

National Guidelines

Medical Management of Rape/Sexual Violence



REPUBLIC OF KENYA

MINISTRY OF HEALTH[©]

Division of Reproductive Health

Acronyms:

3TC	Lamivudine
AZT	Zidovudine
CCC	Comprehensive Care Clinic
Cr	Creatinine
D4T	Stavudine
DCT	Diagnostic Counseling and Testing
DNA	Deoxyribonucleic acid
EC	Emergency Contraception
EFV	Efavirenz
Hb	Haemoglobine
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HVS	High Vaginal Swab
IDR	Indinivir
LFTs	Liver Function Tests
NVP	Nevirapine
OB	Occurrence Book
OPD	Out Patient Department
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
PTSD	Post Traumatic Stress Disorder
SGPT/ALT	Serum Glutamate Pyruvic Transaminase/ Alenine Aminotransfrase
STIs	Sexually Transmitted Infections
U+Es	Urea and Electrolytes
VCT	Voluntary Counselling and Testing

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FOREWORD

The reproductive health service related needs of survivors of sexual violence have been identified as complex and multi-faceted. Sexual violence results in unintended and unwanted pregnancy, transmission of HIV and other sexually transmitted infections, psychological trauma and physical injuries.

Comprehensive care includes counselling, treatment and management of injuries, sexually transmitted infections (STIs), post exposure prophylaxis, HIV care for those who are HIV positive and pregnancy prevention. Unintended pregnancy increases susceptibility to adverse pregnancy outcomes and can result in unsafe abortions or injuries and complications. Of additional concern is the emerging evidence world-wide that sexual violence is an important risk factor contributing towards vulnerability to HIV/AIDS. The national plan for mainstreaming gender into the HIV/AIDS strategic plan for Kenya has identified sexual violence as an issue of concern in HIV transmission, particularly among adolescents. Literature shows that 4% of HIV infection among adolescents is from sexual violence.

Rape trauma syndrome and Post Traumatic Stress Disorder (PTSD) often accompany sexual violence. Psychological care is needed to support clinical care. It includes counselling, for crisis prevention and on-going support of the survivor and their family. Counselling is necessary for HIV testing and PEP adherence. **Comprehensive post sexual violence care therefore includes both counselling and clinical management.**

The aim of these guidelines is to set standards for comprehensive care of survivors of sexual violence. It is expected to provide to all health care workers who come in contact with survivors of sexual violence, a practical reference source for service delivery.

While we acknowledge that there is still much more that needs to be done on forensic systems, these guidelines are a first step towards development of comprehensive policy, communication strategy and referral mechanisms with the criminal justice system.

These guidelines should be available in all health facilities and should be used consistently for management of survivors of violence.



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INTRODUCTION

Rape/sexual violence can result in serious physical injuries, profound psychological trauma, unwanted pregnancy, and infection with HIV and STI's. Care of rape survivors needs to address all of these as well as legal and forensic issues.

Compassion, respect and confidentiality should be offered to all patients, but are particularly important for rape survivors – it is vital that questioning, examination and sample taking cause the absolute minimum of additional distress to these already highly traumatized patients.

Informed consent should be obtained before examination and the purpose of any examination should be made clear to the survivor. Also, the individual should be told that some of the questions are personal and may seem intrusive, but are important in documentation and as part of legal evidence.

Sexual Violence

Sexual Violence has been defined as *“any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting including but not limited to home and work”*¹

Sexual violence includes the use of sexual contact by one person to another against his or her will and may include acts such as forced penetration of the vagina or anus with a penis or other object, touching the perineum including the penis, vagina or anus, oral sex (placing the mouth or tongue on a person’s vagina, penis or anus), rubbing of a penis, hand or other object against another person’s perineum and performing such acts with an animal. However, the law defines each of these activities differently.

Rape and defilement (the legal definition)

While the legal definitions exist, they do not cover all aspects of sexual violence against men, women and children. **These guidelines are designed to cover the management of forced vaginal, anal and/or oral penetration of MEN, WOMEN and CHILDREN with a penis or other objects**, although at present, Kenyan law does not recognize the existence of male rape. Rape is defined by the Kenyan law as having sex with a woman or girl without her consent or with her consent if obtained under threat, force or intimidation of any kind, fear of bodily harm or misrepresentation as to the nature of the act or by a person impersonating her husband.

If the girl is less than 16 years then she is deemed incapable of consenting to sex in law and therefore sex with her is considered rape even with her consent. Technically in law the rape of a girl below 16 years is termed **defilement**. For the act to be considered as rape or defilement, there must be penetration of the vagina with the penis.

Penetration within these guidelines refers to the partial or complete insertion of the penis or other object into the vagina, anus or mouth. No ejaculation is necessary for penetration to be considered to have occurred.

¹ World report on violence and health (2002), World Health Organization, Geneva

1. MEDICAL MANAGEMENT

The management of any **life threatening** injuries should naturally take precedence over all other aspects of post-rape care, but the management of, for example, minor cuts and abrasions should not delay the delivery of other more **time dependent** treatments.

The efficacy of both **Pregnancy Prevention** and **HIV Prevention** decrease rapidly with the length of time from exposure, **so these should be seen as a priority.**

History taking and examination of the patient must be undertaken immediately. It is vital that the examination causes the absolute minimum of added trauma that is possible. History taking will involve documentation of patient details, type of assault, location, time and detail assailants if any. **Careful and precise documentation** of the examination procedure is critical to providing evidence of violence and corroborative evidence in cases of litigation (*Refer to section 4 for guidelines on examination*).

The first point of contact at the hospital should provide basic counselling and attend to the patient with sensitivity.

1.1. Pregnancy prevention

In view of the psychological consequences of conceiving after being raped, every non-pregnant woman/girl of childbearing age not covered by a reliable form of contraception, should be offered emergency contraception (EC). This should include all girls who have had started menstruation, or show secondary sexual characteristics and at risk of precocious puberty.

EC can be given up to 72 hours after rape, but it is more effective the sooner it is given, so administering the first dose **is a priority (along with the first dose of PEP – see below)**.

It should be readily available out of working hours (ie: in casualty), and free of charge in all Government Health Institutions where women are likely to present after being raped.

