THE REPUBLIC  OF THE GAMBIA

NETWORK AGAINST GENDER BASED VIOLENCE (NGBV) THE GAMBIA IN COLLABORATION WITH RATAS & FINDICO OF FINLAND

GUIDELINES ON CLINICAL MANAGEMENT OF GENDER BASED VIOLENCE (GBV)

IN

THE REPUBLIC OF THE GAMBIA

(2018-2023)

FOREWORD

ACKNOWLEDGEMENTS

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ABBREVIATIONS AND ACRONYMS

3TC	Lamivudine
ABC	Abacavir
AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AZT	Zidovudine
CBO	Community based organization
CDC	Centre for Disease Control
CEDAW	Convention on the Elimination of All Forms of Discrimination against Women
CSO	Civil Society Organisation
EFSTH	Edward Francis Small Teaching Hospital
FGDs	Focus Group Discussions
FGM/C	Female Genital Multilation/Cutting
FP	Family Planning
GBV	Gender based Violence
HBIG	Hepatitis B Immunoglobulin
HIV	Human Immunodeficiency Virus
HCT	HIV Counselling and Testing
IR	Inception Report

IM	intramuscular
IU	international units
IV	intravenous
KII	Key Informant Interviews
MoHSW	Ministry of Health and Social Welfare
NGO	Non-Governmental Organization
NSF	National Strategic Framework
PEP	Post exposure prophylaxis
RCH	Reproductive and Child Health
SM	Safe Motherhood
SDF	Social Development Fund
SOPs	Structured Operation Procedures
SRH	Sexual and Reproductive Health
STI	sexually transmitted infections
TDF	Tenofovir
WHO	World Health Organization

GLOSSARY:

"Abuse"- conduct that harms or is likely to cause harm to the safety, health or well being of the complainant;

Abusive Acts- includes physical, psychological, sexual, verbal, economic, social, cultural or similar mistreatment or mishandling which interferes with the integrity of the woman;

"Assailant"- an attacker, perpetrator of assault

"Child" - a person below eighteen years;

"Discrimination against women"- Any distinction, exclusion, or restriction, or any differential treatment based on sex and whose objectives or effects compromise or destroy the recognition, enjoyment or the exercise by women, regardless of their marital status, of human rights and fundamental freedoms in all spheres of life"

Domestic violence means engaging in the following within the context of a previous or existing domestic relationship: acts or threats to commit acts which result in physical assault of another person, sexual abuse, economic abuse, emotional abuse, verbal abuse, psychological abuse, sexual harassment and intimidation and any act that in any way harms or may harm another. It includes any behavior that endangers the safety, health or well being of another person; undermines another person's privacy, integrity and security; detracts or is likely to detract from another person's dignity and worth as a human being (1).

Domestic Relationship – means family relationship, a relationship akin to a family relationship or a relationship in a domestic situation that exists or has existed between a complainant and an alleged offender (1).

Gender-Based Violence (GBV)- is used for describing violence perpetrated against a person based on socially ascribed differences between males and females (2). While the broadest interpretation of GBV is sometimes understood to include specific types of violence against men and boys, the term has historically been and continues to be used primarily as a way to highlight the vulnerabilities of women and girls to various forms of violence in settings where they are discriminated against because they are

female. The United Nations defines violence against women as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (3).

"Girl-Child"- A female child under the age of 18 years

Incest- sexual intercourse between very closely related people

Sexual abuse"- means the forceful engagement of another person in a sexual contact, which includes sexual conduct that abuses, humiliates or degrades the other person or otherwise violate another person's sexual integrity, or a sexual contact by a person aware of being infected with human immunodeficiency virus (HIV) or any other sexually transmitted infection with another person without that other person being given prior information of the infection (1).

Sexual harassment"- means sexual contact without the consent of the person with whom the contact is made, repeatedly making unwanted sexual advances, repeatedly following, pursuing or accosting a person or making persistent, unwelcome communication with a person (1).

Sexual Violence" is defined as, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work" (4).

Survivors- someone who continues to exist despite difficulty or danger

Victims- a person injured or killed or made to suffer

Violence"- includes physical, mental, an emotional, psychological, sexual, verbal or emotional maltreatments or assault;

Violence Against Women"- All acts perpetrated against women which cause or could cause them physical, mental and emotional; sexual, psychological or economic harm, including the threat to take such acts or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public in peace time and during situations of armed conflicts or of war;

"Woman"- includes a girl-child.

1.0 INTRODUCTION

1.1 Gender Based Violence (GBV): a global problem:

The term Gender-Based Violence (GBV) describes violence perpetrated against a person based on socially ascribed differences between males and females. The term has historically been and continues to be used primarily as a way to highlight the vulnerabilities of women and girls to various forms of violence in settings where they are discriminated against because they are female.

GBV is ubiquitous; it occurs in every culture, in all levels of society and in every country of the world. It takes place within a variety of settings, including the home, the workplace, schools and the community. It manifest as rape, sexual abuse and exploitation, wife battering, forced marriage, child marriage, female genital mutilation /cutting, trafficking, physical and psychological violence.

GBV has a significant negative impact on the health of the individual, family, community and the entire population at large. The potential reproductive and sexual health consequences are numerous – unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs), human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/ AIDS) and increased risk for adoption of risky sexual behaviors'. The long term consequences of mental and physical debility may include depression, substance abuse, post-traumatic stress disorder (PTSD) and suicide; chronic pelvic pain, infertility, ectopic pregnancy; and major corrective surgery later in life.

In view of these immediate and long term consequences and the vulnerability of women and girls to GBV, the commission for elimination of discrimination against women (CEDAW) General Recommendation No. 24 (20th session, 1999): article 12: Women and health: acknowledged unequal power relations based on gender; women and adolescent girls are often unable to refuse sex or insist on safe and responsible sex practices. Harmful traditional practices, such as female genital mutilation, early and forced marriage, intergenerational marriage, marital rape; wife inheritance and polygamy without consideration of health implications, would predispose girls and women to the risk of contracting HIV/AIDS and other sexually transmitted diseases.

Similarly, while lack of respect for the confidentiality of patients will affect both men and women, it may deter women from seeking advice and treatment and thereby adversely affect their health and well-being. Women will be less willing, for that reason, to seek medical care for diseases of the genital tract, for contraception or for incomplete abortion and in cases where they have suffered sexual or physical violence. Other factors hindering women from accessing sexual related health (SRH) information promptly as would be expected after a sex related violence may include gender perception of low esteem, power imbalance, socio-economic insecurity and low level of education. These factors are independently associated with poor attitude of women in seeking health help. The reception of victims of gender based violence in the health environments may contribute to poor health seeking if friendly services, privacy and confidentiality cannot be guaranteed.

In recognition of all these facts CEDAW advised member states 'that measures to eliminate discrimination against women are considered to be inappropriate if a health care system lacks services to prevent, detect and treat illnesses specific to women'. 'It is discriminatory for a State party to refuse to legally provide for the performance of certain reproductive health services for women'.

The Gambia government has responded to this CEDAW call for action of elimination of all forms of discrimination against women by promulgation and enactment of legislations and consensus such as; Children's act of 2005, Women's Act of 2010, Domestic Violence act of 2013 and Sexual offences act of 2013, National action plan on reduction of Female Genital Mutilation/Cutting (FGM/C) 2013 and The Gambia National Plan of Action (NPOA) on GBV 2013.

1.2 The Legislations:

In the Women's Act (2010): **"**every woman shall be protected against any form of physical, sexual, psychological, economic harm, suffering, or violence whether occurring in public or private life**"**. **"**Any form of violence is hereby prohibited**"**. That **"**every woman has the right to take decision about her health needs and requirement, and in particular, she has the right to determine the processes concerning reproduction in her body in accordance with international best practices**"**. That **"**access to counseling and rehabilitation services to women who suffer abuses and sexual harassment should be provided**"**.

This recent incidence of rape in the Gambia is unacceptable. This has led to the policy of zero tolerance on the part of Government and Judiciary of the Gambia. Despite the alarming number of cases being reported, it is obvious that a considerable number of incidences of rape remain unreported due to our socio cultural setting**"**.

Children's Act 2005: 'no child is capable of contracting a valid marriage, and a marriage so contracted is voidable. All matters concerning the child, the best interest of the child shall be the paramount consideration''. In conflict of interest a social welfare officer can obtain a court order from children's court to proceed in the best interest of the child''. Guardian means a person who is the guardian of a child by virtue of the provisions of the children's act. He/ She have a primary responsibility for the best interest of the child''. No child shall be subjected to any social and cultural practices that affect the welfare, dignity, normal growth and development of the child''. All forms of child trafficking, prostitution, seduction or sexual exploitation and abuse are prohibited''.

Why are these guidelines needed?

Victims of sexual assault require comprehensive, gender-sensitive health services in order to cope with the physical and mental health consequences of their experience and to aid their recovery from an extremely distressing and traumatic event. The types of services that are needed include pregnancy testing, pregnancy prevention (i.e. emergency contraception), STI testing and/or prophylaxis, post exposure Antiretroviral prophylaxis, treatment of injuries and psychosocial counseling. To ensure coherent, consistent and comprehensive health services for victims and survivors of GBV, a properly articulated, concise and user friendly clinical guidelines is needed.

1.3 Aim of the Guideline:

The aim of this guideline is to improve professional health services for victims of gender based violence by providing:

●Health care workers with the knowledge and skills that is necessary for the management of victims and survivors of GBV;

- Guidance on the establishment of health and forensic services for victims of GBV
- To help national health systems improve the quality of treatment and support provided to victims of GBV;
- To secure standard protocols to guide the process of forensic evidence collection;
- They can be a useful educational tool for health care professionals;
- To achieve reduction of clinical consequences of GBV cases.

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1.4 Using the guidelines:

Clinical guidelines are evidenced based information put together to guide clinical judgement, decision and intervention. The clinical care for victims and survivors of GBV at service delivery point would be more systematic, universal and proactive if effective clinical guidelines are developed, understood, implemented and monitored.

These guidelines will be of interest to a wide range of health care professionals who come into contact with victims of gender based violence or have the opportunity to train health care providers that will attend victims of GBV.

Health professionals can use the guidelines as a day-to-day service document and/or as a tool to guide the development of health services for victims of GBV. The guidelines can also be used to prepare in-service training courses on GBV for health care practitioners and other members of multidisciplinary teams.

1.5 Purpose and scope

The purpose of this guideline is to provide advice that is based on the best evidence where available in order to guide clinicians, nurses or health workers regarding the investigation and management of the gender based violence victims and survivors (GBV).

The guidelines review the clinical circumstances of GBV and provide recommendations regarding screening, diagnosis and management, including subsequent follow up and medico-legal implications (4).

1.6 Background

Overall, the national prevalence rate of common forms of GBV in the Gambia is 75.5%, the strategic intervention was to reduce this prevalence to 30% by 2017 (5). The prevalence of intimate partner violence in pregnancy in a clinical setting in the Gambia was 61.8% (6). More than 80% of Gambian women believe that a man is justified to beat his wife (7).

More often than not, violence will go undetected and the clinical consequences will occur unrecognized, predisposing to chronic physical, reproductive, psychological and emotional debilitating health conditions (5).

Therefore it is important that health care service providers are aware of the tremendous strain GBV puts on survivor's health and take every measure they know to address it. To strengthen knowledge based information, development of clinical management guidelines becomes imperative.

