clinical Management of Rape
<b>DNA</b>	deoxyribonucleic acid
<b>DoH</b>	Directorates of Health
<b>DOLSA</b>	Directorates of Labour and Social Affairs
<b>DVAW</b>	Directorate for Combatting Violence against Women
<b>ECP</b>	Emergency Contraceptive Pills
<b>ELISA</b>	Enzyme-linked Immunosorbent Assay
<b>GBV</b>	Gender-based Violence
<b>GP</b>	General Practitioner
<b>HBV</b>	Hepatitis B
<b>HIV</b>	Human Immunodeficiency Virus
<b>HRP</b>	Humanitarian Response Plan
<b>IDPs</b>	Internally Displaced Persons
<b>IPV</b>	Intimate Partner Violence
<b>IRC</b>	International Rescue Committee
<b>IUD</b>	Intrauterine Device
<b>KRG</b>	Kurdistan Regional Governorate
<b>KRI</b>	Kurdistan Region of Iraq
<b>MOH</b>	Ministry of Health
<b>MOLSA</b>	Ministry of Labour and Social Affairs
<b>NGO</b>	Non-Government Organizations
<b>PEP</b>	Post-Exposure Prophylaxis
<b>PHC</b>	Primary Health Care
<b>PHCCs</b>	Primary Health Care Centers
<b>PSS</b>	Psychosocial Support
<b>RPR</b>	Rapid Plasma Reagin
<b>STIs</b>	Sexually Transmitted infections
<b>TOT</b>	Training of Trainers
<b>TT</b>	Tetanus Toxoid
<b>UN</b>	United Nations
<b>UNFPA</b>	United Nations Population Fund
<b>VCT</b>	Voluntary Counseling and Testing
<b>VCTC</b>	Voluntary Counseling and Testing Center
<b>WHO</b>	World Health Organization

## Forward

Iraq is facing a complex, volatile and growing humanitarian crisis, characterized by massive waves of displacement caused by armed conflict. During displacement, women and girls are mostly at risk of gender-based violence (GBV). There is evidence that the current conflict has exacerbated pre-existing GBV concerns, such as domestic violence, child marriage and forced marriage. Furthermore, the use of sexual violence and the brutalization of women and girls, particularly those from diverse religious and ethnic communities, have been well documented and widespread, especially in areas liberated from Daesh control. Even in displacement settings, threats and risks of GBV against women and girls persist, particularly sexual violence, intimate partner violence, sexual exploitation, harassment and child marriage. Sexual violence has caused devastating effects to women and girls, including a serious compromise on their dignity and well-being.

Recognizing the above-mentioned grave concern, there is an urgent need to expand and strengthen life-saving clinical services for sexual violence survivors. The Ministry of Health, in close collaboration with UNFPA, and in consultation with other UN sister agencies (WHO, UNICEF), other Government Ministries, GBV sub-cluster, child protection sub-cluster and health cluster, has developed the Clinical Management of Rape (CMR) protocol.

The CMR protocol aims to standardize CMR services in Iraq and to create an enabling environment for the provision of and access to quality, confidential and comprehensive survivor-centered CMR services. In addition to providing guidance on procedures for delivering post-rape care, the protocol also emphasizes the importance and need of comprehensive services, including mental health and psychosocial support (MHPSS) and legal support, as well as of coordination and follow-up mechanisms.

With the endorsement of the CMR protocol, the Ministry of Health and other relevant Ministries of the Government of Iraq (GoI) are committed to leading the implementation process of the protocol. UNFPA, together with other international and national partners, will continue to provide the required support. Thus, all service providers working in Iraq are hereby requested to familiarize themselves with the content of this protocol and to use its guidelines as an agreed standard for providing high-quality integrated services to survivors of sexual violence.

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# 1.0 INTRODUCTION

## 1.0 Introduction

Iraq is experiencing a double crisis of displacement. Syrian refugees, which currently total over 2,445,527<sup>1</sup> individuals, have fled the armed conflict in Syria and have sought refuge primarily in the Kurdistan Region of Iraq (KRI). Compounding this crisis is the much larger scale internal displacement of Iraqis who have fled the territorial advancements of Daesh Terrorist Group and the subsequent military operations led by government and allied forces to regain that territory<sup>2</sup>. Over 3.4 million people have been displaced since the beginning of 2014.

Gender-based violence (GBV), including sexual violence, is unfortunately an extensive and alarming element of this dual crisis. Most visibly, Daesh is using sexual violence as a tactic of war, primarily targeting women and girls of specific ethnic and religious minority groups. Those living in areas under Daesh control are at risk of rights violations, abduction, sexual slavery, rape, torture and abuse, especially women. Daesh has systematically used sexual violence against women and girls to instill terror in areas under its control and as a means of suppressing or destroying communities that are not in accordance with its doctrines, targeting specific ethnic and religious communities. The identity politics that underlay the current crisis increase the risk of conflict-related sexual violence, possibly including in cases of returns or potential revenge violence. Even in displacement settings, threats and risks of GBV against women and girls persist particularly sexual violence, growing levels of intimate partner violence (IPV), sexual exploitation, harassment and child marriage. Prior to the recent conflict, sexual violence was perpetrated against women and girls. Assessments and surveys<sup>3</sup> indicate that more than one in five (21%) women in Iraq between the ages of 15- 49 years has suffered physical violence by their husband; and one in three (33%) has suffered psychological abuse.

Some reports suggest that almost 50% of married women have been exposed to some form of violence by their spouse<sup>4</sup>. Forty-six percent (46%) of girls aged 10-14 years were exposed to violence at least once by a family member. Forty-six percent (46%) of currently married women were exposed to at least one form of spousal violence; 44.5% to emotional violence, 5.5% to physical violence, and 9.3% to sexual violence. Current GBV service provision is insufficient to meet the needs of survivors with substantive gaps in the

availability of lifesaving health and GBV case management services across Iraq. Even when services are in place, a lack of knowledge on where to access these and limited capacity of service providers hamper help seeking. Limited freedom of movement among women and girls, distance to services and cultural impediments including shame and stigma remain barriers to accessing care.

Given the immediate as well as long-term negative effects of rape and sexual assault on the physical and mental health of survivors, medical response as a life-saving measure is critical. Clinical management of rape (CMR) is a fundamental component of the lifesaving care needed by survivors of sexual violence and one of the most critical responses.

### Progress to Date

Health care for sexual violence survivors is one of the most critical and life-saving responses and yet in Iraq, there is still insufficient services to meet the needs of survivors. Implementation of the national protocol on CMR remains incomplete, requiring trainings, post-rape care supplies, and support provided to health facilities to provide care in a survivor-centred manner.

In 2013, to address gaps in care for sexual violence survivors, UNFPA supported two Ministry of Health (MOH) personnel to attend a regional Training of Trainers (TOT) training on CMR in Jordan, so as to assume the responsibility as in-country trainers on CMR, to increase capacity and ensure health personnel are trained to provide CMR in a confidential, survivor-centred manner. By the mid-2016, a number of MoH health staff were trained on CMR and 11 health facilities are intended to be fully equipped to provide this care, including the provision of Post Rape treatment kits<sup>5</sup> through the collaboration between the Ministry of Health and UNFPA and some Health Directorates.

The Ministry of Health and Kurdistan Regional Governorate (KRG) Directorate for Combatting Violence against Women (DVAW) and federal and KRG Ministry of Labour and Social Affairs (MOLSA) centres, and women centres/safe spaces run by international and national non-government organizations (NGO) provide GBV case management, including counselling and referrals, to survivors. However, there is a need to improve quality of psychosocial services provided by investing more in human resources. Specialized Mental Health and Psychosocial Support (PSS) services are limited and gaps remain in the quality and availability of comprehensive CMR services across Iraq.

<sup>5</sup> See Annex 9 : Contents of Reproductive Health Kit 3 – Sub- Kit 2: Rape Treatment including Post-Exposure Prophylaxis (PEP) and Emergency Contraceptive Pills (ECP) or Levonorgestrel 0.15mg + ethinylestradiol 0.03mg (4 pills up to 120 hours following rape, followed by 4 other pills in 12 hours),

<sup>1</sup> UNHCR Iraq, Inter-Agency Operational Update, 28 November 2015.

<sup>2</sup> GBV Sub-Cluster Strategy for Iraq, 2016.

