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THE CLINICAL MANAGEMENT OF CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE

TECHNICAL CONSIDERATIONS FOR PEPFAR PROGRAMS

AIDSTAR-One
AIDS SUPPORT AND TECHNICAL ASSISTANCE RESOURCES

Together for girls
We can end sexual violence

FEBRUARY 2013

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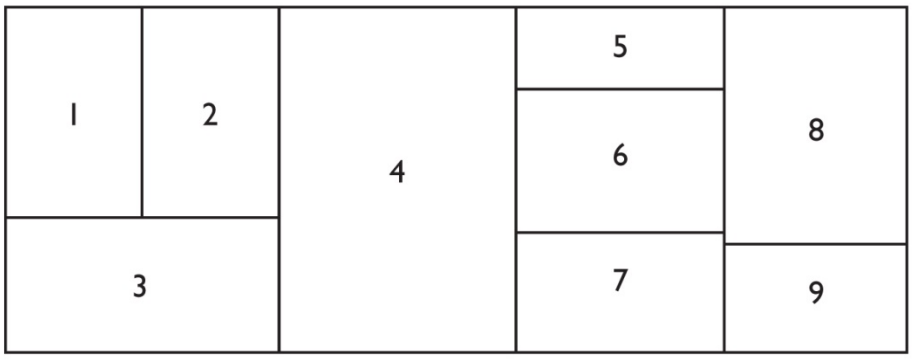

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2. **Philippines, 2011** Angel (not her real name), 16, stands in Zamboanga City, on the island of Mindanao. She was sexually abused and beaten by her employer when she worked as a domestic servant. Today, she lives in one of the city's shelters, where she receives educational and psychosocial support, and is preparing to testify in court against her former employer.

3. **Liberia, 2009** A child's sandaled feet dangle off the ground at a UNICEF-supported safe house just outside of Monrovia, the nation's capital, for survivors women and children who have experienced sexual and gender-based violence. The home, run by the Liberian NGO THINK (Touching Humanity in Need of Kindness), provides counseling, psychosocial support, basic education, and training in both vocational and life skills (including HIV and reproductive health).

5. **Congo, Democratic Republic of the, 2012** Celine (not her real name), 16, attends a sewing class at a UNICEF-supported transit and orientation center in Bukavu, the capital of South Kivu Province. The center, run by the Congolese NGO BVES (Office for Volunteer Services to Children and Health), provides shelter, health and psychosocial services, and education to girls who have survived experienced sexual violence and other abuse.

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AIDS Support and Technical Assistance Resources Project
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Stephanie Weber developed the first draft of the Technical Considerations incorporating feedback from multiple sources and creating the foundation for this document. Dr. Rudo Masanzu provided extensive feedback on drafts of the Technical Considerations, including on current forensic management practices. Emily Koumans (CDC) and Claudia Garcia-Moreno (World Health Organization [WHO]) provided additional feedback and tools. Colleagues from UNICEF's Disability Section and Sergio Meresman (the Inter-American Institute on Disability and Inclusive Development) provided insight into how the needs and rights of children with disabilities should be taken into consideration.

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ACRONYMS

AIDS	acquired immune deficiency syndrome
ARV	antiretroviral drugs
DNA	deoxyribonucleic acid
ECSA-HC	East, Central, and Southern African Health Community
EC	emergency contraception
FGM/C	female genital mutilation/cutting
GBV	gender-based violence
GHI	Global Health Initiative
HBV	hepatitis B virus
HCT	HIV counseling and testing
HIV	human immunodeficiency virus
HIVnPEP	HIV non-occupational post-exposure prophylaxis
HPV	human papilloma virus
HSV	herpes simplex virus
NAAT	nucleic acid amplification test
PEP	post-exposure prophylaxis
PEPFAR	United States President's Emergency Plan for Aids Relief
PRC	post-rape care
SGBV	sexual and gender-based violence
STI	sexually transmitted infection
TD	tetanus toxoid
USG	United States Government
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization

GLOSSARY OF TERMS (MEDICAL)

The following glossary contains useful clinical terminology for providers working with children who have experienced sexual violence and exploitation. This terminology may be useful in documentation.

ABRASION: Superficial scraping away of a portion of skin or mucous membrane. Also known as a graze or scratch.

ANAL FISSURE: A break (split) in the perianal skin that radiates out from the anal orifice. They may be superficial or deep and can be caused by objects going into or coming out of the anus. *A variety of causes include the passage of hard stools (constipation), diseases such as Crohn's disease, and trauma.* Fissures can heal without leaving visible scars.

ANAL LAXITY: Decrease in muscle tone of the anal sphincters resulting in dilation of the anus.

ANAL SKIN TAG: A protrusion of anal verge tissue that interrupts the symmetry of the perianal skin folds. A projection of tissue on the perianal skin. When located outside the midline, causes other than a congenital variation should be considered, including such conditions such as Crohn's disease or trauma.

ANUS: The anal orifice; the outlet of the large bowel, opening of the rectum.

ASSENT: The expressed willingness to participate in services. For younger children who are by definition too young to give informed consent, but old enough to understand and agree to participate in services, the child's "informed assent" is sought. Informed assent is the expressed willingness of the child to participate in services (IRC UNICEF 2012).

BIOLOGIC EVIDENCE: Any type of biological matter including blood, urine, semen, feces, tissue, skin cells, decomposition fluid, saliva, tears, mucus, perspiration, vomit, and pus.

BRUISE: An area of discoloration due to damage to capillaries or larger blood vessels beneath the skin leading to leakage of blood into the surrounding tissues and skin discoloration that varies in color (purple, blue, brown, yellow, etc.). Also known as a contusion. In dark skinned people, bruising can be difficult to see; tenderness and swelling is significant and should be documented.

CHAIN OF CUSTODY/EVIDENCE: The documentation of the chain of custody is a record of times, places, and persons who have been responsible for the evidence from the time it is collected until it is utilized in court.

DEFENSIVE INJURY: Injuries that occur when the victim wards off attacks by the perpetrator using any part of the victim's body. Defensive injuries include bruising, abrasions, lacerations, or incised wounds.

DIASTASIS ANI: A smooth, often "V" or wedge-shaped area at either the 6 or 12 o'clock positions in the perianal region. It is due to the absence of the underlying corrugator external anal sphincter muscle and results in a loss of the usual anal skin folds in the area. *A congenital variant.*

ESTROGENIZED: Effect of the female sex hormone, estrogen, on the genitalia. The hymen takes on a thickened, redundant, and pale pink appearance as the result of estrogenization. *These changes are observed in infants, with the onset of puberty, and as the result of exogenous estrogen.*

FEMALE GENITAL MUTILATION/CUTTING (FGM/C): WHO defines female genital mutilation (FGM) or female genital cutting (FGC) as all procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs whether for cultural or other nontherapeutic reasons.

FRENULUM OF THE PENIS: A small fold of skin that attaches the prepuce to the ventral surface of the penis.

FRIABILITY: A term used to describe tissues that bleed (abnormally) easily. Example: The friability of labial adhesions that, when gently separated, may bleed. Friability of the posterior fourchette: A superficial breakdown of the skin in the posterior fourchette (commissure) when gentle traction is applied causing slight bleeding. *A nonspecific finding due to many different underlying causes.*

GENITALIA: (external) Also called the vulva in females, it includes the mons pubis, labia majora, labia minora, clitoris, and vestibule of the vagina: the vestibule contains the urinary meatus, vaginal opening, and vestibular gland ducts.

GLUTEAL/NATAL CLEFT: The groove between the buttocks that runs from just below the sacrum to the perineum.

HYMEN: A membranous collar or semi collar that surrounds the vaginal introitus and separates the external genitalia from the vagina. The outer surface is squamous epithelium and the inner surface is mucous membrane. All females have this structure and there is wide anatomic variation in morphology.

- **Annular:** The hymenal membrane extends completely around the circumference of the vaginal orifice. *This is a common hymenal configuration.*
- **Bump/mound**: A solid, localized, rounded, thickened area of tissue on the edge of the hymen. *Most commonly found in annular or crescentic hymens.*
- **Cleft/notch:** An angular or "V"-shaped indentation on the edge of the hymenal membrane that does not extend to its base.
- **Crescentic:** Hymen with anterior attachments at approximately the 11 o'clock and the 1 o'clock positions with no hymenal tissue visible between the two attachments. *The most common hymenal configuration in the school-aged, prepubertal child.*
- **Cribriform:** A hymen with multiple openings. *A congenital variant.*
- **Fimbriated:** A hymen with highly folded edges resulting in a flower-like or scalloped appearance. This is a common hymenal configuration in puberty *(also called denticular hymen*).
- **Hymenal orifice:** The opening in the hymenal membrane that constitutes the entrance or outlet of the vagina.
- **Imperforate:** A hymenal membrane with no opening. *An uncommon congenital variant.*
- **Microperforate:** Where the hymenal opening is extremely small. *An uncommon congenital variant.*

- **Redundant:** Abundant hymenal tissue that tends to fold back upon itself or protrude. *A common finding seen in females whose hymenal membranes are under the influence of estrogen (both infants and adolescents).*
- **Septate:** A hymen with band(s) of tissue that bisect the orifice creating two or more openings. *A congenital variant.*
- **Tag:** An elongated projection of tissue arising from any location on the hymenal rim. Commonly found in the midline and may be an extension of a posterior vaginal ridge. *Usually a congenital variant. Rarely caused by trauma.*
- **Transection:** A discontinuity in the hymenal membrane that extends through the width of the hymen to its base. This term is used to describe a healed/non-acute injury. *Partial hymenal disruptions should be referred to as a "laceration" if it is acute (fresh wound) and a "notch" if non-acute. Complete hymenal disruptions should be referred to as a "laceration" if it is acute and a "transection" if non-acute (fresh wound).*

INCISION: Also known as a "cut," an incision is the dividing of the skin as a result of a sharp object coming against the skin with sufficient force to divide the skin.

INFORMED CONSENT: Informed consent means explaining all aspects of the examination to the patient in a manner they can fully understand. Particular emphasis should be placed on the matter of the release of information to other parties, including the police and other parties. This is especially important in settings where there is a legal obligation to report an episode of violence (and hence details of the examination) to relevant authorities. It is crucial that patients and parent/caregivers understand the options open to them and are given sufficient information to enable them to make informed decisions about their care. This is a fundamental right of all patients but has particular relevance in this setting where patients may have been subjected to a personal and intrusive event against their will. It is also important to ensure that a patient has a sense of control returned to them when in medical care. Above all, the wishes of the patient must be respected (WHO 2003).

INTRAVAGINAL COLUMNS/ RIDGES: Raised (sagittally/longitudinally oriented) columns most prominent on the anterior wall with less prominence on the posterior wall that may be attached to the inner surface of the hymen.

LABIA MAJORA: Rounded folds of skin forming the lateral boundaries of the vulva.

LABIA MINORA: Longitudinal, thin folds of tissue within the labia majora. In the prepubertal child, these folds extend from the clitoral hood to approximately the midpoint on the lateral wall of the vestibule. In the adult, they enclose the vestibule and contain the opening to the vagina.

LABIAL ADHESION/FUSION: The result of adherence (fusion) of the adjacent, outermost, mucosal surfaces of the posterior portion vestibular walls. This may occur at any point along the length of the vestibule although it most commonly occurs posteriorly (inferiorly). It may be almost complete (obscuring the entire vestibule) or partial. *A common finding in infants and young children. Unusual to appear for the first time after 6 to 7 years of age. May be related to chronic irritation. Also called labial agglutination.*

LACERATION: An injury/fresh wound in the soft tissues resulting from ripping, crushing, overstretching, pulling apart, bending, or shearing; lacerations result from blunt force. Also called a tear.

LEUKORRHEA: A whitish, viscid (glutinous) discharge from the vagina and uterine cavity through the cervical os. *A normal finding in adolescent and adult females. (The term physiologic discharge is sometimes used.)*

LINEA VETSIBULARIS: A vertical, pale/avascular line across the posterior fourchette and/or fossa navicularis, which may be accentuated by putting lateral traction on the labia majora. *A common finding that is found in girls of all ages including newborns and adolescents.*

MEDIAN (PERINEAL) RAPHE: A ridge or furrow that marks the line of union of the two halves of the perineum.

MONS PUBIS: The rounded, fleshy prominence created by the underlying fat pad, which lies over the symphysis pubis in the female.

PENIS: Male sex organ composed of erectile tissue through which the urethra passes; composed of the shaft and glans; the glans may be covered by foreskin.

PERIANAL FOLDS: Wrinkles or folds of the perianal skin radiating from the anal verge, which are created by contraction of the external anal sphincters.

PERIANAL VENOUS CONGESTION: The collection of venous blood in the venous plexus of the perianal tissues creating a flat or swollen purple discoloration. May be localized or diffuse. It is distinct from bruising. A common finding in children when the thighs are flexed upon the hips for an extended period of time. Also termed perianal venous engorgement or perianal venous pooling.