2.0 CLINICAL MANAGEMENT OF VICTIMS OF GENDER BASED VIOLENCE

Victims and survivors of GBV may not come to a health facility directly in the first instance. They may first approach a friend or family member, the police or even strangers. However, some survivors will come to the health care facility directly. At the facility she may see a doctor, nurse or other health care worker. She may disclose the incident immediately or may present with another complaint and disclose only later. Victims may present at the health facility for the following reasons:

I. Want to lay a charge but need medical care
II. Want to lay a charge but do not know how
III. Do not want to lay a charge but want medical care

The health care worker should be able to Inform survivor of her options:

I. Provide information about laying a charge
II. Offer to call the Police (examination and evidence collection can start while waiting for the police)
III. Offer to conduct examination, collect evidence and provide treatment
IV. Offer to store evidence for some time while she decides whether to lay a charge or not.

Health care workers must never turn a survivor away. Even if the incident happened a very long time ago, survivors can still be examined, treatment (including psychosocial support) and counseling offered and follow up care planned.

2.1 General principles of care:

Greet the patient by name. Use her preferred name. Make her your central focus. Introduce yourself to the patient and tell her your role, i.e. physician, nurse, health worker. Aim for an attitude of respectful, quiet professionalism within the boundaries of your patient's culture. Have a calm demeanour. A victim who has been frightened and has experienced fear wants to be in the company of people who are not frightened.

Be unhurried and give her time to narrate her story. Encourage the survivor to set the pace. Do not rush the consultation. Be empathetic and non-judgmental as your patient recounts her experiences. Do not reprimand a survivor if she has taken actions that destroy evidence. Avoid secondary trauma. Give the victim breaks if needed. Be alert to verbal and non-verbal cues depicting anxiety and distress and respond to them appropriately. Restore control and decision-making to the survivor.

Talk directly to the survivor. Try to engage with the survivor if you have to communicate through an intermediary. Allow survivors to speak in the language of their choice. Use simple language. Make sure that the survivor understands the terminology you use.

Remember, the clinical management consists of many more aspects than just an 'examination' or 'evidence collection process'. The order of the steps in the clinical management is not prescriptive, i.e. steps could be skipped or moved according to the circumstances of the incident and the condition of the survivor. Modify your approach according to the specific needs of survivors. Integrate medical and forensic activities.

2.2 Obtaining consent

Before a full medical examination of the patient can be conducted, it is essential that **informed consent** be obtained. In practice, obtaining informed consent means explaining all aspects of the consultation to the patient. Ensure privacy and confidentiality during this process. Patient should be particularly assured that release of her information to a third party will be strictly on her consent. Always remember, the wishes of the patient must be respected.

2.3 Taking a history

Ensure that informed consent has been obtained verbally.. Explain to the patient that if she decides to pursue legal action against the perpetrator, any information she discloses to you in the course of the examination may become part of the public record. It is essential that this aspect of care is understood and handled cautiously as medical offences such as assault; battery or trespass may be insinuated.

2.3.1 General medical history

As a minimum, the medical history should cover any known health problems (including allergies), immunization status and medications. In terms of obtaining information about the patient's general health status, useful questions to ask would be:

- Tell me about your general health.
- Have you seen a nurse or doctor lately?
- Have you been diagnosed with any illnesses?
- Have you had any operations?
- Do you suffer from any infectious diseases?

When seeking information about medications that your patient may be taking, the following questions may be helpful:

- Do you have any allergies?
- Do you take tablets given to you by a health worker?
- Do you take herbal preparations?
- Do you take any other drug regularly for the purpose of ill health?

A standard reporting form (appendix 1) has been developed to ensure consistency.

2.3.2 Gynaecological history

A patient's recent gynaecological history is of particular relevance in cases of sexual assault. Questions that could be asked include:

- When was the first day of your last menstrual period?
- Have you had any sexual relationship prior to this event?
- Have you had any pregnancies? How many and how were they delivered?
- How many children do you have?
- Were there any complications during delivery?
- Have you had pelvic surgery?
- Do you use contraception? What type?
- Do you have a current sexual partner?
- When did you last have consensual sexual activity? - for sexually active people (Details may be needed if DNA result is required for medico-legal purpose)

2.3.3 The assault itself

Undertaking history on the assault itself is a very sensitive process. The main aims of obtaining an account of the violence inflicted are to: detect and treat all acute injuries; assess the risk of adverse consequences, such as pregnancy and STIs; guide relevant specimen collection; guide forensic examination and allow documentation which should be precise, accurate, without discrepancies.

During the session, always address patient questions and concerns in a non-judgmental, empathetic manner; for instance: use a very calm tone of voice; don't express shock or disbelief; avoid using victim-blaming statements such as, "What did you think would happen?"; "What were you doing out alone?", "What were you wearing?" or "You should have known better."

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The following details about the alleged assault must be documented, using the sexual assault reporting form (appendix 1):

The date, time and location of the assault, including a description of the type of surface on which the assault occurred;

The name, identity and number of assailants; the nature of the physical contacts and detailed account of violence inflicted; use of weapons and restraints; use of medications/drugs/alcohol/inhaled substances; how clothing was removed.

Details of actual or attempted sexual activity should also be carefully recorded, in particular whether or not the following occurred: vaginal penetration of victim by offender's penis, fingers or objects; rectal penetration of victim by offender's penis, fingers or objects; oral penetration of victim by offender's penis or other object; oral contact of offender's mouth with victim's face, body or genito-anal area; forced oral contact of victim's mouth with offender's face, body or genito-anal area; ejaculation in victim's vagina or elsewhere on the victim's body or at the scene.

The use of condoms and lubricant should be noted. Any subsequent activities by the patient that may alter evidence, for example, bathing, douching, wiping, the use of tampons and changes of clothing, should also be documented.

Finally, details of any symptoms that have developed since the assault must be recorded; these may include: genital bleeding, discharge, itching, sores or pain; urinary symptoms; anal pain or bleeding; abdominal pain.

2.4 The physical examination

2.4.1 General principles

It is important to observe the following general principles and procedures throughout:

I. Before starting the physical examination, take time to explain all the procedures to your patient and why they are necessary. Give your patient a chance to ask any questions.

II. Allow the patient to have a family member or friend present throughout the examination, if she so wishes.

III. A chaperone for the patient should always be present, especially if the examiner is male. The primary role of the chaperone, preferably a trained health worker, is to provide comfort and support to the patient. The chaperone also protects the health worker in the event of a patient alleging that the examining health worker behaved in an unprofessional manner.

IV. Throughout the physical examination inform the patient what you plan to do next and ask permission. Always let the patient know when and where touching will occur. Show and explain instruments and collection materials.

V. Patients may refuse all or parts of the physical examination and you must respect the patient's decision. Allowing the patient a degree of control over the physical examination is important to her recovery.

VI. The examination should be performed in a setting that is illuminated, warm, clean and private. Ideally, the accommodation should provide both auditory and physical privacy, with separate areas for undressing (e.g. behind a screen or curtain, or another room) and the couch aligned so as to allow the health worker to approach from the patient's side. A gown should be provided.

VII. If the clothing removed was that worn during the assault and forensic evidence is to be collected, the patient needs to undress over a white sheet or large piece of light paper. Try to provide as much privacy as possible while the patient is undressing. Use a cover gown. If the patient has consented to the collection of her clothing then each item of clothing must be

placed by the examiner's gloved hand into a paper bag. If clothing is to be held for forensic examination, replacement clothing needs to be provided- (see section on forensic examination)

VIII. Examine Head-to-Toe: Note the patient's general appearance, demeanour and mental functioning. If the patient's mental functioning appears impaired, attempt to assess whether the impairment is recent (e.g. due to the effects of alcohol) or symptomatic of a longer-term illness or disability (e.g. mental retardation). Next note the patient's vital signs that are her: blood pressure; temperature; pulse; respiratory rate. The physical examination ends with the examination of the genito-anal area. Note and describe in detail any physical injuries, even if forensic evidence is not being collected. Use body maps to indicate location and size of injury

IX. Photograph any injuries, if possible. A consent form for photography may be necessary.

Other diagnostic tests such as X-rays, CT scan, and ultrasound would be required to exclude fractures, head and neck injuries, brain or spinal cord injuries, or abdominal trauma, as appropriate. Draw blood samples for testing for HIV (informed consent must be obtained for HIV testing), hepatitis B, syphilis and other STIs, as necessary. Any biological evidence should be collected with moistened swabs (for semen, saliva or blood).

The following universal precautions should be observed at all times during the examination:

I. Wear gloves whenever in contact with blood or other body fluids. Change gloves between patients; it may sometimes be necessary to change gloves during the examination in order to prevent contamination.

II. Wash hands with soap and water after any exposure to body fluids or blood, between clients, and after removing gloves.

III. Wear protective eye-wear, masks or face shields if there is a possibility of splashing blood or body fluids into your eyes, face or mouth.

IV. Do not recap used needles; do not bend or break needles after use; dispose of used needles in special impermeable sharps containers immediately after use.

2.4.2 The "Head-to-Toe" physical examination:

A systematic, "head-to-toe" physical examination of the patient should be conducted in the following step-wise manner.

Step 1

First note the patient's general appearance and demeanour. Start with the patient's hands; this will reassure the patient. Take the vital signs, i.e. pulse, blood pressure, respiration and temperature. Inspect both sides of both hands for injuries. Observe the wrists for signs of ligature marks.

Step 2

Inspect the forearms for defense injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body. Defensive injuries include bruising, abrasions, lacerations or incised wounds. In our setting (dark skinned people) bruising can be difficult to see, and thus tenderness and swelling is of great significance. Any intravenous puncture sites should be noted.



Figure 1: Defensive injuries on the forearm

Step 3

The inner surfaces of the upper arms and the armpit or axilla need to be carefully observed for signs of bruising. Victims who have been restrained by hands often display fingertip bruising on the upper arms. When clothing has been pulled, red linear petechial bruising can sometimes be seen.



Figure 2: fingertip bruising on the inner surface of the upper arm

Step 4

Inspect the face. Black eyes can be subtle and difficult to observe in dark skin people.. Look in the nose for signs of bleeding. Gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising. The mouth should be inspected carefully, checking for bruising, abrasions and lacerations of buccal mucosa. Petechiae on the hard/ soft palate may indicate penetration. Check for a torn frenulum and broken teeth. Collect an oral swab, if indicated.



Figure 3: carefully examine the mouth

Step 5

Inspect the ears, not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp. Use an otoscope to inspect the eardrum.

Step 6

Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of haematomas. Hair loss due to hair pulling during the assault may cause large amounts of loose hair to be collected in the gloved hands of the examiner; alternatively, a gentle combing may recover any loose hair.

Step 7

The neck area is of great forensic interest. Bruising on the neck can indicate a life-threatening assault. Imprint bruising may be seen from necklaces and other items of jewelry on the ears and on the neck. Suction-type bruising from bites should be noted and swabbed for saliva before being touched.

Step 8

The breasts and trunk should be examined with as much dignity and privacy as can be afforded. It is generally most convenient to start with the back. It is possible to expose only that area that is being examined. The shoulders should be separately viewed. Subtle bruising and more obvious bruising may be seen in a variety of places on the back. Breasts are frequently a target of assault and are often bitten and so may reveal evidence of suction bruises or blunt trauma. If the breasts are not examined, the reasons for not doing so should be documented.