<sup>3</sup> Working together to address violence against women and girls in Kurdistan, IRC 2012 (WHO/COSIT/KRSO/Ministry of Health Iraq Family Health Survey 2006-2007; Human Rights Watch "at the crossroads – Human Rights in Iraq Eight years after the US-led invasion", 2011, p.21; UNFPA/COSIT/KRSO/Ministry of Youth and Sport Iraq National Youth Survey 2009)

<sup>4</sup> <https://www.gov.uk/government/publications/iraq-country-of-concern/iraq-country-of-concern#womens-rights>; The 2012 I-WISH reported that 46% of married women had been exposed to at least one kind of domestic violence (emotional, physical or sexual).

## Gaps and Challenges

The current humanitarian crisis has placed significant pressure on the health sector and a subsequent focus on emergency response interventions to ongoing and recurrent crises has pushed health services beyond their capacity. Simultaneously, there is an increased demand for health services including CMR due to ongoing waves of displacement and growing levels of sexual violence. According to the Iraq 2016 Humanitarian Needs Overview (HNO), there is still insufficient clinical response for women and girls affected by GBV. Currently, in many locations, CMR services are not accessible for GBV survivors, due to lack of services as well as policy constraints including restrictions on health facilities permitted to provide post-rape care, which is currently only available at selected secondary health facilities in Kurdistan. Implementation of the national protocol on CMR remains incomplete, requiring government endorsement, clarifications on procedures for providing care, trainings, provision of post-rape care supplies, and support provided to health facilities so they are equipped to provide care in a compassionate and competent manner<sup>6</sup>.

The deteriorating humanitarian situation and unprecedented influx of Internally Displaced Persons (IDPs) in Iraq has pushed existing health care provision beyond capacity. In line with the Humanitarian Response Plan (HRP), the Health Cluster is supporting the Ministry of Health (MoH), Directorates of Health (DoH) and health partners to expand health services through mobile medical units (MMU). The Ministry and Directorates of Health remain the primary provider of health services in Iraq, with Health Cluster partners providing front-line health services in targeted geographical areas, including mobile services in hard-to-reach locations and camp-based clinics to bolster existing facilities' capacity to cope with increased demands<sup>7</sup>. These provide life-saving health services including primary health care, emergency reproductive health and nutrition, trauma care, and treatment of mental health and non-communicable diseases. In some locations, Health Cluster non-governmental partners are the only service providers, and it is imperative that they can provide the immediate and lifesaving treatments for sexual violence survivors and at present they are not permitted to do so.

It is recognized that the previous practice of UNFPA providing ad-hoc CMR trainings to health staff conducted by certified trainers in order to preposition CMR capacity within the Government Health Facilities was insufficient. The 2014 conflict resulted in well-documented increases in conflict-related sexual violence and sexual violence more generally across Iraq that stretched the existing capacities of basic service provision, including health services. In this generally constrained environment, medical personnel trained on CMR are too few to offer CMR in all secondary

<sup>6</sup> HNO-Health Cluster 2015

<sup>7</sup> Humanitarian Response Plan, Iraq, June 2015

health facilities in Iraq, and currently CMR is not permitted at primary health centers (PHC). Moreover, there is no systematic follow-up and mentoring of those trained on CMR and this could compromise the quality of CMR services provided to survivors. There is an urgent need to establish a systematic, standardized and well-coordinated mechanisms to provide CMR. This should include clearly defining the roles of various service providers and permitting NGOs to provide CMR, especially but not limited to areas where MoH/DoH presence and capacity is limited (see annex 8) and permitting primary health facilities to provide CMR after being fully equipped.

### 1.1 Goal

This CMR protocol aims to standardize and harmonize CMR services in Iraq taking into consideration the existing services and their capacity, to put in place a system which ensures continuity, sustainability, quality of service delivery, commodity distribution and follow-up, and multi-sectoral coordination under the Ministries of Health, Ministry of Interior and Ministries of Justice, UN agencies, Health Cluster and GBV Sub Clusters and NGOs. This guideline is designed to meet international standards and best practice for CMR service provision to survivors, and is to be used by qualified health care providers who are involved in CMR services for survivors in both emergency and non-emergency settings.

### 1.2 Objectives

The overall objective is to create an enabling environment for the provision of and access to safe, quality, confidential and comprehensive survivor centered CMR services.

### 1.3 Specific objectives

1.3.1 Provide guidance outlining CMR services and procedures for providing post-rape care and treatment in Iraq.

1.3.2 Identify actual services to be provided (including medical, psychosocial/mental health and legal), procedures, coordination and follow-up mechanism, and minimum standards.

1.3.3 Identify human and material resources required for implementation of this protocol.

1.3.4 Provide guidance on the necessary supplies to be appropriately stocked and pre-positioned.

1.3.5 Provide an overall framework for the provision of standardized CMR training and continuous capacity building of health personnel in Iraq.



## 1.4 Methodology for the development of the CMR guidelines

This protocol was developed through the following steps, in wider consultation with all the relevant stakeholders, including the government institutions, GBV Sub cluster, Health Cluster and UN agencies.

- (1) Desk review of the existing documents and literatures:
  - a. Gender-based Violence Sub-cluster Strategy 2016
  - b. UNFPA Reproductive Health Kit Guidelines
  - c. CMR training manuals: IRC/WHO<sup>8</sup>
  - d. Iraq Penal Code Penal Code No. III of 1969
  - e. Criminal Procedures Law No. 23/1971
  - f. Humanitarian Needs Overview (HNO) (protection and Health) 2015
  - g. Humanitarian Response Plan (HRP) 2015 and 2016
  - h. Documentation of Best practices in development of CMR protocols –UNFPA 2016
  - i. Somalia and Egypt CMR protocols
- (2) Provision of the inputs to the protocol contents by the relevant stakeholders, through consultation with stakeholders, including government Ministries, GBV sub-cluster, Child Protection Sub-cluster and Health Cluster
- (3) Inclusion of the comments from review process and finalization of the document
- (4) Validation meetings for this document held with relevant stakeholders

<sup>8</sup> IRC (2009) Clinical Care for Sexual Assault Survivors: A multi Media Training Tool and WHO

## 2.1 Definition of gender based violence (GBV) and related concepts

Gender Based Violence (GBV): Inter-Agency Standing Committee (IASC) defines GBV as “an umbrella term for any harmful act that is perpetrated against a person’s will and that is based on socially ascribed (i.e. gender) differences between males and females”. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

Rape/Attempted Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Any penetration is considered rape. Efforts to rape someone which do not result in penetration are considered attempted rape.

Sexual Violence: Sexual violence includes rape/attempted rape, sexual abuse, and sexual exploitation. Sexual violence is “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work.”

Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion<sup>9</sup>.

### Sexual Assault

Any type of unwanted physical violence or contact that is of sexual nature, including rape.

<sup>9</sup> Caring for Survivors of Sexual Violence in Emergencies, Training Manual, Gender Based Violence AoR, 2011

## **2.0 LAWS AND LEGISLATIONS RELATED TO MEDICAL PRACTICES**

## Child

Any person under the age of 18<sup>10</sup>. The Convention of the Rights of the Child defines a child as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger. The Committee on the Rights of the Child, the monitoring body for the Convention, has encouraged States to review the age of majority if it is set below 18 and to increase the level of protection for all children under 18.

## Child Sexual Abuse

“The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to:

- The inducement or coercion of a child to engage in any unlawful sexual activity,
- The exploitative use of a child in prostitution or other unlawful sexual practices,
- The exploitative use of children in pornographic performances and materials”<sup>11</sup>.

### Child Survivor

A person under the age of 18 years who has experienced GBV.

## Best interests of the child

The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers.

## Survivor/victim

Person who has experienced gender-based violence. The terms “victim” and “survivor” can be used interchangeably. “Victim” is a term often used in the legal and medical sectors. “Survivor” is the term generally preferred in the psychological and social support sectors because it implies resiliency, and this is the term that is used throughout this protocol<sup>12</sup>.

<sup>10</sup>According to the United Nations Convention of the Rights of the Child.

<sup>11</sup> World Health Organization, Social Change and Mental Health, Violence and Injury Prevention, Report of the Consultation on Child Abuse Prevention, pp. 13-17, Geneva, 29-31 March 1999.

<sup>12</sup> Caring for Survivors of Sexual Violence in Emergencies, Training Manual, Gender Based Violence AoR, 2011

## Perpetrator

Person, group, or institution that directly inflicts or otherwise supports violence or other abuse inflicted on another against her/his will.