Options for Emergency Contraception include:

Postinor 2	Two tablets in a single dose
Eugynon or Neogynon	Two tablets <i>stat</i> then repeat after 12 hours
Microgynon or Nordette	Four tablets <i>stat</i> then repeat after 12 hours

Ideally, an anti-emetic should be offered with EC, to reduce the chances of vomiting.

It should be explained to the woman that emergency contraception is to prevent pregnancy and is **NOT** a form of abortion, as termination of pregnancy may be unacceptable to some people. Unless a woman is obviously pregnant, a baseline pregnancy test should be performed. However, this should **not delay** the first dose of EC, as these drugs are not known to be harmful to an early (unknown) pregnancy.

A follow up pregnancy test at six weeks should be offered to all women who return for follow up, regardless of whether they took EC after the rape. If this is positive, or if they subsequently present with a pregnancy, which they feel is as a consequence of the rape, they should be referred for counselling as this is a situation that causes great emotional stress. Termination may be undertaken in accordance to the law.

1.2. HIV Prevention

For many survivors of rape/sexual assault, the thought of becoming HIV infected can greatly add to their psychological distress.

The actual risk of HIV infection without intervention is difficult to quantify, but it is thought to be considerably higher than from unprotected consensual sex, as a result of violent penetration and lack of lubrication, resulting in both microscopic and often also visible mucosal tears.

Children who have been raped are especially at risk due to the immaturity of their mucosal linings and size disproportions resulting in increased trauma. Likewise, forced anal penetration of both adults and children carries a higher risk of transmission.

The HIV prevalence among men who rape is generally considered to be higher than that of the general population, although actual figures are not known in Kenya, as the number of arrests are minimal.

1.2.1. Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) is the administration of one or a combination of Anti-Retroviral drugs (ARV's) for 28 days after the exposure to HIV.

Studies have shown that if PEP is given to health care workers who have been exposed to HIV infected blood from a needle injury, the risk of becoming infected is reduced by about 80%. There is little direct evidence that it works after rape/sexual violence, but it has been shown to be effective after consensual sex in high-risk groups, so most experts agree that it should be beneficial.

Drugs for PEP

These guidelines make recommendations are for the use of **duo-therapy** (ie: two ARV drugs) for 28 days. If the risk of HIV infection from a sexual assault is deemed to be negligible (eg: forced kissing but with no penetration) then it should be explained that PEP is not indicated. PEP is recommended for **men, women, girls and boys** at risk of HIV infection. Significant risk involves **oral, vaginal and/or anal penetration**.

Acceptable options have been given below to increase the chances of an appropriate regime being available in any particular health facility.

Important Note

It is not advised to provide a full months supply on the first visit. It is better to provide enough drugs for a week or so at a time, and to encourage re-attendance for clinical follow up, counselling and adherence support. Exceptions can be made if, for example, the individual lives a great distance away, and is unlikely to return.

Note: The 2003 National ARV guidelines suggested offering 3 ARV's for PEP. Using a third ARV may decrease compliance and increases side effects and cost hence the recommendations for **duo-therapy**. However, where available and affordable and with good infrastructure to support adherence and compliance, **triple therapy** may be recommended.

Recommended PEP Regimens for Adults

AZT + 3TC
Zidovudine 300mg + Lamivudine 150mg
Twice a day for 28 days

Or

D4T + 3TC
Stavudine 40mg* + Lamivudine 150mg
Twice a day for 28 days

***D4T 30mg for Adults <60kg**

Fixed Dose Combinations, where the above combinations of drugs are combined into one tablet, should be used if available. This reduces the number of pills taken and so increases compliance to treatment.

Recommended PEP Drugs for Children (Tablets and Syrup based regimens)

For children PEP is slightly more complex. **The same drugs are used** but the doses must be given according to weight and and/or surface area. Both syrups and tablets can be used.

Syrup Based Regimens for Children

If syrups are available, then more precise dosing is possible. The exact dose can be calculated from the weight and/or surface area, and this should certainly be done for children under 10kg.

AZT (Zidovudine) – 2mg/kg twice a day
plus
3TC (Lamivudine) – 4mg/kg twice a day

or

D4T (Stavudine*) – 1mg/kg twice a day
plus
3TC (Lamivudine) – 4mg/kg twice a day

***Note:** D4T liquid requires refrigeration so is not appropriate unless the carers have a fridge

Tablet Based Regimens for Children

Syrups are the recommended regimens. However, in situations where syrups may not be available, regimens using tablets have been developed based on **weight bands**.

Weight Band	Dose AZT	Dose 3TC
10-20kg	100mg 3 times a day	½ 150mg tab twice a day (75mg)
20-40kg	2x100mg twice a day	1x150mg tab twice a day (150mg)
>40kg	Adult regime	Adult regime

Or

Weight Band	Dose D4T	Dose 3TC
10-14kg	1x15mg cap twice a day	½ 150mg tab twice a day (75mg)
15-19	1x20mg cap twice a day	½ 150mg tab twice a day (75mg)
20-60	30mg cap (or adult FDC)	1x150mg tab twice a day (150mg)

Timing of PEP

The efficacy of PEP decreases with the length of time from exposure to the first dose, therefore administering the first dose **is a priority**.

Studies have shown **low** efficacy (ie: it has insignificant effect) if PEP is commenced after 72 hours after exposure. People presenting later than this should be offered all other aspects of post rape care, **but not PEP**.

HIV Testing

This should be performed at baseline and at 6 weeks (and 3 months if possible), and should be accompanied by appropriate pre and post-test counselling.

Important note

Baseline HIV testing **need not precede administration of PEP**, as testing can cause undue delay in administration of the first dose. Also, many rape survivors will **not be psychologically prepared for HIV testing**, and testing can add considerably to their emotional distress.

If the client is not psychologically ready, the baseline HIV test can be delayed by up to 3 days after commencement of PEP

However, baseline HIV testing is necessary **within 72 hours** of starting PEP, and can be performed at the same time as blood is taken for baseline Hb and other tests as shown below.

If the result is positive, PEP should be **stopped**. It should be explained that the HIV infection has **NOT** occurred as result of the sexual assault, rather from previous exposure. The individual should be referred for ongoing HIV care as well as all other aspects of post rape care.

