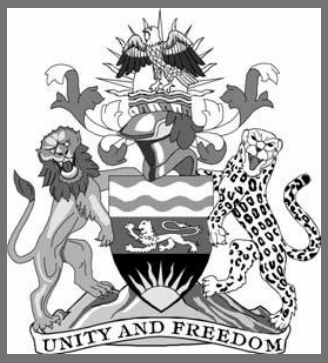

Guidelines for Provision of Comprehensive services for survivors of physical and sexual violence at Health Facilities in Malawi

(One-Stop Centres)

Revised Edition 2012

MINISTRY OF HEALTH

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ACRONYMS

ARV / ART	Ant-retroviral Therapy/treatment
CID	Criminal Investigations Department
EC	Emergency Contraception
HB	Hemoglobin
HIV	Human Immune-Deficiency Virus
PEP	Post Exposure Prophylaxis for HIV
STIs	Sexually Transmitted Infections
VCT	Voluntary Counseling and Testing for HIV
OSC	One-Stop Centre

GLOSSARY OF TERMS

For the purpose of consistency, the following terms have been used throughout the Document. Specific definitions on related items have been provided in the text.

"Victim/Survivor" individuals (eg. women, children, men) who report that they have been physically and sexually assaulted and have lived through the experience

"Patient/Client" individuals who are receiving a service from, or are being cared for by a health care worker

"Health care worker" professionals who provide health services, nurses, doctors, clinical officers, medical assistants, who have specific training in the field of health care delivery

"**Service provider"** means any person or body of persons approved to provide assistance to survivors of domestic violence, and includes the police, community policing forums, faith-based organizations, Government institutions, non-governmental, voluntary or charitable organizations

"Sexual Assault" synonymous with sexual violence; a term covering a wide range of activities, including rape /forced sex, defilement, indecent assault and sexually obsessive behaviour

"Domestic violence" means any criminal offence arising out of physical, sexual, emotional or psychological, social, economic or financial abuse committed by a person against another person within a domestic relationship

"Sexual abuse" includes sexual contact of any kind that is made by force or threat and the commission of, or an attempt to commit, any of the offences under Chapter XV of the Penal Code

"Physical abuse" means any act or omission which causes or is intended to cause physical injury or reasonable apprehension of physical injury

"Intimate partner" a husband, boyfriend or lover

"Child" means a person below/under the age of sixteen years

"Place of safety" means an appropriate place where a child in need of care and protection can be kept temporarily and includes a safety home or a foster home;

"Defilement" According to the Laws of Malawi in the Penal Code (Cap 7:01,138) defilement is defined as any person having carnal knowledge of any girl under the age of sixteen years.

"Rape" as any person having unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in case of a married woman, by personating her husband.

FOREWORD

Sexual assault occurs in every culture, at all levels of society and in every country of the world. Global data suggests that one woman in every five has suffered an attempted or completed rape by an intimate partner during her lifetime. Sexual assault takes place within a variety of settings, including the home, the workplace, schools and in the community.

Globally it is estimated that 13% women and 3% of men worldwide report sexual assault in their lifetime. According to Rape Statistics South Africa of 1998, South Africa recorded the highest per capita rate of reported rape in the world with 116/110,000 of the population (SA Fam Pract. 2008).

There are indications of increased link between Gender-Based Violence and HIV/AIDS. In Sub-Saharan Africa, females account for 75% of HIV prevalence between 15 to 24 years. One factor associated with increased incidence of HIV amongst women and the youths is Gender-Based Violence. Related to children, approximately 40% of genital injuries in South African children are due to sexual assault (CME, 2004).

In Malawi, men initiate sex in 92% of relationships and women feel powerless to refuse sex or negotiate safe sex (Save the Children US 2000). Bisika and Kakhongwe (Centre for Social Research) conducted a literature review in 1999; where they found that 55% of women said they had been raped or forced into sex. Hickey (1999) found that Malawian women felt they could not be raped within marriage, women had to have sex with their spouse, even if they did not want to. Sangala (1999) suggested that men are socialised to believe that it is not normal for women to actively agree to sexual intercourse and that coercion is part of the sex act.

The National Taskforce on Children and Violence, in collaboration with Save the Children (US) in 2000, examined 70 cases of child sexual assault in Kamuzu Central Hospital. Findings indicated that over half of the cases were aged between 2 and 13 years, and that 34% of the cases had been abused by an unknown assailant, followed by 17.1% with a known assailant. However, community members were reluctant to disclose the identity of the abuser if he was known.

Though incidences of sexual and physical assault occur in males in Malawi, there is limited information available.

To prevent child abuse, sexual and physical assault, violence and neglect the government of Malawi has put in place a number of measures to protect children, and women. The Malawi constitution further promotes and provides for enjoyment of human rights by all Malawians, including women and children. It calls for the elimination of sexual assault, and calls for passing of legislation that eliminates customs and practices that discriminate against women. Malawi's penal code provides punishments for cases such as rape, defilement, indecent assault, incest and insulting the modesty of a woman. The Child Care, Protection and Justice Act No 22 of 2010, Protection of Domestic Violence Act and Laws of Malawi also provide remedies against sexual and physical assault.

The October 2003 National HIV policy stated that "Malawians, especially women and children are protected against sexual violence, rape and other forms of coerced sex". This implies that survivors of sexual assault and rape are protected by the Laws of Malawi.

Sexual assault has a negative impact on the health of the population. The potential reproductive and sexual health consequences are numerous – unwanted and unplanned pregnancies, sexually transmitted infections (STIs), including HIV infection. Sexual assault experiences may also affect psychosocial well-being of victims, leading to serious and long-lasting mental health problems. Victims of sexual assault, for example, are more likely to experience depression, drug abuse, post traumatic stress disorder and suicide.

Survivors of sexual assault require comprehensive and gender sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The types of services that are needed include emergency contraception, STI treatment, Post Exposure Prophylaxis for HIV, treatment of injuries and psychosocial counseling.

In addition to providing direct health care, the health sector must act as an important referral point for other services that the survivor may later require, such as social welfare, the police and legal aid. Health care workers are in a position to collect and document the evidence necessary for corroborating the circumstances of the assault. Such evidence is often crucial to the prosecution of cases of sexual and physical assault.

The aim of these guidelines is to set standards for comprehensive care of survivors of sexual assault and rape. It is expected to provide a practical reference source for service delivery to all health care workers in Malawi. Therefore, it is very important to consider incorporating these guidelines in all pre-service training curricula and ensure their availability at all health facilities in the country.

Ministry of Health as the lead implementer of these guidelines will work in collaboration with key stakeholders and agencies which include: Ministry of Women & Child Development, District Social Welfare Officers, Ministry of Justice, the Judiciary, the Police, Non-Governmental Organisations, among others.

Signed

Dr Charles Mwansambo
PRINCIPAL SECRETARY, MINISTRY OF HEALTH

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Mtisunge Mwafulirwa – Social Welfare, Lilongwe
Darlington Akambadi – Mzuzu Police
Ndumanene Silungwe – St John of God Mental Health Services

Signed

Dr Frank Chimbwandira
DIRECTOR OF HIV/AIDS DEPARTMENT, MINISTRY OF HEALTH

1.0 INTRODUCTION

1.1 Development of Guidelines for Comprehensive Services for survivors of Physical and Sexual Violence (One Stop Centres) at health facilities in Malawi

The development process of coming up with the document involved literature review of existing policy guidelines related to the One Stop Centre concept in Malawi and elsewhere. Situational and Gap Analysis on the services offered towards survivors of Sexual Assault was conducted to draw lessons on achievements and areas of improvement. Thereafter, Consultative workshops were conducted with key stakeholders.