PERINEUM: Lies between the posterior fourchette and the anus in the female, and between the base of the penis and the anus in males. The external surface of the perineal body.

PERINEAL BODY: The central tendon of the perineum. Located between the vestibule and the anus in the female and between the scrotum and anus in the male.

PETECHIAE: Small, distinct, pinhead sized hemorrhages that occur when arterioles or venules rupture. May be single or multiple. Frequently caused by increased pressure within the blood vessel, as with straining during vomiting or with strangulation, or by suction. May also be caused by a bleeding disorder, infection, or localized trauma.

POST-EXPOSURE PROPHYLAXIS: Refers to the series of medication given immediately following a high risk sexual abuse or assault incidents to attempt prevention of HIV acquisition.

POSTERIOR FOURCHETTE: Where the labia minora meet posteriorly. This area may be referred to as the posterior commissure in the prepubertal child. A common site of injury following sexual assault.

PUNCTURE: A wound made by a pointed instrument.

SEXUAL ASSAULT EVIDENCE COLLECTION KIT: A box or envelope that outlines specific types of evidence requested from the body of a sexual assault victim which contains the necessary material for that collection and the ability to maintain chain of custody once the evidence is gathered and sealed.

RECTUM: The final, straight portion of the large intestine, terminating in the anus.

REFLEX ANAL DILATION: The dynamic action of the opening of the anus due to relaxation of the external and internal sphincter muscles with minimal buttock traction/separation.

URETHRA: The tubular structure that connects the urinary bladder to the external opening, through which urine passes to the outside.

VAGINA: Tubular structure with convoluted rugae that stretch anatomically from the hymen to the cervix; the vaginal rugae account in part for the ability of the vagina to distend.

VULVA: The portion of the female external genitalia consisting of the labia majora, labia minora, clitoris, vaginal vestibule, hymen, fossa navicularis, and posterior fourchette.

FOREWORD

Both the United States President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Health Initiative (GHI) emphasize preventing, monitoring, and responding to gender-based violence (GBV) as critical to strengthening overall health outcomes. The development of a coordinated, holistic response to GBV, including meaningful screening and counseling for GBV; strengthened collaboration between health care, community-based social support networks, and legal systems; and timely access to and provision of HIV non-occupational post-exposure prophylaxis (HIVnPEP) is a key pillar of both PEPFAR and GHI.

As interventions and evidence around GBV have been strengthened, increasing attention is being paid to the need for addressing sexual violence and exploitation of children and adolescents. Results from the PEPFAR I Sexual Gender-Based Violence (SGBV) Initiative[1] show that, where sexual assault services were introduced to primary health centers in Uganda and Rwanda, a large percentage of patients presenting for care were under the age of 18, yet services were not tailored to the special needs of this age group. These data confirmed what has been known anecdotally throughout Africa and have been further supported with findings from the Violence Against Children Surveys.[2] Significant barriers impede the provision of meaningful, effective services for children and adolescents who have experienced sexual violence, including concerns with ensuring confidentiality, availability of HIVnPEP, training for providers in effective medical protocols (where they exist) for children who experience sexual violence and exploitation, and collaboration between medical, legal, social welfare services, and community-based prevention and support and policy responses to SGBV (Kilonzo et al. 2008).

The availability of international guidance on provision of medical/forensic services for persons under the age of 18 is limited. The East, Central, and Southern African Health Community (ECSA-HC) released guidelines for the clinical management of child sexual abuse in July 2011 (ECSA-HC 2011). Although the World Health Organization (WHO) Africa Regional Office was involved in the development of the ECSA-HC guidelines, to date, WHO has not produced its own clinical guidelines specifically for children.[3] There are examples of local institutions that are addressing care for children and adolescents, but PEPFAR has not provided systematic information or guidance to its implementing partners on this issue.

In response to this gap, PEPFAR's Gender, Orphans and Vulnerable Children, and Pediatric Treatment Technical Working Groups, in coordination with the Together for Girls partnership,[4] convened a one-day expert meeting on April 26, 2012, to develop Technical Considerations on post-rape care for persons under the age of 18 in primary health centers that also provide HIV care. The objectives of this meeting were to:

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[1] See http://www.aidstar-one.com/focus_areas/gender/pepfar_gender_special_initiatives/sexual_GBV_initiative

[2] Special Representative of the Secretary General on Violence Against Children. Global Progress Survey 2011. http://srsg.violenceagainstchildren.org/page/Global_Progress_Survey_2011

[3] WHO is in the process of revising their guidelines, which will include considerations for children.

[4] The Together for Girls partnership, which includes five UN Agencies, led by UNICEF, the U.S. Government through PEPFAR and its implementing partners, CDC Division of Violence Prevention and the Department of State's Office of Global Women's Initiatives, and the private sector, was formed with the specific intent of ending violence against children with a particular focus on sexual violence against girls.

- Review and build upon existing guidelines and documents, including the ECSA-HC guidelines and the adult-focused WHO guidelines for medicolegal care for victims of sexual violence.
- Develop Technical Considerations including key recommendations for the delivery of post-rape care in primary health centers for those under age 18 to inform PEPFAR specifically, and for use by other partners and implementers more broadly.

The technical meeting brought together 28 people including PEPFAR U.S. Government and Together for Girls representatives, as well as experienced providers (clinicians, behavioral scientists, and social workers) with expertise in child protection; sexual exploitation and abuse; care for survivors of violence; emergency pediatrics; child-focused clinical services; HIV prevention, care, and treatment; fistula treatment; and distribution of PEP for HIV. Participants represented 8 countries[5] and 14 organizations.[6,7]

These Technical Considerations are a result of a consultative process that included the meeting and incorporation of specialized input and feedback provided by experienced providers and technical experts after the meeting. This document should be used as a guide to help medical providers better address and respond to the unique needs and rights of children who have experienced sexual violence and exploitation.[8] The focus of these Technical Considerations is on the delivery of clinical post-rape care services and includes information on establishing services tailored to the unique needs of children, preparing for and performing a head-to-toe physical

Box 1:
DEFINITION OF TERMS USED

CHILD WHO HAS EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION: A person under the age of 18 years who has experienced an act of sexual abuse. Child exploitation is the use of children for someone else's economic or sexual advantage, gratification, or profit, often resulting in unjust, cruel, and harmful treatment of the child. This is the predominant term found throughout this document.

CHILD SEXUAL ABUSE: The World Health Organization defines child sexual abuse as 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 (WHO 1999).

[5] Democratic Republic of Congo, Lesotho, Kenya, Mozambique, South Africa, United States of America, Zambia, and Zimbabwe.
[6] Centers for Disease Control and Prevention, EnCompass LLC, Emory University School of Medicine, Family Support Trust Clinic, Greater Nelspruit Rape Intervention Program (GRIP), John Snow, Inc., Liverpool VCT, Care and Treatment, Livingston Pediatric Center of Excellence, Office of the Global AIDS Coordinator, Panzi Hospital/Panzi Foundation, Together for Girls, UNICEF, United States Agency for International Development.
[7] For more information on this meeting go to http://www.aidstar-one.com/focus_areas/gender/resources/technical_consultation_materials/prc
[8] Various terms are used to reflect violence that children face. This document uses the term "children who experience sexual violence and exploitation" (see the Glossary of Terms for a full definition).

examination of children who have experienced sexual violence and exploitation, conducting forensics evidence collection, and ensuring follow-up care and referrals for psychosocial and community support services.

These Technical Considerations use the term "children" to describe individuals under the age of 18 years. This definition falls in line with international conventions as summarized in the definition of "child" in the Glossary of Terms on page 67. The term "adolescent" is not intended to replace the use of children, but instead provide an additional term to describe specific ages, maturation, and developmental stages of individuals aged 10 to 19 years. This document acknowledges that the terms child and adolescent take on different meanings in different contexts.

The term "child who has experienced sexual violence or exploitation" is used throughout this document rather than the terms "victim" or "survivor" (see Box 1 for definitions). Both boys and girls can experience such violence and gender norms underlie the specific manifestations of sexual violence and exploitation experienced by girls and boys.

INTRODUCTION

BACKGROUND

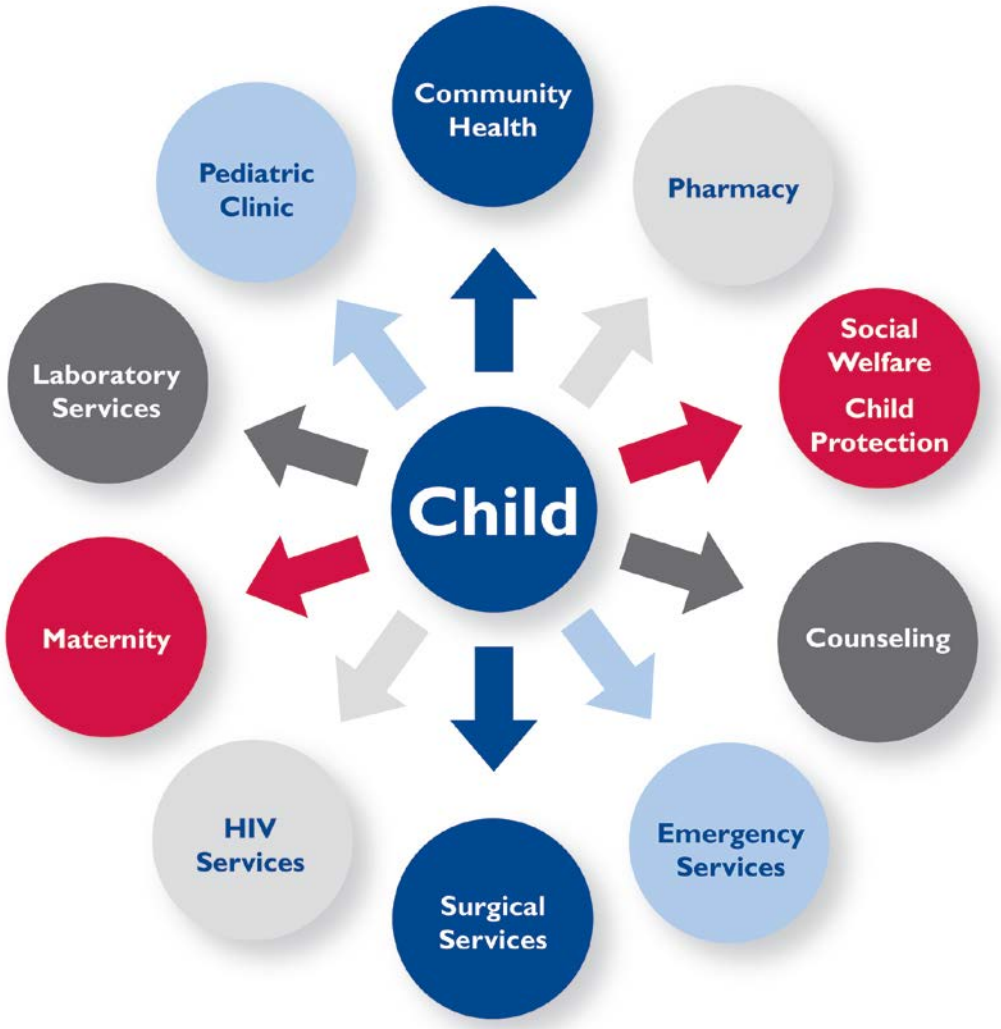
These Technical Considerations aim to serve as a guide for primary health providers on the appropriate care of children and adolescents who have experienced sexual violence and exploitation based on current, evidence-based practices. They are expected to inform the efforts of PEPFAR implementers and other partners engaged in the clinical care of children as well as in HIV/AIDS prevention, care, and treatment to strengthen community-based responses to children who have experienced sexual violence and exploitation. They should be implemented in line with national guidelines in the provider's country of practice.

This document is meant to be used by service providers in health care clinics, to include clinicians, behavioral scientists, social workers, pediatric care providers, child protection workers, HIV specialists, and child-focused clinical service providers. The focus is specifically on the clinical management of children who experience sexual violence and exploitation, but communities should also strive to develop comprehensive systems to respond to the needs and rights of these children. The comprehensive response includes government (e.g., clinics, law enforcement and judiciary, policymakers, social welfare/child protective services, counselors), and nongovernmental and civil society organizations. This comprehensive response is often overlooked, thereby creating a challenge during program implementation (see Chapter 2 for more information on establishing and strengthening the clinical response).

