



Guidelines for Health Staff Caring for Gender-based Violence Survivors

Including Protocol for Clinical
Management of Rape



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

Rape, sexual assault and other forms of GBV are also prominent features of the Syrian conflict. Gender-based violence, including rape is a problem throughout the world, occurring in every society, country and region. Refugees and internally displaced people are particularly at risk of this violation during every phase of an emergency situation. The systematic use of sexual violence as a method of warfare is well documented and constitutes a grave breach of international humanitarian law.

Rape, sexual assault and other forms of GBV are also prominent features of the Syrian conflict. The main types of GBV reported in assessments were domestic violence, early marriages, harassment, sexual exploitation and the fear of sexual violence.

Women and girls report fearing sexual violence and abuse in camp settings, at distribution and service points, when using WASH facilities, when crossing checkpoints or when walking around in their community without a male accompanying them. In areas controlled by Islamic extremist groups, women and girls fear arrest and physical punishment for not adhering to new rules imposed by these groups. The combination of new restrictive rules and fear of sexual violence results in a severe restriction of movement for women and girls.

Sexual violence has taken place in detention centers and by different armed groups. Syrian civil society, as well as the Special Representative of the Secretary General (SRSG) on sexual violence in conflict, confirms this through their reports. The SRSG noted "the rise of extremist groups using sexual violence as part of their key strategic objectives, and the increased targeting, by the same groups, of minorities based on their gender, ethnicity, religion or sexual orientation." There is, however, no accurate estimate of the persons in need who would require GBV-related services. This is in a context where it is noted that cultural sensitivities, stigmatization and traditional norms prevent reporting of GBV. Additionally, new high levels of social tolerance and 'acceptance' toward GBV make reporting and accessing services more difficult.¹

This Clinical Management of Rape Survivors Protocol including Guidelines on Caring for Gender-based Violence Survivors reflects internationally recognized WHO guidance as it applies to current cross-border operations into northern Syria from Turkey, taking into account the protection systems and resources available, and the realities of what can be undertaken in areas which are undergoing continual change.

The protocol was adopted and endorsed by the GBV Sub Cluster (GBV SC) and the Health cluster with the generous support of UNFPA. To reach as many medical personnel as possible inside Syria, an Arabic version has also been made available. The protocol and guidelines are part of a larger strategy to respond to GBV.

The GBV sub-cluster (GBV SC) in Turkey for cross-border operations into Syria

The GBV SC is a coordinating body with the objective to reduce risks and mitigate consequences of GBV experienced by women, girls, boys and men in Syria. It works to facilitate multisectoral, interagency action aimed at prevention of GBV, and to ensure a principled approach to the provision of accessible, prompt, and survivor-centered services to survivors of GBV. The GBV SC focuses on populations affected by the armed conflict in Syria accessible through cross-border operations from Turkey into Syria.

The Health cluster in Turkey for cross-border operations into Syria

The health cluster is a coordinating body with the objective to coordinate the health response in areas of Syria reachable through cross-border work. It is composed of a group of organizations that have been working together to build partnerships and mutual understanding and to apply common approaches to humanitarian health action.

This resource, addressed to all medical personnel working with survivors of GBV in Syria, aims to enable quality, survivor-centred care and advocate for ending GBV.

Anne Kluyskens led the adaptation of the protocol with the support of Syrian gynaecologists and other medical experts, as well as the Health cluster and GBV sub-cluster coordinators.

ABBREVIATIONS

ARV	antiretroviral
DT	diphtheria and tetanus toxoids
DTP	diphtheria and tetanus toxoids and pertussis vaccine
ECP	emergency contraceptive pills
ELISA	enzyme-linked immunosorbent assay
FGM/C	female genital mutilation/cutting
GBV	gender-based violence
GBVIMS	gender-based violence information management system
HBV	hepatitis B virus
HIV	human immunodeficiency virus
IASC	Inter-Agency Standing Committee
IRC	International Rescue Committee
IDP	internally displaced people
IUD	intrauterine device
NGO	non-governmental organization
PEP	post-exposure prophylaxis
RPR	rapid plasma reagin
STI	sexually transmitted infection
Td	tetanus toxoid and reduced diphtheria toxoid
HATIG	human anti-tetanus immunoglobulin
TT	tetanus toxoid
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	voluntary counselling and HIV testing
WHO	World Health Organization

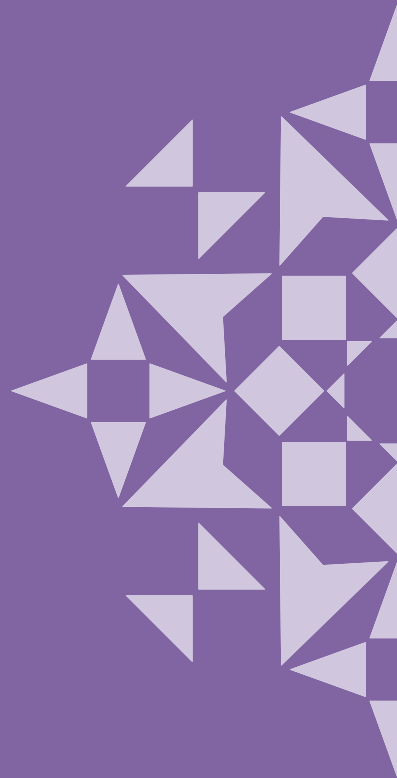
Cervical os²	The opening of the cervix (the neck of the uterus).
Chain of evidence	Documentation and testimony that proves that the evidence has not been altered or tampered with since it was obtained.
Child	A human being, aged < 18 years old.
Chlamydia infection	Sexually transmitted infection (STI) caused by the bacterium, <i>Chlamydia trachomatis</i> , which can damage a woman's reproductive organs. It is often asymptomatic in women, but can lead to scarring and infertility.
Confidentiality	The right of an individual to have personal, identifiable medical information kept private.
Contra-indication	A situation, which makes a particular treatment or procedure inadvisable.
Female genital mutilation/cutting	All procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons.
Emergency	Generally used to refer to situations of armed conflict or natural disaster, often involving the displacement of populations, sometimes as refugees, other times as internally displaced people (IDP).
Emergency Contraception (EC)	The use of a drug or device to prevent pregnancy after unprotected sexual intercourse.
Emergency Contraceptive Pills (ECP)	Hormonal methods (pills) of contraception that can be used to prevent pregnancy after unprotected intercourse. ECPs can be used up to 120 hours (5 days) after unprotected intercourse.
Fistula	<p>An obstetric fistula develops when blood supply to the tissues of the vagina and the bladder (and/or rectum) is cut off during prolonged obstructed labour. The tissues die and a hole forms through which urine and/or faeces pass uncontrollably. A traumatic fistula is caused by sexual violence such as violent rape, mass rape, including forced insertion of objects such as gun barrels and sticks into a survivor's vagina or anus.</p> <p>Vesico-vaginal: Between the bladder and the vagina.</p> <p>Recto-vaginal: Between the rectum and the vagina.</p>
Forced marriage	The marriage of an individual against her or his will.
Forensic evidence collection	Gathering evidence in order to strengthen a case for criminal prosecution.
Gender-based violence (GBV)	GBV is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (i.e. gender) differences between males and females.
Gonorrhoea infection	A sexually transmitted infection (STI), which is often silent (no symptoms) in women, but can cause infertility. In men it often causes discharge.

Hepatitis B	A virus that infects the liver. It is spread through contact with the blood and body fluids of an infected person.
HIV Post-Exposure Prophylaxis (PEP)	Use of antiretroviral drugs within 72 hours following exposure or potential exposure to prevent HIV infection.
Informed assent	It is the expressed willingness to participate in services; for younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services.
Informed consent	Understanding the implications of that to which you agree. Making an informed choice freely and voluntarily by persons in an equal power relationship. That is, s/he understands the consequences of the choice, has equal power, and freely chooses to accept the consequences.
Internally displaced people (IDPs)	IDPs are people who have been forced to flee their homes as a result of or in order to avoid the effects of armed conflict, internal strife, systematic violations of human rights or natural or manmade disasters and who seek protection elsewhere within their country of origin or residence and have NOT crossed internationally recognized state borders.
Intrauterine device (IUD)/ intrauterine contraceptive device (IUCD)	A device inserted into the uterus (womb) to prevent pregnancy. The IUD can be a coil, loop, triangle, or T-shape. It can be plastic or metal. The most common IUD is the Copper T, which contains copper, which stops sperm from making their way up through the uterus. An IUD can also be used as a form of EC if inserted within 7 days of unprotected intercourse.
Medical certificate	A document signed by a medical doctor giving a judgment on somebody's state of health.
Non-governmental organization (NGO)	An organized entity that is functionally independent of, and does not represent, a government or State. It is normally applied to organizations devoted to humanitarian and human rights causes, a number of which have official consultative status at the United Nations.
Pelvic exam	Procedure used to assess the well-being of a female patients' lower genito-urinary tract. External genital exam: Visual inspection & palpation of the external genitalia. Vaginal speculum exam: An instrument called a speculum is inserted into the vagina in order for the examiner to be able to view the vaginal walls and cervix.
Physical assault	An act of physical violence that is not sexual in nature.
Posterior fornix	Recesses in the vagina behind the cervix.

Pre-pubescent	A child at the stage of development just before puberty. Usually, puberty starts between ages 8 and 13 in girls and ages 10 and 15 in boys. The first signs of puberty for girls are breast development, growth of hair in the pubic area and armpits, and acne. Menstruation usually happens last. For boys, puberty usually begins with the testicles and penis getting bigger, then hair grows in the pubic area and armpits. Muscles grow, the voice deepens, and acne and facial hair develop.
Preventive treatment	Medical treatment to protect against disease or infection after suspected or known exposure.
Rape	Non-consensual penetration (however slight) of the vagina, anus, or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
Referral network	A group of providers who you can refer your patient to for care.
Sexual assault	Any form of non-consensual sexual contact that does not result in or include penetration.
Sexually transmitted infection (STI)	Disease transmitted by sexual contact.
Tetanus toxoid vaccination	A type of immunization that protects against tetanus. Tetanus is a bacterial disease that leads to stiffness of the jaw muscles and other muscles. Tetanus is frequently a fatal infectious disease. Tetanus enters the body through deep wounds and puncture wounds, which can be caused by nails, splinters or insect bites, or burns, any skin break, and injection-drug sites.
Urethral meatus	The opening to the urethra. On males this is on the tip of the penis.
Vaginal discharge	Vaginal discharge is a fluid produced by glands in the vaginal wall and cervix that drains from the opening of the vagina. Normal vaginal discharge is white or clear and has a slightly sour smell. Bad smelling, yellow or thick discharge may represent a vaginal or cervical infection.

1. OVERVIEW OF GUIDELINES

- 1.1 TARGET AUDIENCE
- 1.2 PURPOSE
- 1.3 COMPONENTS OF THE CMR PROTOCOL



1.1 Target Audience

The guidelines are designed for use by as many qualified health care providers (health coordinators, medical doctors, clinical officers, midwives and nurses) as possible inside Syria. The guidelines are also available in Arabic.

1.2 Purpose

The guidelines aim at providing an appropriate, common understanding of GBV and highlighting the responsibilities of qualified medical staff, who might be called upon to take care of a survivor of GBV. The protocol focuses on the steps to undertake in the clinical management of rape survivors (CMR). It describes best practices in the clinical management of women, men, boys and girls who have been raped in emergency situations. It explains how (while adopting a survivor-centred approach) to perform a thorough physical examination, record the findings and provide medical care to someone who has been penetrated in the vagina, anus or mouth by a penis or other object.

It does not include detailed information on standard care of wounds or injuries or on psychological counselling, although these may be needed as part of comprehensive care for a survivor of GBV. Neither does it give guidance on procedures for referral of survivors to non-medical institutions. Other reference materials describe this kind of care or give advice on creating referral networks (see Annex 1). The guidelines should be used in combination with the GBV Standard Operating Procedures.

Standard Operating Procedures (SOPs) for Gender-Based Violence Prevention and Response, 2015 GBV Sub-Cluster (Turkey Hub-Syria)

The SOPs describe minimum actions to be taken to respect international standards and a survivor-centred approach in caring for GBV survivors, focusing on clear procedures, guiding principles, roles, and responsibilities for humanitarian actors involved in the prevention of, and response to GBV.

Users of these guidelines are also encouraged to consult the 2015 IASC *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*³, the IASC *Guidelines for Gender-based Violence Interventions in Humanitarian Settings*⁴, the WHO, UNHCR & UNFPA *Clinical Management of Rape e-learning Programme*, UNHCR's *Sexual and Gender-Based Violence Against Refugees, Returnees And Internally Displaced Persons: Guidelines for Prevention and Response* and WHO's *Guidelines for Medico-legal Care for Victims of Sexual Violence*.

While it is recognized that men and boys can be exposed to rape, most individuals who are raped are women or girls; female pronouns are therefore mostly used in the guide to refer to rape survivors, except where the context dictates otherwise. Please also note that the term 'survivor' instead of 'victim' is used, to highlight the strength and resilience of those who overcome GBV.

The guidelines have been adapted to the Syrian context, taking availability of resources, materials and drugs in mid-2015 into account.

1.3 Components of the CMR Protocol

Steps in the survivor-centred clinical management of rape survivors protocol, covered in Section 5 of this guide are:

Step 1: Preparing the survivor for the examination.

Step 2: Taking the history.

Step 3: Collecting forensic evidence in cases of rape.

Step 4: Performing the physical examination.

Step 5: Prescribing treatment.

Step 6: Psychological First Aid and Counselling.

Step 7: Medical certificate.

Step 8: Follow-up care.

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



2. GENDER-BASED VIOLENCE

2.1 DEFINITION

2.2 TYPES OF GBV

2.3 GBV AND HUMAN RIGHTS

2.4 CONSEQUENCES OF GBV

2.5 KEY MESSAGES

2.1 Definition

This guide will use the internationally recognized definition of gender-based violence (GBV) of the Inter-Agency Standing Committee⁵, as a reference:

Gender based violence is an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (i.e. gender) differences between males and females.

Gender-based violence is thus an abuse of power based on gender and that violates human rights. There is never informed consent and all forms are harmful. Consequently, GBV includes much more than sexual assault and rape.

2.2 Types of GBV

In 2006, an initiative was launched to respond to a need in humanitarian settings for safe, harmonized and effective GBV data collection. In the following years, the GBV Information Management System (GBVIMS⁶) was created, which provides today, a simple system for GBV service providers to collect, store and analyse their GBV data (that is comparable across agencies and contexts), and to enable the safe and ethical sharing of reported GBV incident data.

Six types of GBV and their definitions have been agreed upon by the members of the GBVIMS inter-agency partnership, managed by a global team with representation from UNFPA, IRC, UNHCR, UNICEF and WHO:

- **Rape:** non-consensual penetration (however slight) of the vagina, anus, or mouth with a penis or other body part. Also includes penetration of the vagina or anus with an object.
- **Sexual Assault:** any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia and buttocks. Female Genital Mutilation/Cutting (FGM/C) is an act of violence that impacts sexual organs, and as such should be classified as sexual assault. This incident type does not include rape, i.e., where penetration has occurred.
- **Physical Assault:** an act of physical violence that is not sexual in nature. Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury. This incident type does not include FGM/C.
- **Forced Marriage:** the marriage of an individual against her or his will.
- **Denial of Resources, Opportunities or Services:** denial of rightful access to economic resources/assets or livelihood opportunities, education, health or other social services. Examples include a widow prevented from receiving an inheritance, earnings forcibly taken by an intimate partner or family member, a woman prevented from using contraceptives, a girl prevented from attending school, etc. Reports of general poverty should not be recorded.

- **Psychological/Emotional Abuse:** infliction of mental or emotional pain or injury. Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.

- 1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner⁷.
- GBV among female refugees is one of the least talked about dimensions of the Syrian context, but experts say it is occurring at high rates⁸.
- In Jordan, the prevalence of early marriage among all registered marriages for Syrians increasing from 25 per cent in 2013 to 31 per cent in the first quarter of 2014⁹.

While gender inequality and discrimination are some of the root causes of GBV, various other factors determine the type and extent of violence in each setting. In emergencies, as Syria is facing at this moment, norms regulating social behaviour are weakened and traditional social systems broken down. Women and children may be separated from family and community supports, making them more vulnerable to abuse and exploitation due to their gender, age, and dependence on others for help and safe passage. Furthermore, during armed conflicts, sexual violence is often used as a weapon of war, targeting civilian women and children. War-related sexual violence often includes abductions and sexual slavery.

2.3 GBV and Human Rights

Acts of gender-based violence violate a number of human rights principles enshrined in international human rights instruments. Among others, these include: the right to life, liberty and security of the person; the right to the highest attainable standard of physical and mental health; the right to human dignity; the right to self-determination; the right to information; the right to confidentiality; the right to freedom from torture or cruel, inhuman, or degrading treatment or punishment; the right to enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution (See Annex 2).

Human rights are universal, inalienable, indivisible, interconnected and interdependent. Every individual, without regard to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or status, is entitled to the respect, protection, exercise and enjoyment of all the fundamental human rights and freedoms. Gender-based violence, and in particular rape and sexual assault, are widespread international public health problems, serious, life-threatening protection issues and violations of universal human rights.

Health care providers, in collaboration with workers in other sectors, play a major role in the broader community, by identifying and advocating for interventions to prevent GBV and to promote and protect the rights of survivors.

2.4 Consequences of GBV

Survivors of GBV are at high risk of severe and long-lasting health problems, as well as death from injuries, or suicide. More broadly, health consequences can include unwanted pregnancy, unsafe self-induced abortion, infanticide, and sexually transmitted infections, e.g. HIV/AIDS. Psychological trauma, as well as social stigma and rejection, are also common. Most societies tend to blame the survivor in cases of sexual violence, which increases psychological harm (shame, self-hate and depression). Nonetheless, psychological distress should be considered as a normal reaction of the survivor, to an abnormal event.

The IASC GBV guidelines¹⁰ stress the fact that **to save lives and maximise protection, a minimum set of activities must be rapidly undertaken in a coordinated manner to prevent and respond to gender-based violence in emergencies. Survivors of GBV need assistance to cope with the harmful consequences.** They may need life-saving health care, psychological and social support, security, and legal redress (**multi-sectoral approach**). At the same time, prevention activities must be put in place to address causes of, and contributing factors to, GBV particular to the setting.

GBV can have a profound negative impact on every aspect of the lives of the survivors:

- at individual level: e.g. physical harm.
- at household level: e.g. cases where wives who have been raped are subsequently ostracised by family and husband because of loss of their virginity, or seen as impure.
- at community level: e.g. cases where the survivor is blamed for being raped or where a rapist can go free under the penal code, if he marries the survivor.

With its health, emotional/psychological and social consequences, GBV thus also comes with large economic and social costs.

Survivors may react in any number of ways to GBV. 'Whether their trauma reaction is long lasting or not, depends, in part, on how they are treated when they seek help. By seeking medical treatment, survivors are acknowledging that physical and/or emotional damage has occurred. They most likely have health concerns. **The health care provider can address these vital concerns and help survivors begin the recovery process by providing compassionate, thorough and high-quality medical care, by centring this care around the survivor and her needs, and by being aware of the setting-specific circumstances that may affect the care provided**'¹¹.