1.2 One Stop Centres for Survivors of Physical and Sexual Violence

Comprehensive services for survivors of physical and sexual violence will be provided at One-Stop Centres. One Stop Centres (OSCs) are aimed at providing comprehensive services to women, child, and male survivors of sexual, physical and gender based violence. At the Centres all the necessary services including health, social services and police are provided and coordinated in one place. This helps reduce secondary victimisation because survivors do not have to recount the horrific incidents to different service providers.

The OSCs are located within a health facility with linkages to other services based outside the health facility. Referral mechanisms have been established so that police investigators, prosecutors, and social welfare are all involved when a case is registered at the hospital. Review meetings and linkages will be held amongst key stakeholders periodically to discuss progress and address any gaps in the provision of services to women and child survivors of sexual, physical and gender based violence.

Advantages of OSCs are two-fold. On one side, survivors can get comprehensive package of services at one place, minimizing the secondary trauma. Most importantly, OSCs house the necessary response to rape victims. In the case of rape the administration of PEP test is done within 72 hours. Further still, coordinating the different multi sector actors in one place increases the chance of cases reaching prosecution and higher rate of conviction therefore ensure justice and safety for survivors. This is because evidence is collected expediently and all the referral systems for victims are in one place. Linkages to NGOs and faith based organization further ensure that psychosocial services are provided to victims of abuse.

At present, there are four facilities with One Stop Centre (OSC) each operating in the country, namely in Lilongwe, Mzuzu, Zomba and Blantyre. Based on lessons learnt, a feasibility assessment of the existing OSC observed that the integrated service OSC model should be pursued and it is important to facilitate linkage of the relevant

stakeholders which include: policy makers, lawyers, magistrates, police, health workers, agencies such as National Child Justice Forum and Non-Governmental Organisations for proper running of OSCs.

2.0 AIM OF THE GUIDELINES

The guidelines provide guidance to personnel working with women, children, and men who have been sexually and/or physically assaulted or abused on how to assist women and children with access to medical, social and legal services in a holistic and well coordinated manner. They will provide information on procedures to be followed when handling cases of sexual and physical abuse and violence, as well as provide guidance on referral and reporting mechanisms of cases. The guidelines address the needs of children recognizing that children form the largest proportion of survivors of sexual abuse, violence and neglect in the country.

The guidelines will be available at health facilities with One Stop Centres, District Social Welfare Offices, Police and NGOs that provide services to survivors of abuse. Specific to health services, these guidelines aim at improving Malawi's health services for all individuals (women, men and children) who have been survivors of sexual assault by providing:

- A case definition to which these guidelines may apply
- Health care workers with information on the knowledge and skills which are necessary for the management of survivors of sexual assault
- Standards for the provision of both health care and forensic evidence to survivors of sexual assault
- Guidance on the establishment of health and forensic services for survivors of sexual assault.

By making the guidelines available as a resource document to all levels of health care workers, it is hoped that awareness of the problem of sexual assault will be raised and, in turn, the detection rate of such activities increased.

These guidelines focus on care for women, children, although evidence exists that sexual assault in children is comparable in boys and girls, in adulthood, women are much more likely to suffer sexual assault than men. Nevertheless, it is acknowledged that men can be sexually assaulted or raped as well, and these guidelines address a range of health care issues that apply to individuals of both sexes. Specific issues related to children have been identified wherever possible and Chapter 6 is specific to children.

At operational level, the guidelines will be accompanied by implementation plans with details on capacity needs, specific roles and linkages between key stakeholders, monitoring and evaluation, among others.

3.0 LIMITATIONS OF THE GUIDELINES

The guidelines will operate within the limited resources available for a low developing country like Malawi. Though issues of forensic examinations are mentioned, it will be difficult to offer such services in most settings but its worth knowing.

Taking into account the limited resources available, laboratory investigation for STIs should only be carried out in facilities with capable laboratory services. Otherwise, syndromic diagnosis and presumptive treatment should be provided.

The guidelines will be implemented in the context of limited number of service providers whether healthcare workers, social welfare workers, and the police.

The comprehensive management of individuals seeking services due to sexual and physical assault has to strike a balance between using public health approaches and rights-based approaches. For instance, just like survivors, perpetrators of sexual assault, rape or defilement can similarly expose themselves to sexually transmitted infections including HIV, they too, if identified may need health services and thereafter handed over for prosecution and rehabilitation. Another limitation is the management of pregnancies arising from sexual assault and rape.

Currently there is no routine provision of Hepatitis B vaccinations in the public sector in Malawi, but Hepatitis B vaccines may be available in the private sector. If available, Hepatitis B vaccination should be provided to all survivors of sexual assault. As Hepatitis B has a long incubation period it may be given up to 3 weeks post-assault. It should be given at 0, 1 and 6 months intervals.

4.0 SEXUAL ASSAULT AND RAPE

Sexual assault is 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 the relationship with the survivor, in any setting, including but not limited to home, school, prison, the streets and at work' (World Health Organization 2003).

The perpetrator may be an acquaintance, a friend, a family member, an intimate partner or a complete stranger.

Rape is defined as "physical forced or otherwise coerced penetration – even if slightly – of the vulva or anus, using a penis, other body parts or an object" (World Health Organisation 2003).

Rape is defined in the Laws of Malawi, Penal Code (Cap 7:01,132) as any person having unlawful carnal knowledge of a woman or girl, without her consent, or with her consent if the consent is obtained by force or means of threats or intimidation of any kind, or by fear of bodily harm, or by means of false representations as to the nature of the act, or in case of a married woman, by personating her husband.

Any person working with people who have been raped should be aware of the differences between myth and fact. Personal beliefs and attitudes toward rape need to be examined and challenged. It is essential that health care workers and other related service providers understand the need for impartiality. It is not the role of the health care worker to make judgments about the veracity of rape allegations, nor about the innocence or guilt of the alleged perpetrator, this is for the investigators and the courts to decide.

4.1 Health consequences of sexual and physical assault

The common health consequences of sexual and physical assault include:

- Unwanted pregnancy
- Unplanned pregnancy
- Sexual dysfunction
- Unsafe abortion
- Infertility
- STIs including HIV/AIDS
- Pelvic pain and urinary tract infections
- Physical injuries
- Psychological trauma

4.1.1 Genital Injuries

Genital injuries in women are most likely seen in the posterior fourchette, the labia minora, the hymen and the fossa navicularis. The most typical genital injuries include:

- tears
- ecchymosis
- abrasions, redness and swelling

In men, injuries are generally located around the anus and perineum.

4.1.2 Non-genital Injuries

Non-genital injuries include bruising, lacerations, pattern injuries such as belt marks or bite marks, and anal or rectal trauma.

4.1.3 Psychological trauma

The psychological consequences of sexual assault vary from person to person but could include depression, anxiety, social phobias and suicidal behavior.

4.2 Legal implications of sexual assault and rape

Rape and Sexual assault, both in adults and in children is against the laws of Malawi. This means that all cases of rape can be taken into court for prosecution. Both the Child Care, Protection and Justice Act No 22 of 2010 and the Protection of Domestic Violence Act Part X and Part XI consider the key roles of the police, the courts, and witnesses in assisting children and adult survivors of sexual assault and domestic violence.

According to the Medical Council Act and Nurses & Midwives Act (1995); all health care workers registered at either the Medical Council or the Nurses and Midwives council are competent to write and provide a medical report in case of sexual assault and rape, which can be considered a legal document in court. It is therefore important that the medical record is legible and accurately documented, signed and dated by the health care worker who undertook the physical examination.

It is not the health care worker's responsibility to determine whether a person has been raped. That is a legal determination. The health care worker's responsibility is to provide appropriate care, to record the history and other relevant information which can be provided to the police and used for their investigations and/or social welfare for follow-up support.