Blood Monitoring for PEP

Baseline **Haemoglobin** should be taken within 3 days of starting PEP, and repeated at 2 weeks, because of the potential for ARV induced bone marrow suppression.

Ideally **SGPT/ALT** and **Creatinine** should also be checked at baseline and the **SGPT** repeated at 2 weeks, but the inability to do these tests **should not prevent an individual from receiving PEP if otherwise indicated.**

At Baseline: If the **Hb < 6.5, SGPT > 175 or Creatinine > 3.0 (300)** then PEP should not be continued without discussion with a senior clinician experienced in the use of ARV's, as the risks may outweigh the potential benefits in some circumstances.

At 2 weeks: If there is a significant **fall in the Hb** or an **increase in SGPT** compared to the baseline values, then PEP should not be continued without discussion with a senior clinician as above.

Side Effects of PEP

Patients taking PEP should be warned to expect the common side effects such as **nausea, headaches, tiredness and general aches and pains.** They should be counselled that these usually improve with time and do not cause any long-term damage. The purpose of the laboratory monitoring is to pick up the more dangerous side-effects, but these are extremely rare in patients taking ARV's for only one month. .

1.3. Management of physical injuries

This is dependent on the age of the survivor. Ideally children should be admitted and examined under anaesthesia or given first aid and then referred.

Abrasions and superficial lacerations should be cleaned with antiseptic and either dressed or painted with tincture of iodine. A vaginal wash with an appropriate antiseptic should be done **AFTER** all specimen have been taken. Tetanus toxoid 0.5mls should be given in the case of any physical injuries that result in breakage of the skin.

Minor injuries to the vulva and perineum are often best managed as above. However, if the injuries are severe enough to require suturing, it is justifiable for this to be performed under sedation or even under general anaesthesia, if the patient's level of anxiety does not permit repair under local anaesthesia.

High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anaesthesia by a gynaecologist or other qualified personnel and repaired accordingly.

In cases of confirmed or suspected perforation, laparotomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon. Where feasible, in cases involving children, a paediatrician, gynaecologist or surgeon should ideally be consulted.

Analgesics should be provided to relieve the survivor of physical pain both from injuries and that commonly associated with trauma such as headaches.

1.4. Prophylaxis/management of Sexually Transmitted Infections

STI prophylaxis should be offered to all rape survivors. It need **not be given** at the same time as the initial doses of PEP and EC as the pill burden can be intolerable. It should preferably be prescribed for the client and given for uptake within 24hours.

Important note

The HVS performed at presentation is done for legal/forensic reasons (see below) and **not to screen for STIs and guide antibiotic administration**. People with a “normal” HVS should still be offered STI prophylaxis.

Ideally, an anti-emetic should be given

Drugs used for STI Prophylaxis

Non-pregnant adults (male & female)

Norfloxacin 800mg Stat
plus
Doxycycline 100mg BD one week

Children

Amoxycillin 15mg/kg TDS on week
plus
Erythromycin 10mg/kg QDS one week

Pregnant adults

Spectinomycin 2g Stat
OR
Amoxycillin 3g Stat
plus
Probenicid 1g Stat

and

Erythromycin 500mg QDS one week

1.5. Hepatitis B Prevention

The generally available Hep B Vaccines do not provide any protection from infection if given after an exposure (eg: sexual assault), but they do provide protection from future exposures. Administration of the toxoid does however provide some protection, after the exposure has occurred.

Unpublished data suggests that about 40% of health care workers already have immunity to Hepatitis B, though this figure is probably lower in the general population (ie: in rape survivors). It is much less costly to vaccinate all survivors of rape/sexual violence, rather than to test everyone for Hepatitis B antibodies to see who might benefit.

Ideally if Hep B toxoid is available it should be considered for survivors of sexual violence.

2. COUNSELLING

Counselling should be offered to all rape survivors, and should cover three basic areas: Trauma counselling/crisis prevention, HIV pre and post test counselling and PEP adherence counselling on an on-going basis of up to a minimum of 5 sessions. Ideally, referral for long-term on-going trauma counselling should be undertaken.

Counselling should be done by an experienced general counsellor, VCT and/or DCT counsellor who has been trained in trauma counselling and HIV testing in the context of sexual violence. Counselling can be undertaken in the VCT or DCT room, or other room within the hospital that provides privacy for the survivor.

The client should be referred to the counsellor after initial dose of PEP and EC. This will enable the client make an informed choice about HIV testing in order to continue PEP. Where the survivor sees the counsellor within 72 hours and PEP/EC have not been given, the counsellor must ensure that these are provided before commencing counselling.

2.1. Trauma Counselling/Crisis Prevention

This is of priority for the survivor and should attempt to reduce immediate rape trauma disorder and long-term posttraumatic stress disorder. The counsellor needs to spend time exploring the survivors' fears and feelings without undue curiosity or cross-examination. Ideally, counselling should also be offered to partners and families of survivors of sexual violence, who are often also highly traumatized.

Clients who present after 72 hours and are therefore not eligible for PEP should be provided support with initial counselling and ideally referred for long-term on-going support for themselves and their family. These clients must also be referred for medical management including STI prophylaxis or management

2.2. HIV pre- and post-test Counselling

This should follow the established National HIV testing Guidelines. While examining officers may provide information to the client (often the client is highly traumatized), it is essential for the counsellor to clarify the survivors understanding of the information already provided.

- **PEP** (for instance, many patients cannot understand why if they are HIV **negative** they are given HIV drugs, whereas if they test **positive** these drugs are stopped),
- The **Window period** (during the time between exposure to and testing positive for HIV which is approximately 6-weeks, a person will show a HIV negative result if tested but have and can transmit HIV. It is therefore important to discuss previous risks and the possibilities of HIV infection prior to the rape).
- **Emergency Contraception** Termination of pregnancy as an option in case conception occurs as a result of the rape should be discussed (this is allowed in Kenya under these circumstances. It however requires psychiatric evaluation and recommendation).
- **STI prophylaxis**

Safe sex should also be advised (and condoms provided) until follow up testing has been completed given the potential risk of sero-conversion, even in patients taking PEP.

Important note

If the client is not psychologically ready, the baseline HIV test can be delayed by up to 3 days after commencement of PEP.