RESPONSE TO CHILD SEXUAL VIOLENCE AND EXPLOITATION

There are many areas of the health care clinic or facility that may be involved in recognizing and responding to children who have experienced sexual violence and exploitation. These may include areas such as the pediatric clinic where children may disclose to the care provider or the caregiver may bring the child after an assault to seek care. It may even be the maternity clinic where a child who has experienced sexual violence and exploitation is treated for a pregnancy that results from the assault. Any of these clinic areas may be involved in the response and should be working together to ensure that the child has access to the services needed. Given the difficulty in assuring follow-up services in these cases, involving other available resources such as pharmacy, social welfare services counseling, and HIV programs can improve the overall response. Figure 1 illustrates the possible resources drawn upon to develop a child-centered approach to care.

Figure 1. Child-Centered Approach to Care



These Technical Considerations are intended to build upon, not replace, existing guidelines that address the clinical needs of children who experience sexual violence and exploitation, to emphasize and improve the response to and medical management of post-rape care for children. The following publications serve as foundational resources to these Technical Considerations:

- World Health Organization (WHO) Guidelines for medicolegal care for victims of sexual violence, 2003
- East, Central and Southern African Health Community (ECSA-HC) Guidelines for the Clinical Management of Child Sexual Abuse, 2011
- International Rescue Committee (IRC) and UNICEF Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings, 2012
- WHO Manual for the health care of children in humanitarian emergencies, 2008

- USAID Protecting Children affected by HIV against abuse, exploitation, violence, and neglect technical report, 2011(Long 2011)
- WHO and United Nations High Commissioner for Refugees: Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons, 2004
- Save the Children UK: Protecting Children: Community attitudes to child sexual abuse in rural Mozambique, 2007.

FOCUS ON CHILDREN

Child sexual violence and exploitation has been recognized as a critical developmental and human rights issue with important implications for HIV and AIDS prevention, care, and treatment. Globally, an estimated 150 million girls and 73 million boys under the age of 18 have experienced some form of sexual violence and exploitation (Pinheiro 2006). Children in many contexts are in danger of experiencing sexual violence and exploitation across multiple settings within the community, home, and broader society (Population Council 2008; ECSA-HC 2010).

Child sexual violence and exploitation differs in many ways from that of adults and therefore cannot be handled in the same way. Sexual violence and exploitation against children is unique due to children's economic dependence, weak social position (especially girls), and gender inequalities, including high rates of gender-based violence (GBV) and the severe consequences of the HIV epidemic on family and community structures. Not unlike GBV against adults, GBV against children is surrounded by a culture of secrecy, stigma, and silence because it is viewed as a private matter, especially when the perpetrator is a family member. There is also a need to strengthen awareness of child rights, what constitutes violence, and when and how to report it (ECSA-HC 2010).

Sexual violence is often hidden and is most decidedly under reported, and reporting among children is even less likely as the children are often ashamed, frightened, and incapable of verbalizing their experience. Only an estimated 10 to 20 percent of child sexual violence and exploitation cases are reported to authorities (Pinheiro 2006). When children do disclose sexual violence and exploitation it is often part of a process rather than a single event, and over a longer period of time, as compared to adults. This manner of disclosure can have important implications for medical management and the collection of forensic evidence. If a child does present in a clinic, many of their medical, psychological, and legal needs are not yet adequately addressed. This is particularly true in sub-Saharan Africa where many countries do not have comprehensive post-rape care services and gaps exist in coordination and communication between sexual and reproductive health and HIV services, legal and judicial systems, and sexual violence legislation (ECSA-HC 2010).

SHORT- AND LONG-TERM CONSEQUENCES OF CHILD SEXUAL VIOLENCE AND EXPLOITATION

Sexual violence has overarching consequences that can affect children's immediate and long-term health and well-being. Sexual violence and exploitation against girls has been associated with suicidal thoughts, unwanted pregnancy, complications during pregnancy, and sexually transmitted infections (STIs) (Reza et al. 2009). Pregnancy and STIs are some of the immediate consequences of sexual violence and exploitation. Girls younger than 15 years are five times more likely to die in

childbirth than women in their twenties, with pregnancy being the leading cause of death worldwide for women ages 15 to 19 (ICRW 2012).

In addition to these more immediate risks, children who have experienced sexual violence and exploitation have significantly increased rates of alcohol and illicit drug use in adolescence and into adulthood (Dube et al. 2005). There are also mental health effects such as clinical depression, posttraumatic stress disorder, conduct disorders (Danielson et al. 2010), and suicide attempts when compared to those without a history of sexual violence and exploitation (Dube et al. 2005). Women who have experienced sexual violence and exploitation as a child have a two- to threefold risk of being sexually re-victimized in adulthood compared with women without a history of exposure (Classen, Palesh, and Aggarwal 2005).

Sexual violence and exploitation can increase the risk of infectious diseases and chronic disease later in life. Girls who have experienced sexual violence and exploitation are at greater risk of contracting HIV and other STIs. Even if a girl is not infected with HIV immediately after an act of sexual violence and exploitation, research indicates that she becomes more likely to contract infectious and chronic diseases later in life (Jewkes, Sen, and Garcia-Moreno 2002).

Such violence can also negatively affect access to education. Children who have experienced sexual violence and exploitation may be pulled from school by their families and caregivers, or they may choose to leave because of fear and depression. A lack of education, especially for girls, may hinder prospects of earning a sustainable income, and perpetuates and deepens the cycle of vulnerability and dependence. Ultimately, societies pay a deep price for these outcomes. The *State of the World's Children* (UNICEF 2007) found that for each year a girl is educated, her marriage is delayed, subsequently reducing the number of children she has. Educated women are less likely than their uneducated counterparts to die in pregnancy or childbirth.

Recent evidence is beginning to highlight the extent to which boys are also subject to sexual violence and exploitation (Graham 2006; Russell 2007; Sivakumaran 2010; Watchlist 2010). Prevailing gender norms and attitudes, including the misperception that only girls and women can be victims of sexual violence, can translate into an extremely weak response on the part of service providers and therefore poor overall outcomes for boys. Service providers should be aware of the gender norms that underlie the manifestations of such violence experienced by boys and girls and the implications of such norms and attitudes on the ability to identify and provide meaningful services, including follow-up care.

COMPREHENSIVE RESPONSE TO SEXUAL VIOLENCE AND EXPLOITATION AGAINST CHILDREN

Effective clinical interventions for children who have experienced sexual violence and exploitation are only a component of the necessary government and community-wide response. Studies have found that the multidisciplinary approach enhances the quality of health care for those who have experienced sexual violence and exploitation, improves the quality of evidence collection and law enforcement's ability to effectively investigate, and increases prosecution rates over time (Campbell et al. 2012; Crandall and Helitzer 2003). Core components of a comprehensive response to sexual violence and exploitation (including community-based entities) are outlined in Table 1 and described in detail throughout this section.

Establishing a comprehensive response requires collaboration and coordination among a wide range of service providers and stakeholders (governmental and nongovernmental) and a community that is prepared to offer services and interventions to children who have experienced sexual violence and exploitation. Prompt access to services and medical interventions are crucial and include medical forensic evaluation, HIV non-occupational post-exposure prophylaxis (HIVnPEP), and, for girls, access to emergency contraception, when applicable following national laws and protocols.

Comprehensive care meets the range of medical, legal, and psychosocial needs of the child, from the first point of contact through recovery. Health facilities can develop and strengthen individual services but a coordinated effort among all stakeholders to manage the system response effectively is the best way to meet the needs and rights of children.

Table 1. Core Components of a Comprehensive Response to Sexual Violence and Exploitation

Sector	Key Components of Response
Health	Personal protective equipment/blood-borne pathogen protection
	History and physical exam done in a child friendly manner
	Pregnancy testing and emergency contraception, based on national laws and protocols, where applicable and legal
	HIV diagnostic testing
	HIV Counseling
	HIV non-occupational post-exposure prophylaxis (HIVnPEP)
	Prophylaxis and/or treatment for sexually transmitted infections
	Sexual health screening
	Vaccination for hepatitis B and tetanus
	Evaluation and treatment of injuries, forensic examination, and documentation
	Sexual health screening
	Trauma counseling and mental health assessment
	Referrals to/from police and support services
Sector	**Key Components of Response**
Police/Justice	Statement-taking and documentation done in a non-threatening, child-focused manner
	Criminal investigation
	Acquisition and maintaining chain of evidence
	Ensuring the safety of the child
	Prosecution/adjudication of the offender
	Witness preparation and court support
	Referral to/from health and support services

Sector	Key Components of Response
Social Services	Assessment for and referral to psychosocial support services
	Safety assessment and planning
	Provision of safe housing, relocation services, if required
	Reintegration into family/household, if required (including access to education, vocational training, and livelihood support)
	Long-term psychosocial counseling and rehabilitation
	Referrals to/from police and health sectors
	Community awareness-raising and stigma reduction

GUIDING PRINCIPLES FOR MEDICAL PROVIDERS WORKING WITH CHILDREN WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

When caring for children who have experienced sexual violence and exploitation, there are common principles that underlie the decision-making process. Following these principles will ensure service providers that actions taken on behalf of the child are supported by standards of care that aim to benefit the child's health and well-being. It is critical that care and support are provided in a child-friendly manner and that the child is not re-victimized in the process. Table 2 lists these guiding principles and corresponding actions as described in the UNHCR Guidelines on Sexual Violence Response and Prevention and the United Nations Convention for the Rights of the Child (UNHCR 1995).

Table 2. Guiding Principles for Caring for Children Who Have Experienced Sexual Violence

Principle	Actions
Promote the child's best interest	• Secure physical and emotional safety (well-being) throughout care and treatment • Evaluate positive and negative consequences of actions with participation of the child and caregiver (as appropriate) • The least harmful course of action is always preferred • All actions should ensure that the child's rights to safety and ongoing development are not compromised
Ensure the safety of the child	• Ensure physical and emotional safety • All actions should safeguard the child's physical and emotional well-being in the short and long term

Principle	Actions
Comfort the child	• Offer comfort, encouragement, and support • Assure that service providers are prepared to handle the disclosure of sexual violence and exploitation appropriately • Believe the child when they have chosen to disclose sexual violence and exploitation • Never blame the child in any way for the sexual violence and exploitation they have experienced • Make the child feel safe and cared for as they receive services
Ensure appropriate confidentiality	• Information about the child's experience of sexual violence and exploitation should be collected, used, and stored in a confidential manner • Ensure the confidential collection of information during all aspects of care including interviews and history taking • Share information only according to local laws and policies and on a need-to-know basis, after obtaining permission from the child and/or caregiver • Store all case information securely • If mandatory reporting is required under local law, inform the child and caregiver at the time they are seen • If the child's health or safety is at risk, there may be limits to confidentiality to protect the child
Involve the child in decision making	• Children have a right to participate in decisions that have implications in their lives • The level of a child's participation in decision making should be appropriate to the child's level of maturity and age, and local laws • Although service providers may not always be able to follow the child's wishes (based on best-interest considerations), they should always empower and support children and deal with them in a transparent, open manner with respect • If a child's wishes are not able to be followed, then the reasons behind not being able to follow them should be explained
Treat every child fairly and equally	• Utilize the principle of non-discrimination and inclusiveness for all children • All children should be offered the same high-quality care and treatment, regardless of their ethnicity, religion, sex, ability/disability, family situation, status of their parents or caregivers, cultural background, or financial situation, affording them the opportunity to reach their full potential • No child should be treated unfairly for any reason

Principle	Actions
Strengthen children's resiliencies	• Each child has unique capacities and strengths, and possesses the capacity to heal • Identify and build upon the child's and family's natural strengths as a part of the recovery and healing process • Factors that promote the child's resilience should be identified and built upon during the episode of care • Children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from sexual violence and exploitation (Perry 2007)
Health care providers should be appropriately trained and skilled in managing children who have experienced sexual violence and exploitation	All providers responsible for caring for children who have experienced sexual violence and exploitation should: • Undergo training and orientation to the sexual violence/post-rape care clinic and referral protocols • Have specialized training on the medical forensic examination • Have advanced training on and understanding of emergency contraception based on national laws and protocols, where applicable and legal, as well as HIVnPEP, STI prophylaxis, hepatitis B vaccination, and the importance of timely intervention Health care centers should: • Identify and train dedicated practitioners (doctors, forensic nurses, or clinic officers) to provide post-rape care and services for children
The health and welfare of the child takes precedence over the collection of evidence	• Crisis intervention; treatment of serious injuries; and assessment, treatment, and prevention of HIV, pregnancy, and STIs are of primary importance • The welfare of the child ensures that they are able to maintain their dignity after sexual violence and exploitation, and do not feel coerced, humiliated, or further traumatized by the process of seeking services • Children should NEVER be forced to undergo the medical forensic examination against their will unless the examination is necessary for medical treatment (WHO 2003)

Principle	Actions
Reporting to police should not be a prerequisite for obtaining medical care	• The child's decision regarding police involvement should be respected at all times • The child should not be pressured, coerced, or forced to report the sexual violence and exploitation as a condition of receiving their medical care • It is common for health care workers to tell the child that a police report must be made and they must obtain the report form before the facility will conduct the examination • Reporting is often tied to payment of fees, the hospital may only agree to provide free services if the patient has reported the violence to the police and is in possession of the official documentation forms. In most cases, these are procedural rather than legal requirements and should be changed at the facility level. • Efforts should be made by the facility to have a clear policy on reporting, consistent with national policy, that affords the most patient-centered approach • Police forms should be kept ideally at the facility for children who present to the facility first and should be available free of charge • The child should be offered all available services including emergency contraception (EC) where legal, HIVnPEP, and other needed health services even if there is no physician available to sign medicolegal forms, or if the child chooses not to report to the police
Use the person-first approaches to care	• Professionals working with children who have experienced sexual violence and exploitation must have a strong understanding of current approaches to inclusive care of all patients regardless of ability • Recognize that children with disabilities (physical as well as mental/emotional) are at increased risk for sexual violence and exploitation, and have equal right to care and access treatment • Ensure that someone who is trained is available when necessary for communication alternatives (e.g., sign language) for patients who may require this approach

ESTABLISHING AND STRENGTHENING THE RESPONSE TO CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

Effective prevention and intervention responses for children and adolescents who have experienced sexual violence and exploitation incorporate multidisciplinary team models and "it takes a village" approaches. Successful responses to meeting the needs and rights of children who have experienced sexual violence and exploitation include health systems strengthening (e.g., improved facility and infrastructure, increased capacity of providers, strengthened protocols and supervisory systems including record systems for case management), improved referrals from the facility to other services, and strengthened linkages between clinical services and other stakeholder groups.