***In the past, it has been routine to request a letter from the police before a survivor of sexual assault or rape could be attended to. It must be noted that a survivor of sexual assault or rape must be attended to immediately upon arrival in the health facility. The survivor is NOT REQUIRED BY LAW to produce a letter from the police before she can be attended to. Insisting on a police letter will cause a great burden on the survivor and cause* unnecessary delays, and must be avoided at ALL TIMES!!!!!**

Prevention of Domestic Violence Act No.5 of 2006 (Section 37) outlines the duty of police officers to assist survivors by:

- Giving assistance to the survivor;
- Ensuring the welfare and safety of a child dependent or other vulnerable persons;
- Preventing any further breach of the law.

As such, each police station in Malawi has trained police officers in victim support (the Victim Support Unit). These officers are skilled to provide counseling and support to survivors. They will also be the ones who refer the case to the Criminal Investigations Department (CID). The CID will investigate and determine whether a crime has taken place or not.

5.0 SERVICE PROVISION TO SURVIVORS OF PHYSICAL AND SEXUAL ASSAULT

The Prevention of Domestic Violence Act No.5 of 2006 (43) encourages service providers to render assistance to the survivor of domestic violence as may be required in the circumstances including: making arrangements for the survivor of domestic violence to find suitable temporary shelter and to obtain medical treatment, if so required; as well as ensuring that the survivor of domestic violence has access to information about the range of service providers and the kind of support that may be provided by any service provider.

Individuals who have suffered sexual assault, irrespective of the point at which they present at the health facility, should be offered services:

- Full medical history
- Obtain consent for examination.
- Full physical examination.
- Laboratory investigations.
- Recording injuries.
- Treatment and prophylaxis.
- Counseling
- Follow-up care
- Provision of medico-legal report.

5.1 Guiding Principles for Service Provision

5.1.1 Location for Service Provision

Facilities for providing medical services to survivors of sexual assault and rape are characterized by a number of key features, namely: accessibility, security, cleanliness, and privacy.

Feature	Comments
Accessibility	24 hours access to survivors and within easy reach at a health facility
Security	There should be adequate measures to protect survivors, guardians, health care providers and medical records. Strategies could include a guard to control access, adequate lighting, lockable doors and cabinets and fire prevention equipment.
Cleanliness	A high standard of hygiene is required in the provision of any medical service. The facility should also comply to infection prevention standards.
Privacy	Unauthorised people should not be able to view or hear any aspect of the consultation. Hence, the examination room should have walls and a door, not merely a curtain. Assailants must be kept separate from their survivors

The examination room should have a table and chairs and a lockable door. Furthermore, examinations couch with a light source and hand washing facilities. Ideally; blood drawing, VCT, history taking, physical examination and treatment provision should all be conducted in this room. This avoids that the survivor has to move between different departments. During the daytime, the STI clinic could be an appropriate place, while at night time, the Obstetrics and Gyneacology department would be most appropriate.

5.1.2 Useful techniques

The following strategies and techniques are helpful when dealing with survivors of sexual violence:

- Greet the survivor by name; use her preferred name. Make her your central focus.
- Introduce yourself to the survivor and tell her your role, e.g. Nurse, Doctor
- Ensure privacy for history taking, examination and counseling.
- Aim for an attitude of respect, professionalism within the boundaries of your survivor's culture.
- Have a calm demeanour. A frightened survivor will want to be in the company of people who are not frightened.
- Be unhurried, give time.
- Maintain eye contact. Be empathetic and non-judgmental as your survivor recounts her experiences.
- Aim to limit the number of health care workers attending to the survivor: 'one-on-one' care works best in sexual assault cases.
- Ask the survivor if she wants to have a specific person present for support. Ask the survivor if she has any questions.

5.2 Full medical history

5.2.1 History taking

A holistic approach is needed when attending to a sexual assault survivor. Do not rush into taking history, as this may make the client withhold vital information. A careful approach is needed to get a good account of the events surrounding rape through the whole process. Do not put words into the survivor's mouth. Creating a friendly environment gives confidence to our client. Use good communication skills.

Consider the following points in the approach:

- Ensure privacy, safety and adequate time for the survivor.
- Avoid taking survivors through the story more than once.
- If the survivor came with the police, check details given earlier to the police.
- Avoid leading questions, have the survivor describe the assault.
- Encourage them to speak out without interruption.
- Accept the survivor's story in a non-judgmental way. Remember it is up to the police to investigate further the validity of information given.
- Note the normal reactions to rape, such as shock, fear, arousal, anxiety, ensure the survivor that she is not to blame.
- Avoid any distraction or interruptions.

5.2.2 General History

A good history should cover most of the following points:

- Personal details of the survivor, age, where she lives, marital status.
- Ask about general health, visits to health facilities lately and illnesses.
- Ask the survivor if she has attended VCT services
- Ask about medication, current family planning methods used etc.

5.2.3 Gynecological History

Ask about first day of last menstruation, previous births, current sexual partners, presence of vaginal discharge and last consensual sexual intercourse.

5.2.4 History of the Assault

- Date, time and place of assault.
- Name, identity and number of assailants, if known.
- Nature of physical contact and detailed account of assault inflicted

(Specifically it should be noted whether the following occurred:

a) Vaginal penetration by offender's penis, fingers, objects.
b) Rectal penetration by offender's penis, fingers, objects.
c) Oral penetration by offender's penis, fingers, objects.
d) Oral contact with offender's face, penis or genitor-anal area.
e) Ejaculation in survivor's vagina or elsewhere on her body.
f) Condom use.

Finally, details of all symptoms that have developed since the assault must be recorded such as:

a) Genital bleeding, discharge, itching, sores or pain.
b) Urinary symptoms.
c) Anal pain or bleeding.
d) Abdominal pain.

Note that some survivors may experience involuntary orgasms during the assault, and this may cause confusion with the survivor. The fact that the survivor experienced orgasm Does NOT imply consent.

It is advisable to use a standard examination record (see Appendix) for all recording.

5.3 Obtain consent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent be obtained. In practice, obtaining informed consent means explaining all aspects of the consultation to the survivor and/or her guardian. The following items should be discussed in order to obtain consent for examination from the survivor.

a) Explain all aspects of the consultation process to the survivor.
b) Request permission to examine the survivor.
c) Asks if she want a guardian and/or the police to be present.
d) Request for permission to submit medical report to the police if appropriate.
e) Where indicated in special circumstances, under forensic expertise obtain written consent if forensic specimens are to be collected.

It is crucial that the survivor understands all the options open to her and is given sufficient information to enable her to make informed decisions about their care. It is important that a correct environment is provided, one in which the survivor feels secure and does not feel intimidated in any way. Above all, the wishes of the survivor must be respected.

A survivor of sexual assault or rape must be attended to immediately upon arrival in the health facility. The survivor is NOT REQUIRED BY LAW to produce a letter from the police before she can be attended to. Insisting on a police letter will cause a great burden on the survivor and cause unnecessary delays, and must be avoided at ALL TIMES!!!!!

5.4 Full physical examination

During the examination, look for signs that are consistent with the survivor's story, such as bite and punch marks, mark of restraints on the wrists etc. Genital examination should start with inspection in order to assess any obvious injuries, evidence of semen, bleeding. Separation of the labia is advisable, the survivor can assist or the examiner can do it. Look for any signs of infection.

A speculum examination is preferred, unless there is gross genital trauma or if the survivor refuses. It should be followed by a bimanual examination.