## 2.2 Iraq Legal framework

### 2.2.1 Constitutional Provision

Although there is no explicit definition of GBV or rape within Iraqi Constitution, it does provide progressive protections of women’s rights in both social and political spheres, including the rights to dignity and equality. It does confirm equality of all Iraqis in legal terms, making no distinction based on race, color, religion, sect or gender<sup>13</sup>.

### 2.2.2 Iraq Penal Code

The Penal Code<sup>14</sup> is progressive on criminalizing sexual assault as follows:-

#### Article 393

- (1) Any person who has sexual intercourse with a female without her consent or commits buggery with any person without their consent is punishable by a term of imprisonment not exceeding 15 years.
- (2) The following are considered to be aggravating circumstances for this offense:
  - (a) If the victim at the time of the act was under 18 years old
  - (b) If the offender was a relative of the victim to the third generation, or if the offender is the guardian, protector, or custodian of the victim or has authority over the victim or the victim is the offender’s servant.
  - (c) If the offender was a public official, religious leader, or doctor and used the power of his position or the trust in him.
  - (d) If the offense is committed by two or more people in order to prevail over the resistance of the victim or if they commit the offense multiple times.
  - (e) If the victim contracts venereal disease as a result of the offense.
  - (f) If the victim loses her virginity or loses her virginity as a result of the offense.
- (3) If the offense leads to the death of the victim, the penalty will be life imprisonment.
- (4) If the victim was a virgin, the court must order that she receive appropriate compensation.

<sup>13</sup> Iraq Constitution Paragraph 1 item 14; 22/1

<sup>14</sup> Penal Code No. 111 of 1969 (as amended to 14 March 2010)

#### Article 394

- (1) Any person who, outside of marriage, has sexual intercourse with a woman with her consent, or commits buggery with a person with their consent, is punishable by a period of imprisonment not exceeding 7 years if the victim is between the ages of 15 and 18. If the victim was under the age of 15, the offender is punishable by a period of imprisonment not exceeding 10 years.
- (2) It will be considered an aggravating circumstance if the act occurred under circumstances described in Paragraph 393.
- (3) If the victim was a virgin, the court must order that she receive appropriate compensation.

Article 395 - Any person who seduces a woman over the age of 18 with a promise of marriage, has sexual intercourse with her and subsequently refuses to marry her is punishable by detention.

#### Article 396

- (1) Any person who sexually assaults a man or woman or attempts to do so without his or her consent and with the use of force, menaces, deception or other means is punishable by a term of imprisonment not exceeding 7 years or by detention.
- (2) The penalty will be a term of imprisonment not exceeding 10 years if the person against whom the offence is committed is under 18 years of age or the offender is a person described in Sub-Article 2 of Article 393.

Article 397 - Any person who sexually assaults a boy or girl under the age of 18 without the use of force, menaces or deception is punishable by detention. The penalty will be a term of imprisonment not exceeding 7 years of detention if the offender is a person described in Sub-Article 2 of Article 393.

### 2.2.3 Mandatory reporting legislation

The Iraqi legislature addressed mandatory reporting of crimes in general in sporadic articles from different legislations. In the Iraqi Penal Code No. 11 from 1969 (Article 246<sup>15</sup>), the origin of reporting crimes by the public to competent authorities is voluntary, providing that the initiated reporting is either authentic or based on the good-will. Otherwise, when the reporting is neither authentic nor based on good-will, the reporter is faced with criminal charges (Article 245<sup>16</sup>). Article 247 from the Iraqi Penal

15 Article 245 - Any person who is obliged by law to notify a public agent in his official capacity of a certain matter but informs him of matters that he knows to be false or who notifies a public agent in his official capacity of a certain matter that he knows to be false with intent to compel such agent to carry out an act that is contrary to his official duties if such agent is aware of the truth of the matter is punishable by a period of detention not exceeding 1 year plus a fine not exceeding 100 dinars or by one of those penalties.

16 Article 246 - There is no offence if a person notifies in all sincer-

code stipulates that “ - Any person who is obliged by law to notify a public agent of a matter or matters known to him and who willfully refrains from doing so in the prescribed manner or at the time stipulated by law is punishable by detention or a fine. The same penalty applies to any public agent in charge of the investigation or prevention of an offence who neglects to report an offence that is brought to his attention.

This is unless an action is brought as a result of a complaint or the offender is the spouse, ancestor, descendant, brother or sister of that public agent or his spouse’s ancestor, descendant, brother or sister or any relative by marriage of such persons”.

The Criminal Procedures Code 23 of 1971<sup>17</sup> (as amended on 14 March 2009), in Article 48 stipulates that Any public servant who, in the course of performing his duties or as a consequence of performing his duties, learns that an offence has been committed or suspects that an offence has been committed in respect of which proceedings have been instituted without a complaint, and any person who has given assistance in his capacity as a member of the medical profession in a case where there are grounds for suspecting that an offence may have been committed as well as any person who is present when a felony is committed must immediately inform one of the persons specified in Article 47.”

In KRI, the Law on Combating Domestic Violence no. 8/2011, Article 3, Clause 2, stipulated that “workers in the domains of healthcare, education and official sectors shall have the right to report cases to help victims of domestic violence”<sup>18</sup>.

ity or without malice a legal or administrative authority of a matter deserving of punishment.

17 CRIMINAL PROCEDURE CODE 23 OF 1971 (AS AMENDED TO 14 MARCH 2010)

18 There is a discrepancy between the Kurdish version and the Arabic version of law; in the Arabic version the reporting by these identified parties is voluntary since the text of the provision would be translated as “shall have the right”.



### 2.2.3.1 Mandatory Procedures for sexual violence

The absence of specific legislation and procedures to guide responses for sexual violence survivors can have implications on survivors' timely and confidential access to CMR services. For purposes of this protocol, the medical response services to survivors should be immediate and unconditional to any mandatory reporting policies or procedures that constitute an impediment to access to these services. Additionally, the decision by the survivor to refrain from taking legal action should not have negative repercussions for survivor's access to health services. The provision of lifesaving, timely and confidential health care to a survivor is the first priority.

### 2.2.3.2 Proposed Procedure to ensure access to CMR services within this context

This CMR protocol recognizes that mandatory reporting practices and/or procedures can impede survivors access to lifesaving health services regardless of whether the survivors decide to take legal action on their case or not, and whether medical service providers need to report the case to the police or not. Within this CMR protocol, the following procedures and practices will be applied in order to ensure that lifesaving health care for survivors is prioritized and adhere to survivor centered principles.

1- Survivors of sexual violence, including survivors of rape, regardless of whether they decide to pursue legal action or

not must be provided with immediate medical responses: including medical examination offered, medications administered to them to prevent infections and unwanted pregnancy and consent based referrals to other specialized hospital departments, including for forensic examination (if requested), all according to the survivors' wishes, decisions and consent.

- 2- Survivors of sexual violence should not be prevented from accessing health care because of not consenting to reporting to the police. The provision of adequate and timely health care to a survivor is the first PRIORITY.
- 3- Qualified and CMR trained medical staff can provide a primary medical report filled in by the clinician attending the survivor and kept confidentially in a safe place.
- 4- All medical staff providing care to survivors must provide services and referrals based on the informed consent from the survivor, confidentiality, safety, non-discrimination and respect that adheres to survivor-centred care. The needs, wishes and best interest of the survivor take precedence over any mandatory reporting to authorities.
- 5- Medical staff should adhere to GBV guiding principles for providing survivor centred care when performing further physical examinations, collecting forensic evidence, providing a medical certificate, informing the survivor of other services (such as counselling) and providing



referrals. If available, women community health officers' accompaniment should be offered to the survivor for referrals to other services.

6- If the survivor chooses to take a legal action, the medical certificate can be used to fill information into other required legal forms on request after appropriate medical services have been provided.

7- Sexual violence survivors should be offered follow-up health and psychological care regardless of whether or not they decide to pursue legal action. All procedural and legal frameworks remain secondary to providing safe, confidential lifesaving health care for survivors of sexual violence.



# **3.0 GUIDING PRINCIPLES FOR CLINICAL MANAGEMENT OF RAPE**

### 3.1 How to use this protocol

This protocol is intended for use by the Iraqi health care professionals especially for those who are working in emergency situations (with refugees or IDPs) and is also to be used in non-emergency settings to standardize CMR services. In order to do this, the following actions are recommended to be taken

1. Coordinate with the Health Cluster and GBV Sub-cluster [government and NGO/CSOs] and community structures that are involved or should be involved in caring for sexual violence survivors.
2. Conduct regular awareness raising and information sessions with health staff and community members on the protocol, referral pathways and available response services for survivors.
3. Identify the existing referral network between the different sectors involved in caring for survivors (community, health, justice, 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.).
5. Train providers to use the protocol, including what must be documented during an examination for legal purposes if survivors want to pursue legal action.