Although improvements can be made to strengthen the health care response to children and adolescents who have experienced sexual violence and exploitation, care must be taken to assess the existing community strengths and weaknesses, and to identify top priority recommendations in and outside of health care.

It is critical that care and support are provided in a child-friendly manner and that the child is not re-victimized in the process.

INFRASTRUCTURE

The basic framework required for a system wide response includes a legal response that addresses the investigation of the criminal aspects of sexual violence and exploitation against children, a criminal justice response that holds offenders accountable, a health response that addresses the acute and long-term health implications of sexual violence and exploitation against children, and a comprehensive service response (including social welfare services and community-based support) that effectively addresses the child's recovery, rehabilitation, and safety.

Because this document addresses the clinical management of sexual violence and exploitation against children and adolescents, it is the health care infrastructure that will be specifically addressed. However, it is critical that all components of infrastructure be addressed in development

and implementation of programs if there is an expectation that children will be kept safe from sexual violence and exploitation.

FACILITY

Medical forensic examinations should take place at a medical site where there is optimal access to the full range of services that may be required by the child. Ideally this would be a hospital or clinic setting. A child may present with acute health problems (e.g., head injury, hemorrhage) that require urgent medical intervention and treatment. Similarly, there should be ready access to a range of laboratory and counseling services. Children should be able to access services 24 hours a day. If that is not available, then they should access the clinic during hours of operation or the clinic may want to utilize an on-call schedule for response.[9]

Regardless of location, care should be ethical, compassionate, objective, and child-centered—taking into account the child's safety, privacy, and best interests at all times. Ideally, physical surroundings should be child friendly. Paint, posters, blankets, pillows, and toys are relatively inexpensive and can help children feel more relaxed and comfortable in the examination environment.

Resource constraints may preclude the possibility of service provision in an ideal facility, but it is possible to improve the quality of existing facilities by ensuring they are accessible, secure, clean, and private (WHO 2003):

- Security. There may be some antagonism toward sexual violence services (by individuals or communities) so adequate measures should be in place to protect children, staff, health records, and the facility itself. These could include a guard to control access, adequate lighting, video surveillance, lockable doors and cabinets, and fire prevention equipment.
- Cleanliness. A high standard of hygiene is required for any medical service. The facility should comply with local safety and health regulations as they apply to fire, electricity, water, sewerage, ventilation, sterilization, and waste disposal.
- Privacy. Unauthorized people should not be able to view or hear any aspects of the consultation. The examination room(s) should have walls and a door, not merely curtains. Assailants must be kept separate from the children who have experienced sexual violence and exploitation.
- Access. It is important to ensure that facilities are disability friendly and do not create barriers to accessing services, from a physical, communication, or attitudinal point of view. If a new facility is being setup or built, ensure it is inclusive and accessible for persons with disabilities from the outset. It is more cost-effective to do initially than to rebuild/renovate later.

Table 3 provides a listing of minimum standards for providing comprehensive care to children who have experienced sexual violence and exploitation.

[9] On-call systems include having a list of providers who will respond to the clinic to care for children who have experienced sexual violence and exploitation.

Table 3. Minimum Standards for Providing Comprehensive Post-Rape Care (PRC) in Facilities[10]

Facility Capacity	Minimum Standards for Medical Management	Reporting/Recording Requirements for Facility	Minimum Staffing Requirements
All basic health facilities without a laboratory (public and private)	• Emergency management and treatment of injuries and refer as needed • Detailed history, examination, and documentation • Refer patient for HIV screening, PEP/EC, and STI treatment/prophylaxis	• Fill in PRC forms as per local protocol • Maintain PRC register • Ensure that the patient has a copy of the form to take to the laboratory	A trained doctor or nurse
All health facilities with a functioning laboratory (public and private)	• Emergency management and treatment of injuries and refer as needed • Detailed history, examination, and documentation • Provide PEP and EC (even where follow-up is not possible) ± STI treatment/prophylaxis • Where HIV counseling services are available, provide initial counseling	• Fill in PRC forms as per local protocols • Maintain a PRC register • Maintain a laboratory register • Referral to comprehensive PRC facility	A trained doctor or nurse and/or clinical officer A trained counselor (where counseling is offered)
All health facilities with HIV, ARV, or a comprehensive care clinic where ARV can be monitored (comprehensive PRC facilities can be provided) (private and public health facilities)	• Manage and treat injuries • Detailed history, examination, and documentation • Provide EC and PEP, including ongoing management of PEP • Provide STI prophylaxis or treatment • Provide counseling and support, HIV testing, and PEP adherence	• Fill in PRC form as per local protocols • Maintain PRC register • Maintain a laboratory PRC register • Fill in PRC form to follow-up management of children	A trained doctor or nurse and/or clinical officer trained in ARV/PEP management One trained counselor (trauma, HIV testing, and PEP adherence counseling) Laboratory for HIV and hepatitis B virus testing

[10] This chart is adapted from the National Guidelines on Medical Management of Sexual Violence in Kenya.

SETTING

Children and adolescents who have experienced sexual violence and exploitation may present at any point in the health care system. Therefore, all health care facilities should be in a position to recognize sexual violence and exploitation and provide services to children who have experienced sexual violence and exploitation, irrespective of whether a medical forensic examination is required. If not already in place, health care facilities need to develop specific training for staff as well as policies and procedures for providing services to children and adolescents who may have experienced sexual violence and exploitation.

The ideal is that the medicolegal and the health services are provided simultaneously, in the same location, and preferably by the same health practitioner. Policymakers and health workers are encouraged to develop this model of service provision. See Annex 15 for two examples of one-stop centers.

In some countries, the health and medicolegal components of service are provided at different times, in different places, and by different people. Such a process is inefficient, unnecessary, and, most importantly, places unwarranted burden on the child who has experienced sexual violence and exploitation. Ideally, the health care and medicolegal processes are provided simultaneously, at the same time, in the same location, and, preferably, by the same health care provider (WHO 2003).

Regardless of the facility utilized, the space where the provider performs the examination should incorporate the following:

- Child friendly (aesthetically)
- Auditory and visual privacy (a door that closes vs. a curtain between beds)
- Thermally neutral (i.e., not too cold or too hot)
- Clean, facility-provided bed linen and gown for each child
- Proper lighting
- Immediate access to soap and clean water
- Immediate access to clean toilet facilities, and shower if possible
- A table or desk
- A telephone if available
- Access to a sitting/support room for non-offending family members, support personnel etc.
- Availability of simple food and potable water.

EQUIPMENT

Relative to other types of medical facilities (e.g., an emergency department), the costs incurred in purchasing equipment to care for children who have experienced sexual violence and exploitation are relatively small and the initial equipment costs are often one-time purchases. It may be possible to obtain many of the necessary supplies from hospital wards and recurrent equipment costs for disposable items should be minimal.

Annex 4 provides a full list of the equipment required for the provision of a full range of medical and forensic services for children who have experienced sexual violence or exploitation. Lack of financial resources is likely the main factor determining the quality and quantity of equipment provided and maintained. Box 2 provides a list of the minimum equipment required.

Additional equipment required for forensic examinations is included in Chapter 3.

Box 2:
MINIMUM EQUIPMENT REQUIREMENTS

- Examination table/bed/stretcher that allows for positioning in lithotomy
- Powder-free, nonsterile exam gloves
- Specula for **postpubertal** children ONLY
- Culture supplies
- Lubricant
- Evidence collection kits
- Forensic supplies: paper bags, evidence tape for sealing bags, containers, cotton tipped swabs, etc.
- Digital camera if possible
- Facility capacity to store intimate images securely if obtained
- Handheld magnifying glass.

PROGRAM PLANNING, DEVELOPMENT, AND EVALUATING/MONITORING

Monitoring and evaluation are important for maintaining high quality services and a satisfactory level of care. Results from assessing the strengths and weaknesses of a facility can be used to modify and improve services as needed and are useful for administrators and managers when deciding how to allocate scarce resources. Monitoring and evaluation tools may include patient satisfaction surveys and collecting information on the number of children and adolescents who have experienced sexual violence and exploitation seen monthly and who return for follow-up.

When planning or modifying existing services to include caring for children and adolescents who have experienced sexual violence and exploitation, several questions need to be considered and addressed based on the context. These are outlined in Table 4.

Table 4. Program Planning and Development Process

Step or Stage	Planning Process	Considerations
1.	Community Needs Assessment	• Why does the community need to implement or improve its response to children who have experienced sexual violence and exploitation? • What currently happens in the community when a child reports an episode of sexual violence and exploitation? • What are the existing challenges to an effective response? • How will local laws and regulations impact the community response?
2.	Facility Needs Assessment	• What types of health care facilities already exist? • What are the barriers to accessing services? • Who are the health care providers in the area? • What is their experience in caring for children who have experienced sexual violence and exploitation? • What are the educational needs of the providers with regard to caring for children who have experienced sexual violence and exploitation? • What are the laws, regulations, or institutional policies that impact: o consent? o forensic evidence collection? o access to and administration of EC? • What types of laboratory facilities are available? • What types of medication are available? • What types of medical equipment are available?
3.	Program Development and Implementation	• What are the mission, goals, and objectives of the program? • What funding is available? • What services will be offered? • What hours of operation are being considered? • Are these hours accessible to women, children, adolescents, men? • Who are the potential community partners? • What types of referrals are available in the local area (e.g., specialist physicians, rape crisis programs, emergency shelters, specialized children's services)? • Who will be in charge and what qualifications do they require? • Will formal protocols be developed? • Are the roles of specific providers clearly delineated (e.g., nurses, physicians, social workers, health aides)? • How many personnel are required? • Who will conduct necessary education and training of providers and community partners?

Step or Stage	Planning Process	Considerations
4.	Program Evaluation	• What monitoring and evaluation tools are needed and how will they be developed? • What quality assurance mechanisms will be put into place for the care of children who have experienced violence and exploitation? • How will the program evaluate services being delivered (e.g., by using patient satisfaction surveys)? • How will the program track output, performance, and type of services provided (e.g., the number of children who have experienced sexual violence and exploitation seen monthly, the age of the child, the sexes of children served and the number of children who have experienced sexual violence and exploitation who return for follow-up, the number of education or training programs provided to the community or to health care professionals)? • How will the program evaluate patient outcomes (e.g., the number of children who have experienced sexual violence and exploitation who acquired STIs, the number of pregnancies [include information on age and sex of children seeking care] resulting from sexual violence and exploitation) and patient compliance with recommended medication regimen?

THE ROLE AND RESPONSIBILITY OF THE HEALTH CARE PROVIDER

In cases where children and adolescents have experienced sexual violence and exploitation, the clinical provider's responsibility goes beyond the medical care of the child. Providers have a role to play in prevention of sexual violence and exploitation and should be prepared to go to court to ensure there are consequences for violent acts in general, but against children in particular. Below are the roles and responsibilities of health care providers in preparing for and responding to children and adolescents who have experienced sexual violence and exploitation. This care should be provided in a confidential and nonjudgmental manner. It is the role and responsibility of the health care provider to:

- Provide medical care, which includes treatment for injuries, prevention of long-term disease, and consequences from the violence
- Collect forensic samples
- Screen for sexual violence and exploitation
- Communicate with children and adolescents who have experienced sexual violence and exploitation in a compassionate, understanding way
- Recognize the impact that sexual violence and exploitation can have on long-term health and well-being

- Document the pertinent medical forensic history
- Document injuries and conduct a physical assessment
- Screen, counsel, and treat for HIV and other STIs
- Offer HIVnPEP
- Prevent unwanted pregnancy
- Fill out necessary police forms (per country)
- Provide appropriate community-based resource referrals
- Refer for other care and services (depending on what the child or adolescent needs and wants)
- Provide testimony in court if required

It is not the role of the health care provider to determine if a child or adolescent has experienced sexual violence and exploitation. Detailed information regarding the role and responsibility of the health care provider can be found in Chapter 3.