Step 9

The patient can then be reclined for an abdominal examination, that is to say an inspection for bruising, abrasions, lacerations and unusual marks. Abdominal palpation should be performed to exclude any internal trauma or to detect pregnancy.

Step 10

With the patient still in a reclined position, the legs can be examined in turn, commencing with the front of the legs. Inner thighs are often the target of fingertip bruising or blunt trauma (caused by knees). The pattern of bruising on the inner thighs is often symmetrical. There may be abrasions to the

knee (as a consequence of the patient being forced to the ground); similarly, the feet may show evidence of abrasions or lacerations. It is important to inspect the ankles (and wrists) very closely for signs of restraint with ligatures. The soles of the feet should also be examined.

Step 11

It is advisable, if possible, to ask the patient to stand for the inspection of the back. An inspection of the buttocks is also best achieved with the patient standing. Alternatively, the patient may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock.

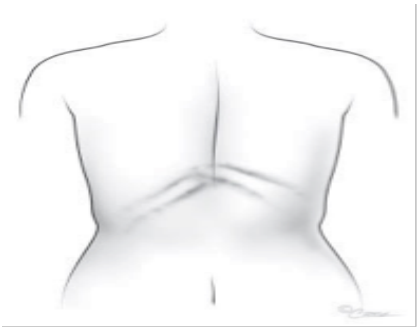


Figure 4: Train line bruising on the back



Figure 5:Abrasions on the lower back from sexual assault on rough road

2.4.3 The genito-anal examination

General principles in conducting a genito-anal examination:

I. Always inspect the anal area before the digital genital examination to avoid cross-contamination
II. Collect specimens from anal area first before moving to genital examination
III. Rectal examination may not be done as a routine. Digital rectal examination is recommended if there is a reason to suspect that a foreign object has been inserted in the anal canal. In a digital rectal examination, the examining finger should be placed on the perianal tissues to allow relaxation of the natural contraction response of the sphincter. Once relaxation is sensed then insertion can take place.
IV. Similarly, proctoscopy need only be used in cases of anal bleeding or severe anal pain post-assault, or if the presence of a foreign body in the rectum is suspected.
V. A speculum examination may not be done as a routine especially in children, virgins, if the patient refuse etc. Deep vaginal specimen can still be collected as long as it does not cause pain or discomfort to the patient.

A routine genito-anal examination should proceed in the following steps:

Step 1

The external areas of the genital region and anus should be examined, as well as any markings on the thighs and buttocks. Inspect the mons pubis. The vaginal vestibule should be examined paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum. A swab of the external genitalia should be taken before any digital exploration or speculum examination is attempted. A gentle stretch at the posterior fourchette may reveal abrasions that are otherwise difficult to see, particularly if they are hidden within slight swelling or within the folds of the mucosal tissue. Gently pulling the labia (towards the examiner) will improve visualization of the hymen (Figure 6). Asking the patient to bear down may assist in visualizing the introitus.
If any bright blood is seen, a thorough examination should be done to identify the source of the bleed.



Figure 6: Gently pull the Labia

Step 2

A speculum examination allows the examiner to inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising. A transparent plastic speculum is preferred. This part of the examination may be particularly difficult for the patient, as it may remind her of the assault. Therefore, the importance of the examination should be carefully explained to the patient prior to gently inserting the speculum. Warming of the speculum prior to use is advisable and can be achieved by immersing the instrument in warm water. If the assault has occurred more than 24 hours but less than 96 hours (approximately) prior to the physical examination, a speculum examination should be performed in order to collect an endocervical canal swab (for semen). If a speculum examination is not conducted (e.g. because of patient refusal) it may still be possible to collect a blind vaginal swab and it should be documented.

Step 3

When necessary a digital rectal examination can then be done after examining the anal verge. Although this examination can be performed while the patient is still in the lithotomy position, it is usually easier to do this with the patient in the left lateral position. Thus on completion of the genital examination, ask the patient to roll over on to her side, and face the wall with her legs drawn up. Respectful covering of the thighs and vulva with a gown or sheet during this procedure is essential. The patient can hold the buttock up herself, if she is comfortable and able to do so. Gentle pressure at the anal verge may reveal bruises, lacerations and abrasions.

2.5 Recording and classifying injuries

Injury interpretation is a complex and challenging matter. Without accurate documentation and expert interpretation of injuries, any conclusions drawn about how injuries occurred might be seriously flawed. This may have profound consequences for both the victim and the accused. It is advised that standard terminology be used in documenting injuries (see glossary)

2.5 Injury description

Adoption of a systematic approach to describing and recording the physical characteristics of wounds will ensure that none of the critical elements are omitted. This should be recorded in the file of the patient during the consultation. See Table 1 for some of the features of wound description

2.5.1 Classification of wounds

When used correctly, a standardized system of wound classification and description may allow deductions about the weapon or object that caused the injury. Wounds are generally classified as abrasions, bruises, lacerations, incisions, stab wounds or gunshot wounds. The main features of each wound category are summarized below.

Abrasions:

Abrasions are defined as superficial injuries to the skin caused by the application of blunt force and are produced by a combination of contact pressure and movement applied simultaneously to the skin. Types of abrasions;

(a) Scratches (e.g. produced by fingernails or thorns);

(b) Imprint (whereby the pattern of the weapon may leave a characteristic abrasion on the skin);

(c)Friction (e.g. grazes from contact with carpet or concrete)

Table 1: DESCRIBING FEATURES OF PHYSICAL INJURIES

FEATURE	NOTES
Site	Record the anatomical position of the wound(s).
Size	The dimensions of the wound(s) should be measured.
Shape	Describe the shape of the wound(s) (e.g. linear, curved, irregular
Surrounds	Note the condition of the surrounding or the 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 accurate ageing is impossible 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.
Classification	Use accepted terminology wherever possible (see Annex 2).
Depth	Give an indication of the depth of the wound(s); this may have to be an estimate.

Bruises:

Bruises are defined as an area of haemorrhage beneath the skin. Bruises are also known as haematoma or contusion. Bruising follows blunt trauma; the discolouration is caused by blood leaking from ruptured blood vessels.

When commenting on bruises, caution must be exercised for the following reasons:

I. The age of a bruise cannot be determined with any degree of accuracy.

II. The apparent colour of the bruise may be affected by skin pigmentation (e.g. bruising may not be readily visible on darker skin) and describing colour could be subjective

III. The site of bruising is not necessarily the site of trauma; for instance: bruising may extend beyond the site of the impact; bruising may appear at a site distant from the impact; visible bruising may be absent despite considerable force being used.

IV. The shape of the bruise does not necessarily reflect the shape of the weapon used (i.e. blood may infiltrate surrounding tissues).

V. The size of the bruise is not necessarily proportional to the amount of force delivered.

Bite marks: These are oval or circular bruises with a pale central area; there may also be some abrasion. In some instances, there may be a discernable dentition pattern

Fingertip bruises: These are caused by the forceful application of fingertips. These usually appear as 1–2 cm oval or round shaped clusters of three to four bruises. There may also be a linear or curved abrasion from contact with the fingernail (see figure 2)

Patterned (imprint) bruises: These occur when a bruise takes on the specific characteristics of the weapon used (e.g. the sole of a shoe). A clothing imprint may also occur when the force is delivered through the clothing and onto the skin.

Petechial bruises. These are pinpoint areas of haemorrhage and are caused by the rupture of very small blood vessels. This type of bruising is usually seen in the face, scalp or eyes after neck compression.

Lacerations

Lacerations are defined as ragged or irregular tears or splits in the skin, subcutaneous tissues or organs resulting from blunt trauma (e.g. trauma by impact).
The main characteristics of a lacerated wound are: ragged, irregular or bruised margins, which may be inverted; intact nerves, tendons and bands of tissue within the wound; the presence of foreign materials or hair in the wound.

Incised wounds

Incised wounds are defined as injuries produced by sharp edged objects whose length is greater than their depth. A knife, razorblade, scalpel, sword or glass fragment may produce incised wounds. It is important to distinguish between lacerations and incised wounds (see Table 2)

TABLE 2
DISTINGUISHING INCISED WOUNDS AND LACERATIONS

FEATURES	**INCISED WOUNDS**	**LACERATIONS**
Borders	Sharply defined edges	Ragged irregular margins
Surrounds	Minimal damage	Bruised or abraded
Blood loss	Variable, often profuse	Variable, often relatively small amounts
Contents	Rarely contaminated	Frequently contaminated; tissue bridges often visible

Stab wounds

Stab wounds are defined as incised wounds whose depth is greater than their length on the skin surface. The depth of such wounds and, in particular, the degree of trauma to deeper structures, will determine the seriousness of the injury, i.e. whether the outcome is fatal or not.
Important points to note with respect to stab wounds include:
The dimensions of the wound may not be the dimensions of the blade.
The depth of stab wounds is affected by a number of factors such as: the amount of force delivered; the robustness of protective clothing; the sharpness of the tip of the blade, tissue resistance and any movement of the victim.

Gunshot wounds

Health workers should have a reasonable working knowledge of ballistics and gunshot wounds. However, it is quite likely that treatment of gunshot wounds will become the responsibility of a surgeon therefore refer as soon as possible.

2.5.3 Genito-anal injuries related to penetration

Trauma to the female genitalia and anus can be caused by forceful penetration. Penetration may be by an erect or semi-erect male penis, by other parts of the body including the fingers and tongue, or by objects of various dimensions and characteristics.
The likelihood and extent of any resultant injuries will depend on: the state of the tissues (i.e. size, lubrication, durability); size and characteristics of the penetrating object; the amount of force used; degree of relaxation in the pelvic and perineal musculature; the position of the perpetrator and angle of penetration.

The posterior fourchette, the labia minora and majora, the hymen and the perianal folds are the most likely sites for injury. Abrasions, bruises and lacerations are the most common forms of injury.

2.5.4 Injury patterns and their interpretation

This is an area that should be approached with caution: the interpretation of injury patterns for medico-legal purposes should only be performed by practitioners with considerable experience in the field.

Assaults produce a huge range of different types of injury; indeed, injuries are as varied as the assaultive actions that caused them.

