Guidelines for the Clinical Management of Child Sexual Abuse

January 2011
Foreword

The fact that child sexual abuse (CSA) in sub-Saharan Africa is a significant problem, affecting millions of children in the region, can no longer be disputed. A comprehensive review of the literature on CSA in sub-Saharan Africa conducted by the East Central and Southern African Health Community (ECSA-HC) in 2010 confirms this fact. In particular, the findings confirm the dire need for a coordinated and holistic response based on a full and proper understanding of children’s rights.

The health sector is a critical part of this coordinated and multisectoral response to ensure that CSA survivors receive quality comprehensive health services to cope with the physical and mental health consequences of the abuse they have suffered and to aid their long-term recovery and rehabilitation following the traumatic event(s). In addition, health care workers are in a position to collect and document the critical evidence needed to corroborate accounts of the assault in the criminal justice system.

The 54th session of the World Health Organization Regional Committee for Africa in September 2004, recommended the development of standardized protocols for clinical care and management of CSA. Many challenges were discussed in the session, notably the prevention and management of CSA which would be integrated into the existing child and adolescent health services, especially at the primary health care level.

At the sub-regional level, ECSA Health Ministers have acknowledged the importance of addressing gender-based violence, including CSA with the adoption of three resolutions in the past five years urging member states to prioritize and accelerate action to end this pervasive human rights issue that has significant public health consequences. In response to these calls for action, ECSA-HC and WHO-AFRO have been committed to providing technical assistance to countries for the development and implementation of tools and guidelines to raise awareness of and build capacity to address the issue.

These Guidelines for the Clinical Management of Child Sexual Abuse recognize that sexual abuse of children is a unique phenomenon where the dynamics are often very different from those of adult sexual abuse. Therefore abuse of this nature cannot be handled in the same way as
adults and special provisions must be made for child survivors of sexual abuse within national health systems.

It is our sincere hope that these generic guidelines will contribute to improving the health sector efforts towards the prevention and management of CSA. We envision that the guidelines will be adapted by member states and made available for implementation in all health facilities to protect and care for our children that are being affected widely by this silent scourge.

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January 2011
Acknowledgements

The East, Central, Southern African Health Community (ECSA-HC) would like to acknowledge the valuable contributions and support of several partners in producing the *Guidelines for the Clinical Management of Child Sexual Abuse*.

This document builds on the extensive work done by the World Health Organization (WHO) in this area. The WHO 2003 *Guidelines for Medico-legal Care for Victims of Sexual Violence* formed the basis for the compilation of these guidelines for children, in addition to the national clinical management guidelines for rape survivors from the ECSA region, specifically Kenya, South Africa, Malawi, Namibia and Zambia.

The development of the guidelines has been a collaborative process and ECSA-HC would particularly like to thank Dr. Jonathan Kaunda Mwansa for leading the writing of this document. We are very appreciative of the inputs from the technical working group we established to guide our work in addressing child sexual abuse in sub-Saharan Africa, with representation from the following organizations:

- Africa’s Health in 2010 Project (managed by AED)
- ECSA member states
- Population Council
- Sexual Violence Research Initiative
- UNFPA- Tanzania
- UNICEF-ESARO
- USAID-Tanzania
- WHO-AFRO

We would also like to acknowledge those who participated in the technical consultation, during which time a draft of this document was reviewed, for their valuable inputs on the relevance of these guidelines for Africa.
The development of these guidelines has been possible through the generous support of the United States Agency for International Development (USAID) Bureau for Africa, through the Africa’s Health in 2010 Project.
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## Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>3TC</td>
<td>Lamivudine</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
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<td>AZT</td>
<td>Zidovudine</td>
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<tr>
<td>ARV/ART</td>
<td>Anti-retro Viral Therapy</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organization</td>
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<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
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<tr>
<td>DNA</td>
<td>Deoxyribonucleic acid</td>
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<tr>
<td>ECSA</td>
<td>East, Central and Southern Africa</td>
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<td>ECSA-HC</td>
<td>East, Central, Southern African Health Community</td>
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<tr>
<td>ELISA</td>
<td>Enzyme-Linked Immuno-Sorbent Assay</td>
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<tr>
<td>EC</td>
<td>Emergency Contraception</td>
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<tr>
<td>ECP</td>
<td>Emergency Contraception Pill</td>
</tr>
<tr>
<td>FBC</td>
<td>Full Blood Count</td>
</tr>
<tr>
<td>GBV</td>
<td>Gender-Based Violence</td>
</tr>
<tr>
<td>HB</td>
<td>Haemoglobin</td>
</tr>
<tr>
<td>HBV</td>
<td>Hepatitis B Virus</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
</tr>
<tr>
<td>HSV</td>
<td>Herpes Simplex Virus</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscularly</td>
</tr>
<tr>
<td>IU</td>
<td>International Unit</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PEP</td>
<td>Post Exposure Prophylaxis</td>
</tr>
<tr>
<td>PTSD</td>
<td>Post Traumatic Stress Disorder</td>
</tr>
<tr>
<td>SGBV</td>
<td>Sexual and Gender-Based Violence</td>
</tr>
<tr>
<td>SSA</td>
<td>Sub-Saharan Africa</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
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<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
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<tr>
<td>UNCRC</td>
<td>United Nations Convention on the Rights of the Child</td>
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<td>UNFPA</td>
<td>United Nations Population Fund</td>
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</table>
UNICEF  United Nations Children’s Fund
VCT   Voluntary Counselling and Testing for HIV
WHO  World Health Organization
WHO-AFRO World Health Organization Regional Office for Africa
Chapter 1: Introduction

1.1 Background

Child sexual abuse (CSA) is a development and human rights issue with immediate and long-term public health consequences. Globally, an estimated 150 million girls and 73 million boys under 18 years have experienced some form of sexual abuse.¹ A comprehensive literature review on CSA in sub-Saharan Africa (SSA) conducted by the East, Central, and Southern African Health Community (ECSA-HC) confirms that African children are in danger of experiencing CSA across multiple settings in their lives including within the home, community, and the broader society.² For example:

- Lifetime exposure to sexual violence was reported by an average of 23% (9-33%) 13-15 year old school children from Namibia, Swaziland, Uganda, Zambia, and Zimbabwe.³
- High levels of sexual coercion at sexual debut were reported by 12-19 year old girls in four countries: In Malawi, 38% of those surveyed said they were “not willing at all” at their first sexual experience followed by Ghana (30%), Uganda (23%) and Burkina Faso (15%).⁴
- 1 in 3 females (13-24 years) in Swaziland have experienced some form of sexual violence in their life. Among incidents that occurred prior to age 18, a third (33%) occurred in females’ own home; 23% occurred in the house of a friend, relative, or neighbor; 19% occurred in a public area/field; 10% occurred in a school building or on school grounds; and 9.5% occurred on the way to or from school.⁵
- Over 92 million females over age 10 are estimated to be living with the consequences of female genital mutilation/cutting (FGM/C) in Africa, with about three million new cases a year.⁶
- Early marriage is generally more prevalent in Central and West Africa – affecting 40% and 49% respectively of girls under 19 – compared to 27% in East Africa and 20% in North and Southern Africa.⁷

Children are especially vulnerable to sexual abuse by nature of their economic dependence, lack of political protection, and relatively weak social position.⁸ Child sexual abuse in SSA
occurs against the backdrop of high levels of poverty; gender inequalities, including high rates of gender-based violence; and the havoc wreaked by the HIV/AIDS epidemic to family and community structures.