The counsellor should obtain informed consent (the client should sign at the back of the laboratory request form). The client should be referred to the laboratory for HIV testing (written results are necessary. Where counselling is done by a VCT/DCT counsellor trained in trauma counselling, or in a VCT/DCT site, **HIV testing should be done in a laboratory** for legal reasons). The counsellor should collect HIV results from the laboratory. Post-test counselling should be provided as per national HIV testing guidelines.

2.3. PEP Adherence Counselling

Subsequent counselling sessions (particularly for clients on PEP) should be booked to coincide with PEP clinic follow ups. Efficacy of PEP is directly linked to the level of adherence, which unfortunately is often poor in this situation. Effective counselling has been shown to increase adherence. Therefore, while trauma counselling and on-going support for survivor and their family is provided drug adherence support counselling is vital for people taking PEP.

Note: It should be remembered that PEP only reduces the chances of HIV infection and does not definitely prevent HIV. This needs to be communicated to the client at the beginning of counselling sessions

2.4. Counselling special cases

Where survivors of sexual assault are children, it is important to provide counselling for their parents/guardians or the adult who brings them/is responsible for their care. Often the adult responsible for the safety of the child feels guilty and blames him or herself for not preventing the violence. If not supported adults may cause more trauma to themselves and the survivor. Consent for HIV testing should be sought from the adult.

Counsellors trained in counselling for trauma, HIV testing and PEP adherence in the context of sexual violence will have skills in providing counselling support for children.

In cases where children are very young (approximately 4 years and below); it is important to explore risks and the possibility of a positive HIV status for the parents (in the event the child's baseline HIV test shows positive results) as part of initial counselling.

3. HISTORY, EXAMINATION, DOCUMENTATION & LABORATORY (LEGAL/ FORENSICS)

There are two types of evidence that need to be collected: evidence to confirm that sexual assault occurred and evidence to link the alleged assailant to the assault

3.1. History, examination and documentation

This is often done poorly. The lack of proper documentation means that even the minority of cases that get to court are often thrown out because of lack of evidence. It is vital that the examination causes the absolute minimum of added trauma that is possible.

All bruises, abrasion, teeth marks etc. to the head, mouth, neck, breasts, perineum, anus and vagina should be documented carefully in the clinical notes in the PRC1² availed in health facilities. This allows the P3 form to be filled effectively, preferably by the person performing the examination (this is not always possible). The PRC1 form should be filled in duplicate and the original given to the client while the copy is left for facility records.

Important note

History taking, examination and documentation is what provides the critical link between the occurrence and survivor, and the health care and criminal justice systems. This process informs the filling in of the P3 form which is the document used by the criminal justice system to investigate, arrest and prosecute perpetrators.

History taking, documentation and examination include: establishing the background of the survivor, survivors account of the occurrence, medical, obstetric and gynaecological history, detailed physical examination, specimen collection, packaging and analysis with clear documentation of all of the above.

The PRC1 form allows for history taking, documentation and examination. It facilitates filling in of the P3 form by ensuring that all relevant details are available and were taken at the first contact of the survivor to a health facility.

The PRC1 form strengthens the development of a chain of custody of evidence by having a duplicate that can be used for legal purposes and showing what specimen were collected, where it was sent and who signed for it.

Note: An absence of physical injuries does not mean that rape/sexual violence including penetration did not occur.

A HVS (if vaginal penetration alleged) should ideally be performed to allow documentation of the presence of spermatozoa. This should be performed only with the individual's consent, with explanation of the reasons for doing it. **It should not be performed** unless it is going to be done properly with the use of a speculum under direct vision, by a trained clinician. This is because poor technique often results in a negative result, which can be highly damaging in court and has resulted in many cases being thrown out. An anal and oral swabs should be taken where there is alleged penetration. Where there are signs of ejaculation or other fluids around the perineum, this should be swabbed and sent to the laboratory.

² This is a form developed from the P3 form that has been developed to aid documentation by examining officers. The term PRC is derived from Post Rape Care form 1. Find attached as appendix

Note: The absence of spermatozoa does not mean that penetration did not occur. This may be due to a number of reasons ranging from poor sampling technique (see above), douching by the patient, the use of condoms, delayed presentation for medical examination or lack of ejaculation by the assailant.

Note: With small children, (or in adults where there is significant vaginal trauma), it is not appropriate to pass a speculum for the purpose of obtaining an HVS only, and this should be written in the notes and any trauma should be carefully documented. If exploration of the genital tract is needed in these circumstances, it should be performed by a gynaecologist, preferably under sedation or anaesthesia.

Any areas where semen is expected or observed should be swabbed for micrology.

3.2. Specimen collection, the laboratory, & preservation of evidence

Torn or soiled clothing should ideally be collected and passed to the police and signed for in a specific rape register³ located at casualty or outpatient department by the police officer who takes away the specimen. Replacement clothing needs to be arranged in these instances.

Normally, the High Vaginal Swab (HVS) taken by the examining clinician should be taken and sent to the laboratory immediately. **The HVS in this situation is not for purposes of screening for STIs.** Information on pre-existing STIs can be found, but it does not provide any information on infection from the rape/sexual violence incidence. While this may be feasible at follow up visits, it is often traumatizing for the clients, and the health care system does not capture those clients who do not come for follow up. It is therefore recommended that STI prophylaxis be given as routine (*refer to section 1.4*).

HIV testing should be done in the laboratory in accordance to the national guidelines for HIV testing. Preferably blood should be drawn intra-venously and used for the various blood tests as per PEP requirements outlined below (this way the blood from one draw can be used for HIV testing and avoids situations where the client has to come back to the lab for more sample collection).

Baseline **Haemoglobin** should be taken within 3 days of starting PEP, and repeated at 2 weeks, because of the potential for ARV induced bone marrow suppression. Ideally **SGPT/ALT** and **Creatinine** should also be checked at baseline and the **SGPT/ALT** repeated at 2 weeks, but the inability to do these tests **should not prevent an individual from receiving PEP if otherwise indicated.**

All tests and results should be recorded in a **laboratory rape register** that should contain information: name, registration number, date, age, sex, investigations done, results and a place for anyone who takes specimen to sign in order to maintain a chain of custody of evidence. The Laboratory rape register should be kept well locked away and accessible to authorized health facility personnel as a measure towards preserving confidentiality.