EDUCATING AND TRAINING HEALTH CARE PROVIDERS

In order to establish a baseline standard of care for children and adolescents who have experienced sexual violence and exploitation, health care providers must be able to differentiate between myth and fact. Several educational standards have been established, depending on the discipline of the provider. For example, there is a South African national curriculum "Caring for survivors of sexual assault and rape: A training programme for health care providers in South Africa." This curriculum was developed using a holistic approach to care and recognizes the central importance of meeting the basic health needs in an effort to mitigate the potential harms of sexual assault. WHO recommends that health care workers providing medicolegal services to children who have experienced sexual violence and exploitation should be given specialized training that addresses the medicolegal aspects of service provision (WHO 2003). It also details an educational program from the International Association of Forensic Nurses with a content outline detailed here. Regardless of discipline, this education should minimally include:

- Social context of sexual violence and exploitation
- Definitions
- Providing child-friendly services
- The medical forensic examination of children
- Accurate interpretation of findings
- Appropriate treatment regimens for prepubescent and adolescent children
- Dynamics of sexual violence and exploitation against children and the challenges associated with disclosure
- Developmentally appropriate history-taking techniques
- Clinical protocol development
- Legal requirements for documentation

- Documentation of examination and treatment
- Issues regarding informed consent
- Avoiding the pressure of other disciplines
- Local legal framework
- Quality control and peer review
- Providers' legal requirements (reporting, etc.)
- Referral to relevant services for children, adolescents, and caregivers available in the community
- Educating other disciplines on the role of the medical provider
- Preventing, identifying, and managing secondary trauma.

In addition to initial education, health practitioners should also be given the opportunity to further their education and training and participate in quality control and peer review processes. Adequate training in the dynamics of sexual violence and exploitation against children and adolescents is essential for health care professionals to ensure that potential harm to children and their families is avoided by missing a diagnosis or by over-diagnosing.

Health care providers should be trained utilizing adult education principles and methods such as participatory learning, critical reflection, discussion, small group work, case studies, demonstrations, and role plays. Whenever possible, training in the actual clinical environment should occur, utilizing providers experienced in the care of children and adolescents who have experienced sexual violence and exploitation.

It is essential that health workers remain objective and as free as possible from any prejudice or bias when caring for children and adolescents who have experienced sexual violence and exploitation. It is possible to provide an objective service without sacrificing sensitivity or compassion.

In many settings, the sex of the health worker may be a critical issue. Directors or managers of health care facilities should ensure that both male and female nurses and physicians are available whenever possible, and are encouraged to receive training in the care of children who have experienced sexual violence and exploitation.

EDUCATION OF LAW ENFORCEMENT

In most countries, standards of care in combination with local protocols, rules, or laws govern the provision of medical forensic services to children who have experienced sexual violence and exploitation. Failure to comply with local regulations may compromise future investigations or judicial proceedings and jeopardize the safety of the child. For this reason, it is imperative that health workers have a good understanding of the care necessary, as well as the local protocols, rules, and laws that impact children who have experienced sexual violence and exploitation.

Equally important is a law enforcement response to children and adolescents who have experienced sexual violence and exploitation that makes investigating and prosecuting child sexual violence and exploitation a priority. Typically, this involves law enforcement working closely with social welfare services, families, and other community resources.

REPORTING CHILD SEXUAL VIOLENCE AND EXPLOITATION

Every community has its own set of laws and policies governing how, and to whom, a report regarding suspected child sexual violence and exploitation should be made. Most communities also have a mandatory reporting structure for professionals working with children, and in many jurisdictions a failure to report may constitute a crime. Typically, reporting laws leave determination of the actual violence to investigators, not the person who reports the crime. It is critical that providers are aware of the local laws governing the reporting of child sexual violence and exploitation. If there are no local laws or policies in place regarding reporting and investigating child sexual violence and exploitation, the health professional in collaboration with other service agents such as social welfare services and child protection will need to determine the most effective course of action to take in order to try to protect the child from further sexual violence and exploitation, see Box 3.

Box 3:
PRIORITY RECOMMENDATIONS

The following elements are integral for provision of quality services for children who have experienced sexual violence and exploitation and should be established in any facility that seeks to meet the needs and rights of these children.

- Reporting mechanisms for child sexual violence and exploitation to criminal justice and child protection authorities
- Acceptable procedures/protocols/documentation for collecting, storing, and transporting evidence samples
- Provision of EC where legal
- Rapid HIV testing and provision of HIVnPEP
- Required legal forms/documentation that are admissible in court
- Legally empowered medical practitioners (nurses, doctors, clinical officers) to conduct the medical examination/sign police forms/give medical evidence in court
- Stated requirements of the child to receive a medicolegal exam
- Understanding of what evidence is admissible in court for cases of child sexual violence and exploitation that can be collected by medical staff (blood, urine, clothing, hair, fibers). Knowledge of availability of forensic evidence analysis
- Persons collecting or handling evidence have knowledge of maintaining proper chain of custody.
- Knowledge of whether a police report is necessary prior to the examination and, if so, how to obtain the necessary form for documentation of the examination
- Have the necessary police forms on-site for necessary documentation
- Identify the person responsible for collecting the signed form and delivering it to police (e.g., in Kenya, it is the person who experienced sexual violence and exploitation)
- Knowledge of what fees (if any) are charged for forensic services, laboratory tests, or necessary forms.

COLLABORATION WITH OTHER SERVICES

It is important that health care workers who provide care to children who have experienced sexual violence and exploitation to collaborate with law enforcement and the judiciary, social welfare services, rape crisis centers, nongovernmental organizations, organizations representing people with disabilities, and other agencies that may be able to assist in meeting the complex needs and rights of children and adolescents who have experienced sexual violence and exploitation. Working collaboratively with this type of network can contribute to the oversight of service delivery, the safety of the child, and the training of other disciplines. The provider's primary role is the provision of health care services, but they must also recognize their role as an integral part of a team responsible for providing a coordinated range of services to children and adolescents who have experienced sexual violence and exploitation. Other members of the interdisciplinary team should include:

- Counseling staff
- Community-based support/crisis advocates
- Social welfare service providers/child protection
- Religious leaders
- Hospital managers
- Pharmacy staff
- Medical and forensic laboratories

MEDICAL FORENSIC MANAGEMENT OF CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

Access to specialized health care and treatment is an essential component of a holistic care response for children who have experienced sexual violence and exploitation. Health care service providers must make preparations to respond thoroughly and compassionately to individuals, including children, who have experienced sexually violence and exploitation. Health staff should be trained in the clinical care of children who have experienced sexual violence and exploitation, and have the necessary equipment and supplies to provide treatment (IRC UNICEF 2011).

The evaluation for sexual violence and exploitation of children includes:

- Obtaining informed consent
- Obtaining a history from all appropriate sources
- Conducting physical examinations
- Treating injuries
- Collecting forensic evidence
- Offering presumptive treatment for STIs
- Offering HIV testing and counseling
- Offering preventive treatment for HIV
- Preventing pregnancy
- Providing psychosocial support and follow-up

If possible, the medical forensic evaluation should be performed by an examiner with developmentally appropriate communication skills who is trained and skilled in the care and treatment of children who have experienced sexual violence and exploitation. Consultation with a specialist in child sexual violence and exploitation or at an assessment center (where they exist) may be helpful when dealing with difficult cases or cases that occur in the context of other family problems such as family violence or substance abuse (ECSA-HC 2011).

It is important for the provider to remember that the primary objective in evaluating children and adolescents who have experienced sexual violence and exploitation is to provide compassionate, developmentally appropriate care and appropriate treatment.

SIGNS AND SYMPTOMS OF CHILD SEXUAL VIOLENCE AND EXPLOITATION

Sexual violence and exploitation can occur throughout childhood and across contexts, cultures, and classes/castes. Service providers need to be aware of the signs and symptoms that suggest the possibility that sexual violence and exploitation has occurred. Signs and symptoms typically fall into physical or behavioral categories, but no one sign or symptom should be used in isolation to suggest that sexual violence and exploitation has occurred. A significant number of children who have experienced sexual violence and exploitation do not display any signs or symptoms of sexual violence and exploitation. Sexual behavior in children can range from normal to abusive, so it is important that clinicians understand what would be considered developmentally appropriate (see Table 5), and how other types of stress or trauma may be impacting the child (e.g., war, family death, etc.) (Friedrich et al. 2001; Silovsky and Niec 2002).

Table 5. Common Sexual Behaviors Among All Children (Hagan et al. 2008) (AAP 2005)

Developmental Stage	Common Sexual Behavior
Preschool (under 4 years)	• Exploring and touching private parts, in public and in private • Rubbing private parts (with hand or against objects) • Showing private parts to others • Trying to touch mother's or other women's breasts • Removing clothes and wanting to be naked • Attempting to see other people when they are naked or undressing (such as in the bathroom) • Asking questions about their own and others' bodies and bodily functions • Talking to children their own age about bodily functions such as "poop" and "pee"
Young Children (4–6 years)	• Purposefully touching private parts (masturbation), occasionally in the presence of others • Attempting to see other people when they are naked or undressing • Mimicking dating behavior (such as kissing or holding hands) • Talking about private parts and using "naughty" words, even when they don't understand the meaning • Exploring private parts with children their own age (such as "playing doctor," "I'll show you mine if you show me yours," etc.)
School-Aged (7–12 years)	• Purposefully touching private parts (masturbation), usually in private • Playing games with children their own age that involve sexual behavior (such as "truth or dare," "playing family," or "boyfriend/girlfriend")

Developmental Stage	Common Sexual Behavior
	• Attempting to see other people naked or undressing • Looking at pictures of naked or partially naked people • Viewing/listening to sexual content in media (television, movies, games, the Internet, music, etc.) • Wanting more privacy (e.g., not wanting to undress in front of other people) and being reluctant to talk to adults about sexual issues • Beginnings of sexual attraction to/interest in peers

A table of sexual behaviors in young children can be found in Annex 14. Box 4 contains a list of physical indicators that may heighten concern for sexual violence and exploitation.

Box 4:
PHYSICAL INDICATORS CONCERNING FOR POSSIBLE SEXUAL ABUSE

- Pregnancy in a child unable to legally consent to sexual activity
- STI in a child beyond the perinatal acquisition period
- Pain, sores, bleeding, injury, and discharge from the genitalia of a prepubescent child
- Disclosure of sexual violence of exploitation by a child or adolescent

CO-OCCURRING FORMS OF VIOLENCE

Children who experience sexual violence and exploitation may also be exposed to other forms of violence (emotional, physical, neglect, etc.) in the family or the environment. It is important that providers be aware of this and screen for other forms of violence during the examination.

Coordination and collaboration across disciplines is a necessary component for the safety planning of a child or adolescent who has experienced sexual violence and exploitation to ensure they are not being continually exposed.

PROVISION OF CARE

In cases of sexual violence and exploitation of children and adolescents it is necessary to understand the distinctions between the prepubertal and adolescent population. Genital injury is rare in prepubertal children and, in this patient population, a speculum examination is unwarranted in most circumstances. DNA evidence is not found beyond 72 hours post assault from the prepubertal child's body, but is more often found on clothing (Christian et al. 2000). However, in the adolescent or postpubertal population, there is an increased risk of ascending pelvic infection that rarely exists in prepuberty, warranting a full pelvic exam. Evidence from the vagina and cervix may be found up to 7 days or 168 hours post assault (Faculty and Forensic and Legal Medicine 2011).