2.5 Key Messages

Adhere to the guiding principles in the medical management of survivors: safety, confidentiality, respect, non-discrimination.

Provide 24/7, confidential services that include at least:

- prevention of pregnancy, STIs, and HIV transmission
- detailed documentation
- referral for further crisis intervention.

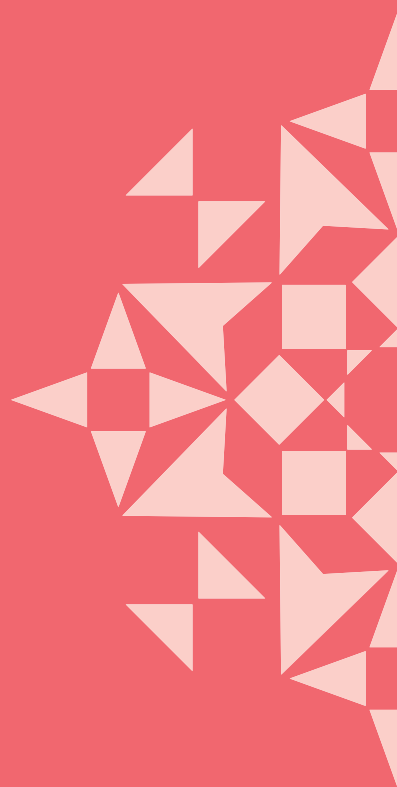
Ensure staff have treatment protocols, forms, and supplies.

Coordinate confidential referral procedures between services (health, psychosocial, safety, other).

3. GUIDING PRINCIPLES AND ROLES OF MEDICAL STAFF

3.1 GUIDING PRINCIPLES

3.2 ROLES OF MEDICAL STAFF



3.1 Guiding Principles

All medical staff can play an important role in reducing the harmful effects of GBV, starting by putting the four guiding principles into practice while caring for survivors of GBV.

- Ensure the physical **safety** of the survivor.
- Guarantee **confidentiality**.
- **Respect** the wishes, the rights, and the dignity of the survivor.
- Ensure **non-discrimination**.

Survivors of GBV have all experienced an abuse of power. It is therefore essential in the path to recovery that service providers give back the control to the survivor and focus on her/his wishes.

Below are some key recommendations for medical practitioners, on how to integrate the guiding principles into their care for GBV survivors:

3.1.1 Ensure the physical safety of the survivor

Always be aware of the security risks a survivor might be exposed to after GBV. Hold all conversations and examinations in a safe setting and limit the number of people allowed in the room (e.g. if requested by the survivor: same-sex health care worker/family/friend).

- Try, as much as the context and your position allow you, to assess the safety of the survivor (Does the survivor have a safe place to go to? Will the survivor be confronted with the potential perpetrator?), and take action to ensure the safety of the survivor, if possible.
- Inform yourself about all options for referral (to a safe place) available to the survivor.

3.1.2 Guarantee confidentiality

Do not share the story of the survivor with others.

If you need to share information with professionals, for instance to organise a referral, you can only do so if the survivor understands what this implies and has given his/her informed consent beforehand.

3.1.3 Respect the wishes, the rights, and the dignity of the survivor

Respect the wishes, needs and capacities of the survivor:

- Every action you take should be guided by the wishes, needs and capacities of the survivor.
- Respect the strength and capacities of the survivor to cope with what happened to her/him.

- After the survivor is informed about all options for support and referral, s/he has the right to make the choices s/he wants.

Treat the survivor with dignity:

- Show that you believe the survivor, that you don't question the story or blame the survivor, and that you respect her/his privacy.

Assure a supportive attitude:

- Provide emotional support to the survivor. Show sensitivity, understanding and willingness to listen to the concerns and story of the survivor.
- Retain a caring attitude, regardless of the type of intervention you make.

Provide information and manage expectations:

- Provide the survivor with information about available services and their quality to enable them to make a choice about the care and support s/he wants.
- Check whether the survivor fully understands all the information, and if necessary, adapt the presentation of the information to the capacity of the survivor at that time.
- Always be clear about your role and about the type of support and assistance you can offer to a survivor.
- Never make promises that you can't keep.
- Always refer the survivor to the appropriate services.

Consider the possibility of accompaniment of the survivor throughout the process – that is, having a supportive, trusted person who is informed about the process accompany the survivor to different services.

3.1.4 Ensure non-discrimination

Treat every survivor in a dignified way, independent of her/his sex, background, race, ethnicity or the circumstances of the incident.

Treat all survivors equally.

Do not make assumptions about the history or background of the survivor.

Be aware of your own prejudices and opinions about GBV and do not let them influence the way you treat a survivor.

3.2 Roles of Medical Staff

The health care workers' responsibilities should exceed providing the purely, required life saving medical care. When applying the above highlighted survivor-centred skills in their care for survivors of GBV, the health care providers will protect survivors from further harm and encourage empowerment.

Informing (telling someone facts so s/he can make an informed decision about what to do) the survivor about his/her options instead of advising (telling someone what you think s/he should do and how s/he should do it) is essential in this process. It shows that the medical professional respects the survivor's opinion and judgment, and ensures that the survivor has control of her/his choices.

The health care provider can help survivors begin their recovery process within the medical facility but they can even do more. They are key reference persons to inform communities about the availability of health care services for survivors of GBV.

4. PREPARING TO OFFER MEDICAL CARE TO GBV SURVIVORS

4.1 SERVICE COMPONENTS

4.2 MINIMUM REQUIREMENTS IN LIMITED
RESOURCE SETTINGS



4.1 Service Components

The health care service must make preparations to respond thoroughly and compassionately to survivors of GBV. Therefore, it is essential that health care providers (doctors, medical assistants, nurses, etc.) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service providing care for GBV survivors. In setting up care for survivors in the clinic, the following questions and issues need to be addressed, and standard procedures developed.

4.1.1 Community Awareness

Members of the community should know:

- what services are available for survivors of GBV;
- why GBV survivors would benefit from seeking medical care; where to go for services;
- that GBV survivors and particularly, survivors of rape should come for care immediately or as soon as possible after the incident, without bathing or changing clothes;
- that GBV survivors can trust the service to treat them with dignity, maintain their security, and respect their privacy and confidentiality;
- when services are available.

4.1.2 Local Legal/Justice Context

Staff in health care services who come into contact with GBV survivors need to know: if any, what local laws and functional courts and policies are in place in your area; what are the local legal requirements with regard to reporting (e.g. who can complete a medical certificate, who can be called to court, etc.), with regard to forensic evidence.

In areas of Syrian reachable through cross-border programs from Turkey, due to the disruption of the legal system, always act in the best interest of the survivor.

Respect his/her wishes, in accordance with the guiding principles of working with survivors of GBV.

Evaluate the pros and cons and always let the safety of the survivor prevail.

4.1.3 Protocols

Set up protocols and standard operating procedures, including giving consideration to the following: is the CMR protocol available to all medical personnel who could be in contact with a survivor of GBV? and what is the vaccination schedule for Tetanus, Hep B?

Ensure the service is set up to contribute as part of a multisectoral approach of survivors of GBV:

- Staff need to know what services are available in their geographical area: secondary health care (surgery, paediatrics and/or gynaecology/obstetrics services), psychological and social support, security, and legal redress services;
- The Standard Operating Procedures for Gender-Based Violence Prevention and Response needs to be available to, and understood by, all medical personnel.

Interagency and inter-sectoral coordination should be established to ensure comprehensive care for survivors of GBV.

4.1.4 Staff

Agree who should provide care and how. All staff in health facilities coming into contact with GBV survivors, from reception staff to health care professionals, should:

- be sensitized and trained;
- provide care according to the protocol and with an awareness of their own attitudes and sensitivities, the sociocultural context, and the community's perspectives, practices and beliefs;
- always respect the four guiding principles of working with survivors and put their survivor-centred skills into practice (see Section 3.0 for guiding principles).
- The principles are: ensure the physical safety of the survivor; guarantee confidentiality; respect the wishes, the rights, and the dignity of the survivor, and ensure non-discrimination.

4.1.5 Clinic, Equipment and Supplies

Setting up a clinic will need to address the following:

- Plan where the care should be provided and what is needed.
- Generally, a clinic or outpatient service that already offers reproductive health services, such as antenatal care, normal delivery care, or management of STIs, can offer care for GBV survivors. To avoid stigmatization, GBV care should be integrated in another existing service and never be labelled as e.g. GBV Clinics.
- The consultation room should ensure confidentiality and privacy e.g. it should have walls and the number of people allowed in the room should be limited to the minimum necessary.

- Services should be available 24 hours a day, 7 days a week.
- All available supplies from the checklist below should be prepared and kept in a special box or place, so that they are readily available for survivors of rape.
- If applicable (see STEP 3), equipment for documenting and collecting forensic evidence should be available.
- Drugs for a STI treatment, post-exposure prophylaxis (PEP) and emergency contraception should be available e.g. through ordering the Reproductive Health Kit n°3 (please contact UNFPA for further information).
- Vaccines should also be made available as much as possible.

4.2 Minimum Requirements in Limited Resource Settings

This checklist gives an overview of all items needed at the level of the medical facility, to enable the medical staff to provide minimum recommended care to survivors of rape. (See Annex 3 for checklist for more advanced settings.)

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
1. Protocol			
Written medical protocol in the language of the medical service provider (Arabic)			
2. Personnel			
Trained (local) health care professionals (on call 24 hours a day)			
A "same language" female health worker or companion in the room during examination			
3. Furniture/Setting			
Room (private, quiet, accessible, with access to a toilet or latrine)			
Examination table			
Light, preferably fixed (a torch may be threatening for children)			
Access to an autoclave to sterilize equipment			
Weighing scales and height chart for children			
Safe, locked filing space to store confidential records			
4. Supplies			
Speculum			
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)			
Resuscitation equipment for anaphylactic reactions			
Sterile medical instruments (kit) for repair of tears, and suture material			
Needles, syringes			
Gown, cloth, or sheet to cover the survivor during examination			
Sanitary supplies (pads or local cloths)			
Pregnancy tests			

Name/Code of the facility:	<p>Available in my medical facility</p> <p>Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)</p> <p>Available in a nearby medical facility (specify which one)</p>		
Governorate:			
District:			
Sub-district:			
5. Drugs			
For treatment of STIs, as per protocol			
For post-exposure prophylaxis (PEP) of HIV transmission, as per protocol			
Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD), as per protocol			
Tetanus toxoid			
For pain relief (e.g. paracetamol)			
Local anaesthetic for suturing			
Antibiotics for wound care			
6. Administrative supplies			
Medical chart with pictograms			
Consent forms			
Information pamphlets for post-rape care (for survivor)			

5. CLINICAL MANAGEMENT OF RAPE SURVIVORS PROTOCOL

5.1 STEPS IN SURVIVOR-CENTRED CARE

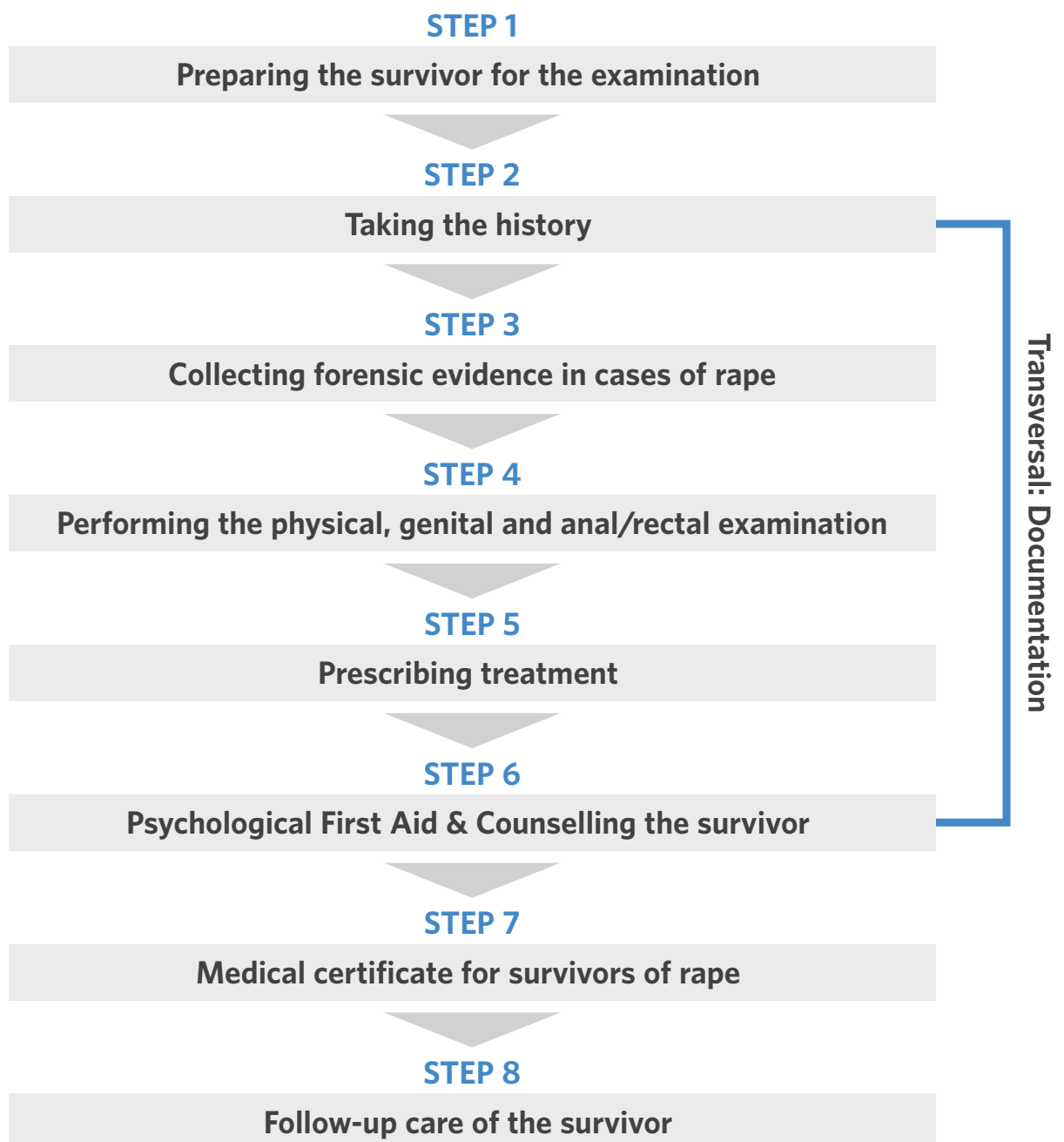
- STEP 1 PREPARING THE SURVIVOR FOR THE EXAMINATION
- STEP 2 TAKING THE HISTORY
- STEP 3 COLLECTING FORENSIC EVIDENCE
- STEP 4 PERFORMING THE PHYSICAL EXAMINATION
- STEP 5 PRESCRIBING TREATMENT
- STEP 6 PSYCHOLOGICAL FIRST AID AND COUNSELLING
- STEP 7 MEDICAL CERTIFICATE
- STEP 8 FOLLOW-UP CARE

5.2 MALE SURVIVORS

5.3 CHILD SURVIVORS



5.1 Steps in Survivor-centred Care



STEP 1.

Preparing the Survivor for the Examination

A survivor of GBV has experienced trauma, and may be in an agitated or depressed state or may show no particular emotion. Particularly a survivor of sexual assault or rape often feels fear, guilt, shame and/or anger. **The health worker must prepare her and obtain her informed consent for the examination, and carry out the examination in a compassionate, systematic and complete fashion.**

Informed consent:

- is a two-way process (between the health care worker and the survivor);
- goes beyond providing a form or document for the survivor to read and sign;
- involves explaining what will happen and answering questions; ensures that survivors are aware of, and understand the purpose and content of the medical history, examination and treatment;
- should continue throughout the medical visit (and follow-up).

See Annex 4 for the Consent Form. See Section 5.3 for guidance on **consent/assent from child survivors**.

Introduce yourself.

Limit the number of people allowed in the room to the minimum necessary, especially during the examination.

- If the survivor wishes, ensure that a trained support person or trained health worker of the same sex accompanies the survivor throughout the examination.
- Ask if she also wants to have a specific person present e.g. family member or friend. Try to ask her this when she is alone.

Determine the best way to communicate and adapt to the survivor's communication skill level and language.

- A survivor may need a translator, but the translator should also be someone he/she is comfortable with and who understands how to maintain confidentiality.
- Avoid medical terminology/jargon.

Obtain informed consent and thus explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.

- Everything does not need to be explained in detail at once. Explain the key steps initially. Then explain important information at each stage allowing the survivor to ask questions, stop and agree, or disagree to any part of the consultation.
- Review the consent form (see Annex 4) with the survivor. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo and that this will not affect access to treatment or care. Explain to her that she can delete references to these aspects on the consent form. Once you are sure she understands the form completely, ask her to sign it. If she cannot write, obtain a thumbprint.

Reassure the survivor that she is in control of the pace, timing and components of the examination. Explain that she can refuse steps of the examination at any time as it progresses.

Reassure the survivor that the examination findings will be kept confidential unless she decides to bring charges.

Apply Psychological First Aid (see Step 6).

Ask her if she has any questions.

Section 5.2 provides guidance on how to prepare male survivors. Section 5.3 provides guidance on how to prepare child survivors.

Provide a survivor with information before doing an exam.

- To increase the survivor's knowledge and comfort.
- To reduce anxiety and the risk of re-traumatization during the exam.
- To give the survivor an understanding of what is involved in the exam and any risks and benefits.
- To guarantee the survivor's rights (to information, human dignity, self-determination).

STEP 2.

Taking the History

The **main purpose** of taking the history is **to guide the medical examination and treatment**.

If applicable (see Step 3), a secondary purpose could be to guide the forensic examination.

Key Considerations

Introduce yourself.

If the history taking is conducted in the treatment room, cover the medical instruments until they are needed.

Before taking the history, review any documents or paperwork brought by the survivor. Do not ask questions that have already been asked and documented by other people involved in the case.

Avoid any distraction or interruption during the history taking.

Make sure the survivor feels comfortable.

- Use calm tone - and if culturally appropriate, maintain eye contact
- Be aware of the survivor's body language and your own. Please also see Step 6: Look and Listen.

Take sufficient time to collect all needed information, without rushing. Proceed at the survivor's own pace.

Let the survivor tell her story the way she wants to. Document the incident in the survivor's own words.

Be thorough but don't force the survivor.

Avoid questions that suggest blame, such as "what were you doing there alone?"

Be compassionate and non-judgmental.

Follow History and Examination form - be systematic.

Explain what you are going to do at every step.

Specific considerations should be taken into account for child or male survivors.

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Section 5.2 provides guidance on taking the history of male survivors. Section 5.3 provides guidance on child survivors.

Questions to avoid: **'Why'** questions. These often make survivors feel defensive. For example, do not ask a survivor "Why didn't you tell anyone you were raped?" Instead ask, "Tell me how you were feeling after it happened."