Permanent preservation of sperms is highly recommended for evidence. This can be done by taking a HVS, smearing it on a glass slide and applying 4 drops of 95% alcohol for fixation as is

³ This has been developed to ensure that data is captured and management of clients can be tracked, and a chain of custody of evidence is maintained from the facility level. Find attached as appendix.

done with a **pap smear** procedure. The slide should be clearly recorded with name, date and registration number and preserved for future evidence.

Evidence to link an alleged assailant to the assault

This essentially involves comparison of DNA samples taken from the alleged assailant and the rape survivor. Given that there is little capacity for DNA analysis at present, and that there are worries that there is an insufficiently stringent “chain of custody of evidence” infrastructure to support it, the time-consuming and often traumatic collection of samples for this purpose **cannot be recommended generally**.

In general, most effort should be expended with documenting evidence that can corroborate the survivor, until the above problems with DNA handling can be overcome.

3.3. Procedures for reporting to the police

Rape survivors should be encouraged to report to the police immediately after medical attention. It is however, an individual choice and should not be forced.

Police should encourage and assist any one presenting to the police station following rape/sexual assault, to attend the nearest health facility as soon as possible, preferably before legal processes commence as both PEP and EC become less effective with time.

What the client should expect at the police station:

- At the police station a report is entered into the Occurrence Book and the survivor is issued with a P3 form. The P3 form should be provided **free of charge**. An OB number should be availed to the survivor.

If the client has not been to the hospital, it is important that they go there immediately after reporting. Other procedures such as writing a statement can be undertaken after initial treatment has been received.

- The police should record the statement of the survivor and any witnesses, and the survivor should sign it only when they are satisfied with what the police have written.
- The P3 form should be completed by an authorized health worker based on the clinical notes found in PRC 1.

Note: The P3 form does not have to be completed immediately. This can be done at a later date after medical evaluation is complete

- While taking the P3 form to be completed it is important for the survivor to have original copies of PRC1 form.

MINIMUM STANDARDS AND MANAGING COMPREHENSIVE PRC

This section provides guidance on minimum standards that should be provided at health facilities depending on what they can offer survivors of sexual violence. It also outlines requirements for managing post rape care facilities

Table 3.1 – Minimum standards for providing comprehensive PRC in health facilities

	Minimum standards for Medical management of survivors	Reporting/recording requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities without a laboratory (public & private)	<ul style="list-style-type: none"> • Manage injuries as possible • Detailed history, examination and documentation (refer for HVS, PEP/EC,STI) 	<ul style="list-style-type: none"> • Fill in PRC1 form in duplicate • Maintain PRC register 	<ul style="list-style-type: none"> • A trained nurse
All health facilities with a functioning laboratory (public & private)	<ul style="list-style-type: none"> • Manage injuries as possible • Detailed history, examination and documentation (including HVS) • Ideally, 1st doses of PEP/EC should be provided (even where follow-up management is not possible) • Where VCT services are available, provide initial counseling 	<ul style="list-style-type: none"> • Fill in PRC1 form in duplicate • Maintain a PRC register (annex 3) • Maintain a PRC laboratory register • Referral to comprehensive post rape care facility 	<ul style="list-style-type: none"> • A trained nurse and/or a clinical officer • A trained counsellor (where counselling is offered)
All health facilities with HIV, ARV or a Comprehensive care clinic (CCC) where ARV can be monitored (comprehensive post rape care facilities can be provided) private and public health facilities	<ul style="list-style-type: none"> • Manage injuries as possible • Detailed history, examination and documentation • Provide emergency and on-going management of PEP • Provide EC • Provide STI prophylaxis or management • Provide counselling for trauma, HIV testing and PEP adherence 	<ul style="list-style-type: none"> • Fill in PRC1 form in duplicate • Maintain PRC register (annex 3) • Maintain laboratory PRC register • Fill in PRC2 form to follow up management of survivors 	<ul style="list-style-type: none"> • 1 medical or clinical officer trained in ARV/PEP management • 1 trained counsellor in (trauma, HIV testing and PEP adherence counselling) • Laboratory for HIV & Hb tests • Preservation of sperms from a HVS specimen can be done in the same way as a pap smear (see section 3.2)

Notes:

1. History taking, examination and documentation and the PRC1 form

- It is the responsibility of the District Medical officer of Health to ensure that the PRC1 form is available in all public health facilities for this purpose in their district
- It is the responsibility of any private health facility to ensure that the PRC 1 form is available for this purpose in their health facility.

2. Reporting and recording PRC

- PRC must be compiled as part of the monthly summary report sent to the District MoH by all health facilities. The report should include: total number of survivors seen, their age, sex, PEP and EC provision, PEP and EC completion.
- PRC1 should be treated as part of confidential client forms and the duplicate stored with the health records office

- The PRC2 form should be available at the place where PEP monitoring is on-going
- The PRC2 forms should be submitted through the DASCO (in a government facility) and any responsible person (in private facilities) to the Division of Reproductive Health Quarterly. It is returns of the PRC2 that will be used to provide continued PEP and EC for health facilities.
- A summary report of PRC should be provided as part of monthly report to the district level