- Make sure you use the appropriate sized speculum (where the insertion of the speculum is painful, it is advisable not to proceed as this may make the survivor uncomfortable for subsequent procedures)
- View the walls of the vagina for an obvious sores, mass, trauma or bleeding
- Check any abnormalities on the cervix including discharge, and pre-existing conditions.
- Every significant finding must be noted.
- Bimanual examination is rarely indicated, where possible, should be conducted last, and only when the survivor had pre-existing genital-urinary complaints suggestive of Sexually Transmitted Infections (STIs) to exclude any existing abnormalities and manage appropriately where indicated.
- Perform an anal examination to rule out bruises, lacerations and abrasions of the anus or rectum. Refer the survivor for surgical review if the injuries are extensive.
- Record all findings as per Standard Record Form (see appendix 2).

5.5 Laboratory investigation

Taking into account the limited resources available, laboratory investigation for STIs should only be carried out in facilities with capable laboratory services. Otherwise, syndromic diagnosis and presumptive treatment should be provided.

It is important to exclude pregnancy in all female survivors of sexual assault or rape within the reproductive age group. Where available, a pregnancy test can be performed to exclude pre-existing pregnancy.

It is recommended that a baseline Haemoglobin (HB) reading will be determined before survivors commence PEP therapy, because of the possible occurrence of anemia due to AZT. If a survivor has an HB = 8 mg/ml Duovir should be replaced with Lamivir S (see chapter on PEP).

If laboratory facilities allow, the following steps should be taken

- Culture for Neisseria Gonorrhoeae from any sites of penetration or attempted penetration. Gram stained slides of urethral, cervical, and rectal specimens for gonococci. Culture for Chlamydia trachomatis should be conducted from any site of penetration or attempted penetration.
- Vaginal swab for microscopy for yeasts, Bacterial Vaginosis, and Trichomonas.

5.6 Recording injuries

Survivors with injuries such as cuts, bruises, and superficial wounds can usually be treated in-situ by the health care worker. Survivors with severe, life-threatening conditions should be referred for immediate emergency treatment.

Any wounds should be cleaned and treated. The following medication may be indicated:

1. Antibiotics to prevent wounds from becoming infected

2. Anti-tetanus booster

3. Medication for the relief of pain, anxiety or insomnia

Tetanus Toxoid Schedule

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

Tetanus Toxoid should be given to all survivors of sexual violence (all sexes, and all ages) if there are any physical injuries of the skin and and/or mucous membranes).

5.7 Treatment and Prophylaxis –EC, STI, HIV PEP, Hepatitis B

5.7.1 Emergency Contraception

Unless the survivor is currently using contraceptive methods, or is currently pregnant; post coital oral contraception (emergency contraception) should be issued as soon as possible but within 72 hours – 120 hours of the assault.

Suggested regimes:

- Postinor – 2: (750µg levonorgesterel) take one tablet orally and repeat 12 hours later

  OR ELSE

- Lo-femenal or Microgynon take 4 tablets orally and repeat 4 tablets orally 12 hours later
- IUCD recommended after 5 days/within 1 week, up to the next menstrual period, clinical judgment is very important

Survivors who are offered emergency contraception to prevent pregnancy following sexual assault must be made aware of the following facts about EC:

a. The risk of becoming pregnant will be decreased if EC is taken within 72 hours of the assault; EC is 97% effective, and the earlier it is taken the more effective it is.
b. EC does not cause an abortion but prevents ovulation, block fertilization and interferes with implantation; they will not affect an existing pregnancy.
c. The pills may cause vomiting and nausea. If vomiting occurs within 1 hour of taking the pills, the dose should be repeated
d. In most cases, the next menstrual period will occur around the expected time or earlier. If it is delayed, a pregnancy test should be performed.

5.7.2 Sexually Transmitted Infections –STIs

Survivors of sexual assault may contract an STI including HIV as a direct result of the assault. It is recommended that routine presumptive therapy after sexual assault is given, because follow up of the survivor can be difficult, and because the survivor may be reassured if offered treatment for possible infection.

The following infections should be covered, Syphilis, Neisseria Gonorrhoea, Chlamydia trachomatis, Trichomonas vaginalis, Bacterial vaginosis, Haemophilus Ducrey, Candida, and preventive prophylaxis for HIV.

The following STI treatment should be given to all survivors:

- Benzathine penicillin 2.4 MU intramuscularly single dose
- Gentamicin 240mg Intramuscularly single dose
- Erythromycin 500mg 6 hourly for seven days
- Metronidazole 2g single dose
- Clotrimazole 500g stat intra-vaginal pessaries single dose

NB: Where there are contra-indications, alternative treatment regimens can be found in the guidelines in the management of sexually transmitted infections using Management of Sexually Transmitted Infections using Syndromic Management Approach (2008).

The survivor's regular sexual partner should be treated for STIs if she has had sexual intercourse with this partner after the sexual assault has taken place, but before the survivor sought medical advice.

5.7.3 Post-Exposure Prophylaxis – HIV PEP

PEP" refers to the treatment of hazardous exposures using antiretroviral (ARV) therapy. ARV therapy started immediately after exposure to HIV may prevent HIV infection, although this protection is not 100%. Treatment should be initiated as soon as possible, but within 72 hours of exposure.

Although the risk of acquiring infection from a single act of sexual intercourse is low, rape is commonly associated with assault and genital tract trauma, which increases the risk of HIV transmission. A rapid HIV test must be conducted after counseling, and the survivor should be provided with the test results.

5.7.3.1 Eligibility Criteria for PEP

Eligible	Not eligible
Persons who present with a history of rape within the previous 72 hours, with a history of penetration, regardless of ejaculation, Survivor tests HIV negative on initial testing Survivor consents to treatment	Person who presents more than 72 hours after rape Survivor tests HIV positive on initial testing (refer to HIV care & support) Victim does not consent to treatment

The survivor should be given PEP regardless of the sero-status of the assailant, as the assailant may be in his window period during time of a negative test outcome.

Operational Considerations for HIV PEP

- **How to start PEP**
    - Start taking PEP as soon as possible after high risk exposure, ideally within 72 hours
    - Starting PEP more than 72 hours after exposure is not effective and shouls not be done
        - However, still do HTC at baseline, at 3 and 6 months
    - Explain dosage and importance of adherence
    - Advise to return immediately if side effects are suspected
    - Advise all exposed adults to practice safe sex and use condoms until confirmed HIV negative at 3 months
    - Give 30 condoms and re-supply as requested
    - Do not stop breastfeeding
    - Write case details in PEP register

PEP follow-up

- At 30 days, completion of ARV prphylaxis
    - Assess adherence
    - Give 60 condoms
- At 3 months, repeat HTC
- At 6 months, repeat HTC
    - If found HIV negative, the survivor can be counseled that she has not been infected with HIV as a result of the exposure.
    - If found HIV positive, the survivor should be HIV infected during follow up, she should be referred for HIV care & support.
    - If a client on PEP is experiencing side effects such as dizziness, fatigue or paleness, she should return to the health facility for further assessment.

PEP Regimen

It is recommended that a baseline Haemoglobin (HB) reading will be determined before survivors commence PEP therapy, because of the possible occurrence of anemia due to AZT. If a survivor has a HB = 8 mg/ml Duovir should be replaced with Lamivir S.

In case of lack of availability, healthcare workers are encouraged to use clinical judgment

Table 13: The PEP Regimen

Drug		Dose	Frequency	Duration
Zidovudine AZT (300mg) Lamivudine 3TC(150mg)	Also known as Douvir	One tablet	Twice a day	30days
ALTERNATIVELY				
Stavudine D4T(40mg) Lamivudine 3TC(150mg)	Also known as Lamivir S	One tablet	Twice a day	30days

PEP therapy should be available at every health facility and at central medical stores. Each health facility should have a bottle of PEP kept in an agreed designated unit for easy, but secure, access. Management should make all staff aware where PEP is kept.