TABLE 3: ASSAULTIVE INJURY PATTERNS

ACTION	SITE	POSSIBLE INJURIES
Bite	Neck	Bite marks, bruising, abrasions Suction-type petechial bruising
	Breasts	Bite marks, abrasions/lacerations to nipples
Blows	Scalp	Bruising (including haematomas), lacerations
	Face	Fractures (cheek, jaw, nose). Dental trauma. Intra-oral bruises/abrasions, frenulum damage Facial bruises (slap marks)
	Eyes	Periorbital haematoma (black eyes) Subconjunctival haemorrhage (bleeding into the white of the eye)
	Ears	Eardrum perforation (usually slapping)

		Bruises/lacerations to ear. Bruises on scalp behind ear
	Neck	Laryngeal skeleton trauma Voice changes (i.e. hoarseness, dysphonia), difficulty with swallowing
	Hands	Knuckle abrasions (punching), bruising, lacerations, fractures
	Limbs	Bruises, abrasions, lacerations, fractures
	Trunk	Bruises, abrasions, fractures (especially ribs)
Defensive responses	Limbs	Bruising (especially on medial and lateral aspects of forearms and hand), "warding off" type injuries Incised wounds (knife, bottle) Lacerations, fractures (blunt implements)
	Hands	Incised wounds to palms and web space (grasping sharp weapon) Incised wounds and bruises to dorsum (deflecting blows) Nail damage (may also occur in counter assault, e.g. scratching

Burns (cigarette burns)	Any part of the body	Circular burns 5–15 mm in size on any part of the body. The burns may be partial or full thickness (flame, scald, contact)
Dragging	Limbs	Abrasions, bruises on exposed skin surfaces
	Trunk	Embedded foreign material
Falls	Limbs	Abrasions, bruising especially to bony prominences (e.g. elbows, knees and heel of hands) Lacerations, fractures
Fingernail scratches	Any part of the body	Linear scratch abrasions to any part of body
Flight	Limbs	Linear curved scratch abrasions from contact with vegetation. Bruises from contact with other objects. Abrasions, bruises on knees, elbows, hands and hips from falls
Grasping	Ears	Bruising Trauma secondary to earring contact/loss
	Limbs	Fingertip bruises, especially to medial aspect of upper arms and forearms, and medial thighs
Hair pulling	Head	Hair follicle haematoma, bald patches, tenderness
Injections	Upper limbs	Puncture site over the course of a vein
Kissing	Multiple sites	Contact with whiskers may cause superficial abrasions and erythema
Ligature/manual compression	Neck	Ligature marks or imprint bruising (necklace, clothing) Fingertip bruises, abrasions (due to

		fingernails) Facial petechiae, intra-oral petechiae, conjunctival haemorrhages
Penetration	Mouth	Pharyngeal bruising, palate bruising, frenulum trauma
Restraint	Limbs	Ligature marks (wrists and ankles), fingertip bruising
Squeezing/ pinching	Breasts	Bruising
Whipping with rope/cord	Trunk/limbs	Linear, curved or looped bruising, abrasions Train line bruises

When assessing and interpreting injuries, the Health workers are required to know the responses to each of the following questions:

- Whether the injuries were due to blunt or sharp trauma (or both);
- How many applications of force were required to produce the injuries,
- The amount of force required to produce such injuries;
- Whether the injuries were sustained at or about the same time;
- The likelihood of the injuries being sustained in the manner alleged or whether there may be some alternative explanation that could also explain the injuries;
- The possible immediate or long-term consequences of the injuries.

It is important to note that the vast majority of rape cases do not have visible genital injuries. This can occur due to a number of reasons (rape did not result in injury, delayed reporting, absence of vaginal contact, non-aggressive perpetrator, non-resistant survivor, inadequate equipment, provider not appropriately trained). Delayed reporting is especially common in children. On the other hand the finding of genital injuries does not immediately imply that rape occurred. This could result from straddle injuries and from forms of consensual intercourse. One can suspect when straddle

injuries have occurred but it is difficult to distinguish injuries due to consensual intercourse from non-consensual intercourse.

2.6 Special Examination Techniques

A number of adjuvant techniques have been developed to assist in the examination of the female genitalia. Most of these methods have not been vigorously evaluated but may be helpful in visualizing pathology. These techniques include:

Toluidine Blue dye – This dye binds to all broken or damaged skin (injuries, inflammation, benign or malignant disease). Toluidine blue dye stains when it binds with cells that have a nuclei. Since the surface layer of the skin contains no nuclei, the dye does not bind to the skin. Therefore, the dye highlights damage in the deeper dermis. The changes in dye uptake are more apparent in fair skin people. External anal and genital specimen should be collected before applying the dye. The dye should be applied before conducting any internal examination. The dye is not applied when the patient has visible injuries or ulcerations.

Foley's Catheter Balloon – This is used to examine the hymen in adolescents when the hymen is highly oestrogenised and very folded. This technique is not recommended for younger children with unoestrogenised hymens. All forensic specimen are collected first then an 18F or larger Foley's catheter with a 5ml balloon capacity is passed through the hymenal orifice midway into the vaginal vault. Inform the patient that she may experience a bit of pressure as the balloon is inflated with 5-10 ml of water or to an amount that is comfortable for the patient. Then, gently guide the balloon towards the hymen. This will expand the hymen so that the edge can be visualized. On completion, deflate the balloon and remove the catheter. You can also allow the balloon to slip out. Record your findings with and without the use of the technique.

Use of Alternative light - UV light that fluoresces at a wavelength of 490nm can be used to visualize semen in a darkened room. It is important to remember to protect the patient's eyes against the UV light. Note that other substances such as urine or body lotions may also fluoresce and semen may not always fluoresce for example when it is moist. Consider collecting specimens from fluorescent areas

Colposcopy – may be useful in detecting micro trauma especially in children. May also be helpful in taking photographs.

Examination under anaesthesia - May be required in some cases:

- Obvious genito-anal trauma i.e. severe bleeding or injuries requiring repair or surgery
- Subtle trauma that is suspicious of rape
- Chronic discharge (in children)
- In a survivor where the examination is difficult to conduct but considered necessary
- In survivors experiencing severe genito-anal pain

Patients should be informed of what procedures will potentially be conducted while she is under anaesthesia. Caution is required when interpreting findings of the anal examination under anaesthesia as there may be a loss of tone due to the anaesthetic agent.

2.7 Diagnostic tests, specimen collection and forensic issues

Depending on the nature of the assault and the severity of the injuries sustained, the patient may require a number of diagnostic tests, such as X-rays, CT scans and/or ultrasound. In addition, a number of specimens may need to be collected for medical testing purposes (e.g. pregnancy, STIs). Which tests and specimens are appropriate should be decided on a case-by-case basis.

It will be of great benefit to the patient if any forensic evidence, if relevant, is collected during the medical examination; ideally, the health worker performing the medical assessment should also provide the forensic or medico-legal service, if properly trained to do this.

It is imperative that health workers who attend victims of sexual violence have a good understanding of the main components and requirements of a forensic examination.

A forensic examination is formally defined as a “medical examination conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion”.

3. FORENSIC SPECIMENS AND MEDICO-LEGAL IMPLICATION

The primary aim of a forensic examination is to collect evidence that may help prove or disprove a link between individuals and/or between individuals and objects or places.

Health workers should be aware of the capabilities and requirements of their forensic laboratory; there is no point collecting specimens that cannot be tested.

3.1 The purpose of forensic specimens

The objective of forensic evidence is to prove or exclude a physical connection between individuals and objects or places. It is a medical examination and procedure conducted to link individuals (victim & assailant) to object, time and place. For e.g. biological traces (i.e. hair, blood, semen, skin fragments) may be found on both the victim and assailant; for instance, the victim's blood could get onto the assailant's clothes. Fragments from the scene (e.g. mud, vegetation) may link a victim and assailant to a particular location, or they may each have left traces of clothing or biological traces at the scene.

Therefore the health care work should be vigilant and follow strictly the following steps:

1. A consent form may be required. Information gained under informed consent may need to be provided to other parties, in particular, law enforcement authorities (i.e. the police) and the criminal justice system if the patient pursues legal action on the case.

2. It takes time to conduct a thorough forensic examination; the examination usually involves a "head-to-toe" inspection of the skin and a genito-anal examination.

3. Detailed documentation is required; information so recorded may be used in criminal proceedings.

4. Certain areas of the body (e.g. the axilla, behind the ears, in the mouth, the soles of feet) not usually examined as part of a routine medical examination are of forensic interest and must be inspected.

5. Unusual specimens, such as clothing, drop sheets and hair, are collected as part of a forensic examination.

6. The chain of custody of specimens must be documented.

7. Opportunities for follow-up examinations may not arise; it is thus vital to make full use of this single patient contact.

8. Prevent contamination by wearing gloves (and where appropriate face masks and gowns) before collecting any specimen.

9. If the suspected assailant is available for examination, he should be examined in a separate room to avoid contamination.

3.2 Forensic specimen collection techniques

When collecting specimens for forensic analysis, the following principles should be strictly adhered to:

Avoid contamination. Ensure that specimens are not contaminated by other materials. Wear gloves at all times. Modern DNA assay systems are very sensitive and may detect small amounts of extraneous material.

Collect early. Try to collect forensic specimens as soon as possible. The likelihood of collecting evidentiary material decreases with the passing of time. Ideally, specimens should be collected within 24 hours of the assault; after 72 hours, yields are reduced considerably.

Handle appropriately. Ensure that specimens are packed, stored and transported correctly.

Label accurately. All specimens must be clearly labeled with the patient's name and date of birth, the health worker's name, the type of specimen, and the date and time of collection.

Ensure security. Specimens should be packed to ensure that they are secure and tamper proof. Only authorized people should be entrusted with specimens.

Maintain continuity. Once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded..

Document collection: It is good practice to compile an itemized list in the patient's medical notes or reports of all specimens collected and details of when, and to whom, they were transferred.

Table 4 is the lists of range of forensic specimens that are typically of interest in cases of sexual violence, together with notes about appropriate collection techniques and comments on their relevance.

TABLE 4: FORENSIC SPECIMEN

SITE	MATERIAL	EQUIPMENT	SAMPLING INSTRUCTIONS
Anus (rectum)	Semen	Cotton swabs and microscope slide.	Use swab and slides to collect and plate material; lubricate instruments with water, not lubricant.
	Lubricant	Cotton swab	Dry swab after collection.
Blood	Drugs	Appropriate tube	Collect 10 ml of blood
	DNA (victim)	Appropriate tube	Collect 10 ml of blood.
Clothing	Adherent foreign (e.g. semen, blood, hair, fibres)	Paper bags	Clothing should be placed in a paper bag(s). Collect paper sheet or drop cloth. Wet items should be bagged separately.
Genitalia	Semen	Cotton swabs and microscope slide	Use separate swabs and slides to collect and plate material collected from the external genitalia, vaginal vault and cervix; lubricate speculum with water not lubricant or collect a blind

			vaginal swab
Hair	Comparison to hair found at scene	Sterile container	Cut approximately 20 hairs and place hair in sterile container.
Mouth	Semen	Cotton swabs, sterile container (for oral washing or dental flossing	Swab multiple sites in mouth with one or more swabs To obtain a sample of oral washings, rinse mouth with 10 ml water and collect in sterile container.
	DNA (victim)	Cotton swab	
Nails	Skin, blood, fibres, etc. (from assailant)	Sterile toothpick or similar or nail scissors/clippers cut and the clippings collected in a Sterile container.	Use the toothpick to collect material from under the nails or the nail(s) can be cut and the clippings collected in a Sterile container.
Sanitary pads/ tampons	Foreign material (e.g. semen, blood, hair)	Sterile container	Collect if used during or after vaginal or oral penetration
Skin	Semen	Cotton swab	Swab sites where semen may be present.
	Saliva (e.g. of kissing, biting or licking), blood	Cotton swab	Dry swab after collection.
	Foreign material (e.g. vegetation, matted hair or foreign hairs)	Swab or tweezers	Place material in sterile container (e.g. envelope, bottle).
Urine	Drugs	Sterile container	Collect 100 ml of urine.

4. TREATMENT AND FOLLOW-UP CARE

Exposure to sexual violence is associated with a range of health consequences for the victim. Comprehensive care must address the following issues: Physical injuries; Pregnancy; STIs; HIV and Hepatitis B; Counseling and Social Support; and Follow-up consultations.

The possibility of pregnancy resulting from the assault should be discussed. If the woman is first seen up to 5 days after the assault took place, emergency contraception should be offered.

If she is first seen more than 5 days after the assault, she should be advised to return for pregnancy testing if she misses her next period.