### 3.2 Define the clinical set-up where CMR services can be provided

All PHCs, hospitals and NGO supported PHCs and Mobile Medical Units (MMU) should be providers of CMR services as long as all they have post rape care supplies, trained staff and a registered Iraq medical practitioner.

Level /Type of Health Facility	Minimum Cadre of Staff	Remarks/comments
Emergency Hospitals	Medical Practitioner (GP /Specialist)	
Maternity Hospitals	Medical Practitioner (GP/Specialist)	
PHCCs	Medical Practitioner (GP/Specialist)	
PHCs	Medical Practitioner (GP/Specialist)	
PHCCs Non-Camps	Medical Practitioner (GP/Specialist)	
NGO-run PHC	Medical Practitioner (GP/Specialist)	NGOs can only collect forensic evidence, but refer to the forensic department for any further forensic action.

### 3.3 Roles and responsibilities of health care providers

Health care providers play a crucial role in providing care to GBV survivors because health facilities are one of the most common first contact points for seeking GBV-related services. Furthermore, they have a regular opportunity to provide information on GBV services, regardless of the reason for the medical visit. As a first contact and/or providers of life-saving services, health care providers bear a responsibility for receiving the clients with sensitivity and compassion, identify their needs and provide required services and referrals.

Therefore, it is recommended that health care providers adhere to the following key GBV guiding principles when providing services:

- Ensure the physical safety of the survivor and those who help the survivor
- Guarantee confidentiality
- Respect the wishes, the rights, and the dignity of the survivor
- Ensure non-discrimination

Furthermore, attention needs to be made for the following areas throughout the whole process of CMR service provision as the guiding principles:

- Provide comprehensive quality CMR services to survivors
- Respect the wishes and dignity of survivors
- Documents should be kept in a lockable cupboards with strict access and clearly assigned custodians

### 3.4 Service providers' attitude towards survivors

- Assure the survivor that his/her information will be strictly kept confidential
- Build trust with survivors (survivor-centered approach)
- Ensure informed consent from survivors for each step of providing care

## 3.5 Overcoming barriers to accessing services

### Referral

- Clear referral mechanisms to be in place and information on the referral mechanism to be disseminated to the staff and communities through posters, media and free hotline number

### Trust

- Capacity building for service providers on best practices on how to provide survivor-centered services and care for child survivors  
- Standardization of the consent form and medical forms

### Safety/Security

- Provision of transportation to survivors to access additional services

In line with these guiding principles, health care providers should create an environment that is conducive to seek help among survivors by ensuring confidentiality and privacy. They need to note that pressure from the social system as well as concern about bringing shame to the families and communities may inhibit disclosure among survivors.

## 3.6 Clinical management of Rape survivors

Sexual violence is a complex issue that requires multidisciplinary responses in order to provide care for the survivors and meet their needs. Although any one can be sexually assaulted, it is a crime that often committed against women and girls especially during humanitarian emergencies and conflict. When a person has been sexually assaulted, she or he is in need of prompt physical and emotional care. In addition to meeting health care needs, there are also legal aspects associated with the occurrence of a sexual assault that may have to be addressed. Both the health care and the legal systems must work in collaboration if the person's best interests are to be served and to assist the person in the healing process.

The guideline has been developed to assist hospitals/PHCs and health care providers in the provision of health and forensic care to those who present to the emergency department as a result of sexual violence.

The guideline is focusing on provision of competent, companionate and confidential care through:

- Documentation of injuries
- Collection of forensic evidence
- Treatment of injuries

- STI treatment and testing
- Post exposure prophylaxis
- Risk of pregnancy and treatment/testing
- Psychosocial support, counselling
- Follow-up

## Step 1 – Making preparations to offer medical care to rape survivors

### Preparing your clinic

The health care service must make preparations to respond thoroughly and compassionately to people who have experienced sexual assault. 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 priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors of rape. Also community should be made aware of available services for GBV survivors. For the supplies and equipment required, please see Annex 10.

### To prepare the survivor for the examination:

- Introduce yourself, your role and confidentiality protocols.
- Ensure that a 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 s/he is in control of the pace, timing and components of the examination.
- Reassure her that the examination findings will be kept confidential unless she decides to bring charges (please refer to Annex 1, consent form).
- 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 (please refer to annex 1, consent form) with her. 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 her to do anything against her will.
- Explain that she can refuse steps of the examination at any time as it progresses.



## Step 2 – Preparing the survivor for the examination

### 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.
- Prepare for bringing on-board a female nurse or service provider during physical examination (advisable to be present at all times during examination). A female physician to perform the physical examination is recommended.
- A sample history and examination form is included in Annex 2. The main elements of the relevant history are described below.

## Step 3 – Taking the history

### 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.
- Survivor may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health provider 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 her, and reassure her of confidentiality if she is reluctant to give detailed information.

### 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 counseling, and follow-up health care.
- Evaluate for possible pregnancy; ask for details of

## A guide for confirming pre-existing pregnancy

No		Yes
	1- Have you given birth in the past 4 weeks?	
	2- Are you less than 6 months postpartum and fully breastfeeding and free from menstrual bleeding since you had your child?	
	3- Did your last menstrual period start within the past 10 days?	
	4- Have you had a miscarriage or abortion in the past 10 days?	
	5- Have you gone without sexual intercourse since your last menstrual period (apart from the incident)?	
	6- Have you been using a reliable contraceptive method	

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

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: Counselling the survivor)

women of reproductive age by a pregnancy test or by history and examination. The following guide suggests useful questions to ask the survivor if a pregnancy test is not possible.

### Step 4 – Collecting forensic evidence

The main purpose of the examination of a sexual assault survivor is to determine what medical care should be provided. Forensic evidence may also be collected to help the survivor pursue legal redress where this is possible. The survivor may choose not to have evidence collected. Respect the choice of the survivor.

#### Why collect forensic 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 analyze 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 analyze evidence should be considered.

#### 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-judgmental way.
- It is not the health care provider's responsibility to determine whether or not a person 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 (please refer to annex 3). 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, gunshot
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)
Color	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

### Samples that can be collected as evidence

If forensic evidence is collected during the medical examination, it should be stored in a confidential and secure manner. The consent of the survivor must be obtained before evidence is collected. Please note the practices in Iraq recommend committee of three person to collect forensic evidence in Iraq.

### The medical certificate/report (please refer to annex 5)

Medical care of a survivor of rape/sexual violence includes preparing a medical certificate. This is a legal requirement in Iraq in case the survivors want to open legal case in the court. 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. 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. 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.

N.B. It is recommended that all health service provider should register the GBV assault in the GBV Log Book: anonymous de-identified data using serial numbering with the aim of tracking of GBV cases, referral and services provided.

If the service provider recognizes symptoms of rape/sexual abuse as stated below whether disclosed or not, he/she does not have to report the case to the legal investigator within the health facility. Nonetheless the survivor retains the

right to accept or refuse medical care without affecting her right in obtaining health services and without any liability on the service provider.

### Step 5 – Performing the physical and genital examination

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 s/he 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 ; some cases may need a specialist ; if available in your area call him/her.
- Always tell her what you are going to do and ask her permission before you do it.
- Assure her that she is in control, can ask questions, and can stop the examination at any time.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).
- The initial 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.

## Treatment of these complications is not covered here.

- Obtain voluntary informed consent for the examination and to obtain the required samples for forensic examination (please consider local procedure applied in Iraq in collecting forensic evidence and informing the legal investigator in case the survivors want to open case in court)
- Prepare for bringing on-board a female nurse or service provider during physical examination
- Record all your findings and observations as clearly and completely as possible on a standard examination form (please refer to annex 2).

## 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. If the survivor reports being throttled, look in the eyes for petechial hemorrhages.
- 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 (please refer to annex 2 and Annex 3), taking care to record the type, size, color 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, urine for toxicology if indicated the medical history and semen), fingernail and swabs 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. 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.
- Take samples according to local evidence collection protocol (see Annex 4). If collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva. DNA analysis is available in Iraq, with the exception of KRG.
- 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. (See forensic evidence collection guidance note annex 4)
- If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline (do not use a speculum when examining children).
- 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 (See forensic evidence collection guidance note annex 4).
- 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. (referral to specialist)
- If indicated, do a recto-vaginal 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 (referral to specialist). N.B.: In the Iraqi culture, 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. In case insertion of speculum is required for the purpose of forensic evidence, see forensic evidence collection guidance note annex 4.