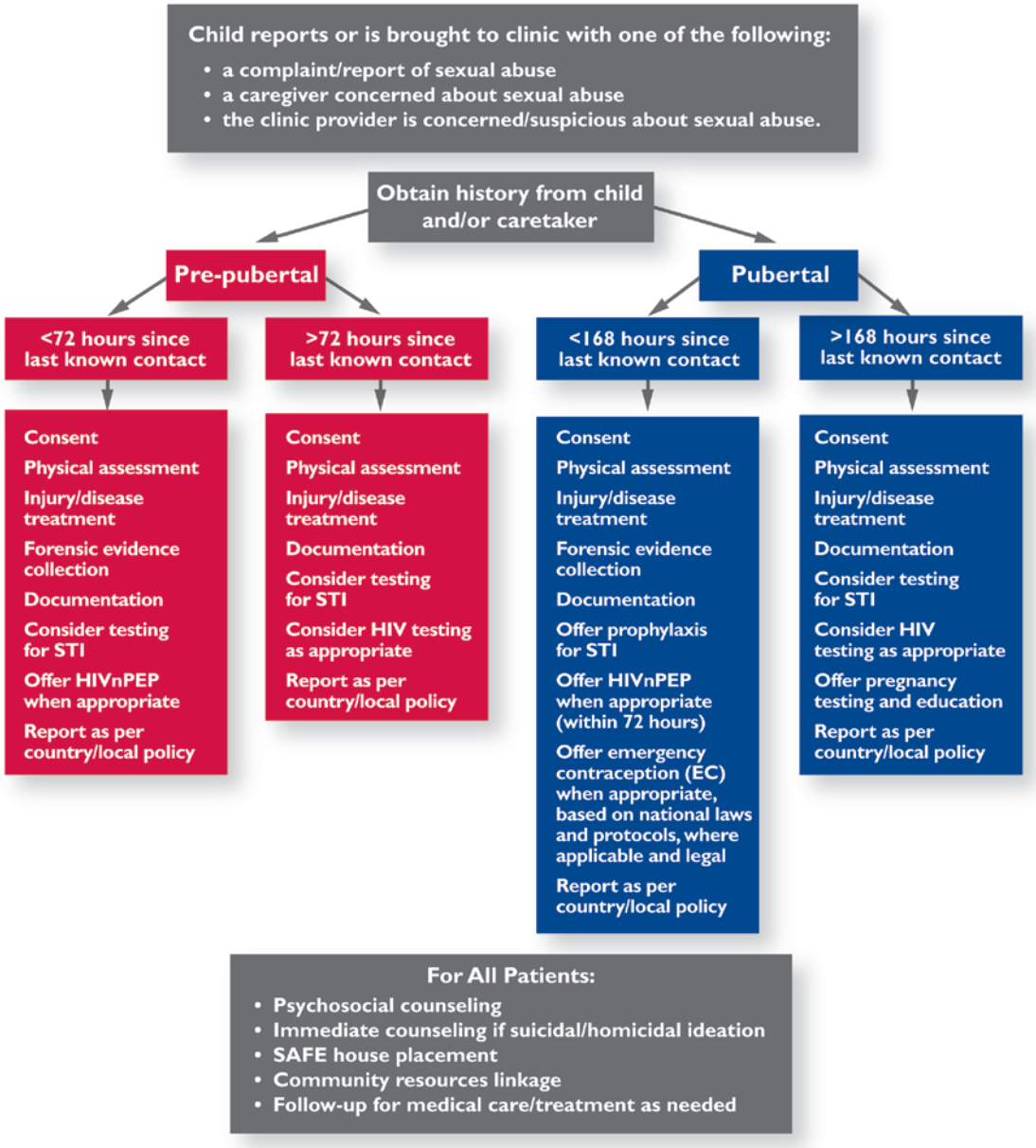
The urgency of medical care is determined by the presentation of the patient, presence of injuries, and nature of the assault. It is important that all providers recognize that the need for emergent treatment of injuries always supersedes evidence collection. Typically children and adolescents who

have experienced sexual violence and exploitation fall into two categories: acute and nonacute. The key to determining the correct category lies with training the service providers who will initially interact with the child. It is critical to remember that each child is unique with individualized needs and concerns. Providers should remain open to those needs.

Be aware that some serious and life-threatening injuries may not be physically visible or even associated with pain (e.g., internal bleeding to the stomach or brain, injury to neck structures in cases of strangulation, fistula, etc.). A full history and physical examination is always the minimum standard of care. All medical care should be delivered utilizing personal protective equipment for the provider to minimize risk of exposure to blood-borne pathogens. Gloves should be worn during the examination and changed frequently throughout any evidence collection procedures to ensure that cross-contamination does not occur.

An algorithm outlining the typical flow of clinical management in child sexual violence and exploitation is seen in the figure here.

Figure 2. Care Algorithm



ACUTE EXAMINATIONS

Depending on the nature and circumstances of the sexual violence and exploitation, as well as the child's preference, if an incident has occurred within the past 168 hours in the adolescent population or 72 hours in the prepubertal, provisions for medical care and evidence collection should be offered.

The most immediate medical/forensic needs are as follows:

- **Medical stabilization/treatment of acute injury or pain**: In some circumstances the nature of the injury (i.e., broken bones, wounds, or internal injuries) will require immediate medical intervention.
- **Prevention of HIV:** The risk for HIV can be reduced if a child is evaluated for and offered HIV post-exposure prophylaxis within 72 hours of the assault.
- **Prevention of pregnancy:** The risk for unwanted pregnancy can be reduced if a child (Tanner stage III and above) is offered emergency contraception within 120 hours of the assault.
- **Evidence collection:** If an adolescent (onset of menses in girls, Tanner stage III in boys [see Annex 3]) has been assaulted within 168 hours of exam, evidence collection should be offered as a provision of their care. If a prepubertal child has been assaulted within 72 hours of the exam, evidence collection should be offered as a provision of their care.

NONACUTE EXAMINATIONS

Regardless of the time of presentation, all children and adolescents who have disclosed sexual violence and exploitation require medical care due to the associated health consequences. Typical DNA evidence collection is not warranted past 168 hours.

MANAGEMENT OF A CHILD WHO HAS EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

COMMUNICATING WITH CHILDREN WHO HAVE EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION

The heart of compassionate and effective service provision relies on the service provider having the appropriate knowledge, attitude, and skills to communicate trust, comfort, and care to the child. It is through the dynamic process of communication (verbal and nonverbal) that positive, helping relationships are developed and healing can occur.

The ability to communicate effectively with children is crucial to sharing information, as well as for encouraging future communication. Accurate and truthful information can be empowering to children and facilitates their involvement in subsequent decision making.

Service providers responding to cases of child sexual violence and exploitation should strive to communicate in a developmentally appropriate manner. Although specific history-taking techniques will need to be adapted according to a child's age and developmental stage, some core communication principles outlined here may help to guide communication, regardless of the child's age, sex, or cultural context (IRC UNICEF 2012).

Core Communication Principles

- Treat the child with respect and dignity throughout the entire examination irrespective of their social status, ethnicity, religion, culture, sexual orientation, lifestyle, sex, or occupation
- Greet the patient by her/his preferred name
- Introduce yourself to the child and tell her/him your role using developmentally appropriate language
- Have a calm demeanor
- Avoid the appearance of being rushed
- Maintain eye contact as much as is culturally appropriate
- Be empathetic and nonjudgmental
- Avoid making assumptions about the nonverbal behavior of children at all developmental levels
- Avoid making assumptions about the way the child feels about the perpetrator or the acts of sexual violence and exploitation (i.e., that the acts were painful, that the child hates the perpetrator)
- Speak at eye level or below
- Establish rapport with the child by discussing things other than the reason for their visit (e.g., school, pets, siblings, etc.).

Communication Techniques

- Children under the age of 4 years are not generally able to give a detailed history. The history is generally obtained by the caregiver presenting with the child, but no information is specifically solicited from the child. However, the child may spontaneously disclose information to the provider during the exam. These spontaneous statements should be recorded in quotations by the provider.
- When developmentally appropriate, the history-taking should occur solely between the child and the provider.
- Whenever possible, open-ended questions should be utilized. Examples of open-ended questions are: "Do you know why you are here today?", "Can you tell me more about...?", "What do you mean by.....?"
- Leading questions are questions where the provider suggests the answer, and they should be avoided. "Did he put his hands on your breasts?" is an example of a leading question. To make the question non-leading, one could say, "Where were you touched on your body?"
- Give the child the ability to make choices throughout (e.g., "Would you like this blanket or that blanket?"). This allows the child to regain control and feel empowered.
- Avoid using the words "why" or "how come" because this tends to assign blame to the child.

- Ask one question at a time.
- Avoid the use of prepositions. Children may not developmentally understand concepts like inside, outside, on, under, etc.
- Young children have no accurate sense of time and should not be questioned with regard to *when* something may have happened to them.

Other considerations for history-taking with children can be found in Table 7.

CONSENT

It is important that providers recognize consent as a process that continues throughout the examination and treatment. Although it almost always involves a formal signed document, consent may be withdrawn at any time. Consideration should be given to capacity and age when determining who may consent for the exam of a child (Medical Protection Society 2011). If the child is not of legal age to consent to medical treatment in the country in which care is being delivered, then a parent or guardian or proxy will need to provide consent. It is critical that providers understand the national laws with regard to consent prior to providing treatment to ensure adherence to the rights of the child. There should be a protocol or policy in place that outlines how to obtain proxy consent when the child or parent/guardian is unable or unwilling to provide consent. This may include obtaining legal proxy to proceed. Annex 5 contains more on the issue of consent and assent during the examination.

Consent for the examination should include information on the collection and disposition of any forensic samples that are collected in the course of the exam. The consent form should include what parties (e.g., the police, law enforcement, and other investigating authorities) the information and specimens obtained during the examination will be released to. Sample consent forms are found in Annex 5.

THE CHILD'S ROLE

Providing children with information about what is happening, and offering them a chance to express their thoughts, helps them to feel safe during their care and treatment. Children's rights in decision making are based on local laws and service provider policies (IRC UNICEF 2012). The child's role in the consent process is dependent not only on local law and policy but also on age and developmental stage of the child or adolescent receiving treatment.

- Prepubertal children often require assent for the exam rather than formal consent, which is obtained from the non-offending parent or guardian.
- Adolescents require both assent and consent for their examination and treatment.

Any examination, however, should not proceed without assent from the child or adolescent. This means that a child should never be held down and forced to comply with the medical forensic evaluation, which can cause further harm and trauma.

TAKING A MEDICAL FORENSIC HISTORY

The purpose of the medical forensic history is to obtain all relevant medical and psychosocial information regarding the child's health, as well as the specific circumstances of the assault. Prior to obtaining relevant medical and incident history, however, it is critical that the provider establish an effective rapport with the child. Because a child's communication ability changes dramatically from developmental stage to developmental stage, the provider's knowledge and comfort with those stages can play an important role in care. See Table 6 for some general considerations in history taking with children. A sample history form can be found in Annex 10 and a medical management job aid is found in Annex 8.

Table 6. Considerations for History-Taking

Developmental Stage	Considerations for History-Taking
Infants/toddlers/preschool (birth to 4 years old)	Children in this age group have limited to no verbal skills and should not be asked to provide any history (see communication techniques above). Non-offending caregivers or adults presenting with the child for care are the primary sources of information about the child and suspected sexual violence and exploitation.
School-aged children (5–9 years old)	Children in this age range should provide a history whenever possible. Caregivers, parents, and guardians may provide supplemental information but should not be involved in the history-taking unless the child refuses to separate. Providers should use non-leading language (see communication techniques above).
Early and later adolescents (10–18 years old)	Children in this age range should provide their own history. Caregivers, parents, and guardians should not be involved in the history-taking to allow the child to express their own viewpoint on what has happened to them. Parents or guardians can inhibit this age group from sharing all information.

Special Circumstances	Considerations for History-Taking
The child who will not speak	If a child cannot or will not speak to the provider, the provider should continue to talk with the child, and explain all of the examination process, but have no expectation that the child will give them a history. It is not unusual for a child who initially will not speak to begin speaking as the examination progresses, and they begin to feel more comfortable with the examiner. It is possible that children may present that have not experienced sexual violence and exploitation. Some children may not be willing to talk about the sexual violence and exploitation—forcing them to talk about this is traumatizing and should not be done.
Children with disabilities	Children with disabilities should be communicated with in the manner in which they are most comfortable (e.g., sign language, Braille, plain language/pictures, or audio aids). It should never be assumed that because a child has some form of disability that they are not capable of communication. Some disabilities affect the way that children and adolescents communicate. It can be difficult to understand them, and difficult for them to understand others, which can also lead to misunderstandings that further impede comprehension. It is important to remember that children with disabilities are at greater risk of sexual violence and exploitation. It is important to respect that some children with disabilities may not wish to have the physical exam as they may not want to share or expose their body with a stranger. It is important to consider the best interest of the child and not use force when a child with disabilities may not be able to communicate on their own.
Female genital mutilation/cutting (FGM/C)	Children with FGM/C should be examined just as those without (see Glossary of Terms – Medical for WHO definitions of FGM/C).

The medical forensic history can guide the evidence collection process. This allows for accurate development of a plan of care. In children, much of this information may need to be obtained from a parent, caregiver, or guardian; however, when developmentally able, the sexual violence and exploitation history should be obtained directly from the child or adolescent. Suggestions for ways to begin history-taking with a child can be found in Box 5.