Despite the pervasive nature of CSA in SSA, it is surrounded by a culture of secrecy, stigma and silence. This is the case for a multitude of reasons including: CSA is seen as a private matter, especially when the perpetrator is within the family; denial, shame, guilt; fear of social stigma; and lack of awareness of individual rights, what constitutes abuse and when and how to report it. The habitual perpetrator is usually someone who is known and trusted by the child, is within or close to the family or has authority over the child.

In SSA, children are relatively more likely to present to police or health facilities than adults after being sexually abused. However, the medical, psychological and legal needs of survivors, especially of children, are not yet adequately addressed in SSA. Many sub-Saharan African countries do not have comprehensive post-rape care services and there are significant gaps in coordination and communications between sexual and reproductive health and HIV services, legal and judicial systems, and sexual violence legislation.

Sexual abuse of children is a unique phenomenon - the dynamics are often very different from those of adult sexual abuse, and therefore abuse of this nature cannot be handled in the same way as adults. For example, children tend to disclose as part of a process rather than a single event, over a longer period of time than adults, which can have negative implications for medical management and the collection of forensic evidence.

It is against this background that ECSA-HC, in collaboration with WHO-AFRO and other partners, has compiled this set of generic clinical management guidelines to emphasize and improve the management of survivors of child sexual abuse in the region.

1.2 Purpose, Objectives and Target Audience

The purpose of these guidelines is to standardize the care of sexually abused children. The specific objectives are to:
(i) Provide standards for medical care; psychosocial care; and collection of forensic evidence for child survivors of sexual abuse

(ii) Equip health providers with guidelines on the examination, treatment, and management of child survivors of sexual abuse

These guidelines were developed for use by a wide range of health care professionals managing child survivors of sexual abuse including doctors, nurses, expert witnesses in a court of law, legal specialists, etc.

1.3 Rationale

The health sector is at the nexus of prevention, treatment and rehabilitation of sexual abuse. The responsibilities of health care providers managing CSA survivors are complex. Health care providers need to not only identify and recognize sexual abuse in children and provide comprehensive care to address their physical and mental needs, but should also be capable of handling their medico-legal needs. Medico-legal services involve the collection and documentation of evidence from survivors of sexual abuse in order to corroborate accounts of the assault in the criminal justice system. Furthermore, the evaluation of children requires special skills and techniques in history taking, forensic interviewing and examination. Health care providers should also be aware of their obligations with respect to national laws requiring mandatory reporting of cases of child abuse to the local authorities or police.

Although some progress has been made in the past decade around post-rape health care in SSA especially in Kenya, Malawi and South Africa, health services continue to struggle to meet both the physical and psycho-social needs of survivors due to the lack of policy, poorly developed services and untrained health workers. Much of SSA lacks tools for medical, legal and educational institutional workers such as doctors, nurses, university lecturers, expert witnesses in a court of law and legal specialists to use in the management and support of CSA survivors. There is a clear need for the current focus on adult medical management of sexual abuse to be balanced with protocols relating specifically to child survivors.
These guidelines were developed to help fill this gap and aim to improve the clinical management of CSA in SSA. These generic guidelines can be adapted for use at different levels of the national health system.

1.4 Methodology

The guidelines were developed mainly by reviewing and adapting existing WHO guidelines for clinical management of rape survivors\textsuperscript{12, 15} and available national guidelines for the management of rape and sexual assault in the ECSA region.\textsuperscript{a} The document draws primarily from the World Health Organization’s (WHO) \textit{Guidelines for Medico-legal Care for Victims of Sexual Violence}.\textsuperscript{12} Additions and adaptations were made to these guidelines for addressing the needs of children in African settings. The draft guidelines were reviewed during an expert technical consultation that ECSA-HC convened in August 2010 on addressing child sexual abuse in sub-Saharan Africa.\textsuperscript{16}

1.5 Definitions

The definition of CSA adopted by these guidelines is the one formulated by the 1999 WHO Consultation on Child Abuse Prevention which states that:

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 consent, or that which violates the laws or social taboos of society.”\textsuperscript{17}

The definition of a child for the purpose of this document is that adopted by both the United Nations Convention on the Rights of Child (UNCRC) and the African Charter on the Rights and Welfare of the Child (the African Charter), which defines a child as being a person below the age of 18 years.\textsuperscript{18, 19}

\textsuperscript{a} National Guidelines from Kenya, Malawi, South Africa, Namibia and Zambia were reviewed.
Chapter 2: Medical Management of Child Sexual Abuse

The evaluation for sexual abuse includes history-taking, physical examination, forensic evidence collection and screening for sexually transmitted infections (STIs). If possible, the evaluation should be performed by a trained and skilled examiner. Consultation with a regional child abuse specialist or assessment center may be helpful in difficult cases, or in cases that occur in the context of other family problems such as family violence or substance abuse.

Urgent evaluation is necessary in all cases and particularly under circumstances such as: abuse within the previous 72 hours, presence of genital or anal injuries requiring treatment, forensic evidence that must be collected immediately, when there is danger of re-abuse or reprisal by the alleged perpetrator and when the victim has reported homicidal or suicidal ideation. It is useful for countries to develop an algorithm/flowchart to guide health providers on the entire process of managing children who have been sexually abused. The experts reviewing this document developed a prototype algorithm that can serve as a reference and be adapted to the local context (Annex 1).

2.1 Physical and Behavioral Indicators of Child Sexual Abuse

There are many broad, non specific indicators of child sexual abuse, and these can be divided into two categories, physical and behavioural (Table 1). 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. Consider sexual abuse if the child complains of sexual abuse, but the absence of signs does not preclude child abuse. Children can display a broad range of abuse-related behaviors even in the absence of any reason to believe they have been sexually abused. Possibly, the most important tool is to encourage parents to communicate with their children about the simple rules surrounding good and bad secrets e.g. “Bad secrets are what another adult tells you not to tell your parents.”
### Table 1. Physical and Behavioral Indicators of Child Sexual Abuse

<table>
<thead>
<tr>
<th>Physical Indicators</th>
<th>Behavioral Indicators</th>
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<tbody>
<tr>
<td>Unexplained genital injury</td>
<td>Regression in behaviour, school performance or</td>
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<td></td>
<td>attaining developmental milestones</td>
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<tr>
<td>Recurrent vulvovaginitis</td>
<td>Acute traumatic response such as clinging behavior and</td>
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<td></td>
<td>irritability in young children</td>
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<tr>
<td>Vaginal or penile discharge</td>
<td></td>
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<tr>
<td>Bedwetting and fecal soiling beyond the usual age</td>
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<tr>
<td>Anal complaints (e.g. fissures, pain, bleeding)</td>
<td></td>
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<tr>
<td>Pain on urination</td>
<td></td>
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<tr>
<td>Urinary tract infection</td>
<td></td>
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<tr>
<td>STIs(^a)</td>
<td></td>
</tr>
<tr>
<td>Pregnancy(^b)</td>
<td></td>
</tr>
<tr>
<td>Presence of sperm(^b)</td>
<td>Inappropriate sexualized behaviors(^c)</td>
</tr>
</tbody>
</table>

Source: WHO 2003. Guidelines for Medico-legal Care of Victims of Sexual Violence.\(^{12}\)

\(^a\) Considered diagnostic if perinatal and iatrogenic transmission can be ruled out.