Table 14: Recommended HIV serology after exposure

Baseline (Day zero)	**Follow-up 2**	**Follow-up 3**
Within 72 hours of exposure	Three months	Six months

If the survivor is found to already be HIV-sero-positive, then PEP should not be started, and appropriate counseling and clinical referral should made.

All persons involved with rape survivors, including the police, must ensure that the rape survivor is brought to hospital as an emergency before detailed questioning takes place in order not to delay PEP initiation. Health care workers must make their own decisions about the need for PEP, based on a history of penetrative sexual assault, and on current HIV status; and not be bound by the police report on whether rape has occurred or not. Counseling on abstinence, use of condoms and drug compliance should be emphasized, and survivors should be fully-equipped with the information on drug side effects.

5.7.4 Hepatitis B Vaccination

Currently there is no routine provision of Hepatitis B vaccinations in the public sector in Malawi, but Hepatitis B vaccines may be available in the private sector. If available, Hepatitis B vaccination should be provided to all survivors of sexual assault. As Hepatitis B has a long incubation period it may be given up to 3 weeks post-assault. It should be given at 0, 1 and 6 months intervals.

5.8 Counseling

Counseling plays an important part in the management of assaulted survivors as it can reduce post-traumatic stress disorder. Not all survivors of sexual assault react in the same way. Some survivors experience immediate psychological distress, others short-term and long-term psychological problems. The amount and length of social support required by survivors of assault varies enormously, depending on the degree of psychological trauma suffered and the survivor's own coping mechanism. Be empathic. Advise her about the post-traumatic symptoms (such as guilt, fear, shame, anger, insomnia, nightmares, mood-swings, suicide thoughts, or self-destructive behaviour) that she may experience.

The following issues need to be reiterated to the survivor:

- Explain that counseling will help to facilitate recovery
- List carefully the history of events, ask about survivors concerns and address them appropriately
- Explain that the survivor did not deserve to be sexually violated
- Reinforce that the assault was not the survivor's fault; that it was NOT caused by her behaviour or manner of dressing. No person ASKS to be sexually assaulted
- Stress that sexual assault is an issue of power and control
- Refer for psychological support as available or necessary (Survivor Support groups, social work, psychologist etc.)
- Assess safety of the survivor and the possibility of recurrence
- Discuss the legal implications and procedures for notifying the police / Survivor Support Unit.
- Further emphasis should be placed on sexual contact tracing, if the survivor has had sexual intercourse with a regular partner, after the assault, and treatment compliance.

5.9 Follow-up care

Follow-up is always necessary in order to identify things which might have been missed on the initial visit and to identify other infections that have long incubation period i.e. syphilis, hepatitis B, HIV sero-conversion. Follow up visit is recommended at 2 weeks post assault. If the client has been given HIV PEP; an HIV test; including pre- and post test counseling must be conducted at 3 months and 6 months post assault.

5.9.1 Two week follow up visit

As a part of the 2-week post-assault visit, the following routine tasks should be performed:

- Examine injuries for proper healing
- Check that client has completed the course of STI treatments
- Conduct examination to syndromically assess client for persistent or new STIs and treat according to the National STI guidelines.

Assess client's emotional state and mental state, and encourage the client to seek counseling if they have not yet done so.

5.9.2 3 & 6 month follow up visits

The physical wounds of the assault have by now gone, but the survivor may require regular post assault counseling (reviewing as necessary issues discussed during the first visit). Apart from counseling, the 3 and 6 month follow up visits are used to conduct follow up HIV testing and discuss the results of the tests performed.

6.0 CHILD SEXUAL ASSAULT

6.1 Definition

" Child sexual assault is 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" (World Health Organisation 2003).

According to WHO (1999); Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in relationship of responsibility, trust or power; the activity being intended to gratify or satisfy the child's needs. 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.

If a girl is less than 16 years of age, by law she is incapable of consenting to sex; and therefore sex with her is considered rape, even with her consent. Technically, rape in a girl less than 16 years old is termed 'defilement'.

According to the Laws of Malawi in the Penal Code (Cap 7:01,138) defilement is defined as any person having carnal knowledge of any girl under the age of sixteen years.

6.2 Authorization of medical treatment

Healthcare workers will seek consent from parent or guardian of the child or other appropriate person, social welfare officer, or police officer may authorize medical, surgical or psychological examination or treatment. In case of immediate health risk and unavailability, neglect, or refusal to consent by parent, guardian or any appropriate person, the social welfare officer or the police officer may consent (Child Care, Protection and Justice Act. No. 22 of 2010, Section 30)

6.3 Child in need of medical examination, treatment and hospitalization

Child in need of medical examination may be brought for medical care by social welfare officer, chief, member of the community, person keeping the child for the time being, or from temporary custody. A child may be hospitalized if necessary. If a child is hospitalized, the social welfare officer shall assume responsibility over maintenance of the child as the person in charge of a place of safety (Child Care, Protection and Justice Act. No. 22 of 2010, Sections 26-29).

It is the duty of the health worker after medical examination or treatment to immediately inform the social welfare officer or police officer where a health worker believes that a child being examined or treated is physically, psychologically or emotionally injured as a result of physical or sexual abuse. A report will be presented to the person who brought the child for medical care (Child Care, Protection and Justice Act. No. 22 of 2010, Section 33).

6.4 Manifestations and Examination of sexual assault in children

Children who have been abused sexually present in different way than adults. Disclosure is often made in some oblique reference to a person or an incident. Observers may notice the following: vague abdominal pains, poor or altered behaviour, withdrawal, abusive words, inappropriate touching, fondling genitals, or difficulty in walking.

Children rarely tell anyone about sexual assaults immediately after the events, and disclosure tends to be a process rather than a single episode. Dealing with sexual assault in children requires special skills in history taking and examination. Decisions about STI testing in children should be made on case-by-case basis.

Many sexual encounters do not produce evidence of physical injuries (i.e. indecent touching, exposure, oral-genital contact etc) while others, such as penetrative sex will cause small, sometimes multiple injuries which heal quickly and leave no scar obvious to the naked eye. However, it is important to note that penetrative sex sometimes cannot produce evidence of physical injury.

Gross trauma of the genital or anal area is easy to diagnose but healed or subtle signs of trauma are more difficult to interpret. Anal penile penetration may leave little or no physical evidence. The longer after an abusive act that a child is examined, the less likely the examiner is to find subtle signs of injury. The scars to the hymen, introitus or fourchette require experience and skill to recognise. It is essential that the child is examined in privacy, accompanied by a trusted guardian and a witness (usually another health care worker). It is preferable that the girl (as it is often a female survivor) is examined by a female health care worker.

Most examinations in children are non-invasive. Speculums should not be used, except in very rare, medically indicated, circumstances. Only suitably experienced healthcare workers are required to perform a genitor-anal examination in children under the age of 16. Where indicated, the child can be referred to paediatricians or gynaecologists. Examination should be conducted for adolescents who have not yet started their first menstrual periods. Male cut-off age at 14 years.

Confidentiality, privacy, documentation, and consent should be considered.

A physical examination of children should keep the following into consideration:

1) Look for evidence of finger imprints in arms and/or legs where the child may have been held down or stopped from screaming.
2) Look in the mouth for evidence of injury from forced oral-penile penetration and the breasts which may have been bitten or squeezed.
3) Injuries to the genitalia may be obvious – bruising, bleeding, grazes, lacerations to the posterior fourchette or/and hymen.
    - Remember that falls on to walls or off bicycles usually cause bruising over the bony parts of the pubic symphysis, and accidental injuries to the introitus are often anterior rather than posterior.
    - Forced vaginal penetration with penis, fingers, or object will usually injure the posterior fourchette at 6 o'clock.