The process for taking a history should proceed in a similar manner to any other medical history-taking:

- Chief complaint
- History of present illness
- Review of systems
- Past medical history, including any history of FGM/C or previous exams for sexual violence and exploitation
- Family and social history

The limitations in attention span due to developmental age and stage will limit the amount of time appropriate for history-taking. Realizing this limitation and recognizing that there are individual variations in children, there are no "standard" time limits or recommendations on time limits for history gathering in children. As a general rule, history-taking will not take more than an hour with children.

Box 5:
WAYS TO BEGIN A HISTORY-TAKING SESSION

- "My name is Jane, I am a doctor. My job is to make sure you are all right."
- "Can you tell me your name?"
- "How old are you?'
- Review Child's Knowledge of Body Parts.
  "What do you call this?" Point to the child's ear.
  Continue in this fashion until the child has named most body parts, including their genitalia. Use the children's language when talking to them about their body parts.
- "Do you know why you are here today?"
- "Do you hurt anywhere?"

When the history has been completed, the provider can help the child prepare for the examination by discussing the procedures, practicing the positions the child may be asked to assume, and assure the child that the examination is to make sure he or she is "all right."

PSYCHOLOGICAL ASSESSMENT

The psychological assessment of the child should include the developmental stage of the child, and any signs of distress the child may be experiencing as a result of the sexual violence and exploitation they have experienced. Often they will have experienced psychological pressure, threats of physical violence, and coercion to participate in the sexual violence and exploitation. Children who

experience sexual violence and exploitation need to feel they are in a safe environment, and the provider should assure that the child is not rushed or hurried through the examination. Children who have experienced sexual violence and exploitation should be assessed for (WHO 2003):

- Signs of depression
- Anxiety
- Symptoms associated with posttraumatic stress disorder such as avoidance, numbing, hyperarousal
- Inappropriate sexual behavior
- Loss of social competence
- Cognitive impairment
- Substance abuse
- Alterations in body image
- Suicidal ideations

PHYSICAL AND ANOGENITAL EXAMINATION

Although there is a desire to separate distinctly the medical from the forensic components of the examination, it cannot be done. The forensic or evidentiary components of the exam, if they are necessary, must be incorporated into all aspects of the medical care itself in order to provide seamless care. For this reason, providers must be prepared to incorporate all evidence collection into the physical examination as it proceeds.

Of equal importance is conveying the fact that the provider is interested in the entire child, not just their genitalia. For this reason, care must be taken by the provider to first focus on the overall head-to-toe thorough assessment and review of systems, before moving to the genital examination (see Annex 6).

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

- Record the height and weight of the child, as well as the head circumference in children younger than 3 years.
- Record the child's Tanner stage of sexual development in either sex (see Annex 3).
- Assess for any injury or disease process on all surfaces of the skin, including the soles of the feet, behind the ears, the axilla, the eyes, and oral cavity/mouth.
- Document the size, location, color, and type (abrasion, laceration, etc.) of any injuries or disease; photo-document if possible.
- Document any injuries or disease process noted.

Once the full review of systems has occurred, the provider can focus on the anogenital examination of the child based on stage of development. A useful list of medical terms is included in this document.

EXAMINATION OF THE PREPUBERTAL FEMALE

Many providers unfamiliar with sexual violence and exploitation evaluations in children believe the examination will be traumatic for the child. For this reason suggestions such as medicating, sedating, or even holding children down may be discussed. In fact, very rarely will children require sedation for an examination. In most instances children are easily taught the exam techniques and are compliant with the requests of the provider conducting it, after the provider has established rapport with the patient.

For prepubescent children, the examination should focus on the external genitalia. **Generally speaking, no speculum or digital examination[11] of prepubescent girls should occur**. Indications for internal examination of girls are outlined in Box 6. Generally speaking, if an internal examination is required, sedation or anesthesia must be considered.

Box 6:
INDICATIONS FOR INTERNAL SPECULUM EXAM IN PREPUBESCENT GIRLS

- Bleeding from the vagina orifice
- Suggestion that a foreign body may be present in the vagina
- External genital injury requiring surgical repair

Specific examination positions should be used to facilitate the examination of genitalia. See Table 7 and illustrations of examination techniques.

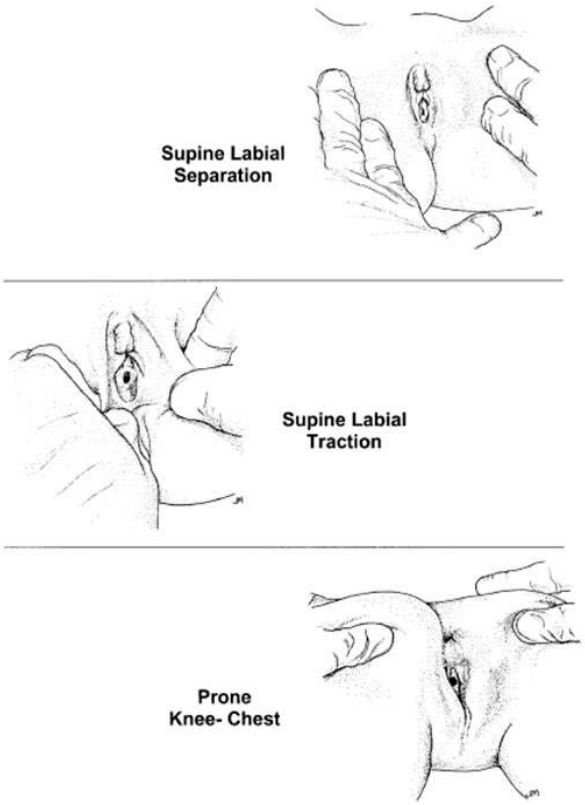
Table 7. Examination Positions and Techniques

Exam Position/ Technique	Description
Supine frog-leg position	Child lying on exam table or lap of a caregiver with feet close together and knees loosely apart. Allows for good visualization of the labia, and ease of use with labial separation and traction techniques
Supine knee-chest	Child lying on exam table or lap of a caregiver, with feet and knees together holding knees to chest (may need assistance). Allows for good visualization of the anus and surrounding tissues.
Prone knee-chest position	Child on exam table in a prone position. Head and torso are flush with the table, knees separated and down on exam table with buttocks raised. Allows for excellent visualization of the anus, surrounding tissues, and rectal cavity during dilation. With use of labial separation and traction, allows for assessment and confirmation of hymenal discrepancy visualized while child was in supine frog-leg.

[11] Digital exam is also not indicated in post-pubertal girls.

Exam Position/ Technique	Description
Labial separation	With the child in a supine frog-leg position, the provider gently separates the child's labia with gloved hands allowing for visualization of the genital structures.
Labial traction	With the child in a supine frog-leg position, the provider gently holds the child's labia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and down toward the anus of the child. The examiner should pay close attention to the area of the posterior fourchette before, during, and after the exam as examiner-induced injury may occur. With the child in prone knee-chest position, the provider gently holds the child's labia majora bilaterally between thumb and forefingers with gloved hands, pulling out toward the examiner and up toward the anus of the child. The examiner should pay close attention to the area of the posterior fourchette before, during, and after the exam as examiner-induced injury may occur.

Illustration of examination positions and techniques[12]

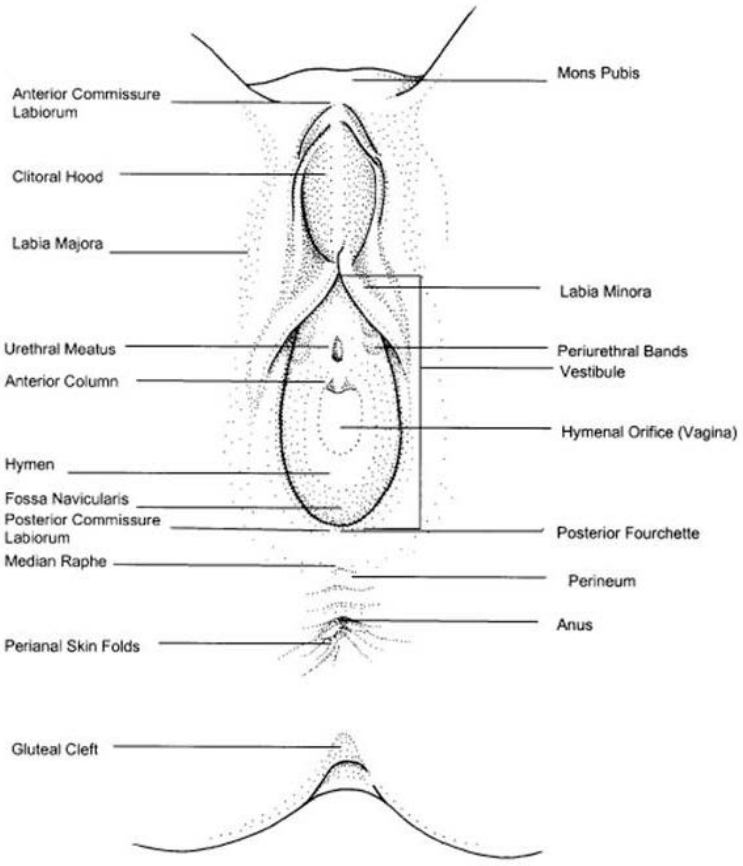


[12] California Medical Protocol for the Examination of Sexual Assault http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CD8QFjAC&url=http%3A%2F%2Fwww.calema.ca.gov%2Fpublicsafetyandvictimservices%2Fdocuments%2Fforms%2520201 1%2Fnumeric%2520forms%2520listing%2Fprotocol%25202-923-2-950.pdf&ei=kiTCUMGsH86brQHn0IGgAg&usg=AFQjCNHJN-bQUneeSUK3pnB_cVVlkoAJjg

In girls, assess the following external genital structures for injury or disease process:

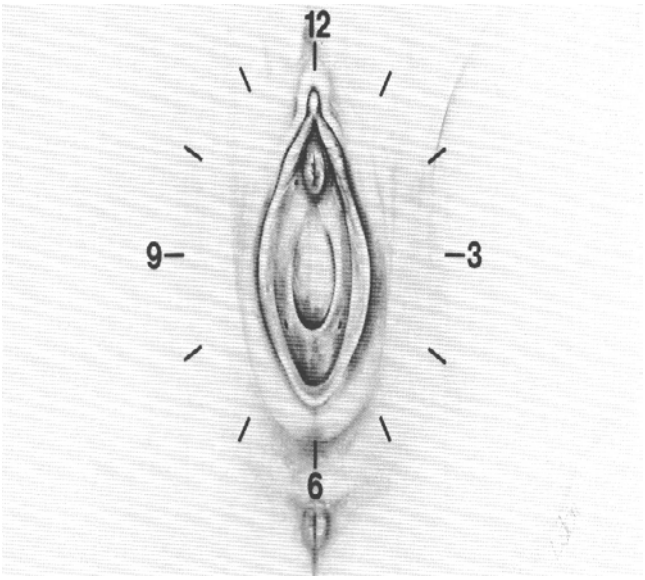
- Mons pubis
- Labia majora and minora
- Clitoral hood and clitoris
- Urethra and periurethral tissues
- Posterior fourchette
- Fossa navicularis
- Hymen
- Vaginal vestibule
- Perineum

Illustration of the Female Genital Anatomy[13]



[13] California Medical Protocol for the Examination of Sexual Assault http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=3&ved=0CD8QFjAC&url=http%3A%2F%2Fwww.calema.ca.gov%2Fpublicsafetyandvictimservices%2Fdocuments%2Fforms%2520201 1%2Fnumeric%2520forms%2520listing%2Fprotocol%25202-923-2-950.pdf&ei=kiTCUMGsH86brQHn0IGgAg&usg=AFQjCNHJN-bQUneeSUK3pnB_cVVlkoAJjg

Illustration of Clock Face Documentation



Documentation of the genital structure assessment and findings should be done using the clock face analogy (see illustration). Some examiners assign the twelve o'clock position to the urethra, causing the clock position to change when the child's position changes. Others have the clock positions remain the same, and always document the position of the child when describing a finding. Each examiner should choose the method that best suits their practice, and adhere to that method for each examination.

The provider superimposes the clock face and uses the appropriate time to document what is observed. It is critical that the provider note the type of injury, size if possible, structure the injury is observed on, and color of injury.

Box 7:
HYMENAL ASSESSMENT TECHNIQUES IN POSTPUBERTAL FEMALES

- Use of a moistened cotton-tipped swab to sweep around the hymenal edge to look for hidden tears/lacerations.
- Use of a small (8Fr) sterile Foley balloon catheter. The catheter is introduced through the hymenal opening into the vagina and the balloon is inflated to a degree that is tolerated (2-3 mL water in the balloon). The catheter is slowly and gently withdrawn until the balloon rests against the internal aspect of the hymen. The catheter is slowly rotated around the clock face to allow full view of the hymenal edge.