- Laboratory testing (forensic medicine function and/or trained health service provider on forensic evidence collection)

Only the samples mentioned in Step 4 need to be collected for laboratory testing. 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 possible for culture. Do a pregnancy test, if indicated and available. Other diagnostic tests, such as X-ray and ultrasound examination, may be useful in diagnosing fractures and abdominal trauma.

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

### Physical examination

It is rare to find any physical evidence more than one week after an assault. If the victim 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).

### 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

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.

- 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.

## Step 6 – Prescribing treatment

Treatment will depend on how soon after the incident the victim 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 victims who present more than 72 hours after the incident. Male victims require the same vaccinations and STI treatment as female survivors.

### Part A: Survivor presents within 72 hours of the incident

#### Prevent sexually transmitted infections

- Survivors of rape should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis. If you know that other STIs are prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.
- Give the 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 (please refer to annex 6 for STI prevention and treatment protocol).
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV/AIDS (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

### Prevent HIV transmission

- 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.
- 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 the survivors of armed conflict.
- PEP usually consists of 2 or 3 antiretroviral (ARV) drugs given for 28 days. 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.
- 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.

### Survivors reporting within 72 hours.

- Tenofovir (TDF) + lamivudine (3TC) are recommended as the preferred backbone regimen for PEP among adults and adolescents, and atazanavir/ritonavir (ATV/r) is the recommended third drug.
- Zidovudine (ZDV or AZT) + lamivudine (3TC) are recommended as the preferred backbone regimen for children 10 years and younger, and lopinavir/ritonavir (LPV/r) is the recommended third drug.
- If the regimen indicated in these guidelines is not available, start with drugs that are immediately available. Ideally this should be 2 nucleotide reverse transcriptase inhibitors (NRTIs) + 1 protease inhibitor (PI). If a PI is not available, prescribe 2 NRTIs, as indicated in the table.
- No baseline laboratory tests are needed to start PEP. If available, the following tests can be helpful: haemoglobin level to detect anaemia, ALAT to assess a clinical suspicion of hepatitis, creatinine clearance in patients with diabetes, hypertension, renal dysfunction or receiving nephrotoxic

drugs (including NSAIDs).

- Prescribing PEP must never be made conditional on the survivor agreeing to have an HIV test. 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, PEP can be initiated and HIV-testing can be addressed again at a follow-up visit. A 28-day PEP treatment is not expected to do harm in someone of unknown HIV status who is actually HIV-positive.
- 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 counselled and referred to appropriate services for providing care for people living with HIV, such as antiretroviral treatment (ART), prevention of opportunistic infections and supplementary feeding.
- PEP is not contraindicated for pregnant women. Pregnant women must be referred for appropriate antenatal care because the pregnancy is at risk after a rape. PEP in breastfeeding women is not contraindicated, but the risks and benefits of continuing breastfeeding while the risk of HIV transmission is not known should be discussed with the mother.
- A full 28-day prescription of ARVs should be provided following initial risk assessment. It is recognized that victims of sexual assaults have a higher rate of therapy defaulting than HIV patients receiving ART. Adherence to the prescribed regime is difficult: Enhanced adherence counseling is of paramount importance.

### Survivors reporting after 72 hours:

- Survivors reporting after 72 hours of the incident should be counseled about the possible risk of transmission and should be encouraged to undergo HIV testing 3 months following exposure.

### Adverse effects

- Nausea, vomiting, headache. While uncommon and not very serious, these effects may compromise treatment adherence. Inform the person that they may occur and stress the importance of continuing the treatment.
- Atazanavir may cause jaundice; this is not due to hepatitis and the drug can be continued.
- Tenofovir (TDF) is contraindicated in a patient with pre-existing renal impairment (creatinine clearance <50 ml/min). However, short term administration (28 days) is unlikely to cause significant renal toxicity. If creatinine testing is not available, avoid use in case of diabetes, hypertension and in patients receiving nephrotoxic drugs.
- Avoid zidovudine (AZT)/lamivudine (3TC) if there are clinical signs of anaemia and/or if haemoglobin is < 8 g/dl.



and children's specific problems of adherence and should therefore take time for thorough counselling to children and their parents/caregivers.

### Counselling survivors on PEP Cover the following points 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.
- There is evidence from research to indicate that PEP is very likely to be effective in reducing the risk of transmission of HIV after rape.
- It is preferable to know the survivor's HIV status prior to starting antiretrovirals, so the best possible recommendation can be made.
- 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.
- Explain the common side-effects of the drugs, such as feelings of tiredness, nausea and flu-like symptoms. Reassure the survivor 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.

### Prevent pregnancy

- Taking emergency contraceptive pills (ECP), or Levonorgestrel 0.15mg + ethinylestradiol 0.03mg (4 pills followed by 4 pills in 12 hours), 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 (is recommended locally).

- If a child vomits within 30 minutes of intake of the medication, give the same dose.
- AZT/3TC tablets for children are dispersible in water and can be split. They can be dispersed into a small volume of water or crushed and mixed with food.
- Lopinavir/ritonavir (LPV/r) tablets must be swallowed and cannot be crushed or split and can be difficult to swallow.
- Lopinavir/ritonavir (LPV/r) is available as syrup for children < 10 kg. This liquid requires refrigeration at 2-8 °C until the point of dispensing and is therefore not included in post rape treatment kits supplied in the context of emergencies. LPV/r will soon be available as pellets. Pellets will be the preferred formulation as they are easier to give and have a less bitter taste.
- In children less than 2 years who are unable to swallow LPV/r tablets, use nevirapine oral liquid 10mg/ml or nevirapine 50mg dispersible tablets (see table for dosage instructions)
- Clinicians must be aware of issues of consent for children

### PEP for adult and Children above 35 Kg

Weight	Drug	Dose per tablet	Dosages	Durations
>35 KG	Tenofovir + Lamivudine (TDF*+ 3TC) + atazanavir/ritonavir (ATV/r)**	300 mg+300 mg 1 tablet x 1/day	300 mg+300 mg 1 tablet x 1/day	28 days
		300 mg/100 mg 1 tablet x 1/day	300 mg/100 mg 1 tablet x 1/day	
* If TDF not available: Zidovudine + Lamivudine (AZT+3TC)		00 mg+150 mg 1 tablet x 2/day	00 mg+150 mg 1 tablet x 2/day	28 days
**If atazanavir/ritonavir not available: Lopinavir/ritonavir (LPV/r)		200 mg/50 mg	200 mg/50 mg	

## PEP for children or <35 Kg

Weight (Kg)	Age	idovudine + Lamivudine (AZT+3TC) fixed dose combination tablets				Lopinavir/ritonavir (LPV/r)\$			
		DT 60mg+30 mg		DT 60mg+30 mg		Tablet 100/25 mg Tablet 200/50 mg		Tablet 100/25 mg Tablet 200/50 mg	
		am	pm	am	pm	am	pm	am	pm
3-5.9kg	0-6month*#	1	1	NR	NR	NR	NR	NR	NR
6-9.9kg	6month 1yrs*#	1.5	1.5	NR	NR	NR	NR	NR	NR
10-13.9kg	1-3yrs	2	2	NR	NR	2	1	NR	NR
14-19.9kg	3-6yrs	2.5	2.5	NR	NR	2	2	1	1
20-24.9kg	6-9yrs	3	3	NR	NR	2	2	2	1
25-34.9kg	9-14yrs	4	4	0.5	1	3	3	2	1

\*LPV/r oral liquid 80/20 mg/ml is preferred for children up to 1 year. This liquid requires refrigeration at 2-8 °C until the point of dispensing and it is therefore not suitable for supply to areas where the cold chain cannot be maintained or for inclusion in post rape treatment kits that are supplied in the context of emergencies.

\$ LPV/r tablets must be swallowed and should not be crushed or dissolved in liquid. Children who are unable to swallow LPV/r tablets should use LPV/r liquid or NVP (if less than 2 years).