Medical History Form

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

Medical History Form Overview

- General info: name or survivor's code, age, ...
- The incident: date, time, penetration,...
- Medical history:
 - > After the incident
 - > Contraceptive use
 - > Menstrual/Obstetric history
 - > History of consenting intercourse
 - > Vaccination status
 - > HIV/AIDS status
- Medical examination
- Genital & anal examination
- Investigations done
- Evidence taken
- Treatments prescribed
- Counselling, referrals, follow up

- **General Information**

Name/survivor's code, current address, sex, date of birth (or age in years).

Date and time of the examination and the names and function of any staff or support person (someone the survivor may request) present during the history-taking and examination or staff's code(s).

- **The Incident**

Ask the survivor to describe what happened. Allow her to speak at her own pace. Do not interrupt to ask for details; follow up with clarification questions after she finishes telling her story. Explain that she does not have to tell you anything she does not feel comfortable with.

Survivors may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health worker understands exactly what happened in order to check for potential injuries, to assess the risk of pregnancy and STI or HIV, and be able to provide the best care possible. Explain this to the survivor, and reassure her of confidentiality if she is reluctant to give detailed information.

- **Medical History**

If the incident occurred recently, determine whether the survivor has bathed, urinated, defecated, vomited, used a vaginal douche or changed her clothes since the incident. This may affect what forensic evidence can be collected.

Information on existing health problems, allergies, use of medication, and vaccination and HIV status will help you to determine the most appropriate treatment to provide, necessary counselling, and follow-up health care.

Evaluate for possible pregnancy; ask for details of contraceptive use and date of last menstrual period.

- **Pre-existing Pregnancy**

In developed country settings, some 2% of survivors of rape have been found to be pregnant at the time of the rape¹². Some were not aware of their pregnancy.

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

A guide for confirming pre-existing pregnancy

(adapted from an FHI protocol¹³)

NO		YES
	Have you given birth in the past 4 weeks?	
	Are you less than 6 months postpartum and fully breastfeeding and free from menstrual bleeding since you had your child?	
	Did your last menstrual period start within the past 10 days?	
	Have you had a miscarriage or abortion in the past 10 days?	
	Have you gone without sexual intercourse since your last menstrual period (apart from the incident)?	
	Have you been using a reliable contraceptive method consistently and correctly? (check with specific questions)	



If the survivor answers **NO** to all the questions, ask about and look for signs and symptoms of pregnancy. If pregnancy cannot be confirmed provide her with information on emergency contraception to help her arrive at an informed choice (see Step 5)



If the survivor answers **YES** to at least 1 question and she is free of signs and symptoms of pregnancy, provide her with information on emergency contraception to help her arrive at an informed choice (see Step 5)

Transversal Step Documentation

It is not the health care provider's responsibility to prove or disprove that a rape occurred. Document your findings without stating conclusions about whether or not a person has been raped. Rape is a legal designation to be proven in court.

In addition, there will not always be signs of physical force or genital injury – this does not mean the rape did not happen. **Your responsibility as a medical practitioner is only to document your medical findings and observations in a thorough and objective way** (witness facts).

Documenting the Case

Use the History and Examination and Pictogram forms (See Annexes 5 and 6)

Record the interview (general info and specification concerning the incident and medical history) and your findings at the examination in a clear, complete, objective, non-judgmental way.

Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds (see Table 1 below). Record your findings on pictograms (see Annex 6). Make sure to document any older injuries or scars that could not be a result of the assault.

Health workers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible (see Table 1), without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.

Completely assess and document the physical and emotional state of the survivor.

Make note of any sample collected as evidence (if applicable, see Step 3).

Use direct quotations from the survivor as much as possible, and put her words or phrases in "quotation marks".

Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".

Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.

Table 1: Describing Features of Physical Injuries

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

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

STEP 3.

Collecting Forensic Evidence

The **main purpose of the examination of a rape survivor is to determine what medical care should be provided.** If applicable (see below), forensic evidence may also be collected to help the survivor pursue legal redress.

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

Do not collect evidence that cannot be processed or that will not be used. In areas of Syria reachable through cross-border programs, most medical facilities are not able to collect forensic evidence at this moment, as they do not meet the above requirements and/or would, by doing so, put the survivor and/or medical staff in danger.

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

Forensic evidence may be used to support a survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and possibly to identify the attacker. Proper collection and confidential and secure storage of forensic evidence can be key to a survivor's success in pursuing legal redress. Evidence should only be released to the authorities if the survivor decides to proceed with a case.

Careful consideration should be given to the existing mechanisms of legal redress and the local capacity to analyse specimens when determining whether or not to offer a forensic examination to a survivor. The requirements and capacity of the local criminal justice system, possible repercussions for the survivor/medical staff and the capacity of local laboratories to analyse evidence should be considered and the survivor should be informed about all.

Documenting injuries and collecting samples, such as blood, hair, saliva and sperm, within 72 hours of the incident may help to support the survivor's story and might help identify the aggressor(s).

If the person presents more than 72 hours after the rape, the amount and type of evidence that can be collected will depend on the situation.

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

The consent of the survivor must be obtained before evidence is collected.

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Forensic evidence can be collected **only if**:

- Timing is appropriate (< 72 hours/ > 72 hrs, in settings where the local law accepts evidence from > 72 hrs) **and**
- There are local possibilities for analysing samples **and**
- Informed consent is obtained **and**
- The chain of evidence can be maintained.

In determining whether or not to offer a forensic evidence exam, it is very important to ask yourself as a medical practitioner or within your medical organization:

- Could forensic evidence be safely collected and stored in your medical facility/ organization? Maintaining the chain of evidence requires a lot of logistical and safety measures.
- Is there a local capacity to analyse specimens?
- Are there trustworthy, progressive mechanisms of legal redress and will forensic evidence be admissible?

See Annex 7 for more information on conducting a forensic examination and on proper sample collection and storage techniques, for settings where evidence collection may be feasible.

STEP 4.

Performing the Physical Examination

The primary objective of the physical examination is to determine what medical care should be provided to the survivor. Work systematically according to the medical examination form. (See Annex 5 for sample form.)

Use the survivor's history to guide the exam to:

- Prioritize survivor's needs and wishes
- Identify and document injuries
- Help guide follow-up care/referrals
- If applicable: Document & collect evidence

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

Key Considerations

Make sure the equipment and supplies are prepared.

Always look at the survivor first, before you touch her, and note her appearance and mental state.

Always tell her what you are going to do and ask her permission before you do it.

Assure her that she is in control, can ask questions, and can stop the examination at any time.

Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).

The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications might include:

- extensive trauma (to genital region, head, chest or abdomen),
- neurological deficits,
- respiratory distress.

The treatment of these complications is not covered here.

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Apply Psychological First Aid (see Step 6).

Obtain voluntary informed consent for the examination and to obtain the required samples for forensic examination, if applicable (see sample consent form in Annex 4).

Record all your findings and observations as clearly and completely as possible on a standard History and Examination form (see Annex 5).

In general:

- A complete physical exam should be done if she presents within a week of the incident.
- The forensic exam is most helpful within the first 72 hours of the incident there can be evidence of sperm up to 72 hours.

If a survivor wants a full exam – regardless of when she presents – this should be done (but forensic documentation may be limited).

Section 5.2 provides guidance on examining male survivors. Section 5.3 provides guidance on child survivors.

Part A: Survivor presents within 72 hours of the incident

1. Physical Examination

Never ask the survivor to undress or uncover completely. Examine the upper half of her body first, then the lower half; or give her a gown to cover herself.

Carefully and systematically examine the patient's body. Start the examination with vital signs and hands and wrists rather than the head, since this is more reassuring for the survivor. Do not forget to look in the eyes, nose, and mouth (inner aspects of lips, gums and palate, in and behind the ears, and on the neck. Check for signs of pregnancy. Take note of the pubertal stage.

Look for signs that are consistent with the survivor's story, such as bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or torn eardrums, which may be a result of being slapped (see Table 1 in the 'Documentation' transversal chapter). If the survivor reports being throttled, look in the eyes for petechial haemorrhages.

Examine the body area that was in contact with the surface on which the rape occurred to see if there are injuries.

Note all your findings carefully on the examination form and the body figure pictograms (see Annexes 5 and 6), taking care to record the type, size, colour and form of any bruises, lacerations, ecchymoses and petechiae.

Take note of the survivor's mental and emotional state (withdrawn, crying, calm, etc.).

Take samples of any foreign material on the survivor's body or clothes (blood, saliva, and semen), fingernail cuttings or scrapings, swabs of bite marks, etc., as forensic evidence, if applicable (see Step 3 and Annex 7).

Even when female genitalia are examined immediately after a rape, there is identifiable damage in less than 50% of cases.

Carry out a genital examination as indicated below. If applicable, collect evidence as you go along (see Annex 7). Note the location of any tears, abrasions and bruises on the pictogram and the History and Examination Form.

Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen:

- Note any scars from previous childbirth or female genital mutilation.
- Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
- Look for any sign of infection, such as ulcers, vaginal discharge or warts.
- Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and adolescents. (See Section 5.3 on child survivors.)

If applicable, take samples for forensic evidence. If collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva, in order to avoid spillage of vaginal contents into anal areas and confusing the source.

If there has been vaginal penetration and there is heavy or uncontrolled vaginal bleeding, gently insert a speculum, lubricated with water or normal saline. (See Section 5.3 on use of speculum with child/adolescent survivors.)

- Under good lighting inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.

If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.

If indicated by the history and the rest of the examination, do an anal/rectal and/or recto-vaginal examination.

- Note the shape and dilatation of the anus. Note any fissures around the anus, the presence of faecal matter on the perianal skin, and bleeding from rectal tears.
- Note the sphincter tone.
- Inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge.
- Heavy bleeding from the rectum or loss of control over urine or faeces may indicate more severe injuries.
- Internal injuries can result from either violent penile penetration or penetration by a foreign object. Such injuries can lead to severe complications, such as fistula or an intra-abdominal infection, and require referral to a facility that can perform surgical repair. Also, if there is bleeding, pain or suspected presence of a foreign object, refer the patient to a hospital.

Fistulae

Vesico-vaginal fistula (VVF) and recto-vaginal (RVF) fistula can develop after injury from rape.

Symptoms could include:

- Incontinence of urine or faeces
- Excessive bleeding or vaginal pain (in acute cases)
- Bad smelling or greenish/yellowish vaginal discharge

→ Refer anyone suspected of having a fistula to the nearest surgical centre.



The knee-chest position should not be used, as it is often the position the assailants use (re-traumatization).

For the anal examination the patient may have to be in a different position than for the genital examination. Write down her position during each examination (supine, prone or lateral recumbent for anal examination; supine for genital examination)

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

Perform a vaginal speculum exam only for the following indications:

- heavy or uncontrolled vaginal bleeding
- foul smelling vaginal discharge when a foreign object is suspected (otherwise treat symptomatically)
- if applicable, forensic evidence collection

A speculum exam should not be performed on:

- a prepubescent child
- any patient who declines the exam (e.g. see also note above)
- A speculum exam on a woman in the second half of pregnancy with vaginal bleeding can cause increased bleeding and should be done only by a health care worker trained in the management of pregnancy complications.

Special Considerations for Elderly Women

Elderly women who have been vaginally raped are at increased risk of vaginal tears and injury, and transmission of STI and HIV. Decreased hormonal levels following the menopause result in reduced vaginal lubrication and a thinner and more friable vaginal wall. Use a thin speculum for genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

Special Considerations for Men

Refer also to Section 5.2 on examining male survivors.

For the genital examination:

- Examine the scrotum, testicles, penis, peri-urethral tissue, urethral meatus and anus.
- Note if the survivor has been circumcised.
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
- Torsion of the testis is an emergency and requires immediate surgical referral.
- If the urine contains large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

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

Physical Examination

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

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

Examination of the Genital Area

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

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

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

Key points to remember for the examination

- Have all equipment and supplies prepared.
- Never ask her to undress completely.
- Start with vital signs, examination of hands and wrists to put the survivor at ease.
- Always look at the survivor first before touching her – be aware of her mental state.
- Be systematic (head to toe, anal, genital).
- Document everything thoroughly using medical terminology and pictograms.
- Be gentle, explain everything and do not do anything without informed consent
- An examination for a survivor takes a long time, make sure you take the vital signs and treat any life threatening complications first.

Laboratory Screening and Testing

If indicated by the history or the findings on examination, further samples may be collected for medical purposes (if laboratory facilities are available):

- If the survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and possibly for culture;
- Samples may be taken from the vagina and anus for STI screening for treatment purposes. Screening might cover:
 - > rapid plasma reagin (RPR) test for syphilis or any point of care rapid test;
 - > Gram stain and culture for gonorrhoea;
 - > culture or enzyme-linked immunosorbent assay (ELISA) for Chlamydia or any point of care rapid test;
 - > wet mount for trichomoniasis;
 - > HIV test (only on a voluntary basis and after counselling);
- Do a pregnancy test, if indicated and available (see Step 2);
- Other diagnostic tests, such as X-ray and ultrasound examination, may be useful in diagnosing fractures and abdominal trauma.

STEP 5.

Prescribing Treatment

What you prescribe will depend on:

1. When the survivor presents to your health facility (within 72 hours after the incident or > 72 hrs)
2. What the survivor experienced.
 - assess the risks (what happened during the attack: e.g. penetration? number of attackers? injuries sustained?...)
3. If survivor is pregnant.

When survivors seek care within 72 hours they can receive the most complete care.

Prophylaxis for STIs is most effective if given within 72 hours but can be given up to 2 weeks after the assault.

After 72 hours it is too late to begin preventative treatment for HIV.

Emergency contraceptive pills can still be given up to 120 hours after the assault; Intra-Uterine Devices up to 7 days.

Take the above deadlines into consideration from the moment the survivor presents him/herself at your medical facility; evenly when prioritizing treating life-threatening emergencies.

Follow the steps in Part A if she presents within 72 hours of the incident; Part B is applicable to survivors who present more than 72 hours after the incident.

Part A: Survivor presents within 72 hours of the incident

1. Prevent Sexually Transmitted Infections

WHO-recommended STI treatment regimens are given in Annex 8.

Survivors of rape should be given antibiotics to treat **gonorrhoea, chlamydial infection** and **syphilis** (see Annex 8). If you know that other STIs are prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.

Give the shortest courses available, which are easy to take. For instance: 400 mg of cefixime plus 1 g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and syphilis.

Oral treatment is preferred as there are always risks associated with injections and oral treatment is just as effective for presumptive STI treatment.

Be aware that women who are pregnant should not take certain antibiotics, and modify the treatment accordingly (see Annex 8).

There is no need for partner treatment; nonetheless you should recommend (after a negative HIV test at the 1st visit) to use a condom with all partners until an HIV-test at 3 months (for those not taking PEP) or 6 months (for those taking PEP) is negative- for HIV prevention.

Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV/AIDS (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

Take the time to explain the treatment to the survivor and encourage her to come for follow-up (see Step 8).

2. Prevent HIV Transmission

WHO-recommended preventive treatment regimens are given in Annex 9.

PEP = post-exposure prophylaxis for HIV; a 28 day course of antiretroviral drugs used to prevent the survivor from becoming infected with HIV. It is NOT a treatment for HIV/AIDS.

Timing is critical! Note: Evidence suggests that PEP should be initiated as soon as possible after potential exposure (and **no later than 72 hours**), therefore you may give this to a survivor before you do a full history.

- Regardless of the prevalence of HIV in your setting, PEP should always be offered to a survivor of rape who presents herself at the clinic < 72 hours since the incident.
- Also, not having an HIV test should never be a reason for not offering PEP.
- Note that even though the prevalence of HIV within the Syrian population before the crisis was low, this rate might have changed as individuals from all around the world have moved to Syria over recent years.

Inside Syria, PEP for rape survivors is available in only few medical structures, but it can be ordered with medical kits e.g. the UNFPA Reproductive Health Kit n°3.

Before you start your service for survivors of rape, make sure the medical staff is aware of the indications for PEP and how to counsel survivors on this issue, or make a list of names and addresses of providers for referrals.

PEP usually consists of 2 antiretroviral (ARV) drugs given for 28 days (see Annex 9 for examples). If you wish to know more about PEP, see the resource materials listed in Annex 1.

If it is not possible for the person to receive PEP in your setting refer her as soon as possible (within 72 hours of the rape) to a service centre where PEP can be supplied. If she presents after this time, provide information on voluntary counselling and testing (VCT) services available in your geographical area. If VCT does not yet exist in your region, advocate for its implementation and/or provide these services in your medical facility.

PEP can start on the same day as emergency contraception and preventive STI regimens, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Risk of HIV transmission increases in the following cases: If there was more than one assailant; if the survivor has torn or damaged skin; if the assault was an anal assault; if the assailant is known to be HIV-positive or an injecting drug user. **If the HIV status of the assailants is not known, assume they are HIV-positive.**

3. Prevent Pregnancy

Taking emergency contraceptive pills (ECP) within 120 hours (5 days) of unprotected intercourse will reduce the chance of a pregnancy by between 56% and 93%, depending on the regimen and the timing of taking the medication.

WHO Recommendations

Provide **Emergency Contraception Pills (ECP) within max. 120 hours (5 days) after rape.** ECP should not be delayed or denied if a pregnancy test is not available or if the survivor does not want one.

Preferred regimen: levonorgestrel 1.5 mg *single dose*
Or: ethinylestradiol 100 mcg + levonorgestrel 0.5 mg, two doses 12 hours apart (Yuzpe)

Alternative: **Intra-Uterine Device (IUD) within max. 7 days after rape:** very effective, but need skills to insert IUD. Contra-indication: Pre-existing pregnancy; a negative pregnancy-test will thus be mandatory before insertion. WHO-recommended preventive regimens are given in Annex 10.

Progestogen-only pills are the recommended ECP regimen. They are more effective than the combined estrogen-progestogen regimen and have fewer side-effects (see Annex 10).

If EC is not registered in your area or not available, provide the usual oral contraceptives, given in different dose and time schedule.

Emergency contraceptive pills work by interrupting a woman's reproductive cycle (by delaying or inhibiting ovulation) and blocks fertilization. ECPs do not interrupt or damage an established pregnancy and thus WHO does not consider them a method of abortion¹⁴.

The use of emergency contraception is a personal choice that can only be made by the woman herself. Women should be offered objective counselling on this method so as to reach an informed decision. A health worker who is willing to prescribe ECPs should always be available to prescribe them to rape survivors who wish to use them.

If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian, who can help her to understand and take the regimen as required.

If an early pregnancy is detected at this stage (<72h) either with a pregnancy test or from the history and examination (see Steps 2 and 4), re-assure the survivor that it cannot be the result of the rape, but watch out for pregnancy complications due to the rape (miscarriage, infections, early labour, etc.).

There is no known contraindication to giving ECPs at the same time as antibiotics and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

What oral EC will NOT do

- oral EC does not interrupt established pregnancy
- oral EC has no effect if a woman is already pregnant
- oral EC will not harm the baby if woman is already pregnant
- EC does not effect a woman's ability to become pregnant in the future

4. Provide Wound Care

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

5. Prevent Tetanus

Tetanus toxoid is available in several different preparations. Check what you have on hand in your medical facility.