\(^b\) Diagnostic in a child below the age of consent.

\(^c\) No one behavior can be considered as evidence of sexual abuse; however, a pattern of behaviors is of concern.

### 2.2 Preparations for Management of a Sexually Abused Child

A survivor is often in a heightened state of awareness and very emotional after an assault due to circulating stress hormones. Consequently, events may be recalled in dramatic detail. Many survivors of sexual assault have described the kindness of the health personnel as being beneficial to their recovery. Conversely, many describe comments made by police, doctors, counselors and others, with whom they have had contact as a result of the assault, as having haunted them for years. This could be exacerbated in children. For this reason, health workers must choose their words with great care when dealing with sexual assault patients and not contribute in any way to re-victimization.
It is imperative to observe some techniques when dealing with all CSA survivors.

- Treat the child with respect and dignity throughout the entire examination irrespective of their social status, race, religion, culture, sexual orientation, lifestyle, sex or occupation
- Greet the patient by her/his preferred name: this will make her/ him your central focus
- Introduce yourself to the patient and tell her/him your role, i.e. physician, nurse, health worker, counselor
- Aim for respectful attitude and be quite professional within the boundaries of your patient’s culture
- Have a calm demeanor; a survivor who has been frightened and has experienced fear wants to be in the company of people who are not frightened
- Be unhurried; give time
- Maintain eye contact as much as is culturally appropriate
- Be empathetic and non-judgmental as your patient recounts her/his experiences

Many survivors cite fear of not being believed as a reason for not reporting sexual assault and, indeed, recovery can be hindered when others disbelieve or blame the patient for the assault. Validation of the patient’s feelings is thus critical to recovery. Body language, gestures and facial expressions all contribute to conveying an atmosphere of believing the patient’s account. However, this does not relieve the health worker from his/her duty to consider carefully what they are being told. There is a big difference between scepticism and naiveté, and it is in between these polarities that the health worker can best satisfy the differing needs of patient, law enforcement, criminal justice system and the wider society. To be seen to be impartial is vital for effective court testimony.

2.3 Obtaining Consent

The purpose of obtaining informed consent is to provide survivors with information about all aspects of the consultation, including options open to them in order to enable them to make informed decisions about their care.
Before a full medical history and examination is conducted, it is essential that informed consent is obtained by ensuring the survivor (parent/guardian in case of children below the age of comprehension) fills in the consent form (Refer to Annex #2 for sample form). However, this provision is not applicable when the care provider reasonably believes the parent(s) or guardian committed the sexual assault on the aforementioned. It is crucial that the survivor understands the options open to them and are given sufficient information to enable them make informed decisions about their care.

2.4 Taking a History

The purpose of history-taking is to obtain routine, background information relating to the medical history of the child, as well as information about any medical symptoms that have arisen, or may result from, the abuse.

It is important for the health worker to create a safe and trusting environment for the interview and eventual examination. Ideally, a history should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly; however, this may not always be possible. Nonetheless, it is important to gather as much medical information as possible. Older children, especially adolescents are frequently shy or embarrassed when asked to talk about matters of a sexual nature. It is a good idea to make a point of asking whether they want an adult or parent present or not; adolescents tend to talk more freely when alone.

History-taking from children, particularly the very young, requires special skills. Try to establish the child’s developmental level in order to understand any limitations as well as appropriate interactions. When gathering history directly from the child it may be worth starting with a number of general, non-threatening questions, for example, “What standard are you in at school?” and “How many brothers and sisters do you have?”, before moving on to cover the potentially more distressing issues. Be non-leading, non-suggestive and document all information as close to verbatim as possible, including observations, interactions, and emotional states of the child and his/her family.

The following pieces of information are essential to the medical history; suggested phrasing of the corresponding questions, if directed to children, is given alongside in italics:
- Last occurrence of alleged abuse (younger children may be unable to answer this precisely). *When do you say this happened?*

- First time the alleged abuse occurred. *When is the first time you remember this happening?*

- Threats that were made, if any

- Nature of the assault, i.e. anal, vaginal and/or oral penetration. *What area of your body did you say was touched or hurt?* (The child may not know the site of penetration but may be able to indicate by pointing. This is an indication to examine both genital and anal regions in all cases)

- Whether or not the child noticed any injuries or complained of pain

- Vaginal or anal pain, bleeding and/or discharge following the event. *Do you have any pain in your bottom or genital area? Is there any blood in your panties or in the toilet?* (Use whatever term is culturally acceptable or commonly used for these parts of the anatomy)

- Any difficulty or pain with voiding or defecating. *Does it hurt when you go to the bathroom?*

- Any urinary or faecal incontinence

- First menstrual period and date of last menstrual period (girls only)

- Details of prior sexual activity (explain why you need to ask about this)

- *Have you had sex with someone because you wanted to?*

- History of washing/bathing since (a recent) assault

When the history has been completed, the healthcare provider can help the child to prepare for the examination by discussing the procedures, assuring the child that the examination is intended to ensure he/she is “all right,” and that no part of the body has been harmed.

### 2.5 General Physical Examination

Physical examination goes hand in hand with evidence collection. The tasks of forensic examination include documenting physical findings; collecting evidence for law enforcement agencies and forensic laboratories; meeting the legal requirements for the collection, storage and transfer of the evidence collected; and creating a complete and accurate medical record that can be presented in a court of law.
A young child should normally be examined in the presence of the parent or guardian who will be able to help in reassuring the child. Ensure there is a support person or trained health worker in the examination room who is the same sex as the survivor.

The physical examination of children should consist of a head-to-toe review and a detailed inspection of the whole body including the genito-anal area (Refer to Annex #3). Examine the survivor's clothing with a good light source before s/he undresses. Collect any foreign debris on the clothes, skin or in the hair (e.g. soil, leaves, grass or foreign hairs, saliva or any other fluids on the child's body or clothing). Collect torn and stained items of clothing, but only do so if you can give replacement clothes or if s/he has some other clothes.

When performing the head-to-toe examination of children it is important to include the following:

- Record the height and weight of the child (neglect may co-exist with abuse).
- Note any bruises, burns, scars or rashes on the skin. Carefully describe the size, location, pattern and color of any such injuries.
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Check for any signs that force and/or restraints were used, particularly around the neck and in the extremities.
- Record the child’s sexual developmental (Tanner) stage and check the breasts for signs of injury (Refer to Annex#4 for the Stages of Puberty in the Female)
- Collect samples from all places where there could be semen on the skin, with the aid of a cotton bud swab, lightly moistened with sterile water, the survivors’ pubic hair may be combed for foreign hairs.
- Take samples and swab the oral cavity if ejaculation took place in the mouth, for direct examination for sperm, and acid phosphatase analysis.