If sexual violence results in a pregnancy that a woman wishes to terminate, further counseling is necessary as the Women Act 2010 states that she has right for abortion if continuation of pregnancy will jeopardize her life.

When appropriate, patients should be offered testing for Chlamydia, Gonorrhoea, Trichomoniasis, Syphilis, HIV and Hepatitis B; this may vary depending on where the patient is first seen although these investigations should be performed routinely at the one stop center.

The decision to offer STI prophylaxis should be made on a case-by-case basis. Routine prophylactic treatment of all patients is the norm here as laboratory facilities for accurate diagnosis of most STIs are lacking.

Health workers must discuss thoroughly the risks and benefits of HIV post-exposure prophylaxis so that they can help their patients reach an informed decision about what is best for them.

Social support and counseling are important for recovery. Patients should receive information about the range of normal physical and behavioural responses they can expect, and they should be offered emotional and social support.

All patients should be offered access to follow-up services, including a medical review at 2 weeks, 3 months and 6 months post assault, and referrals for counseling and other support services.

4.1 Physical injuries

Patients with severe, life-threatening conditions should be referred for emergency treatment immediately at EFSTH, Kanifing General Hospital, Bundung Maternal and Child Health Hospital, Brikama District Hospital, Bwiam General Hospital, Essau District Hospital, Farafeni General Hospital, Basse District Hospital or Bansang District Hospital depending on the closest health facility. However when stabilized, nearby One Stop center is also a referral site for subsequent care. The examining health care worker or other nursing staff can usually treat patients with less severe injuries, for example, cuts, bruises and superficial wounds. Any wounds should be cleaned and treated as necessary. The following medications may be indicated: antibiotics to prevent wounds from becoming infected; a tetanus toxoid booster or ATS (anti tetanus serum); medications for the relief of pain, anxiety or insomnia.

4.2. Pregnancy prevention and management

Most female victims of sexual violence are concerned about the possibility of becoming pregnant as a result of the assault. If a woman seeks health care within a few hours and up to 5 days after the sexual assault, emergency contraception should be offered. If she presents more than 5 days after the assault she should be advised to return for pregnancy testing if she misses her next menstrual period.

4.2.1 Emergency contraception

The most widely used means of pregnancy prevention is the oral administration of the emergency contraceptive pill (ECP), otherwise known as the "morning after pill". ECPs act by preventing or delaying ovulation, by blocking fertilization, or by interfering with implantation. They are not abortion pills and do not affect an existing pregnancy (8)

Criteria for administering ECPs include: a risk of pregnancy; patient presents for treatment within 120 hours of the assault and wants to prevent pregnancy; patient has a negative pregnancy test or it has been determined that she is not currently pregnant (if pregnancy cannot be ruled out with certainty, ECPs can still be prescribed so long as the patient is informed that if she is already pregnant, the pills

will not be effective but neither will they affect the pregnancy nor harm the fetus). The available common ECPs are the progestogens (Levonorgestrel) the dose is 750ug; two tablets (1.5 mg) taken at the same time. If the patient vomits within 1 hour of drug ingestion the dose should be repeated. In the absence of progestin-only pills, combined estrogen-progesterone pills can be given in two doses, 12 hours apart and within 72 hours of the assault.

The Common combined oral contraceptive pill is Microgynon; this can be given as four tablets within 72 hours of the event and repeated 12 hours later. Nausea and vomiting is profound; migraine and dizziness may deter compliance and efficacy of this regimen. The combined oral contraceptive pill is not as effective as levonorgestrel for contraception (9).

The insertion of intrauterine contraceptive device (IUCD) is another option that can be offered within 5 days. This can be continued as a long acting reversible contraceptive if the patients request for an effective contraception (9).

4.2.2 Pregnancy testing and management

Patients should be assessed for the possibility of pregnancy by doing a pregnancy test using the kits. However, most of the testing kits commonly available will not detect a pregnancy before the expected date of menstruation. Advise the patient to make sure she gets tested for pregnancy in the event that she misses her next period. In the event of a confirmed pregnancy, patients should be fully informed of their rights and briefed as to their options.
The choices to be made are then: maintaining the pregnancy and either keeping the infant or giving up the infant for adoption; terminating the pregnancy (on medical grounds).

Choices about emergency contraception and pregnancy termination are personal choices that can only be made by the patient herself. The role of the healthcare provider is to provide the necessary information to help the victim make the decision that suits her best. Her decision must be respected. If the healthcare worker is not willing to provide abortion services on the grounds of conscience (conscientious objection), it is expected that the woman will be referred to someone who can provide abortion services as soon as it is practicable to refer her.

4.3 Sexually transmitted infections

Sexually transmitted infection (STI) may result from assault. Infections most frequently contracted for which there are effective treatment options, are: Chlamydia; Gonorrhoea; Syphilis; Trichomoniasis. Victims may also be at risk of contracting human papilloma virus (HPV), herpes simplex virus type 2 (HSV-2), HIV and the hepatitis B virus;

4.3.1 STI testing

Where appropriate tests and laboratory facilities exist, the following tests for STIs should be offered: Specific test for Neisseria gonorrhoea and Chlamydia trachomatis may be difficult in our environment as the best modality is Nucleic acid Amplification using PCR, however, gram stain and culture of specimen may give clue as to the possibility of these STIs.

Wet mount and culture for Trichomonas vaginalis is readily available; blood sample for syphilis, HIV and hepatitis B testing should be offered following appropriate counseling.

If the test results are positive, patients can be prescribed treatment (4.3.2 – 4.3.4). It is important to note that negative test results do not necessarily indicate a lack of infection as STIs can take between 3 days and 3 months to incubate and become identifiable through laboratory testing. Thus if the sexual assault was recent, any cultures will most likely be negative unless the victim already has an STI. Follow-up tests, at two weeks and 3 months interval should target bacterial and viral infections respectively.

4.3.2 Prophylactic treatment for STIs

In our environment routine prophylactic treatment is strongly recommended as we promote syndromic management of STIs due to lack of appropriate human and material resources including laboratory facilities and the challenges of adequate patient follow up (9).

TABLE 5:WHO STI treatment guidelines (may also be used for prophylaxis)

STI	MEDICATION	REMARKS
Gonorrhoea (10)	Ceftriaxone 250 mg IM as a single dose **PLUS** Azithromycin 1g orally as a single dose OR Cefixime 400 mg orally as a single dose **PLUS** Azithromycin 1g orally as a single dose.	Local resistance data should determine choice of antibiotics but where this is not available, WHO recommends dual therapy. Spectinomycin 2g IM as a single dose can also be used
Chlamydia (11)	Azithromycin 1 g orally as a single dose OR Doxycycline[a] 100 mg twice daily for 7 days	One of these alternatives can be used as well: Tetracycline[a] 500 mg 4 times daily for 7 days Erythromycin 500 mg 4 times daily for 7 days Ofloxacin[a] 200 – 400 mg 2 times daily for 7 days
Syphilis (12)	Benzathine penicillin G 2.4 million IU as a single intramuscular injection.	In cases of allergy to penicillin, one of the following alternatives can be used: Doxycycline[a] 100 mg orally twice daily for 14 days Ceftriaxone 1 g intramuscularly for 10 – 14 days In cases of late syphilis or syphilis of unknown stage, Benzathine penicillin 2.4 million IU intramuscularly weekly for 3 weeks or doxycycline[a] 100 mg orally twice daily for 30 days or erythromycin 500 mg 4 times daily for 30 days can be used.

a Contraindicated during pregnancy.

4.4 HIV/AIDS

The likelihood of acquiring HIV from sexual assault depends on several factors such as: type of assault (i.e. vaginal, oral, anal); vaginal or anal trauma (including bleeding); whether and where on, or in, the body ejaculation occurred; viral load of ejaculate; presence of STI(s); presence of genital lesions in either the victim or perpetrator; intravenous drug use by perpetrator; frequency of assaults; number of perpetrators; HIV status of perpetrator(s); high prevalence of HIV in the area; whether a barrier contraceptive method was used (13, 14).

4.4.1 HIV testing

Sexual assault victims should be offered a baseline test for HIV. Appropriate counseling services should be made available before and after HIV testing. These services should be available on site as a minimum standard.

4.4.2 Post-exposure prophylaxis

It is recommended that a survivor of rape or sexual assault presenting within 72 hours of exposure be counseled and provided with the medicines recommended for post–occupational exposure prophylaxis. It is important to determine the HIV (and Hepatitis) status of the perpetrator/ suspect. If that is not possible, it may be assumed that the perpetrator/ suspect is HIV-positive, and the survivor is provided with post exposure prophylaxis. Currently recommended antiretroviral drugs for post exposure prohylaxis in The Gambia is: TDF+3TC+EVF (Tenofovir, Lamivudine, Efavirenz) (14).

Ethical considerations for PEP in rape cases

1. Forensic examination and legal reporting should NOT be a pre-condition for PEP as the preventive treatment has to be started as early as possible ideally within a few hours after the incident.
2. Before giving PEP to a child, informed consent must be sought from the parent or guardian.

This must include appropriate information on the benefits and risks of starting PEP and the need for adherence to a 4-week protocol.

3. It must be explained that HCT is essential before starting PEP (or at least within a week of starting PEP) as clients who are already found HIV positive will not benefit from PEP but it may cause harm for future treatment needs.
4. Clients who are already found HIV positive must be offered a full and comprehensive care package as described in this manual
5. Access to PEP should be freely accessible to all who suffer sexual assault.

4.5 Hepatitis B

Victims of sexual violence may be at risk for hepatitis B and should therefore be offered testing and immunization. Guideline protocols for the administration of the hepatitis B vaccine, according to patient immunization status, are given in Table 6. Generally speaking, it is not necessary to administer hepatitis B immune globulin (HBIG) unless the perpetrator is known to have acute hepatitis B. The administration of HBIG or the hepatitis vaccine is not contraindicated in pregnant women.

TABLE 6: HEPATITIS B IMMUNIZATION FOR VICTIMS OF SEXUAL VIOLENCE

PATIENT IMMUNIZATION STATUS	TREATMENT GUIDELINES
Never vaccinated for hepatitis B	First dose of vaccine should be administered at the initial visit, the second dose should be administered 1–2 months after the first dose, and the third dose should be administered 4–6 months after the first dose. The vaccine should be administered intramuscularly in the deltoid region. A vaccine without (HBIG) can be used.
Not completed a series of hepatitis B vaccinations	Complete the series as scheduled.
Completed a series of hepatitis B vaccinations	No need to re-vaccinate.

4.6 Patient information:

On completion of the assessment and medical examination, it is important to discuss any findings, and what the findings may mean, with the patient. In particular:

I. Give the patient ample opportunity to voice questions and concerns.

II. Reassure the patient that the incident she suffered was not her fault.

III. Teach patients how to properly care for any injuries they have sustained.

IV. Explain how injuries heal and describe the signs and symptoms of wound infection.

V. Teach proper hygiene techniques and explain the importance of good hygiene.

VI. Discuss the signs and symptoms of STIs, including HIV, and the need to return for treatment if any signs and symptoms should occur. Stress the need to use a condom during sexual intercourse until STI/HIV status has been determined.

VII. Explain the importance of completing the course of any medications given.

VIII. Discuss the side effects of any medications given.

IX. Explain the need to refrain from sexual intercourse until all treatments or prophylaxis for STIs have been completed and until her sexual partner has been treated for STIs, if necessary.