The hymen can be viewed by gently separating the labia majora. The hymen shape, size and edges should be recorded. Anal findings vary from no physical abnormality, to a wheel of oedema around the recently injured anus with anal incontinence, to a dilated, somewhat incontinent anus. If the child is seen shortly after the assault and still wearing the same clothes as at that time, then all clothes should be carefully examined for stains of semen or blood and for rips and tears suggestive of aggression.

6.5 Treatment for STIs in children

Presumptive treatment for STIs of children who have been sexually abused is recommended taking into account the high prevalence rates of STIs in the country.

The suggested STI treatment regimen for children is:

- Gentamicin 6 mg/kg single dose IM
- Metronidazole 5mg/kg every 8 hours for 7 days
- Benzathine Penicillin < 25 kg: 600,000 IU STAT, > 25 kg 1,200,000 IU STAT
- If the child is under the age 8: Erythromycin 12.5 mg/kg every 6 hours for 7 days - If child is 8 yrs or above: Erythromycin 25 mg/kg every 6 hours for 7 days

6.6 HIV Post Exposure Prophylaxis for children

As is the case with adults, data on the efficacy and safety of PEP for HIV prevention in children are inconclusive. However, as a guiding rule, if the child presents within 72 hours of penetrative or injuring sexual assault, and the child's guardian and the child consent, HIV PEP must be considered. A rapid HIV test must be done after counseling of the child and her guardian.

6.6.1 Eligibility Criteria for PEP in Children

Eligible	Not eligible
Physical signs consistent with genital trauma or penetration, anal, vaginal or oral.	Assault occurred more than 72 hours ago
Assault occurred less than 72 hour previously	No physical signs of trauma or penetration
Child is HIV negative on initial testing.	A child who is HIV positive on initial test
Child and guardian consent to the treatment.	HIV testing is refused
	Child or family do not agree to take PEP

6.6.2 Dosage

The drug used for PEP in children is Duovir or LamivirS. Duration is 30 days.

Drug	Body weight	Dose	Frequency	Duration
Zidovudine (AZT) 300mg/ Lamivudine (3TC) 150mg **(Also known as Duovir**	14kgs	¼	Twice a day	30days
	14-24`	½		
	25-34	¾		
	>35	1		
Alternative Regimen				
Stavudine D4T 40mg/ Lamivudine 3TC 150mg (also known as Lamivir S	14kgs	¼	Twice a day	30 days
	14-24	½		
	25-34	¾		
	>35	1		

Notes for PEP in children:

- The child should have a repeat HIV test at 3 months and 6 months post exposure.
- If the child is HIV negative at 6 months, it confirms that HIV infection did not take place
- If the child tests HIV positive at 3 or 6 months, the child needs to be referred for care and support
- Relevant information should be documented in the child's health passport
- It is recommended that a baseline Haemoglobin (HB) reading will be determined before a child commences PEP therapy, because of the possible occurrence of anemia due to AZT. If a survivor has a HB = 8 mg/ml Duovir should be replaced with Lamivir S (see next chapter).
- If there is any doubt, or if there are any questions about providing PEP to children, it is recommended to contact the Department of Paediatrics in the Central Hospitals for further guidance.

6.7 Pregnancy and Emergency Contraception for children

As for pregnancy prevention and management, the recommendations provided for adult women apply equally to girls who have started their menstrual periods prior to the sexual assault.

7.0 CHILDREN IN NEED OF PSYCHO-SOCIAL CARE AND PROTECTION AS A RESULT OF PHYSICAL AND SEXUAL ASSAULT

7.1 Roles and Responsibilities of a Social Worker when managing physical and sexual abuse at OSC

7.1.1 Initial Assessment or Investigation Stage

The social worker will be responsible for carrying out an assessment of the child, the family environment and those reporting the case. The assessment will be carried out with a view of determining the proper course of action on a particular case. The following will be taken into account during assessment:

1) Determine whether an abuse or maltreatment occurred and the nature of maltreatment
2) Make an assessment of the family environment of the survivor including cultural and family beliefs
3) Make an assessment of the level of risk of the survivor
4) Make a determination of the survivors safety
5) Determine emergency needs of the survivor
6) Determine the type of services that will be offered

7.1.2 Case Planning and Service Delivery Stage

The social worker will plan for:

- Safety and security mechanisms in order for the client to return home
- Finding alternative placement for the survivor
- Providing psychosocial counselling for both the survivor and caregiver
- Consultations with caregivers as well as mapping significant people
- Follow up using networks with various stakeholders such as community child protection workers
- Social workers need to obtain informed consent from the survivor

7.1.3 Case Closure

The social worker shall ensure that:

- the child is safe from re-victimization,
- the survivor is coping well,
- the survivors needs have been met and is satisfied with the services provided
- counselling is provided when needed
- the survivor has been reintegrated back into her family or community and has been fully reintegrated.
- Periodic home visits are conducted to see how the survivor is settling.

7.1.4 General Responsibilities

- Maintain and manage OSC data.
- Compile quarterly report and submit to relevant authorities.
- Organise monthly home visit to survivors of abuse
- Maintain and update the referral database and catalogue of organization serving abused children
- Organize for monthly case review meeting with OSC team
- Make case follow ups to Police Stations on the progress of abuse cases reported to them in liaison with the OSC police officer.

7.2 Specific Roles of Enforcement officers

Enforcement officers have a duty to ensure that survivors of domestic violence are accorded proper treatment and are provided with the necessary assistance (Child Care, Protection and Justice Act. No. 22 of 2010, Section 32, 33).

Necessary steps should be taken to protect survivors of domestic violence from any further acts of domestic violence by:

- Explaining to the survivor about his/her right to protection against domestic violence;
- Assisting the survivor to file a complaint against domestic violence;
- Arranging for the provision of medical assistance to the survivor at the nearest health facility;
- Arranging for alternative residence or a temporary safe place of shelter for the survivor;
- Informing the survivor about available legal remedies; and where possible the perpetrator about alternative dispute resolution mechanisms, including counseling and reconciliation.

7.3 Family involvement of children in physical-psycho-social care

It is the duty of members of the family, child care provider and/or members of the community to immediately inform a social welfare officer or a police officer if they believe that a child is physically, psychologically or emotionally injured as a result of ill-treatment, neglect, abandonment, exposure or sexually abused (Child Care, Protection and Justice Act. No. 22 of 2010, Sections 34,35,36).

8.0 DOCUMENTATION AND REPORT WRITING

Healthcare workers have a professional obligation to record the details of any consultation with a sexual assault survivor who comes to the hospital, whether the police are involved or not. The notes should reflect what the survivor said (in her own words), and what was seen and done by the health care worker. This becomes helpful when the courts or police need a medical report. Sometimes survivors may come back after some time, requesting a medical report to use as evidence in court. It is advisable that the 'Sexual Assault and Examination Record' found in the Appendix is used as a framework for recording and reporting.

All information must also be entered in the survivor's health passport. It is advisable that the information should be in either duplicate or triplicate to avoid loss of valuable information, and the health facility should keep a copy of the medical report. One copy of the medical report should be given to the survivor to hand over to the police, in case of prosecution. When giving out a police report, it should be addressed to the requesting police officer and should be sealed. The survivor can have access to her information from the health facility, and there should be an abstract of the management plan in the survivor's health passport books.

It must be emphasized once more that it is not the health care worker's responsibility to determine if a crime has taken place, merely to deliver appropriate care and to record the history and the situation at hand, which can be provided to the police and used for their investigations. The physical examination records should clearly indicate if the findings are consistent with recent sexual penetration or assault.

8.1 Procedures for reporting to the police

Survivors of sexual assault and rape should be encouraged to report to the police immediately after receiving medical care. It is however, an individual choice and should not be forced.