2.5.1 Prepubertal Girl’s Examination

For a young girl, the examiner should focus on the external genital anatomy. The emphasis is on “taking a look, not touching the vagina.”21 Inspect and swab the skin around the anus, the
perineum and vulva (in that order) with cotton-tipped swabs moistened with sterile water. In order to conduct the genital examination in girls, it is helpful to ask the child to lie on the examination table or in the caregiver’s lap using the frog-leg position (Fig. 1), and/or, if comfortable, in the knee chest position. A good light source is essential.

Figure 1. The Frog-leg Position

Look for swellings, bruises, any signs of infections, such as ulcers, vaginal discharge or warts. Collect vaginal specimen with a dry sterile cotton swab.

Examinations of most children with substantiated abuse are normal, in which case the definite diagnosis of sexual abuse will rely on good history taking.

In girls, the external genital structures to be examined are:

- Mons pubis
- Labia minora and majora
- Clitoris
- Urethra
- Vaginal vestibule
- Hymen
- Fossa navicularis
- Posterior fourchette

Digital examination (assessing the size of the vaginal orifice by number of digits inserted) is NOT recommended.
The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration. In most cases, the hymen and surrounding structures will be easily identified. If not, the following technique may be useful for assessing the visualization of the hymen and surrounding structures to check for signs of injury:

- Separate the labia with gentle lateral movements or with anterior traction (i.e. by pulling labia slightly towards examiner as shown in figures 2 and 3).
- Ask the child to push or bear down.

Describe the location of any injuries using the face of a clock, paying close attention to the area between 4 and 8 o’clock, the most probable location of penetrating injury.

**Most examinations in pre-pubertal children are non-invasive and should not be painful. Speculums or proctoscopes and digital or bimanual examinations should NOT be used unless medically indicated. If speculum examination is needed, sedation or anesthesia should be strongly considered.**

If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexae, looking for signs of abdominal trauma, pregnancy and infection. A rectal examination would otherwise suffice.
Figure 2. Gentle labial separation to visualize the structures hidden by redundant skin folds clearly

Figure 3. Further gentle separation with minimal traction to expose hidden structures without causing harm to the child
2.5.2 Adolescent Girl's Examination

The adolescent girl should receive a thorough description of each part of the genital examination in advance, and she should be given a sense of control over the tempo of the examination. She should be allowed to have someone—nurse, friend, or mother—present during the examination if she desires. She is given a gown and sheet and asked to remove her clothes while the clinician is out of the room.

At the minimum, the external vulva and hymen should be inspected with the patient in lithotomy position, and the edges of the hymen assessed by visual inspection. Evidence of transection of the hymen can be assessed by running a saline moistened cotton-tipped applicator around the hymen. Normal hymens in girls who have never been sexually active are extremely unlikely to have “complete cleft” on the lower half. Other genital trauma also should be evaluated. A one-finger water-moistened gloved digital examination (without lubricant) could be done to allow the clinician assess the feasibility of a speculum examination (the smallest useful speculum for adolescent—Huffman speculum—is available and can be inserted without discomfort to allow improved visualization of the cervix and forensic sample collection).

2.5.3 Examination of a Boy

In boys (Fig.4), the genital examination should include the following structures and tissues checking for signs of injury (i.e. bruising, lacerations, bleeding and discharge):

- The glans penis and frenulum
- Urethral orifice
- Prepuce and gentle retraction for the uncircumcised
- Shaft
- Scrotum
- Testicle and epididymis
- Inguinal region
- Perineum
2.5.4 Anal Examination in Both Boys and Girls

In order to examine the anal area (in both boys and girls), place the child in the supine or lateral position and apply gentle traction (Figures 5 and 6) to part the buttock cheeks. Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of sodomy, but also of constipation. Avoid the knee-chest position for the anus, as the assailant often uses it. During the course of an anal examination the following tissues and structures should be inspected, again looking specifically for signs of injury and discharge:

- Anal verge tissues
- Ano-rectal canal
- Peri-anal region and gluteal cleft

Digital examination to assess anal sphincter tone is not recommended.
Figures 5 and 6, showing the anal examination technique in both boys and girls
2.5.5 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 prepubertal girls. A genital examination with normal findings does not, therefore, 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. If hymenal abnormalities are observed when the child is in the dorsal position (i.e. lying on her back), she should also be examined in the knee-chest position to exclude gravitational effects on these tissues.

Physical genito-anal findings are listed below, grouped according to their strength of evidence for sexual abuse and ranging from normal to definitive:

- **Normal and non-specific vaginal findings** include:
  - Hymenal bumps, ridges and tags
  - V-shaped notches located superior and lateral to the hymen, not extending to the base of the hymen
  - Vulvovaginitis, labial agglutination

- **Normal and non-specific anal changes** include:
  - Erythema, fissures, midline skin tags or folds
  - Venous congestion
  - Minor anal dilatation
  - Lichen sclerosis
Anatomical variations or physical conditions that may be misinterpreted or often mistaken for sexual abuse include:

- Lichen sclerosis
- Vaginal and/or anal streptococcal infections
- 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, penis, scrotum or perineum
- 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)
- Condyloma in children over the age of 2 years
- 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

After the examination, the child should be asked to dress in private. Reassurance is an important part of the examiner’s role. Even if findings are present, children can usually be reassured that they will heal nicely.
2.5.6 Differential Diagnosis

Misdiagnosis of sexual abuse can be traumatic for everyone involved. Thus, the differential diagnosis of sexual abuse must be carefully considered in all children, particularly those who present with nonspecific genitourinary complaints or behavioural disturbances and do not volunteer a history of abuse.

The differential diagnosis of child sexual abuse includes other types of genital injury, infection, dermatologic conditions, congenital conditions affecting the perineum, and other conditions affecting the urethra or anus.

2.5.7 Emergency Care

The child should be treated according to the findings. Life threatening emergencies should be attended to as a matter of urgency. Patients with severe, life-threatening conditions or physical injuries should be referred for emergency treatment immediately. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated in situ by the examining health care worker or other nursing staff. 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 (TT) or vaccination (according to local protocols);
- Medications for the relief of pain, anxiety or insomnia.

2.5.8 Disability and CSA

In case of an individual with disability, there is an additional phenomenon associated with sexual abuse referred to as disability-related abuse, in which the perpetrators withhold needed equipment and assistance to coerce sexual contact. In addition, the presence of a disability increases the risk of sexual abuse. A well-thought through history and examination is required while collecting all the necessary forensic evidence as in the case of individual without disability.

2.5.9 Female Genital Mutilation (FGM) as a Form of CSA

Children with FGM should be examined just as those with or without disability. The examiner is advised to stage the FGM as shown in Annex #5.
2.5.10 STI Diagnosis and Treatment

The identification of an STI in a prepubertal child or an adolescent who has not become sexually active may be evidence that the child has been sexually abused. In utero (vertical) transmission (e.g. HIV, syphilis), perinatal acquisition via cervical secretions (e.g. Gonorrhoea, Chlamydia, Human Papilloma virus (HPV), Herpes Simplex virus (HSV), direct contact with infected secretions as a result of non-sexual contact or fomite transmission (extremely rare) should be ruled out, however.