Anti-tetanus immunoglobulin is expensive and needs to be refrigerated. In Syria at this moment, in most medical settings it is not available.

If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.

Use Table 2 below to decide whether to administer tetanus toxoid (which gives active protection) and if available, anti-tetanus immunoglobulin (which gives passive protection).

If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.

Recommend survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

Table 2: Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds¹⁵

TT - tetanus toxoid

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

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

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

HATIG - human anti-tetanus immunoglobulin

History of tetanus immunization (number of doses)	If wounds are clean			
	and < 6 hours old or minor wounds		All other wounds	
	TT*	HATIG**	TT*	HATIG**
Uncertain or < 3	Yes	No	Yes	Yes
3 or more	No, unless last dose >10 years ago	No	No, unless last dose >5 years ago	No

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

** Also ATS (anti-tetanus serum /equine immunoglobulin) could be considered here. **Nonetheless is the administration of HATIG preferred to ATS!** Potential immediate & late adverse effects are more severe after ATS, than HATIG.
Another advantage of HATIG is that it provides a more prolonged effect than ATS, as HATIG's half-life is 21-30 days.

6. Prevent Hepatitis B

Several hepatitis B vaccines are available, each with different recommended dosages and schedules. Check the dosage and vaccination schedule for the product that is available in your medical facility.

The vaccine is relatively expensive and needs to be refrigerated. In Syria at this moment, in most medical settings it is not available.

There is no information on the incidence of hepatitis B virus (HBV) infection following rape. However, HBV is present in semen and vaginal fluid and is efficiently transmitted by sexual intercourse.

If the survivor has not been vaccinated or his/her immunization status is unknown, and the vaccine is available in your setting, vaccinate, no matter how long it has been since the incident.

In Syria where the infant immunization programmes routinely use hepatitis B vaccine, a survivor may already have been fully vaccinated. If the vaccination record card confirms this, no additional doses of hepatitis B vaccine need be given.

The usual vaccination schedule is at 0, 1 and 6 months. However, this may differ for different products.

If not fully vaccinated, encourage the patient to complete the vaccination.

Give the vaccine by intramuscular injection in the deltoid muscle (adults) or the anterolateral thigh (infants and children). Do not inject into the buttock, because this is less effective. Inform the survivor that she may experience redness and tenderness at the vaccination site.

The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It may be given at the same time as tetanus vaccine.

7. Provide Mental Health Care

Social and psychological supports, including counselling (see Step 6), are essential components of medical care for the rape survivor. Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust. At this stage, do not push the survivor to share personal experiences beyond what she wants to share. However the survivor may benefit from counselling at a later time, and **all survivors should be offered a referral to psychosocial services, if these exist.**

If the survivor has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e. without an organic cause), explain to her that these sensations are common in people who are very scared after having gone through a frightening experience, and that they are not due to disease or injury¹⁶. The symptoms reflect the strong emotions she is experiencing, and will go away over time as the emotion decreases.

Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of the symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose may be repeated for a few days with daily assessments.

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

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

1. Sexually Transmitted Infections

If laboratory screening for STIs reveals an infection, or if the person has symptoms of an STI, follow the WHO protocol in Annex 8.

2. HIV Transmission

Generally, it is recommended that the survivor be referred for voluntary counselling and testing (VCT) after 3 months (for those not taking PEP) and 6 months (for those taking PEP), in order to avoid the need for repeated testing.

If VCT does not yet exist in your region, advocate for their implementation and/or provide these services in your medical facility.

3. Pregnancy

If the survivor is pregnant, try to ascertain if she could have become pregnant at the time of the rape. If she is, or may be, pregnant as a result of the rape, counsel her on the possibilities available to her in your setting (see Step 2, Step 6, and Step 8).

If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72 hours, but it is still moderately effective within 120 hours after unprotected intercourse (see Annex 10). There are no data on effectiveness of emergency contraception after 120 hours.

If the survivor presents within seven days of the rape, insertion of a copper-bearing IUD is an effective method of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies). The IUD can be removed at the time of the woman's next menstrual period or left in place for future contraception. Women should be offered counselling on this service so as to reach an informed decision.

A contra-indication for IUD is a pre-existing pregnancy. A negative pregnancy-test will thus be mandatory before insertion. A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment to prevent infections of the upper genital tract (for recommendations see Annex 8 and 10).

4. Bruises, Wounds and Scars

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

5. Tetanus

Tetanus usually has an incubation period of 3 to 21 days, but it can be many months.

Refer the survivor to the appropriate level of care if you see signs of a tetanus infection.

If she has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident.

If there remain major, dirty, unhealed wounds, consider giving immunoglobulin if available (see Table 2 Part A).

6. Hepatitis B

Hepatitis B has an incubation period of 2-3 months on average.

If you see signs of an acute infection, refer the person if possible or provide counselling.

If the survivor has not been vaccinated or his/her immunization status is unknown, and the vaccine is available in your setting, vaccinate, no matter how long it has been since the incident.

7. Mental Health

Please also refer to Step 6: Psychological First Aid and Counselling.

All survivors should be offered a referral to psychosocial services, if these exist. Social support and psychological counselling are essential components of medical care for the rape survivor.

Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust.

Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case, and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose of diazepam may be repeated for a few days with daily assessments.

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

Many symptoms will disappear over time without medication, especially during the first few months. However, if the assault occurred less than 2 to 3 months ago and the survivor complains of sustained, severe subjective distress lasting at least 2 weeks, which is not improved by psychological counselling and support (see Step 6), and if she asks repeatedly for more intense treatment and you cannot refer her, consider a trial of imipramine, amitriptyline or similar antidepressant medicine, up to 75-150 mg at bedtime. Start by giving 25 mg and, if needed, work up to higher doses over a week or so until there is a response. Watch out for side effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the person gets out of bed in the morning. The duration of the treatment will vary with the medication chosen and the response.

If the assault occurred more than 2 to 3 months ago and psychological counselling and support (see Step 6) are not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares, or constant fear, and you cannot refer her; consider a trial of antidepressant medication (see above).

STEP 6.

Psychological First Aid and Counselling

1. Psychological First Aid

Even though trauma-related symptoms may not occur, or may occur and then disappear over time, all survivors of GBV should be offered psychological support.

Emotional reactions of survivors in response to an act of GBV are very personal. Affected people may be very upset, anxious or confused. Some blame themselves for things that occurred during the crisis.

We know that there are certain protective factors in life that provide people with a psychological 'cover' and therefore reduce the likelihood of severe psychological effects when encountering hardship or suffering. In your survivor-centred care to survivors of GBV and assessment of the psychological support needed, it is thus essential to:

- Identify what **protective factors** are present in the survivor's current situation e.g. social support from family and community.

'All communities contain effective, naturally occurring psychosocial supports and sources of coping and resilience. Nearly all groups of people affected by an emergency include helpers to whom people turn for psychosocial support in times of need. In families and communities, steps should be taken at the earliest opportunity to activate and strengthen local supports and to encourage a spirit of community self-help. A self-help approach is vital, because having a measure of control over some aspects of their lives promotes people's mental health and psychosocial well-being following overwhelming experiences. Affected groups of people typically have formal and informal structures through which they organise themselves to meet collective needs. Even if these structures have been disrupted, they can be reactivated and supported as part of the process of enabling an effective emergency response. Strengthening and building on existing local support systems and structures will enable locally owned, sustainable and culturally appropriate community responses.'¹⁷

In your location, identify existing local self-help mechanisms (e.g. women & girls' safe spaces), advocate and promote protective factors.

- Identify **risk factors** that are present in the survivor's current situation and that could have an adverse effect on recovery. E.g. when the abuse occurred in the home setting, ask the survivor if she has a safe place to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. Also e.g. if the survivor has dependants to take care of, and is unable to carry out day-to-day activities as a result of her trauma, provisions must be made for her dependants and their safety.
- Identify (negative and positive) **coping mechanisms** of the survivor by e.g. asking how she/he has possibly coped before.

Coping is the process of adapting to a new life situation, managing difficult life circumstances, making an effort to solve problems, and/or trying to minimise/reduce or put up with stress or conflict¹⁸.

Survivors of GBV may suffer severe emotional trauma and might, individually, cope in very different ways.

Medical personnel should through their Psychological First Aid (see below) and the implementation of survivors-centred approach, encourage and support as much as possible, positive coping.

Examples of individual positive coping:

- Purposeful activities: gardening and farming, cooking, offer help to others
- Engaging in exercise/activities (e.g. walking, reading books)
- Talking about experiences and listening/talking with others or people who love you. Express your feelings as they come
- Getting enough sleep
- Engaging with family, children and friends.

Examples of individual negative coping:

Using alcohol or drugs to self-medicate - Smoking - Sleeping all day - Excessive eating (or not eating) - Violent behaviour, Losing temper - Neglecting personal hygiene - Avoiding and detachment from family/friends.

From the first contact with the survivor, you should provide survivors with Psychological First Aid (PFA). PFA is “a humane, supportive response to a fellow human being who is suffering in ways that respect their dignity, culture and capacities”. As a doctor or other medical professional, it is not expected that you would be an expert counsellor or psychiatrists; only that you would reinforce positive coping mechanisms of the survivors and therefore would: Look, Listen and Link.

Not everyone has or develops significant mental health/emotional problems, but nevertheless are survivors at increased risk of a range of psychosocial distress/disorders. In caring for survivors of GBV, it's important to be attentive to signs/manifestations of psychological distress/disorder and look, listen, and link.

LOOK- Look for signs/symptoms of psychological distress/disorder, such as:

Behavioural	Emotional	Physical/somatic	Cognitive
Extreme disorientation	Acute stress reactions	Headaches	Extreme disorientation
Excessive drug &/or alcohol use	Acute grief reactions	Stomach aches	Inability to accept/cope with death of loved one(s)
Isolation, withdrawal	Sadness, tearfulness	Sleep difficulties	Distressing dreams or nightmares
High risk behaviour	Irritability, anger	Difficulty eating	Intrusive thoughts / images
Regressive behaviour	Feeling anxious, fearful	Worsening of health conditions	Difficulty concentrating
Separation anxiety	Despair, hopelessness	Fatigue/exhaustion	Difficulty remembering
Violent behaviour	Feeling of guilt or shame	Chronic agitation	Difficulty making decisions
Maladaptive coping	Feeling emotionally numb, disconnected		Preoccupation with death/destruction
Suicidal, self-harm	Depression		

LISTEN- Adhere to the guiding principles, apply survivor-centred skills and listen actively:

DO	DON'T
DO ensure and respect confidentiality	DON'T force the survivor to tell the details of what happened to her/him
DO express your interest and concern with your body as well as your words. Being calm and showing understanding fosters a sense of security, respect & caring.	DON'T interrupt or rush her. If someone does not want to talk, your quiet presence and availability can already be very valuable.
DO begin with open-ended, broad questions and check that you understand correctly by repeating back/restating.	DON'T ask 'why' questions as these often make survivors feel as if they are to blame for the incident, but instead help the survivor understand that it's not her fault.
DO believe and validate the survivors experience and acknowledge her emotion (give recognition)	DON'T trivialize or minimize the violence, don't judge or blame the survivor.
DO inform the survivor about all care you can provide and respect her/his wishes.	DON'T advise the survivor, but provide information so he/she can make an informed decision.
DO make referrals and promote access to non-medical services (multi-sector response).	DON'T make promises that you can't keep. Always be clear about your role and about the type of support and assistance you can offer to a survivor.
	DON'T refer the survivor to services that will not provide confidential, respectful care.

LINK- Facilitate access to appropriate assistance, services and resources to meet needs and solve problems, as defined by the survivor. Therefore, gather as much information as possible before caring for survivors (see Section 4.0 Preparing to Offer Medical Care to GBV Survivors) and keep the information up to date, concerning:

what services (psychosocial, psychiatric, safety/security, legal,...) are available in your geographical area e.g. through NGOs, and if they are not in your area, in which they are.

- **when** the services are available and if they are free of charge
- who the **reference point** is at the level of these services (e.g. have the contact details of the reference persons).

A coordinated integrated referral system should be put in place as soon as possible (see Section 4.0 Preparing to Offer Medical Care to GBV Survivors and SOPs¹⁹). Provide information on available options/services so the survivor can make her/his own decision about the way forward and certainly suggest to the survivor to refer her/him to higher-level mental health services, if:

- The problem is beyond your training or capability (always obtain informed consent for referral)
- The person seems to be socially isolated
- The person has hallucinations or feelings of persecution
- There is a significant impairment in daily functioning (e.g. not being able to care for oneself)
- The person can be a danger to others or himself/herself. Signs include: dependency on alcohol or drugs, depression lasting longer than two weeks, severe aggression, active hallucinations, suicidal thoughts, homicidal thoughts, and severe rage.

Key points:

Various reactions to stress, grief, and loss are normal reactions to abnormal events.

In provision of survivor-centred care at medical facility level, you should LOOK, LISTEN & LINK.

Protective factors should be promoted and risk factors reduced.

Positive coping should be encouraged.

Referral should be made, when appropriate.

2. Counselling the Survivor

Counselling must take place from the first contact with the patient. The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, it is a sign that she trusts you. Your compassionate response to her disclosure can have a positive impact on her recovery.

Survivors seen at a health facility immediately after the rape are likely to be extremely distressed and may not remember information given at this time. It is therefore important to repeat it during follow-up visits. It is also useful to prepare standard information in writing, and give the survivor a copy before she leaves the health facility (even if the survivor is illiterate, she can ask someone she trusts to read it to her later).

For recommendations concerning counselling of caregivers of child survivors, please also refer to Section 5.3 Child Survivors.

Below are some important things to remember when counselling the survivor on specific issues. Be aware of your own taboos and pre-conceptions.

• Pregnancy

Women who are pregnant at the time of a rape are especially vulnerable physically and psychologically. In particular they are susceptible to miscarriage, hypertension of pregnancy and premature delivery. Counsel pregnant women on these issues and inform them about the benefits of attending antenatal care services regularly throughout the pregnancy. Their infants may be at higher risk for abandonment; follow-up care is thus also important.

Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of the rape. Emotional support and clear information, regardless of your individual beliefs as medical staff, are needed to ensure that they understand the choices available to them if they become pregnant.

Find out what services are available in your geographical area and provide this information to the survivor e.g.

- There may be adoption or foster care services in your area.
- In many countries the law allows termination of a pregnancy resulting from rape. Furthermore, local interpretation of abortion laws in relation to the mental and physical health of the woman may allow termination of the pregnancy if it is the result of rape. Find out whether this is the case in your local setting. Determine where safe abortion services are available so that you (regardless of your individual beliefs) can refer survivors to this service if they so choose.
- Make sure survivors seek support from someone they trust - perhaps a family member, friend or community worker.

Emergency contraceptive pills cannot prevent pregnancy resulting from sexual acts that take place after the treatment. If the survivor wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her and prescribe this to start on the first day of her next period or refer her to the family planning clinic.

If the woman is pregnant as a result of rape

A pregnancy may be the result of the rape. All the options available, e.g. keeping the child, adoption and, where legal, abortion, should be discussed with the woman, regardless of the individual beliefs of the medical staff or other persons involved, in order to enable her to make an informed decision.

Where safe abortion services are not available, women with an unwanted pregnancy may undergo an unsafe abortion. These women should have access to post-abortion care, including emergency treatment of abortion complications, counselling on family planning, and links to reproductive health services.

Children born as a result of rape may be mistreated or even abandoned by their mothers and families. They should be monitored closely and support should be offered to the mother. It is important to ensure that the family and the community do not stigmatize either the child or the mother. Think of foster placement and, later, adoption if the child is rejected, neglected or otherwise mistreated.

• HIV/STIs

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

- The survivor may be referred to an HIV/AIDS counselling service if available.
- The survivor should be informed (after a negative HIV test at the 1st visit), to use a condom with all partners until an HIV-test at 3 months (for those not taking PEP) or 6 months (for those taking PEP) is negative.
- Provide information concerning the signs and symptoms of possible STIs, and on when to return for further consultation.

• Other

Provide information on proper care for any injuries following the incident, infection prevention (including perineal hygiene, perineal baths), signs of infection, antibiotic treatment, when to return for further consultation, etc.

Provide information on how to take the prescribed treatments and on possible side effects of treatments.

- **Follow-up care at the health facility**

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

Give clear information on any follow-up needed for wound care or vaccinations.

Treatment counselling for female survivors of rape should address:

- Effectiveness of drugs, importance of adherence, side effects
- VCTesting recommended at baseline (1st visit) and 3 months (for those not taking PEP) or 6 months (for those taking PEP)
- Use condoms with all partners until an HIV-test at 3 months (for those not taking PEP) or 6 months (for those taking PEP) is negative.
- Pre-existing pregnancy? Too late for EC, or pregnancy as result of rape? Counsel survivor on all options.
- Importance of follow up visits e.g. for vaccination.
- Return at any time if problems.

STEP 7.

Medical Certificate

Medical care of a survivor of rape includes preparing a medical certificate²⁰. It is the responsibility of the health care provider who examines the survivor to make sure such a certificate is completed.

Only the survivor has the right to decide whether and when to use this document.

The original medical certificate is a confidential medical document that the doctor must hand over to the survivor. A copy should be kept locked away by the medical staff, in order to be able to certify the authenticity of the document supplied by the survivor before a court, if ever requested.

The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story. Depending on the setting, the survivor may use the certificate up to 20 years after the event to seek justice or compensation.

See Annex 11 for examples of medical certificates that can be adapted to each setting (in consultation with a legal expert).

A medical certificate must include:

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

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

The medical conclusion can never state that injuries are the result of a specific assault, since the health care provider did not witness the assault and therefore cannot draw such a conclusion.

Examples of phrasing conclusions could be:

"Injuries observed are /are not consistent with time and circumstances of incident"

"Injuries consistent with blunt force, penetration with sharp object..."

"Absence of injuries does not exclude forceful sexual penetration²¹"

STEP 8.

Follow-up Care

With the unstable situation inside Syria, it is possible that the survivor will not or cannot return for follow-up.

Therefore provide maximum input during the first visit, as it maybe the only visit.

Components of Follow-up

Gather information on **medication** taken (adherence?)

Assess **pregnancy** status (if indicated).

If the patient has **symptoms of a sexually transmitted infection**, provide appropriate testing and treatment.

Counsel on **HIV** and offer testing or refer.

Assess the patient's **emotional state** and ensure she/he has appropriate psychosocial support.

Refer the patient to additional services as needed.

All survivors of GBV will benefit from follow-up medical and psychological care

Ideally, when is a follow-up visit recommended?

For survivors TAKING PEP:

- 1 week
- 6 weeks (1 month 1/2)
- 3 months
- 6 months

For survivors who have NOT been given PEP:

- 2 weeks
- 3 months

STEP 1

STEP 2

STEP 3

STEP 4

STEP 5

STEP 6

STEP 7

STEP 8

Follow-up visit of survivors who are taking post-exposure prophylaxis.