X. Explain rape trauma syndrome (RTS) if indicated and the range of normal physical, psychological and behavioural responses that the patient can expect to experience to both the patient and (with the patient's permission) family members and/or significant others. Encourage the patient to confide in and seek emotional support from a trusted friend or family member.

XI. Inform patients of their legal rights and how to exercise those rights.

XII. Give patients written documentation regarding: any treatments received; tests performed; date and time to call for test results; meaning of test results; date and time of follow-up appointments; information regarding the legal process if desired.

XIII. Assess for patient safety. If it is not safe for the patient to return home, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place that she can go to. Discuss strategies that may help prevent another assault.

XIV. Stress the importance of follow-up examinations at two weeks and three and six months.

XV. Tell the patient that she can telephone or come into the health care facility at any time if she has any further questions, complications related to the assault, or other medical problems.

4.7 Follow-up care:

4.7.1 Medical review

Follow-up visits are recommended at 2 weeks, 3 months and 6 months post assault.

The 2-week follow-up visit:

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

1. Examine any injuries for proper healing.
2. Photograph injuries if indicated (i.e. to document healing, comparisons may be needed in court).
3. Check that the patient has completed the course of any medications given for STIs.
4. Obtain cultures and draw blood to assess STI status
5. Discuss results of any tests performed.

6. Test for pregnancy if indicated. If pregnant, advise about options.
7. Remind patients to return for their hepatitis B vaccination and other immunizations at the scheduled time. Remind them about their scheduled HIV testing at 3 and 6 months as well.
8. Assess the patient's emotional state and mental status, and encourage the patient to seek counseling if they have not yet done so.
9. Make follow up appointment

The 3-month follow-up visit:

The following tasks should be performed at the 3 months post assault visit:

1. Test for HIV. Make sure that pre- and post-testing counseling is available or make the appropriate referral.
2. Assess pregnancy status and provide advice and support.
3. Discuss results.
4. Draw blood for syphilis testing if prophylactic antibiotics were not given previously if indicated.
5. Assess patient's emotional state and mental status and encourage the patient to seek counseling if they have not yet done so.

The 6-month follow-up visit:

At 6 months post assault:

1. Test for HIV. Make sure that pre- and post-testing counseling is available or make an appropriate referral.

2. Discuss results.
3. Administer the third dose of the hepatitis B vaccine.
4. Assess the patient's emotional health and refer as necessary.

4.7.2 Counseling and social support:

Not all victims of gender based violence react in the same way. Some experience immediate psychological distress, others short-term and/or long-term psychological problems. The amount and length of social support and/or psychological counseling required by victims of violence varies enormously, depending on the degree of psychological trauma suffered and the victim's own coping skills and abilities. The level of social support post assault is therefore best determined on a case-by-case basis. Unfortunately, many victims of sexual violence do not pursue counseling only about 24–40% of victims ever seek counseling post assault (15).

The role of psychological counseling, in recovery is well established, yet many victims do not have access to formal services of this nature. This is a priority area for one-stop-centre. These guidelines would like to recommend social support in a group setting as it offers the following benefits: it helps to decrease the isolation that victims often feel; it provides a supportive atmosphere; victims are encouraged to share their experiences; it helps victims to establish their own support network.

4.7.3 Referrals:

Patients should be given both verbal and written referrals for support services which may include: shelters or safe houses; HIV/AIDS counseling; support groups; financial assistance agencies; social service agencies.

The types of referrals given will vary depending on the patient's individual needs and circumstances, and also on the availability of facilities and resources. Patients should be referred to Edward Francis Small Teaching Hospital (EFSTH), Kanifing General Hospital, Bundung Maternal and child health Hospital, Brikama District Hospital, Essau District Hospital, Farafeni General Hospital, Basse District Hospital, Bansang Hospital or nearby One Stop centers for subsequent clinical care putting into consideration available facilities, human resources, where the incident occurred and indication of referral.

5.0 CHILD SEXUAL ABUSE

5.1Definition of child sexual abuse:

Child sexual abuse is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.

Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.

This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in pornographic performance and materials".

Child sexual abuse should not be equated with rape. All children who are raped will have been sexually abused but rape is only one form of child sexual abuse. However all forms of child sexual abuse potentially produce psychological sequelae therefore, it must be taken seriously and managed appropriately and in the best interests of the child irrespective of the form it presents with. Bearing in mind the difference between physical and sexual abuse, sexual activities can be classified into 4 groups:

1. Suspected abuse where the signs or symptoms are compatible with sexual abuse but this has not yet been confirmed by the history as the child is unwilling to talk as a result of coercion or manipulation or the child is too young and therefore unable to talk.
2. Mild or non-contact abuse which includes verbal harassment for example: the adult who repeatedly approaches girls expressing love for them or demanding to be their 'lover' or the class mate or teacher who comments on the physical attributes, or their absence, of girls in the classroom. Although this has no physical sequelae it can be so intrusive and severe that girls may stop attending school with extreme psychological, social and economic sequelae. Other forms of mild abuse include exhibitionism and exposure to pornographic materials.

3. Moderate or contact abuse which involves physical contact between the child and the perpetrator such as fondling of the breasts, anus or genitalia of either party by the other or simulated sexual intercourse but no penetration.
4. Severe or penetrative sexual abuse which includes penetration of the mouth, anus or vagina of the child by any object, not just a penis.

5.2 Physical and behavioural indicators of child sexual abuse:

Physical and behavioural indicators of child sexual abuse are summarized in Table 7. It is important to note that while the presence of one or more of the findings listed in Table 7 may raise concern, it does not necessarily prove that a child has been sexually abused (16).

Many health care professionals rely on indicators of this type to assist in the detection of cases of child sexual abuse, especially in children who are nonverbal. However, these indicators must be used with caution, especially in the absence of a disclosure or a diagnostic physical finding.

TABLE 7: PHYSICAL AND BEHAVIOURAL INDICATORS OF CHILD SEXUAL ABUSE

PHYSICAL INDICATORS	**BEHAVIOURAL INDICATORS[c]**
Unexplained genital injury	Regression in behaviour, school performance or attaining developmental milestones
Recurrent vulvovaginitis	Acute traumatic response such as clingy behaviour and irritability in young children
Vaginal discharge	Sleep disturbances
Bedwetting and fecal soiling beyond the usual age	Eating disorders
Anal complaints (e.g. fissures, pain, bleeding)	Problems at school
Pain on urination	Social problems
Urinary tract infection	Depression
STI[a]	Poor self-esteem
Pregnancy[b]	Inappropriate sexualized behaviours[c]
Presence of sperm[b]	

[a] *Considered diagnostic of child sexual abuse if perinatal and iatrogenic transmission can be ruled out.*

[b] *Diagnostic of child sexual abuse in a child below the age of consent.*
[c] *No one behaviour can be considered as evidence of sexual abuse; however, a pattern of behaviours is of concern. Children can display a broad range of sexual behaviours even in the absence of any reason to believe they have been sexually abused.*

5.3 Assessment and examination of children:

5.3.1 Consent and confidentiality issues:

Suspected child sexual abuse is usually brought to the attention of the health facility by the parent or caregiver and therefore obtaining consent to evaluate the child usually does not produce friction. Occasionally, in dispute situations a caregiver may decide to hide information and subsequently refuse to give consent for the examination of the child. This guideline recommends that the police and the social welfare department should be notified immediately. In the interim, the hospital authority and hospital security should be engaged to ensure the child remains in the health facility until the police / social welfare unit arrives to help the decision making process.

Health care workers are required to always act in the best interest of the child. Codes of practice require all professionals to consider carefully their legal and ethical duties as they apply to patient confidentiality. The child and her parents/guardian need to understand that health care professionals may have a legal obligation to report the case and to disclose information received during the course of the consultation to the authorities even in the absence of consent [Children's Act 2005].

5.3.2 Interviewing the child

Health workers interviewing children in cases of alleged sexual abuse may find it useful to bear in mind the following:

I. All children should be approached with extreme sensitivity and their vulnerability recognized and understood.

II. Try to establish a neutral environment and rapport with the child before beginning the interview.

III. Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions.

IV. Always identify yourself as a helping person.

V. Ask the child if she knows why they have come to see you.

VI. Establish ground rules for the interview, including permission for the child to say she doesn't know, permission to correct the interviewer, and the difference between truths and lies.

VII. Ask the child to describe what happened, or is happening to them in their own words.

VIII. Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning (or free narrative) has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity.

IX. Also consider interviewing the caretaker of the child, without the child present.

5.3.3 Genito-anal findings

In practice, clear physical findings of sexual abuse are seldom seen in children because child sexual abuse rarely involves physical harm. Many studies have found that normal and non-specific findings

are common in sexually abused pre-pubertal girls (17, 18). This is more profound in boys as genito-anal trauma may not be seen.

Therefore, a genital examination with normal findings does not preclude the possibility of sexual abuse. Moreover, in the vast majority of cases the medical examination will neither confirm nor refute an allegation of sexual assault.

Certain sexual actions are unlikely to produce physical injuries (e.g. orogenital contact) while others (e.g. penetration of the anus, or penetration of the labia but not the hymen) may not necessarily produce injuries. The amount of force used will be the determining factor in such circumstances. Gross trauma to the genital and/or anal area is easier to diagnose, but healed or subtle signs of trauma are more difficult to interpret.

The position in which the child is examined is critical to the interpretation of the medical observations. The genital examination must be done in two positions - the supine (frog) position and the prone knee-chest or left lateral position. This is particularly important if hymenal abnormalities are observed when the child is in the supine position (i.e. lying on her back), she should also be examined in the knee-chest position to exclude gravitational effects on these tissues. In each position two techniques need to be used – labial separation and labial traction. The external genitalia (labia majora and minora, clitoris, vestibule, posterior fourchette, fossa navicularis and perineum) need to be assessed for signs of acute trauma and the 'internal' genitalia (hymen and vagina) need to be examined for signs of acute trauma as well as for any structural changes suggesting penetration. Complications of sexual intercourse such as sexually transmitted infections and pregnancy need to be excluded.

It is best to start the examination in the supine position. Get the child to lie on her back with her heels touching each other in the midline and drawn up towards her buttocks. Keeping the heels in the midline she needs to relax her adductor muscles, open her legs and allow her knees to fall outwards towards the couch. This is good for the examination of the lower abdomen, thighs, external genitalia and hymenal membrane but not good for the examination of the vagina

After finishing the examination in the supine position, the child should be examined in the knee-chest position. The child needs to lie prone with her face to one side and her arms next to her head or hanging over the edge of the couch. Keeping her chest on the bed she must lift her pelvis and draw her legs up until her knees are in line with her hips. The knees are then placed 15 cm apart and the pelvis tilted towards the ceiling. This position is good for the examination of the anus, the posterior rim of the hymen, fossa navicularis and vagina. With good positioning and a bright light, it is possible to see the cervix in two out of three young girls. It is also the ideal position for taking specimen.


Figure 7: Supine (frog) position


Figure 8: Knee-Chest position

An anal examination must always be included as part of the assessment of a sexually abused child. It is best done with the child in the knee-chest or left lateral position. A rectal examination seldom contributes to the assessment and is generally unnecessary. Infants and toddlers can be examined on their mother's lap with their knees flexed and their thighs resting on the abdominal wall.