When evaluating a child, and there is need for STI screening, it is important know when the abuse occurred, as STI cultures are likely to be negative, unless the child has a pre-existing infection. A follow-up visit one week after the last sexual exposure may be necessary in order to repeat the physical examinations and to collect appropriate specimen for STI testing.

If STI testing is deemed appropriate, the following should be performed as part of the initial and follow-up examinations:

- Cultures for *Neisseria gonorrhoea* and *Chlamydia trachomatis*, using only standard culture systems
- Wet-mount microscopic examination of vaginal swab specimen for *Trichomonas vaginalis*
- Dark-field microscopy or direct fluorescent antibody testing of specimen(s) collected from vesicles or ulcers for *Treponema pallidum*; where available, tissue culture for HSV
- Collection of a serum sample for analysis in the event of positive follow-up tests, or, if the last incident of sexual abuse occurred more than 12 weeks before the initial examination, immediate analysis for antibody to sexually transmitted agents.

In pre-pubertal children, swabs for STIs are only indicated where symptoms (e.g. vaginal discharge, pain) are present. Genital swabs in pre-pubescent children should be taken from the vaginal orifice or canal. Cervical specimens are only required in adolescents (i.e. those at Tanner stage II of puberty or later), as adolescents may have asymptomatic infections. Presumptive treatment for infection should be offered in all sexually abused children. Children and adolescents who test positive for an STI should be treated according to the local or national protocol.
Table 2. Prophylaxis for Sexually Transmitted Infections

<table>
<thead>
<tr>
<th>Children aged &lt;7</th>
<th>Amoxycillin 15mg/kg tds 1/52</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Erythromycin 10mg/kg qds 1/52</td>
</tr>
<tr>
<td>Children aged &gt; 7</td>
<td>Norfloxacin 800mg stat dose</td>
</tr>
<tr>
<td></td>
<td>Doxycycline 100mg bd 1/52</td>
</tr>
</tbody>
</table>

2.5.11 HIV Testing and Post-Exposure Prophylaxis

Sexual assault survivors should be offered a baseline HIV test, following an informed consent. If there are appropriate facilities for confidential HIV testing and counseling, this could be done on-site. Alternatively, the patient could be referred to an HIV specialist or to a center that specializes in confidential HIV testing and counseling. Appropriate counseling services should be made available before and after HIV testing. Ideally, these services should be available on site. If not, the appropriate referrals should be arranged.

Post-exposure prophylaxis for HIV is an area where practice is changing frequently. For these reasons health workers are strongly urged to:

- maintain knowledge of the current recommendations in this field
- familiarize themselves with local or national policy and/or guidelines
- ensure that they are aware of the costs, risks and benefits of the various regimes so that they are able to fully inform their patients of these issues

The risk factors for acquiring HIV from a sexual assault will determine whether or not PEP should be offered to a patient. Health workers should refer to local protocols dealing with PEP, if they exist. The child and health worker must evaluate the risks and benefits of initiating or refraining from PEP treatment and decide together the best option for the patient. The child and his/her family needs to be fully informed of the following:

- the limited data regarding the efficacy of PEP
- possible side effects of the medications
- the need for strict compliance when taking the medications
- length of treatment
- importance of follow-up
the need to begin treatment immediately to maximize effect of medications

If prescribed, PEP should be initiated within 72 hours of an assault and be given for 30 days. Patient liver enzyme levels should be measured and a complete blood count (CBC) made prior to the commencement of PEP (to establish baseline values) and then monitored at regular intervals until the treatment has been completed. If the initial test results for HIV were negative, patients should have the test repeated at 6, 12 and 24 weeks after the assault. If available, a professional specializing in HIV infection in children should be consulted prior to prescribing PEP.

Recommended drugs depend on local or national protocols. Lamivudine (3TC), Stavudine (d4T) and Zidovudine (ZDV/AZT) are usually used (Table 4). Some experts recommend the addition of a third ARV to the ZDV and 3TC where that is possible, and more particularly in zones where ARVs are available: Indinavir, nelfinavir, or lopinavir/ritonavir.

Table 3 Recommended PEP Regimen for Children

<table>
<thead>
<tr>
<th>Medicine</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>Zidovudine (AZTZDV)</td>
<td>2mg/kg</td>
</tr>
<tr>
<td>Lamivudine (3TC)</td>
<td>4mg/kg + 3TC</td>
</tr>
<tr>
<td>Lopinavir/Ritonavir (LPV/RTV)</td>
<td>10/2.5 mg/kg</td>
</tr>
<tr>
<td>Stavudine (D4T)</td>
<td>1mg/kg</td>
</tr>
<tr>
<td>3TC 4mg/kg + LPV/RTV10/2.5mg/kg</td>
<td>bd for 28 days</td>
</tr>
</tbody>
</table>

Common side effects include: Nausea, headaches, fatigue, general body malaise etc. Survivors on PEP should be warned of these potential side effects. Hepatotoxicities and nephrotoxities
are least likely in people taking PEP for 28 days, though it is important to take baseline liver and kidney function tests.

2.5.12 Hepatitis B Testing and Prophylaxis

Survivors of sexual violence may be at risk for hepatitis B and should therefore be offered testing and immunization. A variety of hepatitis B vaccines, with varying dosages and immunization schedules, are available throughout the world. Health workers should use the appropriate type of vaccine, dosage and immunization schedule for their local area. The administration of hepatitis B immune globulin (HBIG) or the hepatitis vaccine is not contraindicated in pregnant women.

If the patient has never been 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 (adolescents) or the thigh (infants and children). Do not inject the vaccine in the buttock because it is less efficient if injected in this place. For no completed series of hepatitis B vaccinations, complete the series as scheduled. No need to re-vaccinate completed series of hepatitis B vaccinations.

<table>
<thead>
<tr>
<th>Dosing schedule</th>
<th>Administration schedule</th>
<th>Duration of immunity conferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>1st HBV dose</td>
<td>At first contact</td>
<td>Nil</td>
</tr>
<tr>
<td>2nd HBV dose</td>
<td>4 weeks after 1st dose</td>
<td>1–3 years</td>
</tr>
<tr>
<td>3rd HBV dose</td>
<td>5 months after 1st dose</td>
<td>10 years</td>
</tr>
</tbody>
</table>

2.5.13 Pregnancy Testing and Management

Most adolescent female survivors of sexual violence are concerned about the possibility of becoming pregnant as a result of the assault. If she 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.

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.

Criteria for administering ECPs include:
—risk of pregnancy;
—patient presents for treatment within 5 days 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 foetus).

There are no known medical conditions for which ECP use is contraindicated. Medical conditions that limit the continuous use of oral contraceptive pills do not apply for the use of ECPs. Some jurisdictions require the patient to sign an informed consent form for emergency contraception. Pre-packaged ECPs are available in some, but not all, countries. If pre-packaged pills are not available, other oral contraceptives can be substituted (There are two main categories of ECPs, the combined estrogen-progesterone pill, and the progestin-only pill (i.e. levonorgestrel only). The preferred regimen for emergency contraception is the latter. Relative to the progestin-only pill, the combined estrogen-progesterone pill appears to be more likely to cause side-effects such as nausea and vomiting. With all ECPs, the sooner they are taken after the assault, the more effective they are. The recommended dosing regimens for ECPs depend on local or national protocol; important points are as follows:
- Progestin-only ECPs can be given in a single dose, up to 5 days after unprotected intercourse (Postinor 2 is commonly used).