However, it is the responsibility of any professional (health care provider, teacher, police officer, etc) to protect children from further sexual abuse. In the case that the guardians of a child survivor do not wish to pursue the case, it is the responsibility of the health care provider to report the case to the police. It must be noted that the determination whether abuse/rape has occurred is left to the police and its investigators, not to the person who reports the alleged crime. Police should encourage and assist all survivors presenting at the police station, to attend to the nearest health care facility as soon as possible, preferably before legal processes commence as both PEP and EC become less effective with time.

It is also suggested that the police open a case even before the survivor attends to hospital which can then be followed-up and confirmed by the medical record. An

individual responsible for the interface between hospital and survivor should collect the form from either the police or hospital and facilitate processing of the case.

APPENDIX 1

EXAMINATION RECORD OF SEXUAL ASSAULT AND/OR RAPE IN MALAWI

A.) MEDICAL REPORT FOR SEXUAL ASSAULT OR RAPE (To be completed in own handwriting by the Medical Examiner)			
(A.)DEMOGRAPHIC INFORMATION			
POLICE STATION	**CASE NO/CR**	**INVESTIGATING OFFICER & NUMBER**	**TIME/ DAY /MONTH /YEAR**
Name of medical practitioner: **Registered Qualifications:** **Phone:** **Fax:** **Place of examination:**			**Physical practice Address & Stamp**
Full names of person Examined		**Sex**	**Date of birth/ Apparent Age**

Location of the client/NOK/person reporting

(B.) Medical history/General History

1. Indicate relevant medical/surgical/psychiatric history(For children include history of behavioral problems and family history)			
2. HIV status if Known		**Date Test conducted**	
3. Relevant Gynecological History	**First day of Last Menstrual Period**	**Average number or days between menstrual periods**	**Age at Menarche(for children)**
	Was patient menstruating at the time of assault	**Previously sexually active**	**Pregnancy?**
	Pregnancy history	**Current Contraceptive used**	**History of genital Trauma, surgery or bleeding**

(C.) HISTORY OF THE OFFENCE/INCIDENT

Details from other parties

- **(e.g. Police, Family, Witness)**

- **Details from Survivors:**

  4) **Date(s) of assault(or period over which assaults occurred, number of assaults, and date of last assault):**

     - **Time**
     - **Location**
     - **Assailant(s) names, number relationship to survivor, if any)**
     - **HIV status of assailant(s) if known**
     - **Alcohol consumed by (survivor/assailant)**
     - **Drugs consumed by (Survivor/assailant)**
     - **Weapons used; threats made by (assailant)**

Relevant details of the assault

Current Symptoms /Complaints from the client

Summary of sexual Assault(Please indicate if survivor was assaulted by more than 1 assailant					
		Assailant 1	**Assailant 2**	**Assailant 3**	**Assailant 4**
Vaginal Penetration	**Attempted or completed**				
	Ejaculated Yes/No?				
Anal Pentration	**Attempted or completed**				
	Ejaculated Yes/No				
Oral Penetration	**Attempted or completed**				
	Ejaculated Yes/No				

	Ejaculated on the body (if yes indicate site)				
	Saliva on the body (indicate site)				
Objects used for penetration?	**Vagina(Yes/NO)**				
	Anus (Yes/NO)				
	Mouth (Yes/No)				

POST ASSAULT		
	Yes	**No**
Survivor changed clothes before coming to the health facility?		
Survivor cleaned clothes before coming to the health facility?		
Survivor bathed/showered before attending health facility?		
Survivor had sexual intercourse before coming to the health facility?		
Survivor vomited/brushed teeth before attending health facility?		

RECENT INTERCOURCE (Intercourse during the past week?) **(if yes provide details, date, time, with whom, whether condom or contraceptive was used)**

Notes on Forensic examination

The extent of the examination will be largely directed by the history and clinical observations, if there is any doubt, complete external inspection is preferable. When describing wounds, consider describing "Site, size, shape, surroundings, color, borders and depth)

Classify wounds

Abrasion: **Disruption of the outer-layer of skin**

Bruise: **Area of hemorrhage beneath the skin**

Laceration: **Splitting or tearing of tissues secondary to blunt trauma**

Incision:a cutting type of injury with usually clear, regular margins

Stab: **a wound of greater depth than length, produced by a sharp object**

A speculum examination may be required for adults or post sexually active children, indications include, Genital pain,, Bleeding, Foreign body(used during assault and possibly still present).

A bimanual examination is rarely indicated post sexual assault. Well-trained healthcare providers are qualified to perform a genito-anal examination in children under the age of 16.

GENERAL EXAMINATION

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<tr><th colspan="3">GENERAL EXAMINATION</th></tr>
<tr><td colspan="3">Condition of clothing

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<tr><td>Height (cm)</td><td>Mass</td><td>General body build</td></tr>
<tr><td colspan="3">Clinical findings in every case, the nature, position and extent of the abrasion, wound or other injury must be described and noted together with its probable date and manner of causation. The position of injuries and wounds must be noted on the sketch.

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<tr><td colspan="3">Mental Health and emotional status

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<tr><td colspan="3">Clinical evidence of drugs or alcohol

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<tr><td colspan="3">Conclusions:

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<tr><td colspan="3">Name of Practitioner(Print)</td></tr>
<tr><td colspan="3">Signature of Practitioner:</td></tr>
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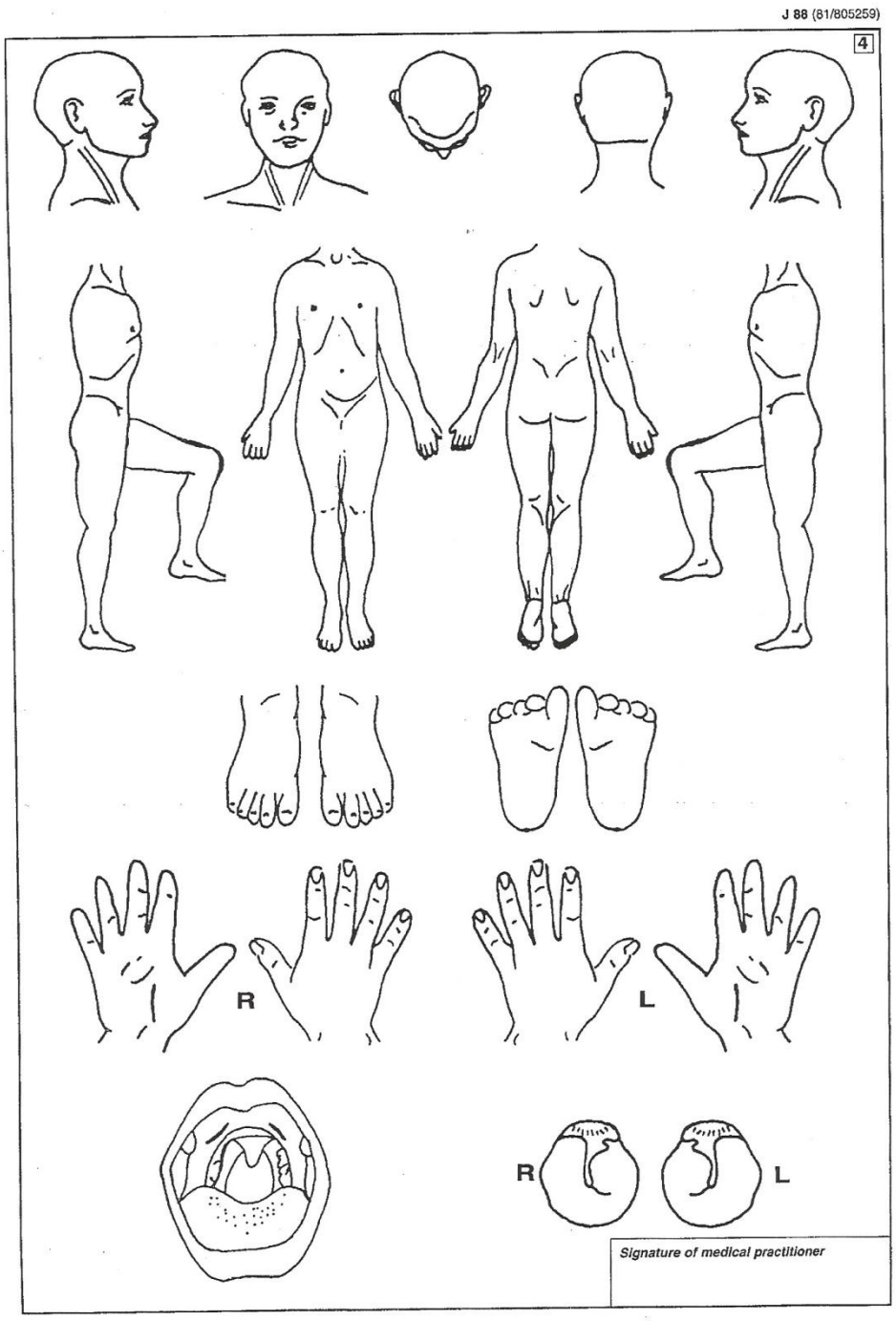
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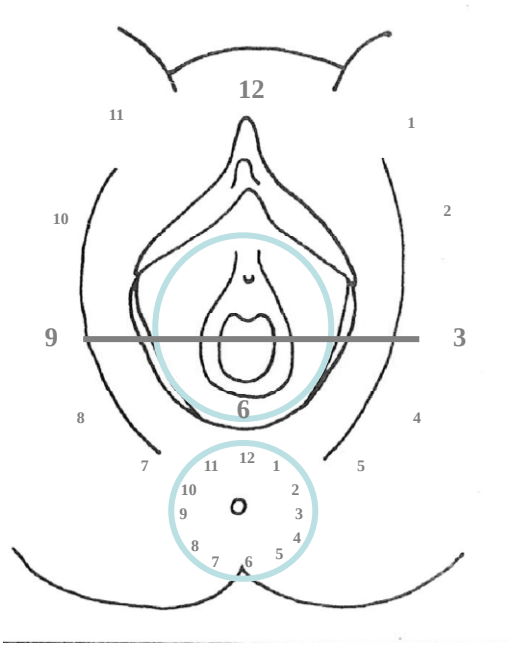
Signature of medical practitioner