Physical genito-anal findings are listed below:

Normal and non-specific vaginal and anal changes include: vulvovaginitis; labial agglutination; erythema; fissures; midline skin tags or folds;

Anatomical variations or physical conditions that may be misinterpreted or often mistaken for sexual abuse include: failure of midline fusion; non-specific vulva ulcerations; urethral prolapse; female genital mutilation; unintentional trauma (e.g. straddle injuries); labial fusion (adhesions or agglutination).

Findings suggestive of abuse include: acute abrasions, lacerations or bruising of the labia, perihymenal tissues; hymenal notch/cleft extending through more than 50% of the width of the hymenal rim; scarring or fresh laceration of the posterior fourchette not involving the hymen (but unintentional trauma must be ruled out); significant anal dilatation or scarring.

Findings that are definitive evidence of abuse or sexual contact include: sperm or seminal fluid in, or on, the child's body; positive culture for N. gonorrhoea or serologic confirmation of acquired syphilis (when perinatal and iatrogenic transmission can be ruled out); intentional, blunt penetrating injury to the vaginal or anal orifice.

5.4 Health consequences:

Both the physical and psychological health problems that are associated with sexual abuse in children have been well documented (19, 20).

The physical health consequences include: gastrointestinal disorders (e.g. irritable bowel syndrome, non-ulcer dyspepsia, chronic abdominal pain); gynaecological disorders (e.g. chronic pelvic pain, dysmenorrheoa, menstrual irregularities); somatization (attributed to a preoccupation with bodily processes).

The following psychological and behavioural symptoms have been reported in child victims of sexual abuse: depressive symptoms; anxiety; low self-esteem; symptoms associated with PTSD such as re-experiencing, avoidance/numbing, hyper arousal; increased or inappropriate sexual behaviour; loss of social competence; cognitive impairment; body image concerns; substance abuse.

5.5 Treatment and Follow up:

This is essentially as in the adult care. These include treatment of physical injuries, genito-anal injuries, STIs prevention and treatment, PEP; Vaccination against Hepatitis B if not immunized; Patient information should be given to the parents or caregiver. Counseling and psycho-social support and treatment for psychological problems. Health workers will need to ensure that the child is not returning to an environment where the abuse is more likely to occur. This may involve the Social Welfare Department and the Gender and Child Welfare Unit of the police.

5.6 Female Genital Mutilation/Cutting (FGM/C)

In the Gambia the National prevalence rate of FGM/C among women age 15-49 years old is 76.3% (5). Similarly, the national prevalence rate of girls age 0-14 years old that have any form of FGM/C is 42.4%.. Unfortunately, a significant percentage (64.2%) of young women who would be parents tomorrow wants FGM/C to continue (5). Therefore, to achieve 30% reduction of FGM/C among girls between 0-14 years may be a difficult task.

FGM/C is a GBV of significant negative health impact. It is a burden and the associated poor reproductive and sexual life is enormous. This could range from acute emergency conditions during excision to inability to consummate marriage, difficult/obstructed labour, and operative interventions (21). The relationship of obstetrics fistulae (VVF, RVF) and severe FGM/C is well established and the clinical outcome is regrettable.

Therefore measures to reduce infliction of a preventable injury should be supported. The National Action plan (5) has reduction implementation strategies. The clinical manifestation could be physical injuries or psychological and these management guidelines should be used in the holistic approach of the care of victims.

In 2015, Gambia's parliament passed a bill outlawing FGM/C for the first time. But with high rates among the current population it may be many years before the health benefits of this ban are felt.

5.7 Other forms of GBV

Child Marriage and Wife Battery are all forms of GBV with clinical manifestation of either physical or genito-anal injuries or psychological consequences. The effective use of these guidelines would offer appropriate care to victims and survivors of these forms of GBV.

6.0 DOCUMENTATION

6.1 Documenting cases of sexual abuse: a check-list for health workers

The following check-list is intended to assist health workers develop their documentation skills:

Document all pertinent information accurately and legibly. All documentation should be written in an impartial manner.

Notes and diagrams should be created during the consultation; this is likely to be far more accurate than if created from memory.

Notes should not be altered unless this is clearly identified as a *later* addition or alteration. Deletions should be scored through once and signed, and not erased completely.

Ensure that the notes are accurate; deficiencies may cast doubts over the quality of the assessment.

Record verbatim any statements made by the victim regarding the assault. This is preferable to writing down your own interpretation of the statements made.

Record the extent of the physical examination conducted and all "normal" or relevant negative findings.

Records should not contain inappropriate comments (like the patient is fat) or unnecessary information (like the suspected perpetrator's name)

Records should be stored securely in the health care facility. Records are confidential (records owned by health facility but information owned by patient). The records are not automatically presented in court but may be subpoenaed by a court of competent jurisdiction. Records may be used in a civil case. Police authorities should not access your records.

Ideally, standardised forms should be used (see Sexual Assault Examination Form in appendix 1).

Records should be dated (with time) and signed on each page.

6.2 Contents of medical Record:

I. Who provided history
II. To whom information was given
III. Name of interpreter and language used
IV. Written consent:
V. Who provided consent and what procedure followed to obtain consent
VI. Record as much information as possible regarding the rape. This will assist with the care of the survivor and for the interpretation of findings.
VII. In children, record history in their words
VIII. Record normal and negative findings
IX. Record if special techniques were used (and the findings with and without the techniques).
X. Body diagrams and photographs are meant to supplement, not replace, written notes
XI. Photographs must be stored in a separate system with restricted access. Remember to take a separate and specific consent before taking photigraphs.
XII. In detainees who were sexually assaulted, record who requested the examination, the people who were present at the examination, reasons for examination, instructions issued to survivor and custodial authorities.

6.3 Body diagrams

Body diagrams should complement written records.There should be no discrepancy between records and diagrams (ensure that left and right are appropriately labeled to correspond to the patient's left & right). Consider using different colour pens if there are many injuries. Injuries can be cross-referenced to written records by numbering or labeling. Remember to record injuries on all diagrams e.g. an injury on the right side of the face should be drawn on both the anterior and left lateral diagrams. Drawings should be made approximately to scale and match the number of injuries recorded. Areas of swelling, erythema, bruising, pain and tenderness can be shaded. Body diagram is particularly helpful when describing the genito-anal examination (clock face notation is used to help in description)

7.0 VICARIOUS TRAUMA AND COUNTER TRANSFERENCE

Vicarious trauma refers to a transformation in the self of a trauma worker or helper that results from empathic engagement with traumatized clients and their reports of traumatic experiences. It is a special form of countertransference stimulated by exposure to client's material. It is the emotional residue of exposure that counsellors have from working with people as they are hearing their trauma stories and become witnesses to the pain, fear and terror that trauma survivors have experienced.

Vicarious trauma can have a huge impact on people who work with victims of gender-based violence and is an important cause of burnout and feelings of compassion fatigue. There is considerable individual difference in susceptibility and it is very important to be able to recognise the symptoms.

Managing and preventing the adverse effects of vicarious trauma require the development of self-awareness, and ability to reflect on and monitor our responses to individual cases, and to work through and deal with our feelings. Ideally this should be done in a debriefing with a supervisor who is a trained counsellor, but peer support can be very effective too.

Addressing vicarious trauma is an imperative for health services. Good quality care can only be provided in institutions take an interest in the wellbeing of staff, structure work to keep levels of trauma as low as possible, encourage evaluation of levels of vicarious trauma and provide support. Otherwise services will be negatively affected and staff turnover will be high.

Vicarious traumatisation is manifested in our: emotional expression; interpersonal contact and changes in thinking. It can persist for months or years after the work. It may result in long-term changes to our beliefs, expectations and assumptions about self and others. This may compromise our ability to provide optimum care and remain responsive to the well being of patients.

Symptoms of vicarious trauma include:

- Fatigue, sadness and depression
- Cynicism, discouragement, loss of compassion
- Hyper-arousal, sleep disturbances, intrusive nightmares
- Somatic problems – head aches, joint pain, irritable bowel syndrome
- Feelings of helplessness, disbelief
- Anger, irritability

- Thinking a great deal about work outside of work time
- Imagining the things that have happened to your patients could happen to you
- Feelings of vulnerability and fear and constantly looking out for potential dangers
- Replaying the survivor's traumatic events in your mind all the time
- Replaying interventions with survivors in your mind
- Planning and worrying about future interventions with survivors

When not properly dealt with, this may also contribute to burn out which may manifest in the health worker as:

- Loss of empathy for patients which can result in more judgmental and harsh behaviour towards survivors
- Staff may not even like themselves for being this way, but can't really control their responses any longer
- Unwillingness to hear the details of the survivor's trauma, which can manifest in a lower likelihood of asking questions to facilitate dialogue.

Coping strategies to protect against vicarious trauma often focus on individually orientated approaches e.g. balancing life and work adequately, ensuring time for exercise and leisure activities, self-care, debriefing and peer support. Peer engagement helps to normalise the reactions experienced in the work place, and provide a safe environment in which to share and process these experiences. Institutional factors play a vital role in helping health workers who work traumatized people to cope with their work. Health care providers are more vulnerable to vicarious trauma the longer the number of hours spent working with traumatised survivors. Thus, institutions need to give adequate consideration to the number of people working in these units and the duration of their stay in the units. Organising work such that workloads are shared among groups of colleagues and ensuring a mix of patients seen is particularly important in preventing vicarious trauma. Supervisors will also need to deliberately create a stress free work environment that encourages subordinates to speak out and seek for professional

help when they are beginning to notice the symptoms of burn out and vicarious trauma. Time off and interventions from co-workers can usually assist in burnout reduction.

Good self-care requires that health care workers are keenly aware of the way in which the work with survivors affects them. Healthcare providers need to develop an awareness of their working style and the early warning signs of vicarious traumatization. It should be dealt with appropriately in a timely manner. This will assist the health care worker to remain empathically engaged. Acknowledging one's own history of traumatic events and fears is important because unprocessed negative experiences are likely to interact destructively with a survivor's traumatic experience. Thus, enhanced self knowledge results in enhancing the connection between one's self and others, deepening one's own awareness, and balancing work and personal lives.

8.0 ONE STOP CENTRE

The one stop Centre is an ideal facility for managing GBV cases.

The components:

It is recognized that very few places will be in a position to provide and enjoy the perfect facility.

However, in the event that a health worker was consulted about service provision for victims of sexual violence, they might refer to the need for "a private, discrete suite with ready access to an emergency department of a hospital" comprising:

1. An examination room, equipped with, and laid out as follows:

An examination couch positioned so that the health worker can approach the patient from the right-hand side; the couch must allow examination with the legs flopped apart (dorsal or lithotomy position);

Thermally neutral (i.e. not too cold or too hot);

Auditory and visual privacy (particularly for undressing);

Clean bed-linen and a gown for each patient;

Lighting sufficient to perform a genito-anal examination;

Hand-washing facilities (with soap and running water);

Forensic supplies: a table or desk for documenting and labeling specimens; a lockable door to prevent entry during the examination; a telephone.

2. A separate room containing a table and chairs where a support person could talk with the patient, and facilities for offering patients refreshments and a change of clothing and also for children who may be attending as patients or accompanying an adult.