# In children less than 2 years who live in settings where LPVr syrup is not available, or cold storage facilities are not available, use Nevirapine as follows: Nevirapine oral liquid 10mg/ml or Nevirapine 50mg dispersible tablets

0 - 6 months: 5ml or 1 tablet every 12 hours (twice daily)

6 months -1 year: 8 ml or 1.5 tablets every twelve hours (twice daily)

DT = Dispersable Tablet

NR = Not Recommended

3 Adapted from : [Revision of the malaria and PEP modules, addendum to the malaria and post-exposure prophylaxis \(PEP\) sections of the Interagency Emergency Health Kit 2011.](#)

- 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.
- 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 and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.



Type	Dose	Taken
Levonorgestrel postinor-2 (progestin only)	1500 micrograms (two 750 mcg tablets)	One tablet 12 hours apart (Total 2 tabs)
Combined oral contraceptives (ethinylestradiol+ progestin) (50µg)	The equivalent of 500 micrograms levonorgestrel or 250 of norgestrel or Levonorgestrel 0.15mg + ethinylestradiol 0.03mg (4 pills followed by 4 pills in 12 hours),	2 tabs 12 hours apart (total 4 tabs)
Combined oral contraceptive low dose(30µg)	(30µg)	4-tabs 12 hours apart (total 8 tabs)

- 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

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

### Prevent hepatitis B

#### Good to know

- Find out the prevalence of hepatitis B in your setting, as well as the standardized MOH vaccination schedules.
- Provide post-exposure prophylaxis against hepatitis B. If vaccine is not available as it requires refrigeration, please refer the survivor.
- 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.

- As HBV infant immunization programmes is routinely use hepatitis B vaccine, a survivor may already have been fully vaccinated (please cross check in the medical history); If the vaccination record card confirms this, no additional doses of hepatitis B vaccine need to be given.

#### HB Vaccine:-

According to Iraq the vaccination schedule is at day 0, then after one month and 6 months.

- 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), is essential component of medical care for the rape/sexual violence 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. 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

Dosing Schedule	Administration Schedule	Duration of Immunity conferred
1st TT dose	At first contact	Nil
2nd TT dose	1 month after 1st TT	1-3 years
3rd TT dose	6 months after 2nd TT	5 years
4th TT dose	1 Year after 3RD TT	10 years
5th TT dose	1 Year after 4th TT	20 years

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.

- 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 annexed to the this guideline.

### HIV transmission

- In case in your settings testing is available for HIV, it 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.
- In case HIV testing is not available, refer the survivor for the nearest Voluntary Counseling and Testing Center (VCTC) for HIV.

### 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.
- If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, taking progestogen-only emergency contraceptive pills or Levonorgestrel 0.15mg + ethinylestradiol 0.03mg (4 pills followed by 4 pills in 12 hours), 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.
- 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 (please refer to annexed to this guideline see Annex 6).

### Bruises, wounds and scars

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

### Tetanus

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

### 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 counselors, 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 a specialist. Please consult DOLSA/ DVAW/ GBV working group for referral system.
- 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. Consult DOLSA for shelters or GBV working group.
- Enlist the assistance of the counseling services, community service providers, and law enforcement authorities, including police or security officer as appropriate (Please contact DVAW, DOLSA or GBV working group for available referral pathway system at your clinic). If the survivor has dependents 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 dependents 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.
- 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 behavior or manner of dressing. Do not make moral judgments of the survivor.

## 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.
- 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 her partner 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 s/he has questions or other health problems. Encourage him/her to return in two weeks for follow-up evaluation of STI and pregnancy (see Step 8 below).
- Give clear advice on any follow-up needed for wound care or vaccinations.

## Step 8 – Follow-up care of the survivor

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

## 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 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 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).

## Care for child survivors

### General

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

### Initial Assessment:

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

### Informed Consent:

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. Adolescents may

be able to give consent themselves depending on local laws. The child should never be examined against his or her will, whatever the age, 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 in-drawing, and a breathing rate of more than 60 breaths/minute.

### Create a safe environment

- Take special care in determining who is present during the interview and examination (remember that it is 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, favorite 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?);

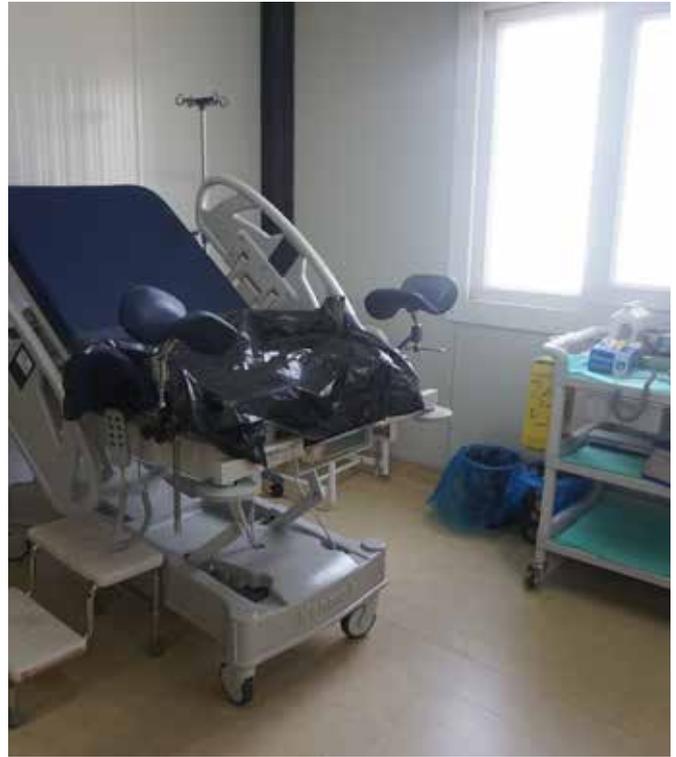
- how the rape/abuse was discovered;
- who did it, and whether he or she is still a threat;
- if this has happened before, how many times and the date of the last incident;
- whether there have been any physical complaints (e.g. bleeding, dysuria, discharge, difficulty walking, etc.);
- whether any siblings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

### Checklist for interviewing a child-

- Begin by introducing yourself, explaining who you are; build some trust, perhaps by asking a few questions about neutral topics, e.g., school, friends, who the child lives with, favorite activities.
- Communicate clearly that the child is not in trouble.
- Make sure the child is as comfortable as possible (e.g. Does the child need food or water, a blanket, etc.?)
- Ask the child if she knows why she is there and listen carefully to the response to help you judge her comprehension of the situation and level of stress.
- Explain what this interview is about.
- Tell the child that she can ask questions at any time if she doesn’t understand something. Assure the child it is okay to respond to any questions with “I don’t know.”
- Check that it is okay to take notes and explain why you need them.
- The amount of information and the questions that you will need to ask may vary.
- Invite the child to describe what happened, listen carefully and record the details.
- Be patient; go at the child’s pace; do not interrupt or interrogate.
- Ask only one question at a time. Keep questions short and simple<sup>19</sup>.
- Give enough time for the child to complete her answers – be patient and don’t interrupt.
- Make sure that the child can understand the words you use and the questions you ask. Think about the child’s age and make sure you use the right level of language.
- Make sure you understand what the child is saying to you. This is especially important and difficult in relation to some of the words used to describe the genitals and sexual activity.
- Some children might want to communicate in another way – have paper, crayons, pencils and a doll available in case children are more comfortable drawing pictures or demonstrating on the doll.
- If the child is very distressed, stop and offer to take some time. Recognize and respond to the child’s emotions during the interview. Demonstrate concern and understanding.
- Show honesty, especially in response to the child’s questions. Never promise things that you cannot guarantee.
- Provide reassurance and give the following messages:
  - It was not her fault
  - She deserves help not blame

<sup>19</sup> IRC CLINICAL CARE FOR SEXUAL ASSAULT SURVIVORS

- Explain to the child his or her options and potential outcomes.
- If you need to share any information, explain to the child who you will share the information with, what will be shared and what will be done with this information. Ask the child to identify any concerns with this. Discuss any potential consequences to the child's safety that may result from sharing this information.
- Thank the child and explain what will happen next, including any referrals to other services you plan to make – don't make promises or offer false hope.



### Prepare the child for examination

- As for 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.