- 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.

If the patient vomits within 1 hour of taking ECPs the dose needs to be repeated. Patients who are given ECPs prescription must be fully briefed about their medication. Although nausea, vomiting, and breast tenderness have been associated with the use of ECPs in some patients, symptoms are usually only brief and mild. Women may also have some spotting/bleeding after taking ECPs. Serious side effects are rare.

- Female patients should be assessed for the possibility of pregnancy. When available, pregnancy testing kits can be offered. However, most of the testing kits commonly available will not detect a pregnancy before expected menstruation.

- Advise the patient to make sure she gets tested for pregnancy in the event that she misses her next menstruation.

- 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:

— maintain the pregnancy and either keep the infant or give up the infant for adoption;

— terminate the pregnancy (if the health of the patient is at risk).

In order to advise their patients, health workers must have a good working knowledge of the law governing matters of this nature as it applies to their local jurisdiction. In many countries where abortion is otherwise illegal, pregnancy termination is allowed after rape. If a woman wishes to terminate her pregnancy, she should be referred to legal, safe abortion services.

Choices about emergency contraception and pregnancy termination are personal choices that can only be made by the patient herself. Your role is to provide the necessary information to help your patient make the decision that suits her best. Above all, respect your patient’s decision.
Chapter 3: Forensic Examination and Evidence Collection

3.1 Forensic Evidence Collection

A forensic examination is defined as a “medical examination conducted in the knowledge of the possibility of judicial proceedings in the future, requiring medical opinion”. The forensic examination includes documenting physical findings; collecting evidence for law enforcement agencies and forensic laboratories; meeting the legal requirements for the collection, storage, and transfer of the evidence collected; and creating a complete and accurate medical record that can be presented in the courts of law. Although the principal aim of a forensic examination is to serve the needs of the judicial system, there can never be a justification for compromising medical care or treatment of a patient to allow a forensic procedure to be performed.

Material evidence, when identified, is invaluable in the investigation of allegations of sexual abuse. Institutions that provide care to survivors of sexual abuse must have an organized approach to the collection of forensic evidence. Forensic evidence is typically collected using kits that are specified by state or hospital protocol. The instructions for obtaining and labelling specimens must be followed carefully. In addition, the kit must be sealed, stored, and transferred to law enforcement authorities in a manner that maintains an unbroken chain of evidence. The sexual assault kit has a checklist of all the evidence needed to be collected for forensic purposes as well as instructions. Included in the kit is a bar coded consent form to be completed by the health care provider and signed by the survivor.

Depending on the nature of the assault and the severity of the injuries sustained, the patient may require a number of diagnostic tests. 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. Health workers should check with their clinic, hospital or laboratory the type of medical specimens that are required, when and how they should be collected, and how long each test takes to process.

It will be of great benefit to the survivor 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
so. Similarly, the patient will benefit if the forensic examiner is able to provide acute care and/or make referrals as necessary.

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

### 3.2 Purpose of Forensic Specimens

The close encounter of the assailant, survivor and crime scene may result in an interchange of traces of evidence (Loccard’s principle). 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.

On the basis of the facts available and information provided by the survivor and investigators, the health worker must decide which specimens to collect from the individuals involved. When faced with such decisions, it is important to be mindful of what purpose the specimen will serve, what link is potentially going to be established and whether such a link may assist the investigation of the case.

Table 5 lists the 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. Important points to keep in mind when conducting an examination of a survivor of sexual violence with a view to obtaining forensic evidence are as follows:

- 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 survivor pursues legal action on the case.
- It takes time to conduct a thorough forensic examination; the examination usually involves a “top to-toe” inspection of the skin and a genito-anal examination.

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\(^{b}\) Loccard’s exchange principle states that, every contact leaves a trace... wherever he steps, whatever he touches, whatever he leaves, even unconsciously, will serve a silent witness against him. Not only his fingerprints or his footsteps, but his hair, the fibre from his clothes, the glass he breaks, the tool mark he leaves, the paint he scratches, the blood or semen he deposits or collects.” (Kenya National Guidelines on Management of Sexual Violence in Kenya, 2nd ed, 2009.)
Detailed documentation is required and information so recorded may be used in criminal proceedings.

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.

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

Chain of custody of specimens must be documented. This refers to the process of obtaining, preserving and conveying of evidence through accountable tracking mechanisms from the community, health facility and finally to the police. A paper trail in the movement of evidence with regard to collection of samples, analysis, investigation and litigation should be kept.

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

There is a wide range of specimens that could be collected in order to assist the criminal investigation process. It is essential that health workers have a clear understanding of the capabilities and requirements of their forensic laboratory. For instance:

- What specimens can be tested? Refer to Table 5.
- How should individual specimens be collected, stored and transported? It is important to be aware of the fact that all aspects of the collection, transport and analysis of forensic specimens may be subject to legal scrutiny, the results of which may affect the outcome of criminal proceedings.
- How are results made available?

All these questions need to be considered before a forensic service is provided. There is no point collecting specimens that will not or cannot be tested.
### Table 5. Forensic Specimens

<table>
<thead>
<tr>
<th>Site/Sample</th>
<th>Material</th>
<th>Equipment</th>
<th>Sampling instructions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anus (rectum)</td>
<td>Semen</td>
<td>Cotton swabs &amp; microscope slides</td>
<td>Use swab &amp; slides to collect and plate material; lubricate instruments with water, not lubricant; dry swab after collection</td>
</tr>
<tr>
<td></td>
<td>Lubricant</td>
<td>Cotton swab</td>
<td></td>
</tr>
<tr>
<td>Blood</td>
<td>Drugs</td>
<td>Appropriate tube</td>
<td>Collect 10ml of venous blood</td>
</tr>
<tr>
<td></td>
<td>DNA (survivor)</td>
<td>Appropriate tube</td>
<td>Collect 10ml of blood</td>
</tr>
<tr>
<td>Clothing</td>
<td>Adherent foreign material (e.g. semen, blood, hair, fibres)</td>
<td>Paper bags</td>
<td>Clothing should be placed in a paper bag. Collect paper sheet or drop cloth. Wet items should be bagged separately</td>
</tr>
<tr>
<td>Genitalia</td>
<td>Semen</td>
<td>Cotton swabs and microscope slides</td>
<td>Use separate swabs &amp; slides to collect &amp; plate material collected from the external genitalia, vaginal vault &amp; cervix; lubricate speculum with water, not lubricant or collect a blind vaginal swab</td>
</tr>
<tr>
<td>Hair</td>
<td>Comparison with hair found at scene</td>
<td>Sterile container</td>
<td>Brush the hair especially pubic hair, for possible foreign hair</td>
</tr>
<tr>
<td>Mouth</td>
<td>Semen</td>
<td>Cotton swabs, sterile container</td>
<td>Swab multiple sites in mouth with one more swabs. To obtain a sample of oral washings, rinse mouth with 10 ml water and collect in sterile container</td>
</tr>
<tr>
<td></td>
<td>DNA (survivor)</td>
<td>Cotton swab</td>
<td></td>
</tr>
<tr>
<td>Nails</td>
<td>Skin, blood, fibres, etc. (from assailant)</td>
<td>Sterile toothpick or similar or nail scissors /clippers</td>
<td>Use toothpick to collect material from under the nails or the nail(s) can be cut &amp; the clippings collected in a sterile container</td>
</tr>
<tr>
<td>Sanitary pads/tampons</td>
<td>Foreign material (e.g. semen, blood, hair)</td>
<td>Sterile container</td>
<td>Collect if used during or after vaginal or oral penetration</td>
</tr>
<tr>
<td>Skin</td>
<td>Semen</td>
<td>Cotton swab</td>
<td>Swab sites where semen may be present</td>
</tr>
<tr>
<td></td>
<td>saliva (e.g. at sites of kissing, biting or licking), blood</td>
<td>Cotton swab</td>
<td>Dry swab after collection</td>
</tr>
<tr>
<td></td>
<td>Foreign material (e.g. vegetation, matted hair or foreign hairs)</td>
<td>Swab or tweezers</td>
<td>Place material in sterile container (e.g. envelope, bottle)</td>
</tr>
<tr>
<td>Urine</td>
<td>Drugs</td>
<td>Sterile container</td>
<td>Collect 100ml of urine</td>
</tr>
</tbody>
</table>