Clock face notation



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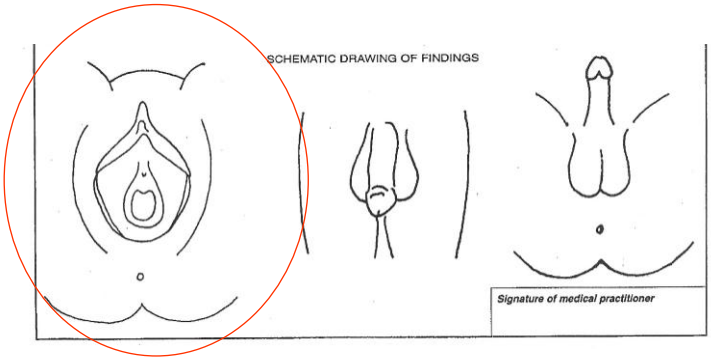

SAMPLES TAKEN FOR INVESTIGATION			
Forensic examination taken urine taken for pregnant test			**Seal number of evidence collection kit**
Name of officer receiving specimen: **Rank and service number:**			**Signature**
Conclusions …… …… …… ……			

ANAL EXAMINATION

Skin Surrounding the Orifice

1	Hygiene	4	Abrasions	7	Redness/ Erythema
2	Pigmentation	5	Scars	8	Bruising/ Haematoma
3	Fissures/cracks	6	Swelling/thickening	9	Tags

Orifice

10	Tears/fissures	14	Reflex dilatation	17	Twitchness/ Winking
11	Swelling/thickening of rim(tyre sign)	15	Shortening version of anal canal	18	Discharge
13	Funneling	16	Cupping		

Digital examination

19	Presence of hard faeces in the rectum	21	thickening of anal verge
20	Laxity/ pressure on anal orifice	22	Tone(sphincter grip)

Conclusions:

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MALE GENITALIA

1	Genital development	6	Pubic hair	11	Prepuce and frenulum
2	Glans	7	Shaft	12	Scrotum
3	Testis	8	Epididymis	13	Vas deferens

4	**Ulceration**	**9**	**Penile discharge**	**14**	**Smegma**
5	**Presence of faeces**	**10**	**Circumcision**	**15**	**Urethral orifice**

Conclusions.....

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APPENDIX 2: CHECK LIST FOR SEXUAL ASSAULT AND RAPE SURVIVOR ASSESSMENT

INDICATE WITH A TICK IF COMPLETED		
1	Inform survivor about the procedure and obtain verbal consent	
2	Obtain History (see examination record)	
3	Conduct full physical examination(see examination record form)	
4	Attend to physical injuries	
5	Provide antibiotics to prevent wound infection(if applicable)	
6	Provide Tetanus booster(if Applicable)	
7	Provide wound relief medication(if indicated)	
8	Provide Emergency Contraception (if eligible)	
9	Provide presumptive treatment for STIs	
10	Provide PEP (if eligible)	
11	Provide Hepatitis B vaccine if available	
12	Conduct counseling and partner notification and police referral	
13	Schedule follow-up visit at 2 weeks, 3 months and 6 months	
14	Complete medical examination record and provide survivor with one copy	
15	Complete health Passport	

10 REFERENCES

1. Guidelines for Medico-legal care for victims of sexual violence – World Health Organisation 2003 ISBN 92 154628 X
2. Developing guidelines for the management of sexual assault victims at Lilongwe Central Hospital Amon Signal Gideon Nkhata; MSc thesis for University College London
3. Management of Sexually Transmitted Infections using Syndromic Management Approach – Malawi Guidelines 2002
4. Malawi Ministry of Health ARV guidelines – October 2003
5. Malawi Government – The Malawi Police Service Victim Support Training manual
6. Medical Council Act 1995 – Personal Communication Mr. Moyo
7. Nurses and Midwives Council Act 1995 – Personal Communication Mrs. Kapyepye
8. Domestic Violence in Malawi – An awareness handbook – Women & Law in Southern Africa Research Trust (WLSA) phone: 01.641534 wlsa@mw.celtelplus.com
9. Women and Rape - Centre for Advice, Research and Education on Rights – Malawi CARER Phone 01.643261 malawicarer@malawi.net
10. Emergency management of injuries sustained during child sexual assault, Child Sexual Assault, July 2004
11. The management of sexual assault victim at Odi District Hospital in the North-West Province: How can the quality of care be improved? SA Fam Pract, 2008
12. Sexual & Gender-Based Violence in Africa, Population Council, 2008
13. Guiding Brief: National Management Guidelines for Rape, Sexual Assault and other related Sexual Crimes, YEZINGANE NETWORK, August 2010
14. Developing an Integrated Model for Post-Rape and HIV Post-Exposure Prophylaxis in Rural South Africa, Population Council, November, 2007
15. Malawi National Sexual and Reproductive Health and Rights Policy, Ministry of Health,

August 2009

16. African Regional Training Programme for Care and Support of Sexual Assault Survivors, Workshop Report, Zimbabwe, July, 2009
17. Clinical Management of HIV in Children and Adults, Malawi Integrated Guidelines for Providing HIV services 2011
18. Women and Laws in Southern Africa Research Trust(WLSA)
19. Child Care, Protection and Justice Act No. 22 of 2010
20. Prevention of Domestic Violence Act No. 5 of 2006
21. National Guidelines on Management of Sexual Violence in Kenya, 2009