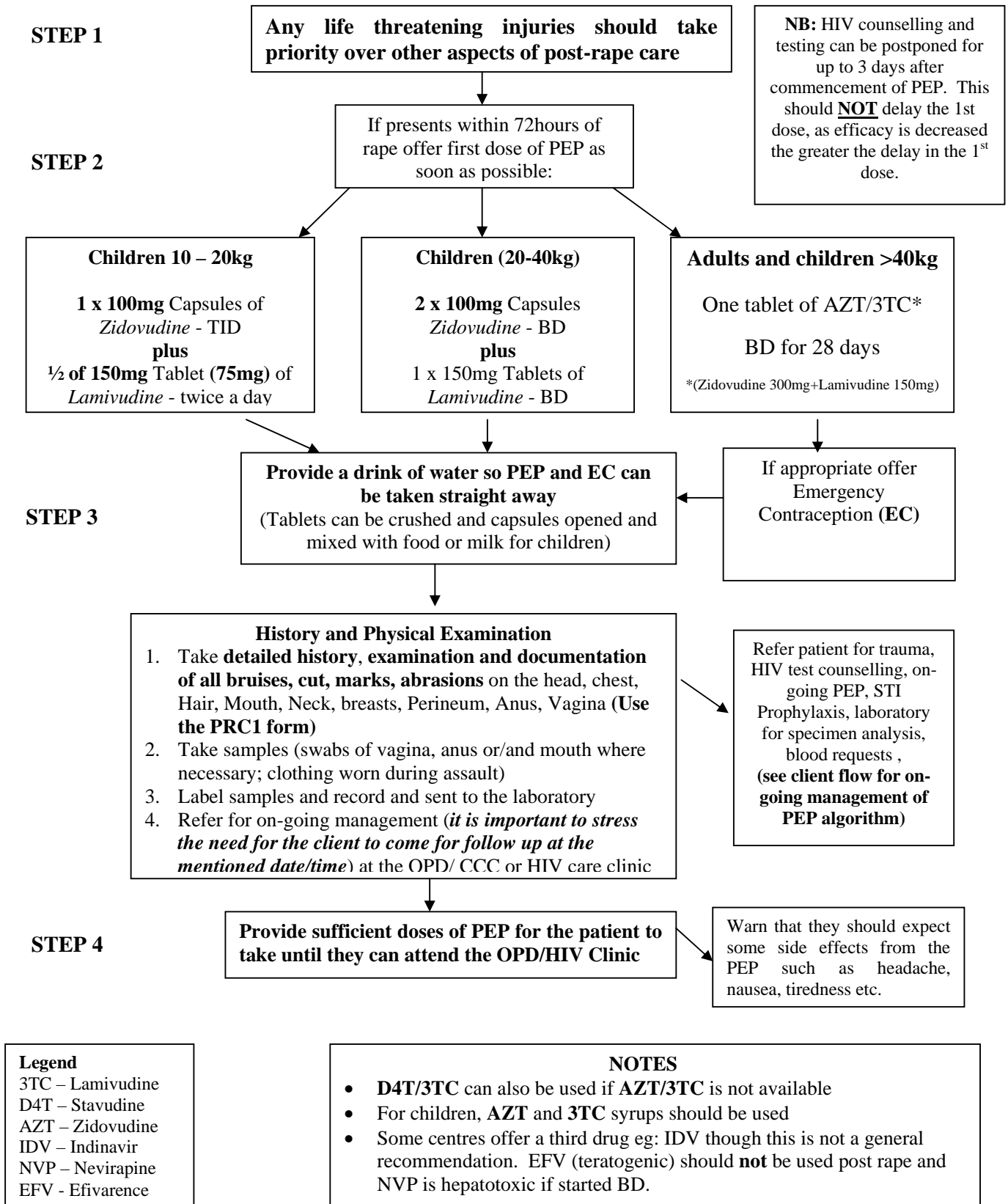
3. Laboratory services:

There are some services that are optional and additional. These include:

- Laboratory: SGPT/ALT, Creatinine and full LFTs and U+Es.

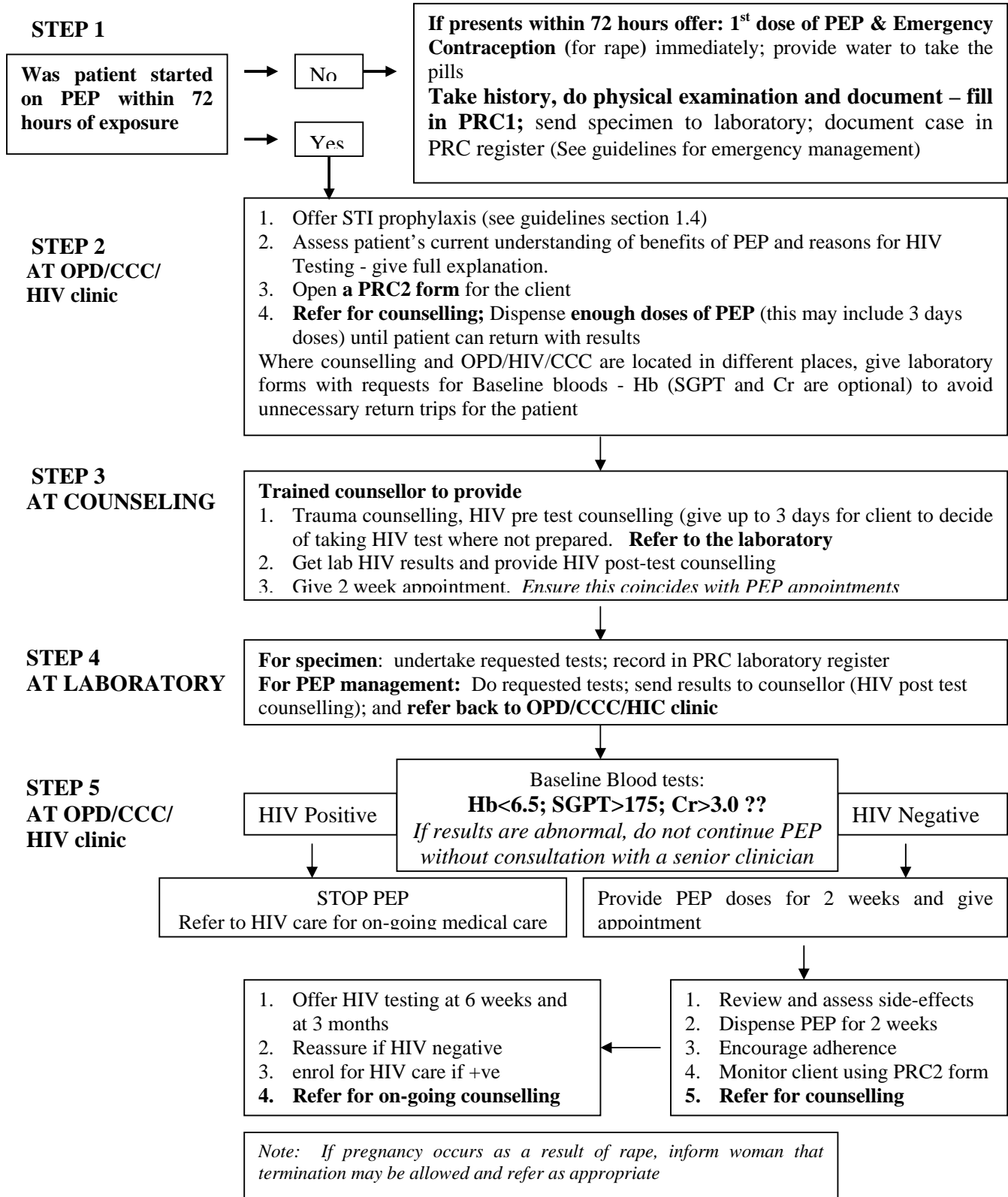
Flow Chart for the emergency Management of Rape Survivors at casualty and OPD/HIV clinic – HIV and Pregnancy Prevention