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3.3 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. Analytical laboratories should be able to provide guidance on special requirements for specimen handling and storage. As a general rule, fluids should be refrigerated; anything else should be kept dry.

- **Label accurately.** All specimens must be clearly labelled 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 specimens have been collected, the subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded. It is advisable to check with local authorities regarding the protocols for the recording of such information.

- **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.

Recognizing that the welfare of the survivors is always the first responsibility of healthcare providers, although forensic examinations can be stressful, survivors often benefit from careful collection of evidence and documentation of findings.
Chapter 4: Psychological, Social, and Community Interventions

4.1 Social, Cultural, and Community-based Assistance

Health services serve as gatekeepers for children on non-accidental injury. These children require intervention from a coordinated and skilled team of health professionals, social workers, NGOs staff and even volunteers, for psychological and social support. Interventions to be provided by the health/medical team are described earlier in Chapter 2. Due to the high number of cases of CSA, social workers need to develop intervention, which address the crisis and facilitate the child's healing process. Social services should be provided in a coordinated fashion, and considered in conjunction with similar services provided by community groups.

Social workers have multiple roles, depending on their training and legal provisions regarding their duties:

- Interviewing role (assessment/facilitate disclosure)
- Therapeutic role (facilitating the healing)
- Empowerment role (teach safety skills)
- Protection role (safety of the child)
- Monitoring role (monitoring and follow up)
- Advocacy role (informing and counseling)

The following general guidelines apply to social workers and counsellors in managing cases of child sexual abuse:

- Provide unconditional acceptance and support to the child and his/her family. Respond to a request for counseling or support as promptly as possible, to ensure that assistance is provided at the time it is most needed, when the complainant is feeling most vulnerable.
- Inform every abused child of the importance of prompt preventative medication for sexually transmitted diseases, including HIV, and pregnancy. Help the complainant to obtain such medication as quickly as possible. Make sure that a problematic financial situation is not hindering the use of such medication, if possible find a sponsor to fund the preventative medication if necessary.
• Provide or arrange transport to the nearest doctor, hospital or clinic if the complainant does not have his/her own transport.

• Make sure that the child receives all necessary medical attention for injury or health problems, which arise in the aftermath of the sexual abuse. It may be necessary to accompany the complainant to the hospital or health facility to ensure that she/he actually gets necessary treatment.

• Make sure that the child knows when to have follow-up tests for, HIV, STIs and pregnancy. If possible, offer to be available to provide additional counseling and support when the child comes in for these follow-up tests.

• Explain to the complainant why pre-and post-test HIV counselling is important, and arrange such counseling sessions for the complainant if he/she wishes to undergo an HIV test. Also arrange for follow up counselling for the complainant with an appropriately qualified HIV/AIDS counsellor in the event of the complainant having contracted HIV as a result of the sexual abuse.

• If the child has become pregnant as a result of the sexual abuse, explain to her options, including adoption and legal abortion. Should she choose adoption or abortion, assist her throughout this process, and provide the necessary support. The complainant may find this process more traumatic than the actual sexual abuse, and she should be supported unconditionally.

• Counsel the complainant and provide her/him with all the necessary psychosocial support. Offer to arrange specific counselling for the complainant at any appropriate stage, and also for other family members. Explain the importance of counselling to the complainant, in order to resolve long-term feelings.

• Prepare the complainant for the court case by explaining the procedure and by physically accompanying the complainant to the courtroom in advance of the trial if he/she wishes.

• Compile a report which could be used in the criminal trial, even if this is not specifically requested. If the prosecutor or the court wants to make use of a social worker report in court, they should request this in writing long enough in advance to allow enough time for proper investigation of all relevant circumstances.

• Keeping in mind that some reactions to sexual abuse may surface only after time has elapsed; make regular follow-up contact with the complainant for at least one year following the abuse. Make sure that the debriefing process continues until after the
trial has come to an end. Maintain continuity by keeping the same social worker if possible.

- Identify local organisation through which the rape complainant might receive support. She/he might want to become a volunteer on issues of combating violence at an appropriate stage, which could be helpful to his/her healing process.

- If possible, set up support groups of persons from the same community who have experienced sexual abuse and offer the complainant the choice of participating in such support groups.

- Keep detailed records of sexual abuse cases. This information may be important if a report is requested for use in the criminal case. It will also help the social worker or counsellor to assess the complainant’s responses and measure her/his recovery process.

- Consider referring the sexually abused child to a specialised agency, a counselling organisation, a psychologist, a child psychiatrist or any other appropriate person or group for information or assistance. A referral involves more than just giving the complainant a name or a telephone number. Collect information about services that are available locally. Try to meet personally with persons and groups who work with survivors in your area for more effective links.

- If the child seems to be in need of specialised services but declines a referral, try to find out the reasons for the refusal to see if there is problem that can be overcome.

Cultural management that do not take account of the child’s best interest, have to be prohibited. A management approach that favors a plug-in complete care, including physical, psychological and social matters should be promoted.

### 4.2 Psychological Assistance

The individual psychological impact is a function, not only of the unconscious senses attributed to the aggression and to the place that this event will occupy in the psychic, but also of the psychological state existing beforehand, with the survivor. Whatever the nature of the aggression, the trauma is not the same for each child. Many sexually abused children may have co-morbid conditions that require specific treatment and support.

The indication for psychotherapy has to be based on the presence or on prevention of the psychological distress, regression or pathological consequences. Similarly, it is necessary to
evaluate if the state of distress seems temporary and surmountable or if it is intensified such that it disturbs the development of the child, encloses him/her in an insurmountable traumatic reaction or crystallizes a psychopathology. Do not forget that each child reacts in a unique manner. General therapeutic orientations aim to:

- help the child to overcome a sharp psychological distress even if it is reactive and temporary
- help the child to proceed to the psychic conflicts management
- help the child to overcome the pathogenic meanings attributed to the aggression.