One-week follow-up visit

- Evaluate post-exposure prophylaxis (side-effects and adherence). If not supplied at the first visit, provide the additional three-week supply of post-exposure prophylactic medication.
- Check that survivor has taken the full course of any medication given for STIs. Evaluate for STI, treat as appropriate, and provide information on voluntary counselling and testing for HIV (see Steps 5 and 6: test at 1st visit and 6 months after the incident & start of PEP).
- After a negative HIV test at 1st visit, recommend condom use until an HIV-test at 6 months is negative.

Six-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 2, 5, and 6).
- If prophylactic antibiotics were not given, evaluate for STIs, treat as appropriate, and (if not done in previous visits,) provide information on voluntary counselling and testing for HIV (see Steps 5 and 6: test at 1st visit and 6 months after the incident & start of PEP).
- After a negative HIV test at 1st visit, recommend condom use until an HIV-test at 6 months is negative.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Three-month follow-up visit

- Evaluate for STIs, and treat as appropriate. Test for syphilis if prophylaxis was not given.
- Assess pregnancy status, if indicated.
- If not done in previous visits, provide information on voluntary counselling and testing for HIV (see Steps 5 and 6: test at 1st visit and 6 months after the incident & start of PEP).
- After a negative HIV test at 1st visit, recommend condom use until an HIV-test at 6 months is negative.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Six-month follow-up visit

- Assess pregnancy status, if indicated.
- Offer voluntary counselling and testing for HIV to survivors who had a negative test during the first visit.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Follow-up visits for survivors who have not been given post-exposure prophylaxis.

Two-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 2, 5, and 6).
- Check that survivor has taken the full course of any medication given for STIs.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate, and provide information on voluntary counselling and testing for HIV (see Steps 5 and 6: test at 1st visit and 3 months after the incident).
- After a negative HIV test at 1st visit, recommend condom use until an HIV-test at 3 months is negative.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Three-month follow-up visit

- Evaluate for STIs, and treat as appropriate.
- Test for syphilis if prophylaxis was not given.
- Assess pregnancy status, if indicated.
- Offer voluntary counselling and testing for HIV to survivors who had a negative test during the first visit.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

5.2 Male Survivors

It is very important to recognize that men and boys do experience GBV e.g. rape/sexual assault.

Male survivors are even less likely than women to report the incident, because of extreme embarrassment, shame, criminalization of same sex-relationships and slowness of institutions and health workers to recognize the extent of the problem.

While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.

The needs of male survivors are essentially the same of those of females, but oftentimes the subject is even more sensitive and many providers are uncomfortable. The key to providing good care to male survivors is to be calm and professional yourself and to convey to the survivor your respect. Take the four guiding principles into account when taking care of male survivors too.

In most cultures, society perceives men as being capable of defending themselves. Being unable to do so may make a man question his manhood.

Male survivors may prefer to have a consultation with a female health care provider. Make sure to ask the survivor in the beginning of the consultation if they want to consult with a female or male medical practitioner.

Men may have great difficulty expressing their emotions as many societies discourage them from doing so.

Male survivors may feel guilty if they had an erection and ejaculated during forced anal intercourse.

- **Reassure** these men that these are normal reflexes they could not control as this can happen from stimulation of the prostate. Tell them: "This was a terrible thing that happened to you. The body reacts in ways we cannot control during such an attack, including getting an erection and even ejaculating. It does not mean that you liked it."

Men may also be hesitant to reveal the rape for fear that others will find out and question his manhood and sexuality.

- **Reassure** him that all his information will be kept completely confidential.

Remind him that the assault was not his fault.

5.2.1 Modifying the Physical Exam for Males

(See also above in Step 4.)

Examine the scrotum, testicles, penis, peri-urethral tissue, urethral meatus and anus.

Note if the survivor has been circumcised.

Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.

Torsion of the testis is an emergency and requires immediate surgical referral.

If the urine contains large amounts of blood, check for penile and urethral trauma.

If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.

Be aware that prostate infections caused by anal penetration can be difficult to treat and require antibiotics for an extended period of time.

If relevant, collect material from the anus for direct examination for sperm under a microscope.

5.3 Child Survivors

GBV is always a brutal and intrusive act which impacts heavily on children, on their current stage of development, and possibly also on later stages of development.

Specific behaviour of children after GBV should always be seen in the context of their current stage of development. Some children will react with behaviour that shows a temporary regression to a previous developmental stage (e.g. a child which starts bedwetting again). Other children will show delayed development after the abuse (e.g. learning problems at school) or give the impression to develop faster in certain areas of development (e.g. manifesting sexualised behaviour at an early age).

5.3.1 General

Find out about specific local laws in your setting that determine who can give consent for minors; also e.g. when the minor presents him/herself without parent/caregiver at your medical facility, or in the event that you suspect that the parent/ caregiver is the perpetrator.

Furthermore, gather information on local laws on mandatory reporting of cases of child abuse. Obtain a copy of the local child abuse management protocol and information on customary police and court procedures. Know who can be called to court as a witness of the facts (that means reiterating the findings as he or she recorded them; see Annex 7).

Evaluate each case individually and thoroughly - in some settings, reporting suspected sexual abuse of a child can be harmful to the child, if protection measures are not possible.

In any case the health care provider should act in the best interest of the child and consider the child's safety first.

"It is critical to consider the child's ethnic, religious, cultural and linguistic background. Account for the physical and developmental level of the child and the mental health status of the child. Respect the importance of the child's upbringing, stability and nurturing family relationships. Consider the child's wishes and concerns. Also consider the legal/cultural repercussions for the child and caregivers that could occur in the context where you are treating the child (or where the child is returning). It is important to create a safe environment for the child. Pay attention to who is present during the interview. Try to speak with the child alone to ask them who she/he wants in the room during the history and examination. Use creative methods (e.g. games, story telling, or drawing) to help put young children at ease and facilitate communication. Use age-appropriate language and terms. Never coerce, trick or restrain a child who you believe may have experienced sexual violence. These are techniques often used by perpetrators and use by health care providers will further harm the child. Encourage the child to ask questions about things she/he doesn't understand or is concerned about."²²

The issue of 'best interest of the child' is specifically highlighted in the United Nations Convention on the Rights of the Child²³(CRC -see Annex 12) and mentions that when adults make decisions, they should think about how their decisions will affect children. The CRC is the treaty that sets the human rights standards for children. **It defines a child as any human being below the age of 18.** This Convention, accepted by almost all States, states that children are entitled to protection, care and development (e.g. autonomy & empowerment). **It has been signed by Syria in 1990 and ratified in 1993.**

Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is also recommended that they receive special training in examining children who may have been abused.

The child should never be examined against his or her will, whatever the age, unless the child is in a life-threatening situation.

A parent or legal guardian should sign the consent form(s) (examination and forensic evidence collection if applicable -see Step 3), unless he or she is the suspected offender (see general note above). Adolescent minors may be able to give consent themselves.

Please find concrete guidance in Table 3 below, on obtaining consent and age-tailored informed assent²⁴.

Table 3: Children and Informed Consent/Informed Assent

Age Group	Child	Caregiver	If not caregiver or not in the child's best interest	Means
0-5	-	Informed consent	Other trusted adult's or caseworker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, Written consent
12-14	Informed assent	Informed consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written assent, Written consent
15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written consent

The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital.

<p>Such complications include:</p> <ul style="list-style-type: none"> • convulsions; • persistent vomiting; • stridor in a calm child; • lethargy or unconsciousness; • inability to drink or breastfeed 	<p>In children younger than 3 months, look also for:</p> <ul style="list-style-type: none"> • fever; • low body temperature; • bulging fontanelle; • grunting, chest indrawing, and a breathing rate of more than 60 breaths/minute
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The treatment of these complications is not covered in detail here.

5.3.2 Receiving the Child Survivor: Create a Safe Environment

Take special care in determining who is present during the interview and examination. Remember that it is possible that a family member is the perpetrator of the abuse. Always ask the child who he or she would like to be present, and respect his or her wishes.

It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present e.g. another trained, same-sex health care worker of the clinic.

For the examination, either a parent or guardian or a trusted person should be present.

Introduce yourself to the child.

Sit at eye level and maintain eye contact.

Assure the child that he or she is not in any trouble.

Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favourite activities.

5.3.3 Prepare the Child for Examination

As for adult examinations, there should be a support person or trained health worker whom the child trusts in the examination room with you.

Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.

Explain what will happen during the examination, using terms the child can understand.

With adequate preparation, most children will be able to relax and participate in the examination.

It is possible that the child cannot relax because he or she has pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.

Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of GBV and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse.

It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

5.3.4 Take the History

Begin the interview by asking open-ended questions, such as "Why are you here today?" or "What were you told about coming here?" Ask yes-no questions only for clarification of details.

Avoid asking leading or suggestive questions.

Assure the child it is okay to respond to any questions with "I don't know".

Be patient; go at the child's pace; do not interrupt his or her train of thought.

For girls, depending on age, ask about menstrual and obstetric history.

The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:

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

5.3.5 Conduct the Examination

Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:

- Note the child's weight, height, and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the parent's lap. Older children should be offered the choice of sitting on a chair or on the parent's lap, or lying on the bed.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do not carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size).
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury. A speculum may be used **only** when there has been vaginal penetration & there is heavy or uncontrolled vaginal bleeding. In this case, a speculum examination of a pre-pubertal child is usually done under general anaesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- If you can not rule out that the child has been penetrated, you should ensure (for boys and girls) an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Do **not** carry out a digital examination to assess anal sphincter tone.

5.3.6 Laboratory Testing

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations²⁵:

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

In rare cases, a child cannot be examined because he or she is highly agitated. Only if the child cannot be calmed down, and physical treatment is vital, the examination may be performed with the child under sedation. Use e.g. diazepam or promethazine hydrochloride. Oral sedation will take 1-2 hours for full effect. In the meantime allow the child to rest in a quiet environment.

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

5.3.7 Treatment

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

Routine prevention of STIs is not usually recommended for pre-pubertal children. However, in settings with a high prevalence of sexually transmitted diseases, presumptive treatment for STIs should be part of the protocol (see Annex 8).

Recommended dosages for post-exposure prophylaxis to prevent HIV transmission in children are given in Annex 9.

5.3.8 Counselling

Ways to help children cope

- Inform parents about normal reactions to stressful events (of adults and children).
- If children show stress reactions, this does not indicate a failure on the caregiver's part.
- Parents who have difficulties in caring for their children because of severe mental health problems should be referred to qualified mental health care professionals (e.g. psychologists).

Young Children

Be patient with children who start demonstrating behaviours they did when they were younger (e.g. sucking thumb or wetting the bed). This is common. Give them extra time and attention.

Remind children often that they are safe and they are not to blame. DO NOT respond in harmful ways to children's' stress reactions (e.g. beating, abandonment, belittling, mocking).

Keep young children close if they feel fearful/clingy.

Maintain routines and schedules as possible (e.g. schooling, meals, bed-time).

Involve children in decision making as appropriate (e.g. let them make simple decisions).

Facilitate play and social support (e.g. consider known games, songs and dances, make home-made toys, facilitate gathering of children and caregivers in safe spaces).

Give simple answers and accurate information about what happened without scary details.

Teenagers

Give reassurance, time, attention and regular routines.

Provide facts about what happened & what is going on now.

Allow them to be sad, don't expect them to be tough - Don't force talking.

Listen to their thoughts and fears without being judgmental.

Set clear rules and expectations.

Encourage and allow them to be helpful.

Encourage activities and ensure a quiet space: recreational groups; discussions; purposeful activities; continued or informal education.

Counsel caregivers on strategies for supporting young children and teenagers.

5.3.9 Follow-up

Follow-up care is the same as for adults.

If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse.



ANNEXES

Guidelines on Caring for Gender-based Violence Survivors Including Protocol for Clinical Management of Rape

Cross-border programs from Turkey into Syria

- ANNEX 1 ADDITIONAL RESOURCE MATERIALS**
- ANNEX 2 GBV AND HUMAN RIGHTS**
- ANNEX 3 MINIMUM CARE FOR RAPE SURVIVORS IN LOW RESOURCE SETTINGS**
- ANNEX 4 SAMPLE CONSENT FORM**
- ANNEX 5 SAMPLE HISTORY AND EXAMINATION FORM**
- ANNEX 6 PICTOGRAMS**
- ANNEX 7 FORENSIC EVIDENCE COLLECTION - SAMPLE COLLECTION AND STORAGE**
- ANNEX 8 PROTOCOLS FOR PREVENTION AND TREATMENT OF STIS**
- ANNEX 9 PROTOCOLS FOR POST EXPOSURE PROPHYLAXIS OF HIV INFECTION**
- ANNEX 10 PROTOCOLS FOR EMERGENCY CONTRACEPTION**
- ANNEX 11 MEDICAL CERTIFICATES**
- ANNEX 12 CONVENTION ON THE RIGHTS OF THE CHILD (CRC)**



Annex 1. Additional Resource Materials

General Information

Clinical Management of Rape. E-learning Programme. WHO, UNHCR & UNFPA. 2009.
<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>

Guidelines for Integrating Gender-based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery. Inter-Agency Standing Committee. 2015.

https://interagencystandingcommittee.org/system/files/2015_iasc_gender_based_violence_guidelines.pdf

Clinical Management of Sexual Assault: A Multimedia Tool. IRC and UCLA. 2008. (CD-ROM)
<http://iawg.net/ccsas/> or <https://www.dropbox.com/sh/tb6mInOt2b5cd7z/AAAYQHq26T5KOyf1llkqRBRva>
 and: <http://iawg.net/ccsas/ccsas-resources/>

Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook - Field Testing Version. Geneva. WHO. 2014. (<http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/>)

Responding to Intimate Partner Violence and Sexual Violence Against Women. WHO Clinical and Policy Guidelines. WHO. 2013. (<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>)

Improving the Health Sector Response to Gender Based Violence. A Resource Manual for Health Care Professionals in Developing Countries. International Planned Parenthood Federation/Western Hemisphere Region (IPPF/WHR). 2010.
[http://new.paho.org/hq/dmdocuments/2010/GBV_cdbookletANDmanual_FA_FINAL\[1\].pdf](http://new.paho.org/hq/dmdocuments/2010/GBV_cdbookletANDmanual_FA_FINAL[1].pdf) or
<http://www.ippf.org/europe/our-work/what-we-do/gender/health-care-initiatives>

Sexual and Gender-Based Violence Against Refugees, Returnees and Internally Displaced Persons: Guidelines for Prevention and Response. Geneva, UNHCR. 2003. (<http://www.unhcr.org/3f696bcc4.html>).

Guidelines for Medico-Legal Care for Victims of Sexual Violence. Geneva. WHO. 2003.
http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies. Inter-Agency Standing Committee. 2005.
 See GBVAoR site: <http://gbvaor.net/tools-resources/> for resources in Arabic, English, etc.

Information on GBV coordination

The Gender-Based Violence Area of Responsibility (GBVAoR): [http://gbvaor.net/tools-resources/Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings](http://gbvaor.net/tools-resources/Handbook%20for%20Coordinating%20Gender-based%20Violence%20Interventions%20in%20Humanitarian%20Settings.pdf). GBV AOR. 2010.

See GBVAoR site: <http://gbvaor.net/tools-resources/> for resources in Arabic, English, etc
 Establishing Gender-based Violence Standard Operating Procedures (SOPs) for Multisectoral and Inter-Organizational Prevention and Response to Gender-Based Violence in Humanitarian Settings. IASC. 2008.

<http://gbvaor.net/wp-content/uploads/sites/3/2015/03/Gender-Based-Violence-Resource-Tools-2005.pdf>

Standard Operating Procedures (SOPs) Workshop Package (Facilitator & Participants' Guide & PPTs). GBV AOR. 2010.

<http://gbvaor.net/resources/gbv-sop-workshop-manual/>

<http://gbvaor.net/resources/gbv-sop-ppts/>

<http://gbvaor.net/resources/sop-training-workshop-participants-manual/>

Humanitarian Charter and Minimum Standards in Humanitarian Response. The Sphere Project. 2011.
<http://www.sphereproject.org/handbook/>

Information on ethics

WHO Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. World Health Organization. 2007. (<http://www.who.int/reproductivehealth/publications/violence/9789241595681/en/>)

Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women. Geneva. World Health Organization. 2001. (http://www.who.int/gender-equity-rights/knowledge/who_fch_gwh_01.1/en/)

Information on GBV data management

The Gender-based Violence Information Management System (GBVIMS): <http://www.gbvims.com/resources/>

Reporting and Interpreting Data on Sexual Violence from Conflict-Affected Countries. "DOs and DON'Ts". UN Action. 2008.

<http://www.stoprapenow.org/uploads/advocacyresources/1282164733.pdf> or <http://www.stoprapenow.org/key-documents/index/?t=10&p=2>

Summary of Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies. UN Action. 2007. <http://gbvaor.net/resources/summary-ethical-safety-recommendations-researching-documenting-monitoring-sexual-violence-emergencies-stop-rape-2007/>

Information on reproductive health

Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A Distance Learning Module. Women's Refugee Commission. Revised 2011.

<http://misp.iawg.net/archive/pdf/cheat%20sheet/MISP%20cheat%20sheet%20rev.04%202010.pdf> and <http://iawg.net/resources/MISP%20Advocacy%20Sheet%20-%20IAWG%20FINAL%20Nov09.pdf>

Reproductive Health in Refugee Situations: An Inter-Agency Field Manual. Geneva, UNHCR, 1999.
<http://www.unhcr.org/3bc6ed6fa.html>

Inter-Agency Field Manual on Reproductive Health In Humanitarian Settings. Revision for Field Review. Inter-Agency Working Group on Reproductive Health in Crises. 2010.
http://www.who.int/reproductivehealth/publications/emergencies/field_manual/en/

Addressing Violence Against Women and Girls in Sexual and Reproductive Health Services. UNFPA. 2010.

<http://www.unfpa.org/publications/addressing-violence-against-women-and-girls-sexual-and-reproductive-health-services>

Information on mental health

IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings. IASC. 2007. See GBVAoR site: <http://gbvaor.net/tools-resources/> for resources in Arabic, English, etc

Mental Health in Emergencies: Psychological and Social Aspects of Health of Populations Exposed to Extreme Stressors. Geneva. WHO. 2003. (<http://www.who.int/hac/techguidance/pht/8656.pdf>)

Mental Health and Psychosocial Support for Conflict-Related Sexual Violence: Principles and Interventions. Summary. WHO. 2012. (http://www.who.int/reproductivehealth/publications/violence/rhr12_18/en/)

Psychological First Aid: Guide for Field Workers. WHO. 2011.

http://www.who.int/mental_health/publications/guide_field_workers/en/

Information on sexually transmitted diseases

Guidelines for the Management of Sexually Transmitted Diseases. Revised version. Geneva. WHO. 2003. (WHO/RHR/01.10) (<http://www.who.int/hiv/pub/sti/pub6/en/> or <http://www.who.int/reproductive-health/publications>).

other WHO guidelines concerning STIs: <http://www.who.int/reproductivehealth/publications/rtis/en/>

Information on emergency contraception

Emergency Contraceptive Pills: Medical and Service Delivery Guidelines. Third Edition. International Consortium for Emergency Contraception (ICEC). Washington DC. 2012.