Compassion, respect and confidentiality should be offered to all patients, but they are particularly important in rape survivors, due to the intense trauma they have suffered. Counselling should be offered as part of post-rape care. Emergency doses of Post Exposure Prophylaxis (PEP) and also Emergency contraception (EC) should be available in Casualty.



Client Flow for On-going Management of PEP in OPD or HIV Clinics

Compassion, respect and confidentiality should be offered to all patients, but they are particularly important in rape survivors, due to the intense trauma they have suffered.





Post Rape Care Form 1 (PRC1)

National rape Management guidelines: Examination documentation form for survivors of rape/sexual assault (to be used as clinical notes to guide filling in of the P3 form)

Date	Province code	District code	OP/IP NO.
------	---------------	---------------	-----------

Name..... Date of Birth Sex

Contacts

Date & time of examination: Date & time of assault:

Place assault occurred

No. of. Assailants: Alleged assailants: Known (relation to victim): Un known

Chief complaints/presenting symptoms

Circumstances surrounding the incident (patient account) remember to record – (*Penetration, How/where, What was used?, Struggle*).....

Type of assault (oral /vaginal/anal/other sex)

Use of condom Yes No

Incident already reported to police? Yes (which station & when?)....., No

Attended a health facility before this one? Yes (Which one, where) No.....

Were you treated? Yes..... No..... Were any notes given to you? Yes..... No.....

Comments

Significant Medical History/Surgical

Obs/Gyn History: Parity..... Contraception type..... LMPKnown pregnancy?

Date of last sexual intercourse -----

General condition: Bp temp RR pulse rate

Physical examination (indicate sites and nature of injuries, bruises and marks outside of the genitalia)

Psychological assessment

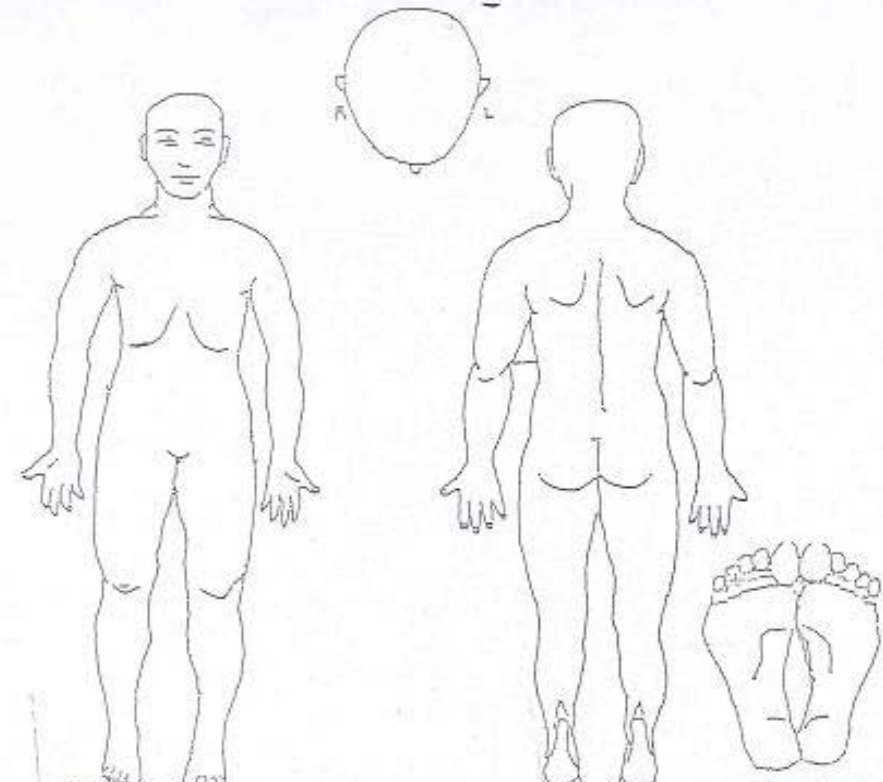
- Demeanour? (calm, look her age or not etc)
- Mental state (normal. confused, flashback, hyper-aroused, dazed, coma, retarded, extremely calm)
- Did the patient change clothes: Yes: _____ No: _____
- Observation of state of clothes: *Stains, tears, colour, where the clothes worn were taken??*
- Were the clothes put in non-plastic paper bags? Yes no
- Were the clothes given to the police? Yes no
- Did police sign rape register at the health facility? Yes no
- Has the person had a bath ,had a long or short call-specify)? Yes: ... No: Comments:

DOES THE SURVIVOR HAVE ANY DETAILS ON THE ASSAILANT? (is the assailant known, is there any relation, did the assailant leave any marks on the assailant?).....**D**

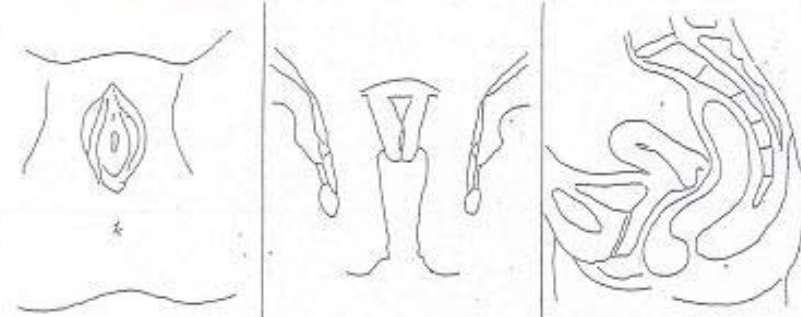
SKETCH OF PERSON Anterior view
Posterior view