Thought must be given to providing support and/or counseling to survivors and those caring for the child. This may be required even if the child itself is not assessed as needing therapy. A believing and supportive mother or non-offending caregiver can be a strong determinant for a good prognosis.¹²

The indication of psychotherapy for the child or the adolescent sexually abused cannot be justified without a rigorous evaluation of the victim, her/his needs and desire of care.
Chapter 5: Follow-up Care and Management

5.1 Reporting Abuse

Every community has its own set of laws governing how, and to whom a report regarding suspicion of CSA should be made. Most communities also have a mandatory reporting structure for professionals working with children and in many jurisdictions as a failure to report CSA would constitute a crime. Typically, the reporting law leaves the final determination as to whether or not abuse occurred to the investigators, not the reporters. It is important that health workers are aware of the laws governing the reporting of CSA as it applies in their own area. Not every community will have such legislation, and under these circumstances, the health professional will need to decide on the most effective course of action to take in order to try to protect the child from further abuse.

5.2 Follow-up Treatment

The timing of follow-up examinations is dependent on the nature of the injuries and the conditions being treated. Health care workers are advised to use their own judgement when determining how soon after the initial visit a follow-up examination should be done, allowing for the fact that injuries in the genital area heal very quickly in children. The following conditions warrant special mention:

- If the initial exposure to sexual abuse was recent at the time of the first examination, a follow-up visit at 1-2 weeks may be required to conduct STI testing.

- Blood tests for HIV, hepatitis B and syphilis, whether done at the initial visit or not, may require repeating at 12 weeks, and again at 6 months.

In some cases, a follow-up examination can be viewed more as a psychosocial follow-up measure to ensure that the appropriate counseling referrals have been made and that there is adequate support for the child and family. Some centers use follow-up appointments as an opportunity to provide prevention and safety teaching to children and families.
References

5. Reza A et al. 2007. A National Study on Violence Against Children and Young Women in Swaziland. Swaziland: UNICEF.
Annexes

Annex 1: Algorithm for the Clinical Management of CSA
**Annex 2: Sample Consent Form**


**Name of Facility**

Note to the health worker: Read the entire form to the survivor, explaining that she can choose any (or none) of the items listed. Obtain a signature, or a thumb print with signature of a witness.

I, ................................................................. (print name of survivor) authorize the above-named health facility to perform the following (tick the appropriate boxes):

<table>
<thead>
<tr>
<th>Conduct a medical examination, including pelvic examination</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of finger nails, blood samples, and photographs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide evidence and medical information to the police and law courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Signature.............................................................................
Date......................................................................................

Witness.................................................................................
Annex #3

The “top-to-toe” physical examination
A systematic, “top-to-toe” physical examination of the patient should be conducted in the following step-wise manner. The numbered list of actions refers to the numbered body parts shown in Fig. below.

**Step 1** - First note the patient’s general appearance and demeanor. 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. Trace evidence may need to be collected (some jurisdictions require fingernail scrapings).

**Step 2** - Inspect the forearms for defence 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 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.

**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. Similarly, when clothing has been pulled, red linear petechial bruising can sometimes be seen.

**Step 4** - Inspect the face. Black eyes can be subtle. 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.
**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. Electrostatic forces can, however, cause large amounts of loose hair to be retained in the head until the patient next takes a shower or bath.

**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 jewellery 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; for example, the gown may be taken aside on the right side of the back and then the left side of the back. The shoulders should be separately viewed. Subtle bruising and more obvious bruising may be seen in a variety of places on the back. If the patient is able to sit up on the couch, the gown can be taken down to the upper breast level just exposing the upper chest on the right and left and then each breast can be examined in turn. 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 trace evidence. 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 of the legs. 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. The latter method may be the only option if the patient is unsteady on her feet for any reason, but does not afford such a good view of the area. Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibres, grass, soil).

As a general rule, the presence of any tattoos should be documented in the examination record, together with a brief description of their size and shape, as these may become a means of assessing the accuracy of the observations of the examining practitioner in court. Similarly, obvious physical deformities should be noted. If tattoos and obvious deformities are not recorded, the medical examiner should be prepared to justify his/her decision. The examiner should weigh up the evidential value of observations of this nature against the prejudicial value they may have when discussed in front of a jury on a case-by-case basis.

The use of Wood’s lamps to detect semen on areas of skin where this is suspected is no longer recommended clinical practice. Wood’s lamps do not fluoresce semen as well as previously thought, and more reliable methods of detecting semen (e.g. swabs) should therefore be used.
Figure: Inspection sites for a “top-to-toe” physical examination of victims of sexual violence
Annex #4
Stages of Puberty in the Female

STAGES OF PUBERTY

Pubic hair:
Stage 1. Pre-adolescent. The vellus over the pubes is not further developed than that over the abdominal wall, i.e. no pubic hair.

Stage 2. Sparse growth of long, slightly pigmented downy hair, straight or slightly curled, chiefly along labia.

Stage 3. Considerably darker, coarser and more curled. The hair spreads sparsely over the junction of the pubes.

Stage 4. Hair now adult type, but area covered is still considerably smaller than in adult. No spread to the medial surface of thighs.

Stage 5. Adult quantity and type with distribution of the horizontal (or classically 'feminine') pattern. Spread to medial surface of thighs but not up linea alba or elsewhere above the base of the inverse triangle (spread up linea alba occurs late and is rated stage 6).
Annex #5

WHO Classification of Female Genital Mutilation (FGM)


<table>
<thead>
<tr>
<th>Type</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type I</td>
<td>Excision of the prepuce, with or without excision of part or all of the clitoris. Other terms used to describe Type I FGM procedures include circumcision, ritualistic circumcision, sunna and clitoridectomy.</td>
</tr>
<tr>
<td>Type II</td>
<td>Excision of the clitoris with partial or total excision of the labia minora. Other terms used to describe Type II FGM procedures include clitoridectomy, sunna, excision and circumcision.</td>
</tr>
<tr>
<td>Type III</td>
<td>Excision of part or all of the external genitalia and stitching/narrowing of the vaginal opening. Other terms used to describe Type III FGM procedures include infibulation, Pharaonic circumcision and Somalian circumcision.</td>
</tr>
<tr>
<td>Type IV</td>
<td>Unclassified. Unclassified or type IV forms of FGM include:</td>
</tr>
<tr>
<td></td>
<td>— pricking, piercing or incising of the clitoris and/or labia;</td>
</tr>
<tr>
<td></td>
<td>— stretching of the clitoris and/or labia;</td>
</tr>
<tr>
<td></td>
<td>— cauterization by burning of the clitoris and surrounding tissue;</td>
</tr>
<tr>
<td></td>
<td>— scraping of tissue surrounding the vaginal orifice (angurya cuts) or cutting of the vagina (gishiri cuts);</td>
</tr>
<tr>
<td></td>
<td>— introduction of corrosive substances or herbs into the vagina to cause bleeding or for the purpose of tightening or narrowing it;</td>
</tr>
<tr>
<td></td>
<td>— any other procedure which falls under the WHO definition of female genital mutilation given above</td>
</tr>
</tbody>
</table>