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

Age	Signs
Baby / Small child (0 to 5 years)	<ul style="list-style-type: none"> <li>• Increased crying</li> <li>• Always frightened / sad</li> <li>• Clings to caregivers</li> <li>• Nightmares / does not sleep</li> <li>• Hyperactive / Inactive</li> <li>• Failure to grow</li> </ul>
Children (6 to 12 years)	<ul style="list-style-type: none"> <li>• Increased crying</li> <li>• Always frightened / sad</li> <li>• Aggressive or sexualized play</li> <li>• Afraid of going to sleep in the dark</li> <li>• Wets the bed</li> <li>• Refuses to talk or to eat</li> <li>• Runs away from home</li> <li>• Complains of headaches / stomach aches</li> </ul>
Adolescents (13 to 19 years)	<ul style="list-style-type: none"> <li>• Withdrawal / won't talk about feelings</li> <li>• Makes plans for revenge</li> <li>• Runs away from home</li> <li>• Nightmares</li> <li>• Self-harming</li> <li>• Eating disorders</li> <li>• Substance abuse</li> <li>• Depression / suicidal thoughts</li> </ul>



- 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 pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury.

- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a pre-pubertal child is usually done under general anesthesia.
- 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

- 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 gonorrhea 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). Follow your local protocol.

### **If the child is highly agitated**

In rare cases, a child cannot be examined because he or she is highly agitated. Only 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 diseases, presumptive treatment for STIs should be part of the protocol (please refer to local protocol annexed 6). Also refer to Step 6 in this guideline for PEP prescriptions for children.

### **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.

### **Referral**

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



# 4.0 ANNEX



## Annex 1 – Consent Form

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/he 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 a client)

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 2- Sample history taking from

Confidential

code:

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	

### 2. THE INCIDENT

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

Existing health problems
History of female genital mutilation, type

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		Sterilization	
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					
Allergies					
Current Medication					
Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments	
HIV/AIDS status	Known		Unknown		

## 4. MEDICAL EXAMINATION

Appearance (clothing, hair)		
Mental state (calm, crying, anxious, cooperative, depressed, other)		
Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature): Unknown Comment
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

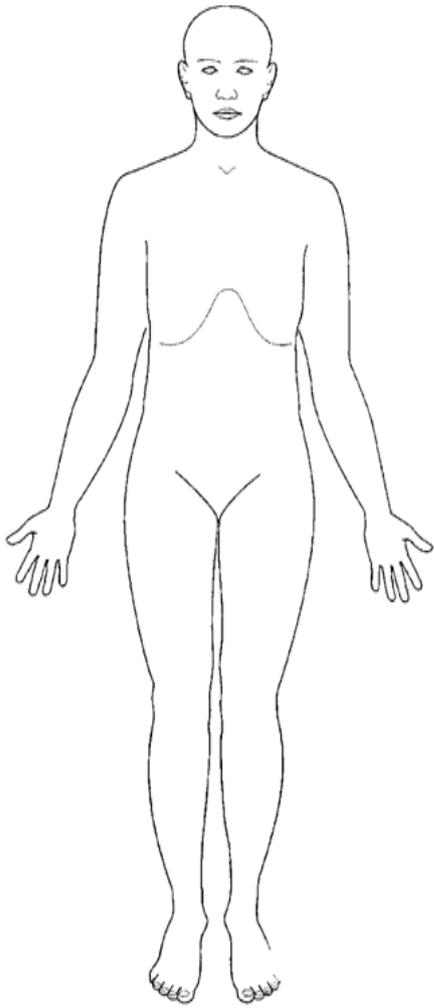
General mental condition	
Survivor plans to report to police OR has already made report	Yes No
Survivor has a safe place to go to Yes No	The survivor has someone to accompany her/him Yes No
Mental counselling provided:	
Follow-up required	
Date of next visit	

Name of health worker conducting examination/interview: \_\_\_\_\_

Title: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

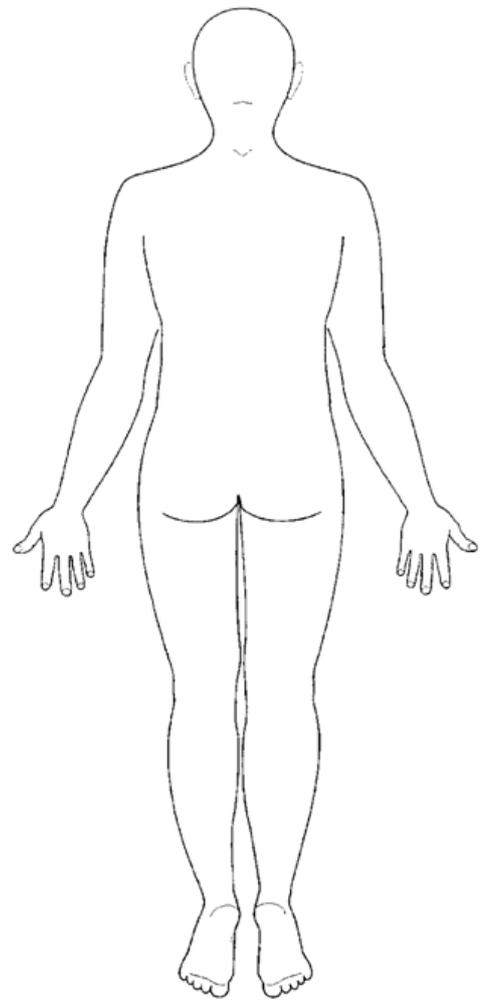
## Annex 3 – Pictograms

Right



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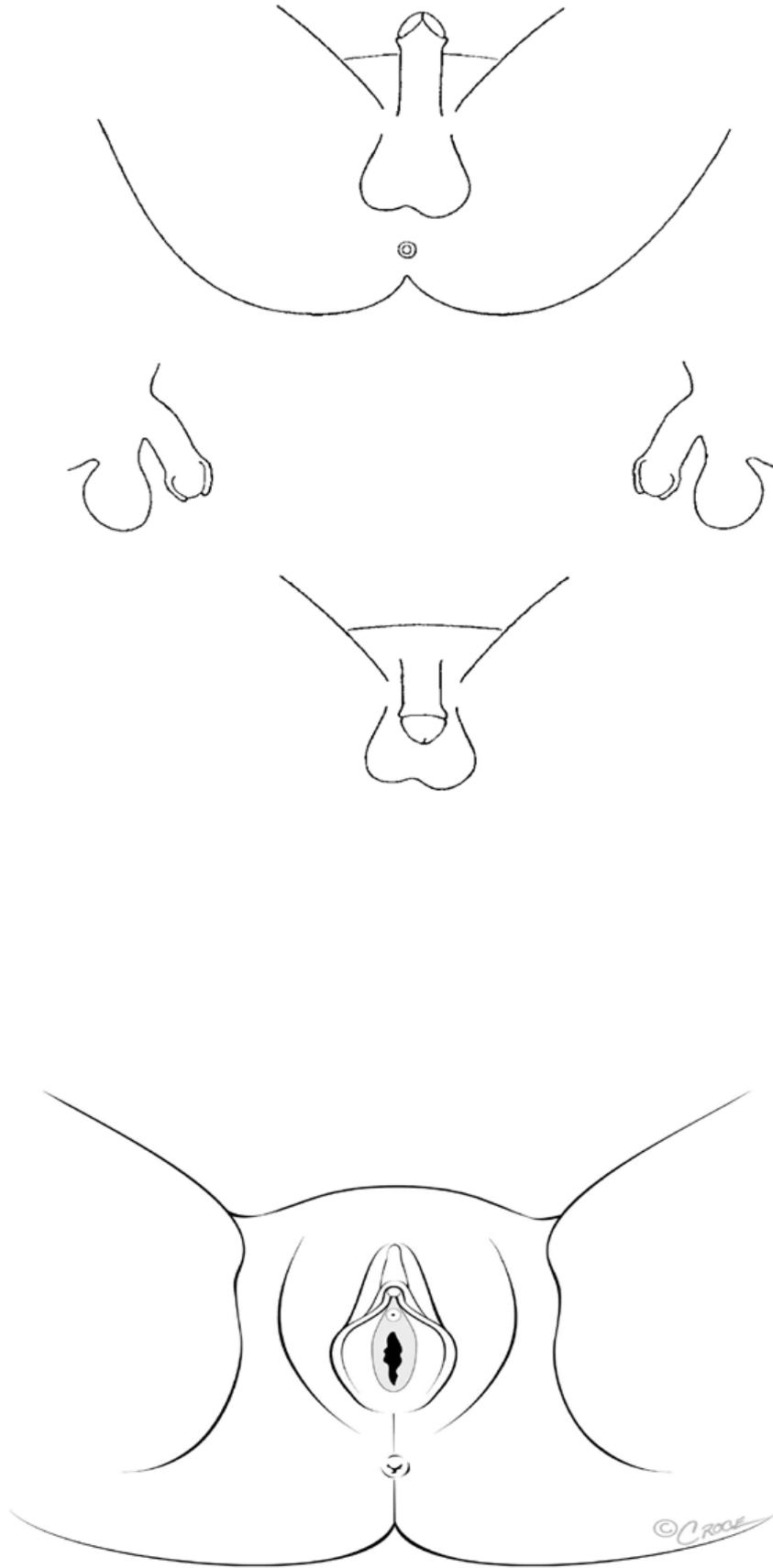
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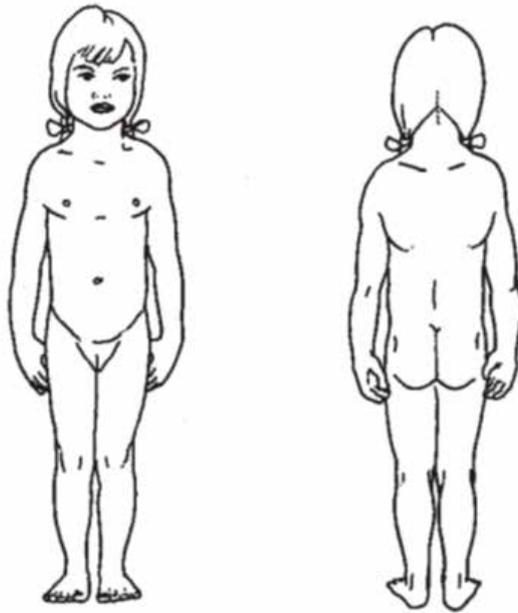
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## Annex 4- Forensic evidence collection