PLEASE USE THE SKETCH BELOW TO INDICATE INJURIES, INFLAMMATIONS, MARKS ON VARIOUS BODY PARTS OF THE SURVIVOR

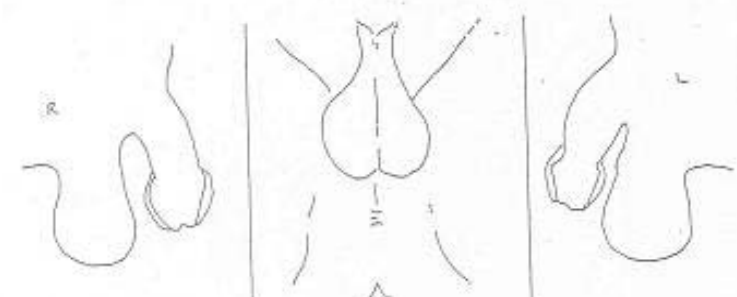
COMMENTS.



FEMALE GENITALIA.



MALE GENITALIA.



GENITAL EXAMINATION (OF THE PATIENT/COMPLAINANT – INDICATE DISCHARGES, INFLAMMATION, BLEEDING)

Female: Describe in detail the physical state of and any details:

- outer genitalia:
- vagina/hymen.....
- Cervix:
- Anus

Male: Describe in detail the physical state and all details:

- outer genitalia:
- anus:

other significant orifices(oral cavity----of tongue, palate, etc-----)

Comments:

Immediate management: PEP 1st doses If so, how many tablets EC

stitching/surgery if so, please comment

Any other treatment/medication/management.....

Client referred to:

Police station VCT/DCT/counselling Laboratory OPD/CCC/HIV clinic

Other (please specify)

Doctor's name:..... **Signature:**..... **Date**

(B) Laboratory samples

Sample type	Test	Please tick what applies		Comments
		National government lab	Health facility lab	
External Vaginal Swab	Sperm			
	DNA/CS			
	Other			
Internal (high) vaginal swab	Sperm			
Urine	P/T			
	Microscopy			
	Other			
Anal swab				
Skin swab				
Blood				
Other				

(C) Chain of custody

These/All/Some of the samples packed & issued (please specify)

To Dr/Mr/Mrs-----sign-----

Date..... Time

By Dr/Mr..... Sign



Ministry of Health Division of Reproductive Health (Post Rape Care Form 2 - PRC2)

ON-GOING MANAGEMENT OF PATIENTS AND DATA COLLECTION AT ARV/PEP/CCC clinic

Date Province code District code OP/IP/CCC number Client surname First name

2. Age (years)

3. Sex 1 Female 2 Male

4. Weight (kg)

5. Education level?

- 1 None 2 Some primary 3 Some secondary 4 Some post-secondary

6. Occupational exposure

- 1 None 2 Unskilled 3 Skilled 4 Student 5 Professional 9 Other

(specify)

7. Marital status

- 1 Never married 2 Steady partner (not married) 3 Married 4 Widowed 5 Separated/Divorced 9 Other (specify)

8. Injury date and time?

Date (dd/mm/yy)

Time (hours/mins)

9. Arrival at District Hospital

Date (dd/mm/yy)

Time (hours/mins)

10. Where did client present?

- 1 Casualty/out patient dept 2 PEP/CCC clinic 3 V/DCT 9 Other (specify)

11. How many hours between injury and presentation?

12. Did the client present in less than 72 hours after injury?

13. Was the first dose of PEP given 1 Yes 2 No

14. If yes, when was it given?

Date (dd/mm/yy)

Time (hours/mins)

15. If not, why?

16. Was EC given?

1 Yes 2 No

If not why?

1. Was the assailant known?

- 1 Known with blood relations 2 Known with no blood relation 3 Not known 4 Not indicated

Indicate No of assailants

14. added details:

15. If SV/Rape, what type?

- Human Objects 1 Vaginal penetration 2 Anal penetration 3 Oral penetration 4 Multiple penetrations 9 Other (specify)

16. Was the Post Rape Care form1 (PRC 1) filled?

- 1 Yes 2 No 3 Not known

17. Were there any injuries that required surgical repair?

- a. Genitalia 1 yes 2 No b. Other parts of the body 1 yes 2 No

5. (specify/key comments)

18. STI prophylaxis/management given

- 1 Yes 2 No 3 not known

19. Were laboratory services provided?

- High Vagina Swab 1 Yes 2 No Anal swab 1 Yes 2 No Other (please specify)

15. Was reporting done to the police?

- 1 Yes 2 No 3 Not Known

16. Did the police collect and sign for any specimen taken from the hospital?

- 1 Yes 2 No 3 Not Known

14. HIV baseline test done?

- 1 Yes 2 No

15. If yes, HIV test results

- 1 HIV +ve 2 HIV -ve

17. Was counselling for trauma and for HIV testing offered?

- 1 To the client 2 To the guardian of the client 3 No 4 Not indicated/known

26. Blood monitoring tests (baseline)

- 1. Hb: 1 Yes 2 No 2. Creatinine 1 Yes 2 No 3. SGPT/ALT 1 Yes 2 No

Other (specify/comments on abnormalities)

Was PEP continued after baseline tests?

- 1 Yes 2 No

4. 28 Regime prescribed?

29 If PEP was discontinued, why?

- 1 HIV positive 2 Abnormal blood results 3 Client did not return with results 5 Other (specify)

30 PEP- follow up

Table with columns for Week (1, 2, 4, 6) and Date, and rows for PEP/CC C follow up, Counselling follow up, Other (specify)

31 Side effects at follow up? show dates

32 PEP completed? (at week 4)

- 1 Yes 2 No

33 If No, why?

- 1 Discontinued by clinician 2 Self discontinued

34b. if self discontinued, why

- 1 Side effects (common & mild) 2 Toxicity (explain)

34 PEP outcomes at week 4

- 1 HIV -ve 2 HIV +ve 3 Not known

35 PEP outcomes at month 3

- 1 HIV -ve 2 HIV +ve 3 Not known

Seen by:

Sign

Date