<http://www.cecinfo.org/publications-and-resources/icec-publications/>

Selected Practice Recommendations for Contraceptive Use. Second edition. Geneva. WHO. 2004. http://www.who.int/reproductivehealth/publications/family_planning/9241562846index/en/

Information on post-exposure prophylaxis of HIV infection

Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV infection. Recommendations for a Public Health Approach. WHO. 2013. (<http://www.who.int/hiv/pub/guidelines/arv2013/en/> or <http://www.who.int/hiv/pub/en/>)

Global Update on the Health Sector Response To HIV. Executive summary. WHO. 2014.

<http://www.who.int/hiv/pub/progressreports/update2014-executive-summary/en/>

Updated U.S. Public Health Service guidelines for the management of occupational exposures to HBV, HCV, and HIV and recommendations for post exposure prophylaxis. Morbidity and mortality weekly report. 2001. 50(RR-11), Appendix C, 45-52 (<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm>).

Information on the abortion policies of countries

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

Health worker roles in providing safe abortion care and post-abortion contraception. Geneva, WHO. 2015.

http://www.who.int/reproductivehealth/publications/unsafe_abortion/en/

Safe abortion: Technical & policy guidance for health systems. Geneva, WHO. 2015.

http://www.who.int/reproductivehealth/publications/unsafe_abortion/en/

Information on protection

Activities of the Inter-Agency Standing Committee Task Force on Protection from Sexual Exploitation and Abuse.

<http://www.pseataaskforce.org/>

UNHCR Handbook for the Protection of Women and Girls. UNHCR. 2008.

<http://www.refworld.org/docid/47cfc2962.html>

Women in an Insecure World: Violence against Women - Facts, Figures and Analysis. Vlachová, M. and Bion, L. Geneva Centre for the Democratic Control of Armed Forces, DCAF. 2005.

<http://www.dcaf.ch/Publications/Women-in-an-Insecure-World>

Information on rights

Convention on the Rights of the Child. New York. United Nations. 1989. (<http://www.ohchr.org/en/professionalinterest/pages/crc.aspx> or http://www.unicef.org/crc/files/Rights_overview.pdf).

Convention on the Elimination of All Forms of Discrimination against Women. New York. United Nations. 1979.

<http://www.ohchr.org/EN/ProfessionalInterest/Pages/CEDAW.aspx> or <http://www.ohchr.org/en/hrbodies/cedaw/pages/cedawindex.aspx>

United Nations Secretary-General's Bulletin on Special Measures for Protection from Sexual Exploitation and Sexual Abuse (ST/SGB/2003/13). Secretary-General's Bulletin. United Nations. 2003.

<https://oios.un.org/resources/2015/01/ST-SGB-2003-13.pdf>

GBV training material

Caring for Survivors of Sexual Violence in Emergencies package. Inter-Agency Standing Committee (IASC) Sub-Working Group on Gender in Humanitarian Action with support from the GBV AoR. 2010.

<http://www.gbvim.com/resources/> under: 'Additional Resources: Caring for Survivors'

Clinical Management of Sexual Assault: A Multimedia Tool. IRC and UCLA. 2008. (CD-ROM)

<http://iawg.net/ccsas/> or <https://www.dropbox.com/sh/tb6mlnOt2b5cd7z/AAAYQHq26T5KOyf1llkqRBRva>

and: <http://iawg.net/ccsas/ccsas-resources/>

Clinical Management of Rape. E-learning Programme. WHO, UNHCR & UNFPA. 2009.
<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>

Working with Gender Based Violence Survivors. Reference Training Manual for Frontline Staff. United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA). 2012.
<http://www.unrwa.org/userfiles/2012061162152.pdf>

Minimum Initial Service Package (MISP) for Reproductive Health in Crisis Situations: A distance learning module. Women's Refugee Commission. Revised 2011.
<http://misp.iawg.net/> or <http://www.iawg.net/resources/MISP2011.pdf>

Information specifically concerning GBV and children

Caring for Child Survivors. GBV Responders' Network. IRC.
<http://gbvresponders.org/response/caring-child-survivors/#CCSTrainingMaterials>

Caring for Child Survivors Training. UNICEF & IRC. 2015.
<http://gbvaor.net/resources/caring-child-survivors-training/>

Caring for Child Survivors of Sexual Abuse. UNICEF & IRC. 2010.
<http://gbvaor.net/resources/caring-child-survivors-sexual-abuse-2012/>

Caring for Child Survivors of Sexual Abuse in Humanitarian Settings. A Review of Promising Practices to Improve Case Management, Psychosocial & Mental Health Interventions, and Clinical Care for Child Survivors of Sexual Abuse. UNICEF & IRC. 2011. (<http://gbvaor.net/resources/caring-child-survivors-sexual-abuse-humanitarian-settings/>)

Annex 2. GBV and Human Rights

Acts of Gender-based violence violate a number of human rights principles enshrined in international human rights instruments. Among others, these include:

- **Right to life, liberty and security of the person.**
- **Right to the highest attainable standard of physical and mental health:** Survivors of GBV have a right to receive good quality health services, including reproductive health care to manage the physical and psychological consequences of the act, including prevention and management of pregnancy and STIs. It is critical that health services do not in any way “revictimize” survivors.
- **Right to human dignity:** Survivors of GBV should receive treatment consistent with the dignity and respect they are owed as human beings. In the context of health services, this means, as a minimum, providing equitable access to quality medical care, ensuring patients’ privacy and the confidentiality of their medical information, informing patients and obtaining their consent before any medical intervention, and providing a safe clinical environment. Furthermore, health services should be provided in the mother tongue of the survivor or in a language she or he understands.
- **Right to non-discrimination:** Laws, policies, and practices related to access to services should not discriminate against a survivor of GBV on any grounds, including race, sex, colour, or national or social origin. For example, providers should not deny services to women belonging to a particular ethnic group.
- **Right to self-determination:** Providers should not force or pressure survivors to have any examination or treatment against their will. Decisions about receiving health care and treatment (e.g. emergency contraception) are personal ones that can only be made by the survivor herself. In this context, it is essential that the survivor receives appropriate information to allow her to make informed choices. Survivors also have a right to decide whether, and by whom, they want to be accompanied when they receive information, are examined or obtain other services. These choices must be respected by the health care provider.
- **Right to information:** Information should be provided to each client in an individualized way. For example, if a woman is pregnant as a result of rape, the health provider should discuss with her all the options legally available to her (e.g. abortion, keeping the child, ...). The full range of choices must be presented regardless of the individual beliefs of the health provider, so that the survivor is able to make an informed choice.
- **Right to privacy:** Conditions should be created to ensure privacy for survivors of GBV. Other than an individual accompanying the survivor at her request, only people whose involvement is necessary in order to deliver medical care should be present during the examination and medical treatment.
- **Right to confidentiality:** All medical and health status information related to survivors should be kept confidential and private, including from members of their family. Health staff may disclose information about the health of the survivor only to people who need to be involved in the medical examination and treatment, and with the express consent of the survivor.
- **Right to freedom from torture or cruel, inhuman, or degrading treatment or punishment.**
- **Right to freedom of movement, opinion, expression, and association.**
- **Right to enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution.**
- **Right to education, social security and personal development.**
- **Right to cultural, political and public participation,** equal access to public services, work and equal pay for equal work.

Annex 3. Minimum Care for Rape Survivors in Low Resource Settings

Minimum examination

A medical examination should be done only with the survivor's informed consent. It should be compassionate, confidential, and complete, as indicated and described in Step 4.

Minimum treatment

Give compassionate and confidential treatment as follows (see Step 5):

- treatment and referral for life threatening complications
- treatment or preventive treatment for STIs
- prevention of HIV transmission: post-exposure prophylaxis (PEP)
- prevention of pregnancy: emergency contraception (EC)
- wound care
- prevent Tetanus
- supportive counselling
- referral to social support and psychosocial counselling services

Checklists

Items needed at the level of my medical facility, to be able to provide care to survivors of rape:

1. List for settings with limited resources; Minimum requirements.
2. List for advanced settings.

1. List for settings with limited resources; MINIMUM requirements.

In setting with Limited Resources – MINIMUM REQUIREMENTS

List of items needed at the level of my medical facility, to be able to provide minimum recommended care to survivors of rape

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
1. Protocol			
Written medical protocol in the language of the medical service provider (Arabic)			
2. Personnel			
Trained (local) health care professionals (on call 24 hours a day)			
A "same language" female health worker or companion in the room during examination			
3. Furniture / Setting			
Room (private, quiet, accessible, with access to a toilet or latrine)			
Examination table			
Light, preferably fixed (a torch may be threatening for children)			
Access to an autoclave to sterilize equipment			
Weighing scales and height chart for children			
Safe, locked filing space to store confidential records			
4. Supplies			
Speculum			
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)			
Resuscitation equipment for anaphylactic reactions			
Sterile medical instruments (kit) for repair of tears, and suture material			
Needles, syringes			
Gown, cloth, or sheet to cover the survivor during examination			
Sanitary supplies (pads or local cloths)			
Pregnancy tests			
5. Drugs			
For treatment of STIs, as per protocol			
For post-exposure prophylaxis (PEP) of HIV transmission, as per protocol			

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD), as per the protocol			
Tetanus toxoid			
For pain relief (e.g paracetamol)			
Local anaesthetic for suturing			
Antibiotics for wound care			
6. Administrative supplies			
Medical chart with pictograms			
Consent forms			
Information pamphlets for post-rape care (for survivor)			

2. List for advanced settings.

In advanced settings

List of items at the level of my medical facility, to be able to provide care to survivors rape

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
1. Protocol			
Written medical protocol in the language of the medical service provider (Arabic)			
2. Personnel			
Trained (local) health care professionals (on call 24 hours a day)			
A "same language" female health worker or companion in the room during examination			
3. Furniture / Setting			
Room (private, quiet, accessible, with access to a toilet or latrine)			
Examination table			
Light, preferably fixed (a torch may be threatening for children)			
Magnifying glass (or colposcope)			
Access to an autoclave to sterilize equipment			

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
Access to laboratory facilities/ microscope/ trained/ technician			
Weighing scales and height chart for children			
Safe, locked filing space to store confidential records			
4. Supplies			
'Kit' for the collection of forensic evidence. This could include:			
Comb for collecting foreign matter in pubic hair			
Syringes/needles (butterfly for children)/ tubes for collecting blood Glass slides for preparing wet and/or dry amounts (for sperm)			
Laboratory containers for transporting swaps			
Paper sheet for collecting debris as the survivor undresses			
Paper bags for collection of evidence			
Paper tape for sealing and labeling containers/bags			
Cotton-tipped swabs/applicators/gauze compresses for collecting samples			
Set of replacement clothes			
Tape measure for measuring the size of bruises, lacerations, etc.			
Speculum			
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)			
Resuscitation equipment			
Sterile medical instruments (kit) for repair of tears, and suture material			
Needles, syringes			
Gown, cloth, or sheet to cover the survivor during examination			
Sanitary supplies (pads or local cloths)			
Pregnancy tests			
Pregnancy calculator disk to determine the age of a pregnancy			
5. Drugs			
For treatment of STIs, as per protocol			
For post-exposure prophylaxis (PEP) of HIV transmission, as per protocol			

Name/Code of the facility:	Available in my medical facility	Not yet available in my medical facility, but funds are available for it and it's planned to be in place by (specify a date)	Available in a nearby medical facility (specify which one)
Governorate:			
District:			
Sub-district:			
Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD), as per the protocol			
Tetanus toxoid, tetanus immuno-globulin			
Hepatitis B vaccine			
For pain relief (e.g paracetamol)			
Anxiolytic (e.g diazepam)			
Sedative for children (e.g diazepam)			
Local anesthetic for suturing			
Antibiotics for wound care			
6. Administrative supplies			
Medical chart with pictograms			
Forms for recording post-rape care			
Consent forms			
Information pamphlets for post-rape care (for survivor)			

Annex 4. Sample Consent Form

Notes on completing the consent form

Consent for an examination is a central issue in medico-legal practice. Consent is often called “informed consent” because it is expected that the survivor (or his/her parent(s) or guardian if survivor is under 18 years old) will receive information on all the relevant issues, to help the survivor make a decision about what is best for her/him at the time.

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

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

- What the history-taking process will involve.
- The type of questions that will be asked and the reason those questions will be asked.
- What the physical examination will involve.
- What the pelvic examination will involve.
- That the physical examination, including pelvic examination, will be conducted in privacy and in a dignified manner.
- That during part of the physical exam, the survivor will lie on an examination couch.
- That the health care provider will need to touch her for the physical and pelvic examinations.
- That a genital-anal examination will require the survivor to lie in a position where her genitals can be adequately seen with the correct lighting.
- That she can refuse any aspect of the examination she does not wish to undergo.
- That specimen collection (where needed) involves touching the body and body openings with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva.
- *If applicable (see Step 3): That clothing may be collected. And that not all of the results of the forensic analysis may be made available to the survivor and why.*
- That she will be asked to sign a form, which indicates that she has been provided with the information and documents what procedures she has agreed to.

Sample: Consent form

(CONFIDENTIAL - to keep in a locked, secure place)

Name of the health facility:

Note to the health worker:

This form should be read to the survivor (or his/her caretaker/guardian if survivor is under 18 years old) in her/his first language. Clearly explain what the procedure for the medical examination etc. involves and explain that he/she can choose any (or none) of the items listed. Obtain a signature, or a thumbprint with signature of a witness.

The survivor can change his/her mind at any time and a new form can be completed.

I,

(write the name of the survivor), authorize the above-named health facility to perform the following (tick the appropriate boxes; do not leave any blank boxes):

	YES	NO
Conduct a medical examination	<input type="checkbox"/>	<input type="checkbox"/>
Conduct pelvic examination	<input type="checkbox"/>	<input type="checkbox"/>
Conduct a speculum exam (if medically indicated)	<input type="checkbox"/>	<input type="checkbox"/>
<i>If applicable (see Step 3):</i>		
<i>Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails and blood sample.</i>	<input type="checkbox"/>	<input type="checkbox"/>

I understand that I can refuse at any time, any aspect of the examination that I don't wish to undergo.

Signature or thumbprint of the survivor:
(or caretaker/guardian if survivor is under 18 years old)

Date:

Signature or thumbprint of the Witness:

Annex 5. Sample History and Examination Form

Sample: Medical History and Examination Form – Survivors of Rape

(CONFIDENTIAL – to keep in a locked, secure place)

Patient's CODE:

1. GENERAL INFORMATION

First Name		Last Name or Patient's CODE:	
Current Address			
Sex	Age	Date of birth (day-month-year)	
Date / Time of examination		In the presence of	

In case of a child include (if applicable): name of school, name of caregiver or guardian

2. INCIDENT

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

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

3. MEDICAL HISTORY

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

Contraception use Yes No (if Yes, please fill in the below)

Pill	IUD	Sterilisation
Injectable	Condom	Other

Menstrual/obstetric history

Last menstrual period (day-month-year)	Menstruation at time of event: <input type="checkbox"/> Yes <input type="checkbox"/> No
Evidence of pregnancy: <input type="checkbox"/> Yes <input type="checkbox"/> No	Number of weeks pregnant _____ weeks
Obstetric history	

History of consenting intercourse (only if samples have been taken for DNA analysis)

Last consenting intercourse within a week prior to the assault	Date:	Name of individual:
Existing health problems		

*Allergies**Current medication*

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Known		Unknown	

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)

Mental state (calm, crying, anxious, cooperative, depressed, other)

Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature)		
Pulse rate	Blood pressure	Respiratory rate	Temperature	

Physical findings

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

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

5. GENITAL & ANAL EXAMINATION

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

6. INVESTIGATION DONE

Type and location	Examined/sent to laboratory	Result

7. EVIDENCE TAKEN (if applicable)

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

8. TREATMENTS PRESCRIBED

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

9. COUNSELLING, REFERRALS, FOLLOW-UP

General psychological status

Survivor plans to report to police OR has already contacted local support services (e.g. psychosocial services, etc):

Survivor has a safe place to go

Yes No

Has someone to accompany her/him

Yes No

Counselling provided:

Referrals

Follow-up required

Date next planned visit:

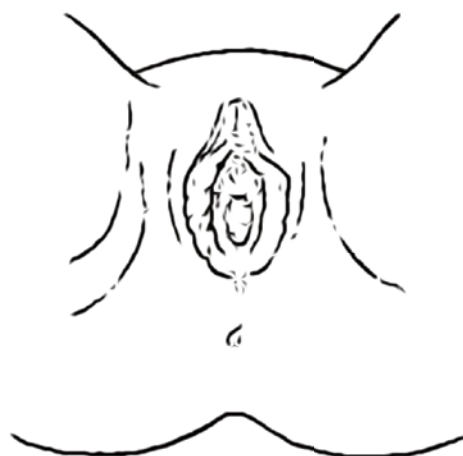
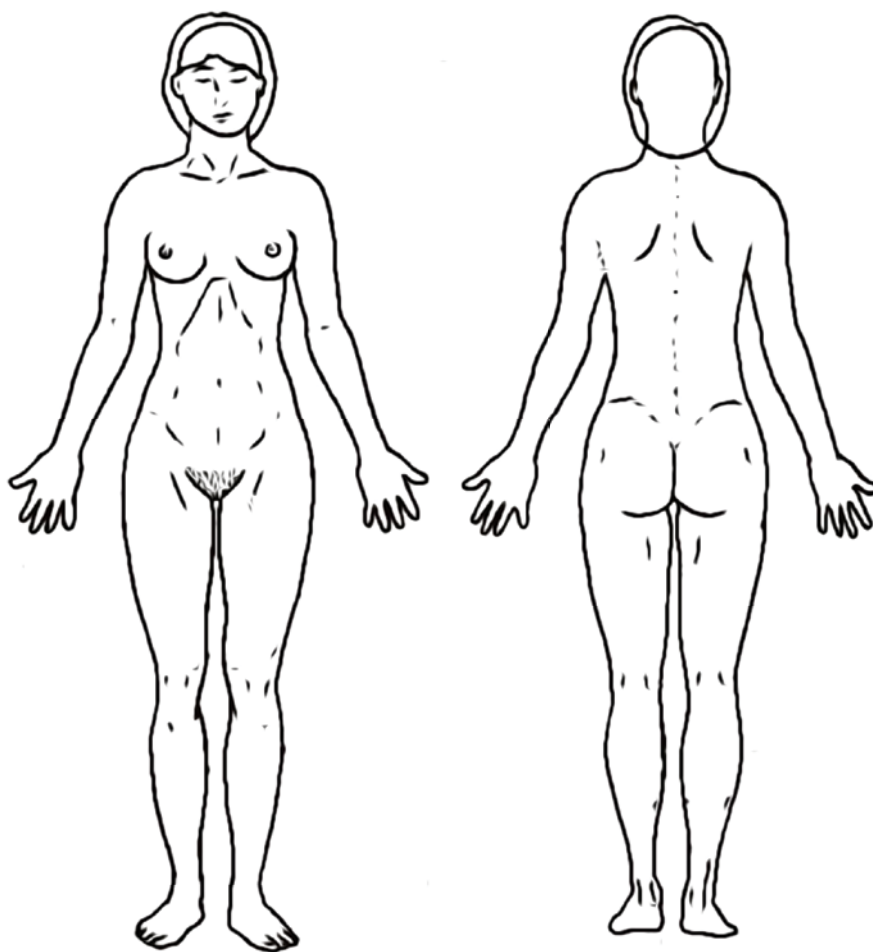
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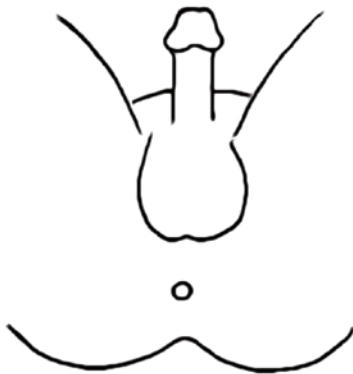
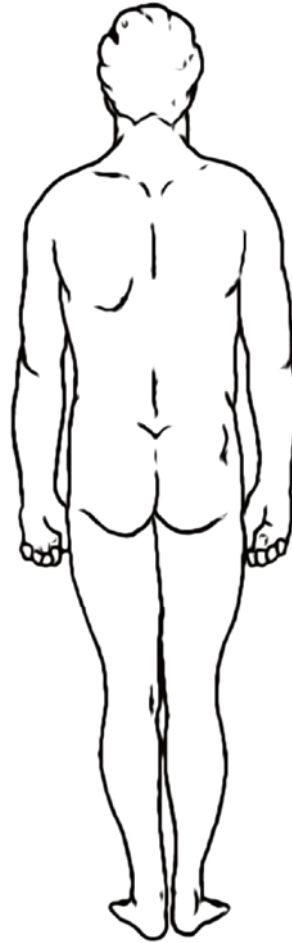
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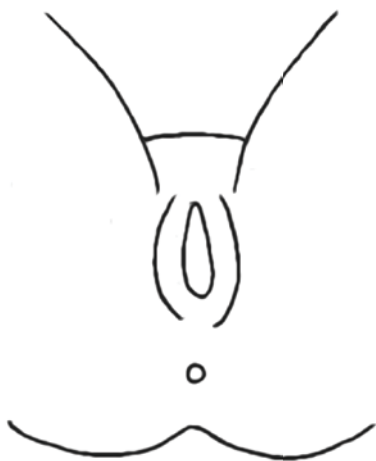
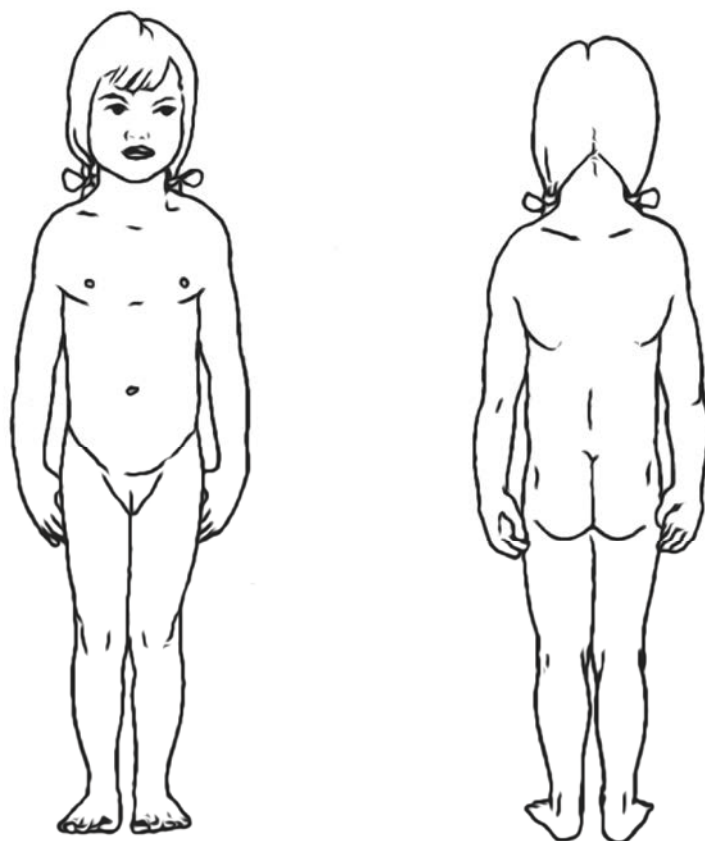
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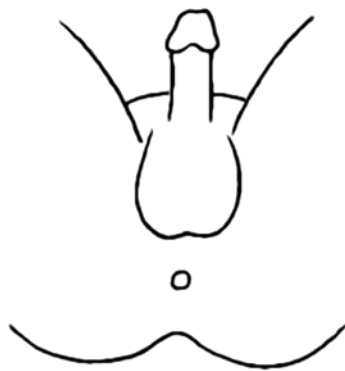
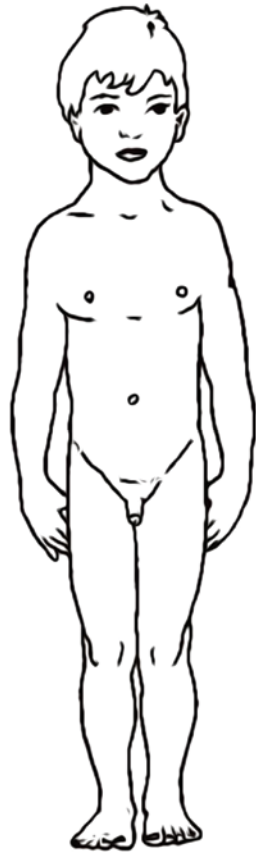
Signature:

Annex 6. Pictograms









Annex 7. Forensic Evidence Collection – Sample Collection and Storage

Reminders:

1. In most medical settings inside Syria, forensic evidence will **NOT** be collected, as it cannot be properly stored, analysed and/or is not admissible in court at this time.

2. Forensic evidence can be collected **ONLY IF**.....

- > Timing is appropriate (< 72 hours/ > 72 hrs, in settings where the local law accepts evidence from > 72 hrs)

AND

- > There are local possibilities for analysing samples

AND

- > Informed consent is obtained

AND

- > The chain of evidence can be maintained

Do not collect evidence that cannot be processed or that will not be used.

As stated in Step 3, the capacity of laboratories to analyse forensic evidence differs considerably. This annex describes the different types of forensic evidence that can be collected and outlines procedures for doing so. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence. In the Syrian context, health workers should familiarize themselves with local protocols and resources.

Do not collect evidence that cannot be processed.

WHEN

Forensic evidence should be collected during the medical examination and should be stored in a confidential and secure manner. The informed consent of the survivor must be obtained before evidence is collected.

It is not enough to ask if she wants to prosecute. She needs to understand what exactly her options are and what the forensic exam involves. Once she fully understands she can decide whether to sign the consent form.

Work systematically according to the medical examination form (see Annex 5). Explain everything you do and why you are doing it. Evidence should only be released with consent of the survivor (when he/she decides to proceed with a case).

Samples that can be collected as evidence

- Injury evidence: physical and/or genital trauma can be proof of force and should be documented (see Table 1 in transversal step: Documentation) and recorded on pictograms.
- Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g. if replacement clothing is not available) describe its condition.
- Foreign material (soil, leaves, grass) on clothes or body or in hair may corroborate the survivor's story.
- Hair: foreign hairs may be found on the survivor's clothes or body. Pubic and head hair from the survivor may be plucked or cut for comparison.
- Sperm and seminal fluid: swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis.
- DNA analysis, where available, can be done on material found on the survivor's body or at the location of the rape, which might be soiled with blood, sperm, saliva or other biological material from the assailant (e.g., clothing, sanitary pads, handkerchiefs, condoms), as well as on swab samples from bite marks, semen stains, and involved orifices, and on fingernail cuttings and scrapings. In this case blood from the survivor must be drawn to allow her DNA to be distinguished from any foreign DNA found.
- Blood or urine may be collected for toxicology testing (e.g. if the survivor was drugged).

Types of evidence

- Medical documentation of
 - > Injuries
 - > Presence of sperm (<72 hours)
 - > State of clothes
- Clothes
- Foreign materials e.g. soil, leaves, grass
- Other material that can be used for DNA analysis e.g. hair, fluids (sperm, seminal fluid, blood, etc)
- Blood or urine

Supplies for forensic examination

- sterile swabs and a rack for drying them
- urine and blood sample containers
- clean white paper, paper bags, envelopes and a box
- unused comb
- wooden stick (e.g., toothpick) for fingernail scrapings
- sterile saline, sterile water, glass slides

- gown or alternative covering for patient
- spare clothes to replace those taken as evidence
- legal forms (if they are available/applicable) and pictograms

Inspect and examine

Inspection of the body

- Document all injuries in as much detail as possible (see transversal step: Documentation).
- Examine the survivor's clothing under a good light before she undresses. Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, foreign hairs). Ask the person to undress while standing on a sheet of paper to collect any debris that falls. **Do not ask her to uncover fully.** Examine the upper half of her body first, then the lower half, or provide a gown for her to cover herself. Collect torn and stained items of clothing only if you can give her replacement clothes.
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit her) or semen on the skin, with the aid of a sterile cotton-tipped swab, lightly moistened with sterile water if the skin is dry.
- The survivor's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity for direct examination for sperm and for DNA and acid phosphatase analysis. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.
- Take blood and/or urine for toxicology testing if indicated (e.g. if the survivor was drugged).

Inspection of the anus, perineum and vulva

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

Examination of the vagina and rectum

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

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis).
- Using a cotton-tipped swab, collect fluid from the posterior fornix for examination for sperm. Put a drop of the fluid collected on a slide, if necessary with a drop of normal saline (wet-mount), and examine it for sperm under a microscope. Note the mobility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.

Samples examined by the crime lab may show sperm from the posterior fornix for up to approximately five days and from the cervical os for up to approximately 12 days after sexual assault.

- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina for acid phosphatase analysis.
- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

A careful written recording should be kept of all findings during the medical examination that can support the survivor's story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence (with the survivor's consent) if the case goes to court.

Maintaining the chain of evidence

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

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

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

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

Reporting medical findings in a court of law

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

In most settings the health care provider is expected to give evidence as a witness of the facts (that means reiterating the findings as he or she recorded them).

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

Conduct yourself professionally and confidently in the courtroom:

- Dress appropriately.
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whomever you are speaking to.
- Use precise medical terminology.
- Answer questions as thoroughly and professionally as possible.

- If you do not know the answer to a question, say so. Do not make an answer up and do not testify about matters that are outside your area of expertise.
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions.

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

Annex 8. Protocols for Prevention and Treatment of STIs

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

Note: In many countries, *Neisseria gonorrhoeae* (bacterium that causes gonorrhoea) is widely resistant to several antibiotics. Find out if resistance has been identified in your area and what the adapted **local** STI treatment protocol in your setting is.

STI	Treatment	
Gonorrhoea	ciprofloxacin	500 mg orally, single dose (<i>contraindicated in pregnancy</i>)
	cefixime	or 400 mg orally, single dose
	ceftriaxone	or 250 mg intramuscularly, single dose
Chlamydial infection*	azithromycin	1 g orally, in a single dose
	doxycycline	or 100 mg orally, twice daily for 7 days (<i>contraindicated in pregnancy</i>)
Chlamydial infection in pregnant women*	azithromycin	1 g orally, in a single dose
	amoxicillin	or 500 mg orally, 3 times daily for 7 days
Syphilis	benzathine benzylpenicillin**	2.4 million IU, intramuscularly, once only (<i>give as two injections in separate sites</i>)
Syphilis, patient allergic to penicillin	azithromycin	2 g orally, in a single dose (<i>Note: this antibiotic is also active against chlamydia</i>)
	doxycycline	or 100 mg orally twice daily for 14 days (<i>contraindicated in pregnancy</i>) (<i>Note: this antibiotic is also active against chlamydia</i>)
Syphilis in pregnant women, allergic to penicillin	azithromycin	2 g orally, in a single dose (<i>Note: this antibiotic is also active against chlamydia</i>)
	erythromycin	or 500 mg orally, 4 times daily for 14 days (<i>Note: this antibiotic is also active against chlamydia</i>)
Trichomoniasis	metronidazole	2 g orally, in a single dose or as two divided doses at a 12-hour interval (<i>contraindicated in the first trimester of pregnancy</i>) <i>1st trimester: use vaginal ovule (typical)</i>
	tinidazole	or 2 g orally, in a single dose

* The regimens in the table above are the Recommended regimens for Chlamydial infection.

Alternative Regimens for Chlamydial infection are: Erythromycin base 500 mg orally, 4 times daily for 7 days; or Erythromycin ethylsuccinate 800 mg orally, 4 times daily for 7 days.

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

Give one easy to take, short treatment for each of the infections.

Example

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

- cefixime 400 mg orally + azithromycin 1 g orally

or

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

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

WHO-recommended STI treatments for children and adolescents

(may also be used for presumptive treatment)

STI	Weight or Age	Treatment (child/adolescent)	
Gonorrhoea	< 45 kg	ceftriaxone	125 mg intramuscularly, single dose
		spectinomycin	40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose
		cefixime	8 mg/kg of body weight orally, single dose
	> 45 kg	Treat according to adult protocol	
Chlamydial infection	< 45 kg	azithromycin	20 mg/kg orally, single dose
		erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	> 45 kg but < 12 years	erythromycin	500 mg orally, 4 times daily for 7 days
		azithromycin	1 g orally, single dose
	> 12 years	Treat according to adult protocol	
Syphilis		benzathine benzylpenicillin*	50 000 IU/kg intramuscularly (up to a maximum of 2.4 million IU), single dose
Syphilis, patient allergic to penicillin		Erythromycin 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days	
Trichomoniasis	< 12 years	metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	> 12 years	Treat according to adult protocol	

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

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

Annex 9. Protocols for Post Exposure Prophylaxis of HIV Infection

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

There are currently no conclusive data on the effectiveness of post-exposure prophylaxis (PEP) in preventing transmission of HIV after rape. However, based on experience with PEP for occupational exposure and mother to child transmission, experts believe that **starting PEP as soon as possible (but only within 48-72 hours after the rape)** is beneficial.

Before you start your service, make sure staff is aware of the indications for PEP and how to counsel survivors on this issue or make a list of names and addresses of providers for referrals.

Note that even though the prevalence of HIV within the Syrian population before the crisis was low, this rate might have changed as individuals from all around the world have moved to Syria over recent years.

Prevent HIV transmission – post-exposure prophylaxis (PEP)

- > If incident <72 hours
- > Assess risk of HIV transmission
- > Regimen: Zidovudine (AZT) + Lamuvidine (3CT) 300mg/150mg - 2 x daily
- > Prescribe for 28 days

Condom use should be encouraged until an HIV-test at 6 months is negative (for those taking PEP and that had a negative HIV test at 1st visit)

Post-exposure prophylaxis using two antiretroviral drugs

Regimen

- This preventive treatment consists of two ARV drugs, to be taken twice a day for 28 days.
- The drugs are zidovudine (ZDV or AZT) and lamivudine (3TC). These drugs are available combined in one tablet called Combivir.
- Survivors may be given a one-week's supply of PEP at the first visit, with the remainder of the drugs (another 3-weeks' supply) given at the one-week follow-up visit. **For survivors who cannot return for a one-week assessment for logistic or economic reasons, a full supply should be given at the first visit.**
- There are no contraindications to starting PEP on the same day as emergency contraception and STI prophylaxis, although the doses should be spread out, and if possible taken with food, to reduce side-effects such as nausea.
- **Pregnancy** is not a contraindication to PEP, and it should be prescribed to pregnant women in the same manner as to non-pregnant women. Women who are less than 12 weeks pregnant should be informed that the possible effects of the drug on the fetus are not known. (Ensure that pregnant women are referred for appropriate antenatal care.)

- Survivors who are known or found to be **HIV-positive** should not be offered PEP. While it is not likely to do harm, there is no expected benefit. Such people should be appropriately counselled and referred to special programmes for people living with HIV/AIDS (PLHA), such as supplementary feeding and opportunistic infections' treatment.

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

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

Children*

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

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

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

Side-effects

Gastrointestinal side-effects may occur in up to 50% of people taking ZDV/3TC, but they are relatively minor. Appropriate counselling will help people take the full treatment.

Testing and counselling

Routine blood testing, with full blood count and liver enzymes, is not recommended for patients on zidovudine and lamivudine. Blood tests should be performed only if indicated by the survivor's clinical condition.

Administration of PEP must never be made conditional on the person agreeing to have an HIV test.

All survivors should be offered voluntary counselling and HIV testing (includes HIV/AIDS info, pre-test & post-test counselling and plans for decreasing risk behaviour). HIV testing is not mandatory. Survivors who cannot or do not want to undergo HIV testing and who are not already known to be HIV-positive, should be offered PEP if indicated. A short PEP treatment is not expected to do harm in someone of unknown HIV status who is actually HIV-positive.

Counselling for HIV testing may be particularly difficult with a person who has just gone through the ordeal of sexual assault/rape. The survivor may not be ready for the additional stress of HIV-testing and receiving the result. If the survivor does not want to be tested immediately, PEP can be initiated and HIV-testing can be addressed again at the one-week follow-up visit.

The following points should be covered when counselling the survivor on PEP:

- The level of risk of HIV transmission during rape is not exactly known, but the risk exists (particularly in settings where HIV prevalence is high).
- It is preferable to know the survivor's HIV status prior to starting antiretrovirals, so the best possible recommendation can be made for her.
- The survivor is free to choose whether or not to have immediate HIV-testing. If she prefers, the decision can be delayed until the one-week follow-up visit.
- The efficacy of PEP in preventing seroconversion after rape is not known, but there is evidence from research on prevention of mother-to-child transmission and prophylaxis after occupational exposure to indicate that PEP is very likely to be effective in reducing the risk of transmission of HIV after rape.
- Provide information on what to do when she/he missed a dose:
 - > If recognized < 6 hours: take the dose
 - > If 3 or more consecutive days missed: discontinue treatment
- Explain the common side-effects of the drugs, such as feelings of tiredness, nausea and flu-like symptoms. Reassure her that these side-effects are temporary and do not cause long-term harm. Most side-effects can be relieved with ordinary analgesics, such as paracetamol.
- Provide the survivor with a patient information leaflet, adapted and translated in the local language.

What if you do not have PEP in your own facility

- Know where to refer a survivor before she/he arrives
- Advocate for having PEP at your clinic:
 - > Provide first dose as soon as possible within 72 hours after the rape
 - > Reducing transport and waiting time to referral centre
 - > Cost-effective for high-risk cases.

Annex 10. Protocols for Emergency Contraception

Emergency contraceptive pills

Regimen

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

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

or

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

Treatment with either regimen should be started as soon as possible after the rape because research has shown that efficacy declines with time. Both regimens are effective when used up to 72 hours after the rape, and continue to be moderately effective if started between 72 hours and 120 hours (5 days) after. Longer delays have not been investigated.

The levonorgestrel-only regimen can be taken as a single dose of 1.5 mg of levonorgestrel as soon as convenient, ideally not later than 120 hours after the rape. With the combined estrogen-progestogen regimen, a first dose should be taken as soon as convenient, but not later than 120 hours after the rape, and a second dose 12 hours later.