### Samples that can be Collected as Evidence

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

### Good to Know

- DNA analysis is available in Iraq and can be done on material found on the survivor's body or at the location of the assault, which might be soiled with blood, sperm, saliva or other material from the assailant (e.g., clothing, sanitary pads, handkerchiefs, condoms). In this case, blood from the survivor must be drawn to allow her DNA

to be distinguished from any other DNA. Blood or urine may be collected for toxicology testing (for example, if the survivor was drugged).

### 1. MAINTAINING THE CHAIN OF EVIDENCE

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

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

- All clothing, cloths, swabs, gauze and other objects to be analyzed need to be well dried at room temperature and packed in paper (not plastic) bags.
- Samples can be tested for DNA many years after the incident, provided the material is well dried.
- Blood and urine samples can be stored in the refrigerator for five days. To keep the samples longer they need to be stored in a freezer. Follow the instructions of the local laboratory.
- All samples should be clearly labeled with a confidential identifying code (not the name or initials of the survivor), date, time, type of sample (what it is, from where it was taken) and the collectors name, and put in a container.
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your name across the tape. Evidence should be released to the authorities only if the survivor decides to proceed with a legal case and only to the extent that it relates to the case (see Annex 1: Sample consent for release of information).

## Annex 5: 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:

- - - - -  
- - - - -

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 adult Survivors

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:

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

Signature of the clinician:-----

## Annex – 6 : Recommended STI treatments for adults

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 recommend STI treatment for Children and Adolescent

STI	Weight/age	Drug	Drug
Gonorrhoea	Under 45 kg	Ceftriaxone or spectinomycin or Cefixime	125 mg IM single dose 40 mg/kg IM (up to a maximum of 2g) single dose
Chlamydia	Under 45 kg	Azithromycin or erythromycin	20 mg/kg orally, single dose 50 mg/kg per day (up to a maximum of 2 g) divided into 4 doses a day for seven days
	45 kg or over but <12 years	Azithromycin or erythromycin	1g orally, single dose 500mg orally, four times a day for seven days
	12 years +	Treat according to adult protocol	
Syphilis	Under 45 kg	Benzathine benzyl penicillin	50 000 IU/kg IM (up to a maximum of 2,4 m IU) single dose
	45kg or over	Treat according to adult protocol	
If allergic to penicillin		Erythromycin	50 mg/kg per day, orally (up to a maximum of 2g) divided into four doses a day for 14 days
Trichomoniasis	Under 12 years	Metronidazole	5 mg/kg orally three times a day for seven days
	12 year +	Treat according to adult protocol	

20 Not : treatment for syphilis may be omitted if the presumptive treatment regimen include azithromycin which is effective against incubating syphilis, unless resistance has been documented in the settings

21 Prevention of trichomoniasis is not generally recommended for pre-pubescent girls, and is only indicated in cases with vaginal or anal penetration. For older children metronidazole may be included.

Their parents should be told what symptoms to look for and encouraged to return for follow-up



## Annex 8: Roles and responsibility Matrix

Health care provider	Physician at primary Health care centre	Physician at District or Governorate Hospital	Physicians in NGO-supported PHCs, including Mobile Medical Units/ Teams	Nurse	Social Worker
Preparing the survivor for the examination	x	x	x	x	-
First Aid Psychological support	x	x	x	x	x
Taking History including screening questions for suspected cases	x	x	x	-	-
Collecting Forensic evidence	x	x	x	-	-
Performing General Physical examination	x	x	x	-	-
Performing Genital Examination (inspection)	x	x	x	-	-
Performing genital examination (internal)	x	x	x	-	-
<b>Prescribing Treatment</b>					
First Aid treatment: suturing wounds, support vital functions	x	x	x	x	-
Hepatitis B Vaccine	x	x	x	x	-
Emergency Contraceptive	x	x	x	-	-
Prophylactic STDs	x	x	x	-	-
PEP for HIV	x	x	x	-	-
Documentation and registration in GBV Log book	x	x	x	x	x
Medical Certificate	x	x	x	-	-
Reporting to legal Authorities	x	x	x	-	-

## Annex 9 -KIT 3: Post Rape Treatment Kit Content

Use: Management of the immediate consequences of sexual violence.

Instructions: Health personnel should have been trained to:

- conduct pregnancy tests;
- prescribe emergency contraception, if the client chooses to have this;
- prescribe presumptive treatment for STIs and post-exposure prophylaxis (PEP) to prevent HIV infection;
- Counsel clients and refer clients to psychosocial and protection services.

Target population: Kit contents are based on the assumptions that around 25% of the population are sexually active women (25% of 10 000 = 2500); 2% of these will be raped (50 women); in addition 10 children will be raped (5 weighing less than 30 kg and 5 weighing 30 kg or more); 50% of clients will need a pregnancy test. PEP must be given within 72 hours of the assault. It is assumed that 30 adults and 8 children (4 weighing 10–19 kg and 4 weighing 20–39 kg) present within that time limit.

Medication	Quantity
Levonorgestrel, tablet, 1.5 mg, (treatment: single dose)	55 package
*Azithromycin, capsule, 250 mg	220
*Azithromycin, oral suspension, 200 mg per 5 ml, bottle 15 ml	5
**Cefixime, tablet, 200 mg	110
**Cefixime (as trihydrate), dry syrup for oral suspension, 100 mg/5 ml, bottle 30 ml	10
Tenofovir (TDF) + lamivudine (3TC), tablets 300+300 mg (adults: 1 tab/day for 28 days)	900
Atazanavir (ATV) + ritonavir (r), tablets 300+100 mg (adults: 1 tab/day for 28 days)	900
Zidovudine (AZT) + lamivudine (3TC), tablets 60+30 mg (children: see treatment protocol)	1440
Lopinavir (LPV) + ritonavir (r), tablets 200+50 mg (children: see treatment protocol)	240
Lopinavir (LPV) + ritonavir (r), tablets 100+25 mg (children: see treatment protocol)	180
<b>Medical devices: Renewable</b>	
Pregnancy test, temperature stable	25
Bag (envelope), plastic, for drugs, approximately 10 x 15 cm, pack of 100	1

\*Azithromycin: for patients 45 kg or over, treatment is a single dose of 1 g (4 x 250 mg capsules). For patients less than 45 kg, treatment is 20 mg/kg.

\*\*Cefixime: for patients of 45 kg or over, treatment is a single dose of 400 mg. For patients less than 45 kg, treatment is 8 mg/kg.

Remarks:

- ☐ Men may also present after rape and should receive appropriate treatment and referral.
- ☐ For tetanus and hepatitis vaccines, refer to the nearest operational health centre.

## Annex 10: Check list of needs for clinical management of rape survivors

Protocol	Available
Written medical protocol in the language of the services provider	
<b>Human resources</b>	
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	
<b>Furniture and equipment</b>	
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	
<b>Supplies</b>	
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,	
Paper bags for collection of evidence*	
Paper tape for sealing and labelling containers/bags*	



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