3. Shower and toilet for the patient.

4. A room for the police.

5. A reception area that could also be used as a room for waiting family and friends

6 Functioning laboratory facilities capable of performing all basic investigations in these guidelines

7 Regular electricity supply and running tap

8 Trained staff and effective use of algorithms

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Appendix 1: Sexual Assault Report Form

NAME OF HEALTH FACILITY_____

OBSTETRICS AND GYNAECOLOGY DEPARTMENT

REPORT BY AUTHORISED MEDICAL PRACTITIONER ON THE COMPLECTION OF A MEDICAL-LEGAL EXAMINATION

To be completed in legible handwriting and signed on every page

A. DEMOGRAPHIC INFORMATION

1. Police Station	2. Hos. Case No.	3. Police Investigating Officer (Name and Number)	4. Time Date Month Year ☐☐:☐☐ ☐☐ ☐☐ ☐☐☐☐

5. Name of Medical Practitioner:

6. Registered Qualifications:

7. Phone Number:

8. Email:

9. Place of Examination:

10. Full Names of Person Examined:

11. Sex M☐ F☐

12. Date of Birth/Apparent Age

13. Nationality:

14. Parent or Escort's Name:

15. Tel. No:

16. Place of Incident:

17. Region

B. HISTORY IN CASE OF ALLEGED SEXUAL ASSAULT

1. Age of Menarche ☐☐	2. No. of Pregnancies ☐☐	3. No. of Deliveries ☐☐	4. Duration of Pregnancy (If applicable) ☐☐ Weeks

5. Contraception (Indicate with X) Yes☐ No☐

6. Method and last date of application /ingestion ☐

7. First day of last Menstruation

8. Duration of period ☐☐

9. Duration of Cycle ☐

10. Date and time of last intercourse with consent	11. Number of consensual sexual partners during last 7 days	12. Condoms Yes☐ No☐

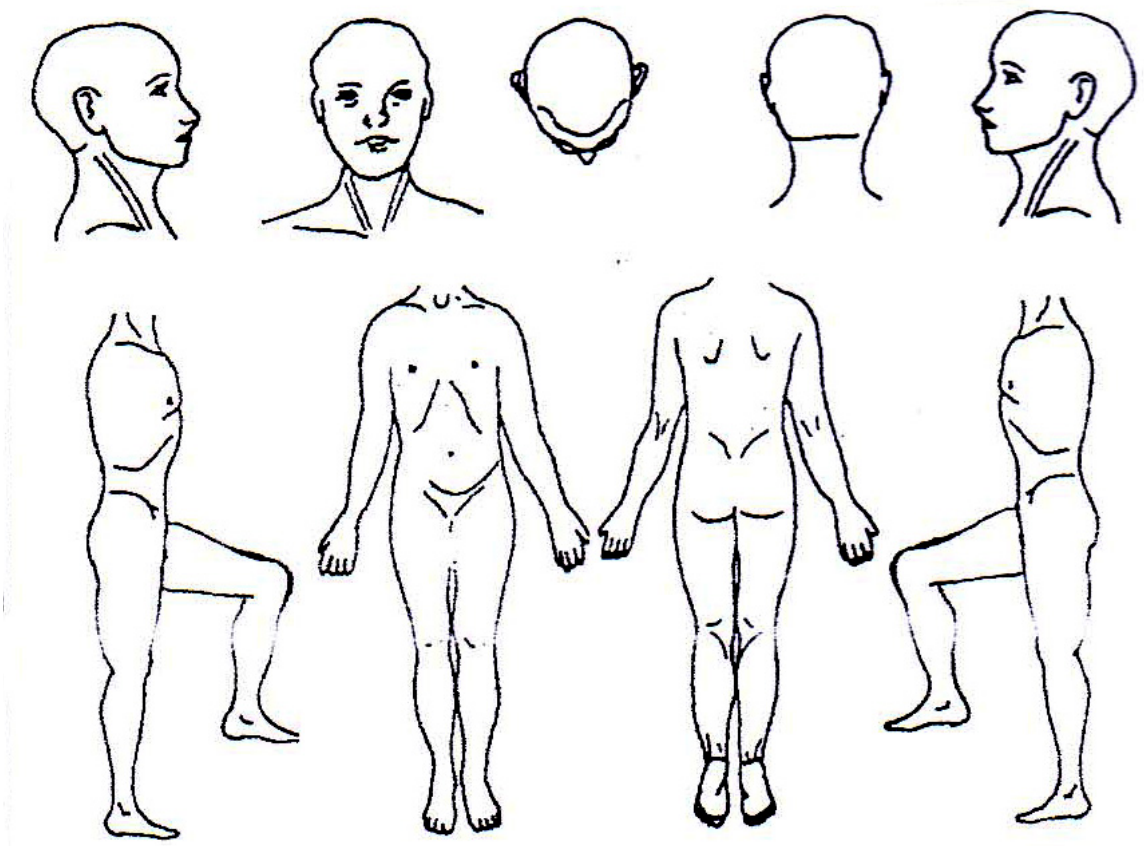
13. Since the alleged offence took place has the person (Indicate with X)

bathed☐ washed☐ douched☐ showered☐ urinated☐ changed clothing☐

History of assault in Victim's own words **(Please include details of perpetrator if known to survivor)**:

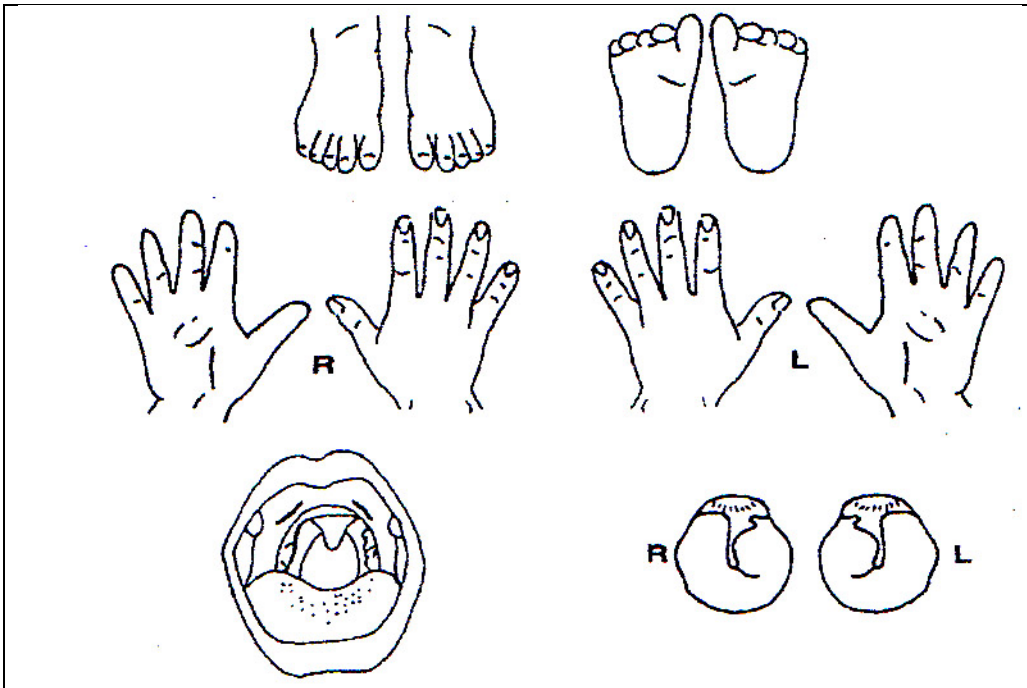
Relevant Medical History and Medication

C. GENERAL EXAMINATION		
1. Condition of Clothing		
2. Height (cm)	3. Weight (Weight)	4. General Body Build
5. Clinical findings in every case the nature position and extent of the abrasion would or other injury must be described and noted together with its probable date and manner of causation the position of all injuries and wounds must also be noted on the sketches.		
6. Mental health and emotional status		
7. Clinical evidence of drugs or alcohol		
8. Conclusion **Signature of Medical Practitioner:** **……**		



Signature of Medical Practitioner:

.....

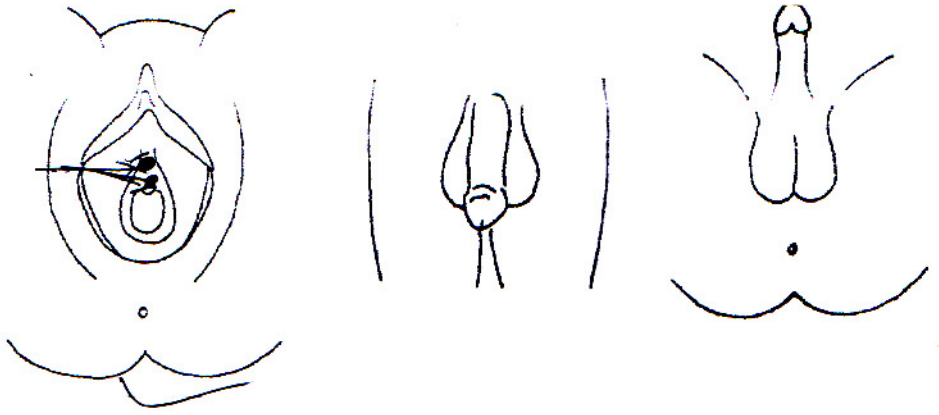


Signature of Medical Practitioner:

.....

D. GYNAECOLOGICAL EXAMINATION (State Clinical Findings)

1. Breast development tanner stage 1-5 ☐	2. Pubic hair tanner stage 1-5 ☐	3. Mons pubis
4. Clitoris	5. Frenulum of clitoris	
6. Urethral orifice	7. Para-urethral folds	
8. Labia Majora	9. Labia minora	
10. Posterior fourchett: Scanning lears	bleeding increased friability	
11. Fossa navicularis		
12. Hymen configuration	13. Operating diameter (mm) Transverse ☐☐	Vertical ☐☐
14. Swelling	15. Bumps	16. Clefts
17. Fresh tears (position)	18. Synechiae	19. Bruising
20. Vagina: numbers of fingers admitted	bleeding: discharge	tear:
21. Cervic	erosion bleeding	discharge other
22. Penneum		



Signature of Medical Practitioner:

.....

E. ANAL EXAMINATION (State clinical findings)

SKIN SURROUNDING THE ORIFICE

1. Hygiene	4. Abrasions:	7. Redness / erythema:
2. Segmentation: haematoma:	5. Scars:	8. Bruising /
3. Fissures / cracks:	6. Swelling / thickening:	9. Tags:

ORIFICE

10. Tears / tissues: winking:	13. Reflex dilatation:	16. Twitchiness /

11. Swelling /thickening of rim (tyre sign):	14. Shortening / eversion of anal canal:	17. Discharge:
12. Funneling:	15. Cupping	

DIGITAL EXAMINATION

18. Presence of hard faeces in rectum: 20. Thickening of anal verge:

19. Laxity (pressure on anal orifice): 21. Tone (sphincter grip):

22. CONCLUSION:

F. SAMPLES TAKEN FOR INVESTIGATION

1. Forensic specimen taken: Urine sample for pregnancy: positive ☐ negative ☐	Seal number of evidence collection kit:
2. Specimen handed to: Name: Signature:	Rank and Force number:

3. Other specimen taken:

HIV Test	positive ☐	negative ☐
HBSAg		
VDRL		
ECS m/c/s		
HVS m/c/s		
Other test (Pls state)		

Name of Chaperon: …….. **Signature of Chaperon: ……**

4. **CONCLUSION:**

Date of follow up visit: …… **Signature of Medical Practitioner: ……**