There are products that are specially packaged for emergency contraception, but at present they are registered only in a limited number of countries. *If pre-packaged ECPs are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills, which are available for family planning (see the table below for guidance).*

Regimen	Pill composition* (per dose)	First dose (number of tablets)	Second dose, 12 hours later (number of tablets)
Levonorgestrel only	750 µg	2	0
	30 µg	50	0
	37.5 µg	40	0
Combined	EE 50 µg + LNG 250 µg or EE 50 µg + NG 500 µg	2	2
	EE 30 µg + LNG 150 µg or EE 30 µg + NG 300 µg	4	4

*EE = ethinylestradiol; LNG = levonorgestrel; NG = norgestrel.

(Adapted from: Consortium for Emergency Contraception, *Emergency contraceptive pills, medical and service delivery guidelines*, second edition. Washington, DC, 2004).

Side-effects

The levonorgestrel regimen has been shown to cause significantly less nausea and vomiting than the Yuzpe regimen.

- If vomiting occurs within 2 hours of taking a dose, repeat the dose.
- In cases of severe vomiting, EC can be administered vaginally.

Testing and counselling

A pregnancy test can provide very important information, but ECP should not be delayed or denied if a test is not available or if the survivor does not want one.

Don't forget to provide her with condoms for use in the immediate future.

Refer all pregnant women who have been raped to antenatal care as they are at higher risk (miscarriage, premature delivery, hypertension).

Counsel the survivor about how to take the pills, what side-effects may occur, and the effect the pills may have on her next period. ECPs do not prevent pregnancy from sexual acts that take place after their use, they are not a long-term family planning method and will not prevent future pregnancy.

Make it clear to the survivor that there is a small risk that the pills will not work. If they work, menstruation will occur around the time she would normally expect it. It may be up to a week early or a few days late. If she has not had a period within a week after it was expected, she should return to have a pregnancy test and/or to discuss the options in case of pregnancy. Encourage follow-up.

Explain to her that spotting or slight bleeding is common with the levonorgestrel regimen and that it is nothing to worry about. This should not be confused with a normal menstruation.

Precautions. ECPs will not be effective in the case of a confirmed pregnancy.

ECPs may be given when the pregnancy status is unclear and pregnancy testing is not available, since there is no evidence to suggest that the pills can harm the woman or an existing pregnancy. There are no other medical contraindications to use of ECPs.

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

If the survivor presents within 7 days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle), insertion of a copper-bearing IUD is an effective method of emergency contraception. It will prevent more than 99% of expected subsequent pregnancies.

Women should be offered counselling on this service so as to reach an informed decision.

A contra-indication for IUD is a pre-existing pregnancy. A negative pregnancy test will thus be mandatory before insertion.

A **skilled** provider should counsel the patient and insert the IUD.

If an IUD is inserted; make sure to give full STI treatment, as recommended in Annex 8.

The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Annex 11. Medical Certificates

Sample: Medical Certificate – survivors of rape – CHILD

(CONFIDENTIAL – to keep in a locked, secure place)

I, the undersigned: (NAME, first name)

Title: (Indicate the function)

On this date and time (day-month-year, time)

Certify having examined at the request of: (Name of father, mother, legal representative)

Child: (NAME, first name),

Date of birth: (day-month-year)

Address: (current address of the parents or place of residence of the child)

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

**During the meeting,
stated:**

(name of the person accompanying the child)

This child presents the following signs:

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

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

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

Anal examination:

Other examinations carried out and samples taken:

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

Certificate prepared on this day and handed over to

(name of parent or legal representative) **as proof of evidence.**

Signature of the clinician

Sample: Medical Certificate – survivors of rape – ADULT

(CONFIDENTIAL – to keep in a locked, secure place)

I, the undersigned: (NAME, first name)

Title: (Indicate the function)

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

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

Date of birth: (day-month-year)

Address: (current address of the adult)

She/He declared that she/he was the survivor of rape on (day-month-year, time)

at (place)

by (known or unknown person)

Ms, Mrs, Miss, Mr

presents the following signs:

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

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

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

Anal examination:

Other examinations carried out and samples taken:

Evaluation of the risk of pregnancy:

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

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

Signature of the clinician

Annex 12. Convention on the Rights of the Child (CRC)

A summary of the rights under the Convention on the Rights of the Child²⁶

Article 1 (Definition of the child): The Convention defines a 'child' as a person below the age of 18, unless the laws of a particular country set the legal age for adulthood younger. The Committee on the Rights of the Child, the monitoring body for the Convention, has encouraged States to review the age of majority if it is set below 18 and to increase the level of protection for all children under 18.

Article 2 (Non-discrimination): The Convention applies to all children, whatever their race, religion or abilities; whatever they think or say, whatever type of family they come from. It doesn't matter where children live, what language they speak, what their parents do, whether they are boys or girls, what their culture is, whether they have a disability or whether they are rich or poor. No child should be treated unfairly on any basis.

Article 3 (Best interests of the child): The best interests of children must be the primary concern in making decisions that may affect them. All adults should do what is best for children. When adults make decisions, they should think about how their decisions will affect children. This particularly applies to budget, policy and law makers.

Article 4 (Protection of rights): Governments have a responsibility to take all available measures to make sure children's rights are respected, protected and fulfilled. When countries ratify the Convention, they agree to review their laws relating to children. This involves assessing their social services, legal, health and educational systems, as well as levels of funding for these services. Governments are then obliged to take all necessary steps to ensure that the minimum standards set by the Convention in these areas are being met. They must help families protect children's rights and create an environment where they can grow and reach their potential. In some instances, this may involve changing existing laws or creating new ones. Such legislative changes are not imposed, but come about through the same process by which any law is created or reformed within a country. Article 41 of the Convention points out the when a country already has higher legal standards than those seen in the Convention, the higher standards always prevail.

Article 5 (Parental guidance): Governments should respect the rights and responsibilities of families to direct and guide their children so that, as they grow, they learn to use their rights properly. Helping children to understand their rights does not mean pushing them to make choices with consequences that they are too young to handle. Article 5 encourages parents to deal with rights issues "in a manner consistent with the evolving capacities of the child". The Convention does not take responsibility for children away from their parents and give more authority to governments. It does place on governments the responsibility to protect and assist families in fulfilling their essential role as nurturers of children.

Article 6 (Survival and development): Children have the right to live. Governments should ensure that children survive and develop healthily.

Article 7 (Registration, name, nationality, care): All children have the right to a legally registered name, officially recognised by the government. Children have the right to a nationality (to belong to a country). Children also have the right to know and, as far as possible, to be cared for by their parents.

Article 8 (Preservation of identity): Children have the right to an identity – an official record of who they are. Governments should respect children's right to a name, a nationality and family ties.

Article 9 (Separation from parents): Children have the right to live with their parent(s), unless it is bad for them. Children whose parents do not live together have the right to stay in contact with both parents, unless this might hurt the child.

Article 10 (Family reunification): Families whose members live in different countries should be allowed to move between those countries so that parents and children can stay in contact, or get back together as a family.

Article 11 (Kidnapping): Governments should take steps to stop children being taken out of their own country illegally. This article is particularly concerned with parental abductions. The Convention's Optional Protocol on the sale of children, child prostitution and child pornography has a provision that concerns abduction for financial gain.

Article 12 (Respect for the views of the child): When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account. This does not mean that children can now tell their parents what to do. This Convention encourages adults to listen to the opinions of children and involve them in decision-making -- not give children authority over adults. Article 12 does not interfere with parents' right and responsibility to express their views on matters affecting their children. Moreover, the Convention recognizes that the level of a child's participation in decisions must be appropriate to the child's level of maturity. Children's ability to form and express their opinions develops with age and most adults will naturally give the views of teenagers greater weight than those of a preschooler, whether in family, legal or administrative decisions.

Article 12 (Respect for the views of the child): When adults are making decisions that affect children, children have the right to say what they think should happen and have their opinions taken into account.

Article 13 (Freedom of expression): Children have the right to get and share information, as long as the information is not damaging to them or others. In exercising the right to freedom of expression, children have the responsibility to also respect the rights, freedoms and reputations of others. The freedom of expression includes the right to share information in any way they choose, including by talking, drawing or writing.

Article 14 (Freedom of thought, conscience and religion): Children have the right to think and believe what they want and to practise their religion, as long as they are not stopping other people from enjoying their rights. Parents should help guide their children in these matters. The Convention respects the rights and duties of parents in providing religious and moral guidance to their children. Religious groups around the world have expressed support for the Convention, which indicates that it in no way prevents parents from bringing their children up within a religious tradition. At the same time, the Convention recognizes that as children mature and are able to form their own views, some may question certain religious practices or cultural traditions. The Convention supports children's right to examine their beliefs, but it also states that their right to express their beliefs implies respect for the rights and freedoms of others.

Article 15 (Freedom of association): Children have the right to meet together and to join groups and organisations, as long as it does not stop other people from enjoying their rights. In exercising their rights, children have the responsibility to respect the rights, freedoms and reputations of others.

Article 16 (Right to privacy): Children have a right to privacy. The law should protect them from attacks against their way of life, their good name, their families and their homes.

Article 17 (Access to information; mass media): Children have the right to get information that is important to their health and well-being. Governments should encourage mass media - radio, television, newspapers and Internet content sources - to provide information that children can understand and to not promote materials that could harm children. Mass media should particularly

be encouraged to supply information in languages that minority and indigenous children can understand. Children should also have access to children's books.

Article 18 (Parental responsibilities; state assistance): Both parents share responsibility for bringing up their children, and should always consider what is best for each child. Governments must respect the responsibility of parents for providing appropriate guidance to their children – the Convention does not take responsibility for children away from their parents and give more authority to governments. It places a responsibility on governments to provide support services to parents, especially if both parents work outside the home.

Article 19 (Protection from all forms of violence): Children have the right to be protected from being hurt and mistreated, physically or mentally. Governments should ensure that children are properly cared for and protect them from violence, abuse and neglect by their parents, or anyone else who looks after them. In terms of discipline, the Convention does not specify what forms of punishment parents should use. However any form of discipline involving violence is unacceptable. There are ways to discipline children that are effective in helping children learn about family and social expectations for their behaviour – ones that are non-violent, are appropriate to the child's level of development and take the best interests of the child into consideration. In most countries, laws already define what sorts of punishments are considered excessive or abusive. It is up to each government to review these laws in light of the Convention.

Article 20 (Children deprived of family environment): Children who cannot be looked after by their own family have a right to special care and must be looked after properly, by people who respect their ethnic group, religion, culture and language.

Article 21 (Adoption): Children have the right to care and protection if they are adopted or in foster care. The first concern must be what is best for them. The same rules should apply whether they are adopted in the country where they were born, or if they are taken to live in another country.

Article 22 (Refugee children): Children have the right to special protection and help if they are refugees (if they have been forced to leave their home and live in another country), as well as all the rights in this Convention.

Article 23 (Children with disabilities): Children who have any kind of disability have the right to special care and support, as well as all the rights in the Convention, so that they can live full and independent lives.

Article 24 (Health and health services): Children have the right to good quality health care – the best health care possible – to safe drinking water, nutritious food, a clean and safe environment, and information to help them stay healthy. Rich countries should help poorer countries achieve this.

Article 25 (Review of treatment in care): Children who are looked after by their local authorities, rather than their parents, have the right to have these living arrangements looked at regularly to see if they are the most appropriate. Their care and treatment should always be based on "the best interests of the child". (see Guiding Principles, Article 3)

Article 26 (Social security): Children – either through their guardians or directly – have the right to help from the government if they are poor or in need.

Article 27 (Adequate standard of living): Children have the right to a standard of living that is good enough to meet their physical and mental needs. Governments should help families and guardians who cannot afford to provide this, particularly with regard to food, clothing and housing.

Article 28: (Right to education): All children have the right to a primary education, which should be free. Wealthy countries should help poorer countries achieve this right. Discipline in schools should respect children's dignity. For children to benefit from education, schools must be run in an

orderly way – without the use of violence. Any form of school discipline should take into account the child's human dignity. Therefore, governments must ensure that school administrators review their discipline policies and eliminate any discipline practices involving physical or mental violence, abuse or neglect. The Convention places a high value on education. Young people should be encouraged to reach the highest level of education of which they are capable.

Article 29 (Goals of education): Children's education should develop each child's personality, talents and abilities to the fullest. It should encourage children to respect others, human rights and their own and other cultures. It should also help them learn to live peacefully, protect the environment and respect other people. Children have a particular responsibility to respect the rights their parents, and education should aim to develop respect for the values and culture of their parents. The Convention does not address such issues as school uniforms, dress codes, the singing of the national anthem or prayer in schools. It is up to governments and school officials in each country to determine whether, in the context of their society and existing laws, such matters infringe upon other rights protected by the Convention.

Article 30 (Children of minorities/indigenous groups): Minority or indigenous children have the right to learn about and practice their own culture, language and religion. The right to practice one's own culture, language and religion applies to everyone; the Convention here highlights this right in instances where the practices are not shared by the majority of people in the country.

Article 31 (Leisure, play and culture): Children have the right to relax and play, and to join in a wide range of cultural, artistic and other recreational activities.

Article 32 (Child labour): The government should protect children from work that is dangerous or might harm their health or their education. While the Convention protects children from harmful and exploitative work, there is nothing in it that prohibits parents from expecting their children to help out at home in ways that are safe and appropriate to their age. If children help out in a family farm or business, the tasks they do be safe and suited to their level of development and comply with national labour laws. Children's work should not jeopardize any of their other rights, including the right to education, or the right to relaxation and play.

Article 33 (Drug abuse): Governments should use all means possible to protect children from the use of harmful drugs and from being used in the drug trade.

Article 34 (Sexual exploitation): Governments should protect children from all forms of sexual exploitation and abuse. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 35 (Abduction, sale and trafficking): The government should take all measures possible to make sure that children are not abducted, sold or trafficked. This provision in the Convention is augmented by the Optional Protocol on the sale of children, child prostitution and child pornography.

Article 36 (Other forms of exploitation): Children should be protected from any activity that takes advantage of them or could harm their welfare and development.

Article 37 (Detention and punishment): No one is allowed to punish children in a cruel or harmful way. Children who break the law should not be treated cruelly. They should not be put in prison with adults, should be able to keep in contact with their families, and should not be sentenced to death or life imprisonment without possibility of release.

Article 38 (War and armed conflicts): Governments must do everything they can to protect and care for children affected by war. Children under 15 should not be forced or recruited to take part in a war or join the armed forces. The Convention's Optional Protocol on the involvement of children in armed conflict further develops this right, raising the age for direct participation in armed conflict to 18 and establishing a ban on compulsory recruitment for children under 18.

Article 39 (Rehabilitation of child victims): Children who have been neglected, abused or exploited should receive special help to physically and psychologically recover and reintegrate into society. Particular attention should be paid to restoring the health, self-respect and dignity of the child.

Article 40 (Juvenile justice): Children who are accused of breaking the law have the right to legal help and fair treatment in a justice system that respects their rights. Governments are required to set a minimum age below which children cannot be held criminally responsible and to provide minimum guarantees for the fairness and quick resolution of judicial or alternative proceedings.

Article 41 (Respect for superior national standards): If the laws of a country provide better protection of children's rights than the articles in this Convention, those laws should apply.

Article 42 (Knowledge of rights): Governments should make the Convention known to adults and children. Adults should help children learn about their rights, too. (See also Article 4.)

Articles 43-54 (implementation measures): These articles discuss how governments and international organizations like UNICEF should work to ensure children are protected in their rights.

REFERENCES

- 1 *Whole of Syria GBV Sector, Voices: GBV Assessment Findings, 2015*
- 2 *Definition/description out of the CCSAS – Facilitator's Guide by IRC/UCLA, 2008*
- 3 *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery, Inter-Agency Standing Committee, 2015.* https://interagencystandingcommittee.org/system/files/2015_iasc_gender_based_violence_guidelines.pdf
- 4 *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies, Inter-Agency Standing Committee, 2005.* See GBVAoR site: <http://gbvaor.net/tools-resources/> for resources in Arabic, English, etc
- 5 *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery, 2015, Inter-Agency Standing Committee.* https://interagencystandingcommittee.org/system/files/2015_iasc_gender_based_violence_guidelines.pdf
- 6 GBVIMS site: <http://www.gbvims.com/resources/>
- 7 *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence, 2013, World Health Organization, the London School of Hygiene & Tropical Medicine, and the South African Medical Research Council.* <http://who.int/reproductivehealth/publications/violence/9789241564625/en/> (<http://www.who.int/reproductivehealth/publications/violence/en/index.html>)
- 8 *Hidden crisis: violence against Syrian female refugees, The Lancet, 2015, www.thelancet.com Vol. 385 June 13*
- 9 *A Study on Early Marriage in Jordan, 2014, UNICEF, www.unicef.org/media/files/UNICEFJordan_EarlyMarriageStudy2014-email.pdf*
- 10 *Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on prevention of and response to sexual violence in emergencies, 2005, Inter-Agency Standing Committee.* See GBVAoR site: <http://gbvaor.net/tools-resources/> for resources in Arabic, English, etc.
- 11 *Center for Health and Gender Equity (CHANGE)*
- 12 *Sexual assault nurse examiner (SANE) development and operation guide. 1999, Washington, DC, United States Department of Justice, Office of Justice Programs, Office for Victims of Crime, (www.sane-sart.com)*
- 13 *Checklist for ruling out pregnancy among family-planning clients in primary care. 1999, Lancet, 354(9178).*
- 14 *Emergency Contraception: A Guide For Service Delivery, 1998, World Health Organization, 1998 (WHO/FRH/FPP/98.19).*
- 15 *Adapted from: Benenson, A.S. Control of communicable diseases manual. Washington DC, 1995, American Public Health Association*
- 16 *Resnick H, Acierno R, Holmes M, Kilpatrick DG, Jager N. Prevention of post-rape psychopathology: preliminary findings of a controlled acute rape treatment study, 1999, Journal of anxiety disorders, 13(4):359-70.*
- 17 *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings, page 100.*
- 18 *Operational Guidance Mental Health and Psychosocial Support Programming For Refugee Operations, UNHCR, 2013, page 72*
- 19 *Standard Operations Procedures for Gender-Based Violence Prevention and Response, 2015, GBV-Sub Cluster Turkey Hub – Syria*
- 20 *Adapted from Medical care for rape survivors, 2002, MSF, December.*
- 21 *From: Professor Lorna J Martin, HOD Division of Forensic Medicine, University of Cape Town.*
- 22 *Standard Operations Procedures for Gender-Based Violence Prevention and Response, 2015, GBV-Sub Cluster Turkey Hub – Syria*
- 23 *Fact Sheet: A summary of the rights under the Convention on the Rights of the Child. UNICEF. http://www.unicef.org/crc/files/Rights_overview.pdf*
- 24 *Caring for Child Survivors of Sexual Abuse, 2013, IRC/UNICEF*
- 25 *From Guidelines for the management of sexually transmitted infections, revised version. 2003, World Health Organization (WHO/RHR/01.10)*
- 26 *Fact Sheet: A summary of the rights under the Convention on the Rights of the Child. © UNICEF. http://www.unicef.org/crc/files/Rights_overview.pdf*



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