EXAMINATION OF THE POSTPUBESCENT FEMALE

The adolescent girl who has reached puberty should receive a full pelvic examination in addition to the rest of the history and physical. The same examination techniques (see Box 7) may be employed as with the prepubescent; however, the lithotomy (laying on their back, knees bent, feet in stirrups, and thighs apart) position will also be used as performance of a speculum examination is standard practice.

The examiner should give a description of the examination to the child prior to beginning. It should be made clear to the child that she has a right to decline any portion of the examination as the provider moves along. This will give the child back a sense of control over the examination, and her body. She should be allowed to have someone—nurse, friend, or mother—present during the examination if she desires.

FEMALE GENITAL MUTILATION/CUTTING (FGM/C)

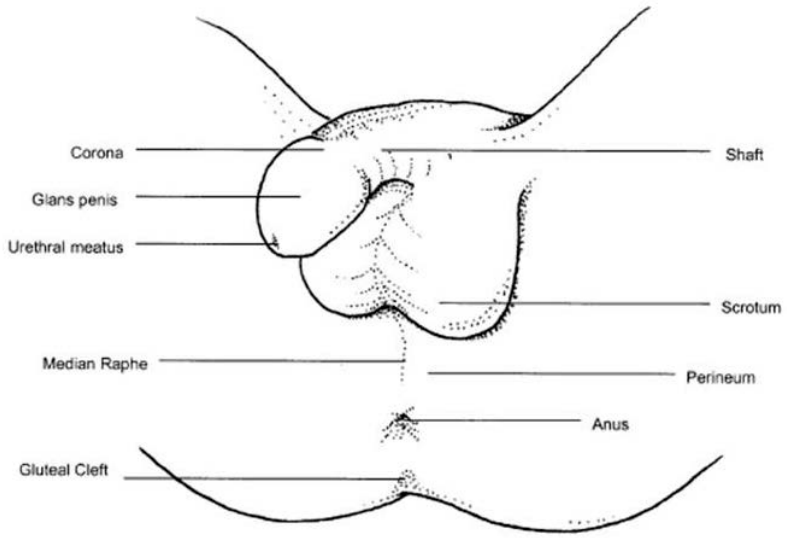
Observation and documentation of any existing FGM/C that has been performed on the child should be done using the WHO classification system. FGM/C can impact the long-term health of young women and girls, including pain, infection, prolonged bleeding, hemorrhage, urinary tract infections, and pregnancy complications (Kiragu 1995). Local laws vary with regard to FGM/C as a mandatory report of child sexual violence and exploitation.

EXAMINATION OF THE MALE

In boys, the genital examination should include the following structures and tissues, checking for signs of injury or disease process:

- Prepuce of the glans
- Glans penis and frenulum
- Urethral meatus
- Penile shaft
- Scrotum
- Testes
- Inguinal region
- Perineum

Illustration of the Male Genital Anatomy



ANAL EXAMINATION OF THE MALE AND FEMALE

Examination of the anus in children is best approached utilizing either the supine or prone knee-chest positions. In either position, apply gentle traction to part the buttock cheeks. During the course of an anal examination the following tissues and structures should be inspected, again looking specifically for signs of injury or disease process:

- Perianal area, paying particular attention to the perianal folds
- Anal verge/margin
- Anorectal canal
- Anus
- Gluteal cleft

A digital examination should only be used in cases where laxity of the sphincter is observed during the exam. Anoscopy is not routinely utilized, unless there is bleeding, obvious trauma, or question of lodged foreign body.

THE COLPOSCOPIC EXAMINATION

A colposcope is a noninvasive binocular field microscope with adjustable light illumination that creates a magnified image. It may also provide photographic capability for taking still or video images. When available, colposcopes are utilized for magnification of the anogenital area of children who have experienced sexual violence and exploitation to aid in identification of injury or disease process. It allows for a permanent record of the genital examination findings and in obtaining a second opinion. It also facilitates peer review, teaching, and training.

Because the cost of a colposcope is significant, many sites will not have them available. Providers can utilize any handheld magnifying device to aid in assessment of the genitalia.

EVIDENCE COLLECTION IN ACUTE SEXUAL ASSAULT

When a child presents for care acutely following sexual violence and exploitation, evidence collection should be offered as a provision of medical care. General forensic principles are outlined in Table 8. Evidence obtained during the exam may be helpful in any criminal justice proceedings that result from the report of sexual violence and exploitation. Evidence collection is usually done utilizing a standardized evidence kit. Common sampling is outlined in Table 10. Despite the presence of a standardized kit, the collection of evidentiary samples should proceed based on the details obtained by the examiner during the patient history. In the instance of children developmentally unable to give a clear history, evidence collection should be based on standard specimens collected under protocol.

Basic evidence collection is built on the foundational understanding that where contact between two objects exists, there also exists the possibility of material transfer: Locard's exchange principle (DeForest, Gaensslen, and Lee 1983). Any contact between an offender and child, as well as the crime scene itself, may have potential corroborating evidence left behind. This evidence may be in

the form of trace materials and/or body fluids from the offender. As the body of the child is assessed, forensic samples should be taken from the areas where possible evidence may exist.

Table 8. General Forensic Considerations

Consideration	Rationale
Wear gloves throughout the evidence collection process, and change them frequently when examining different body areas.	Prevents possible contamination of specimens and exposure to blood/body fluids.
Collect evidence as soon as possible	The likelihood of obtaining viable specimens decreases over time.
When collecting specimens for medical testing and forensic samples, collect forensic samples first	There is an increased likelihood of obtaining biologic materials with the first specimens collected.
Handle specimens appropriately	Ensure that specimens are packaged, dried, and transported properly. Clothing evidence should be bagged individually in paper bags.
Label specimens accurately	Label all specimens clearly with the name of the patient, the date of birth, the source of the specimen, the date and time collected, and the health care provider's name or initials (according to policy).
Ensure security of specimens	Specimens should be packaged and sealed to ensure that the specimens are not tampered with.
Minimize the number of people who handle the evidence/specimens	This will help to ensure that the chain of custody is maintained.

The standardized evidence kit, if available, should be utilized. National protocols should be followed. Forensic specimens should be adequately dried to prevent possible degradation of DNA. In instances where this is not possible, materials should be packaged in material that will not retain moisture (i.e., paper versus plastic). Labeling and packaging should be done in a manner that ensures the integrity of samples is maintained. Table 9 provides the material, equipment, and instructions for evidence collection.

Chain of custody should be documented and maintained from the time of obtaining it from the child to the release of the materials to law enforcement. This will ensure that the integrity of the evidence is maintained. Annex 9 provides a job aid on the clinician's role in evidence collection.

Table 9. Evidence Collection

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
Penile/oral penetration with or without ejaculation	***Oral swabs***	Seminal fluid if oral penetration within 2 days	Sterile cotton-tipped swabs	Use two dry swabs to swab/rub over the oral cavity (e.g., under tongue, around teeth, cheeks, and gums)
In all cases of evidence collection	***Buccal swabs***	Patient's reference DNA sample	Sterile cotton-tipped swabs	Use two swabs to swab/rub over the inner aspect of each cheek at least 20 minutes after patient has had food or drink This should be completed *after* Oral Swabs
If drug-facilitated sexual assault is suspected If crime lab does not accept buccal swab for reference DNA sample	***Blood***	If drug-facilitated sexual violence and exploitation is suspected within 24 hours of the exam	Blood tube containing potassium oxalate OR at least 1.5% sodium fluoride + potassium oxalate or OR EDTA (ethylenediamine tetraacetic acid)	Collect 10 mL of venous blood
If drug-facilitated sexual assault is suspected	***Urine***	If drug-facilitated sexual violence and exploitation is suspected within 120 hours of the exam[14]	Appropriate sterile container with at least 1.5% sodium fluoride preservative	Collect a minimum of 90 mL of urine
If the patient broke a fingernail during the assault or scratched or dug at the body of the assailant	***Fingernail swabs***	Skin, blood, fibers, etc. (from assailant); and for comparison with any broken nails found at scene	Sterile cotton-tipped swabs × 2 Sterile water	Moisten first swab with sterile water and clean under fingernails; repeat with the second dry swab (two swabs for each hand). Only collect fingernail clippings if a nail was broken during the assault

[14] Society of Forensic Toxicologists Drug Facilitated Sexual Assault Fact Sheet: http://soft-tox.org/sites/default/files/DFSA-Fact-Sheet.pdf

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
If the assailant put their mouth anywhere on the patient, collect a specimen If foreign material or debris is seen during exam, collect specimen	***Other body surface specimens***	Body fluids/DNA; other possible foreign materials (skin within 48 hours) Foreign material (e.g., vegetation, matted hair, or foreign hairs)	Cotton-tipped swabs × 2 per site Sterile water Bindle/pharmacy fold	Moisten first swab with water and swab/rub over sites where semen, body fluids, or DNA may be present; repeat with the second dry swab Place foreign material in bindle, and enclose and seal in evidence envelope
Vaginal/penile penetration or other genital to genital contact	***Genitalia: Pre-pubertal*** External Genital	Body fluids/DNA; other possible foreign material	Cotton-tipped swabs Sterile water	Moisten first swab with sterile water and thoroughly swab/rub over the external genitalia; repeat with the second dry swab
Vaginal/penile penetration or other genital to genital contact	***Genitalia: Pubertal*** External Genital Low Vaginal High vaginal	Body fluids/DNA; other possible foreign material	Cotton-tipped swabs Sterile water Speculum and water-based lubricant (e.g., K-Y, Pedicat, Gelcat)	Moisten first swab with sterile water and thoroughly swab/rub over the external genitalia; repeat with a second dry swab Insert a dry swab into the lower one third of the vagina (approximately 2–4 cm beyond the vaginal orifice) and use a gentle rotational movement to obtain a sample; repeat with a second dry swab Pass a lubricated sterile speculum into the vagina; insert a dry swab and swab/rub over the mucosal lining of the upper two thirds and fornices of the vagina; repeat with a second dry

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
	Cervical			swab; if it is not possible to pass a speculum, attempt to obtain two vaginal swabs With the speculum in place, use two dry swabs, one at a time, to swab the face of the cervix
Anal/penile penetration; rectal/penile penetration; oral/anal penetration or contact	***Anorectal:*** Perianal Anal Canal	Body fluids/DNA; other material	Cotton-tipped swabs Sterile water	Moisten first swab with water and swab/rub over perianal area/folds; repeat with the second dry swab Using another two swabs, repeat the same procedure for the anal canal
Oral contact; anal or rectal contact; foreign material suspected (i.e., lubricant)	***Penile Swabs:*** Penile shaft and prepuce (foreskin) Glans	Body fluids/DNA; other material	Cotton-tipped swabs Sterile water	Moisten first swab with water and swab/rub over the shaft of the penis and prepuce/foreskin (when present); repeat with the second dry swab Repeat the same procedure for the glans, avoiding the urethra (the urethra will result in the patient's own DNA being obtained)
If the patient is wearing the same clothes as at the time of the assault; collect the underpants only if the patient has changed clothes since the assault	***Clothing***	Adherent foreign material (e.g., semen, blood, hair, fibers)	Paper bags	Clothing worn at the time of the assault should be placed in a paper bag; wet items should be dried if possible; all items should be bagged separately
If the patient was wearing a tampon/pad/diaper at the time of the	***Sanitary pads, tampons, panty-***	Body fluids/DNA; other foreign material (e.g.,	Appropriate sterile container Small clamp	Collect if used during or after vaginal or anal penetration

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
assault or immediately following; if a condom is found in or on the patient's body from the assault	***liners, diapers, condoms***	semen, blood, hair)		For condoms: use small clamp to close off open end and place in sterile container

INTERPRETATION OF CLINICAL FINDINGS

A wide range of normal clinical findings can be expected during the examination of children. Anatomical variations and disease processes exist in all populations, and may be mistaken for sexual violence and exploitation. For that reason, providers should be educated at a minimum on normal variants and conditions commonly mistaken for sexual violence and exploitation. Research shows that less than 10 percent of children who have experienced sexual violence and exploitation have abnormal exams (Adams 1994). Table 10 has some common findings that may be mistaken for sexual violence and exploitation.

Table 10. Differential Diagnosis of Genital Findings (not all inclusive)

Anatomical Variations & Disease Processes	Common Findings Mistaken for Sexual Violence and Exploitation
FGM/C	See Glossary of Terms - Medical
Labial agglutination or adhesion	The result of adherence (fusion) of the adjacent, outermost, mucosal surfaces of the posterior portion vestibular walls. This may occur at any point along the length of the vestibule although it most commonly occurs posteriorly (inferiorly). A common finding in infants and young children. Unusual to appear for the first time after 6 to 7 years of age. May be related to chronic irritation.
Lichen sclerosis	An uncommon, chronic, atrophic condition that creates patchy, white skin that is thinner than normal. Lichen sclerosis may affect skin on any part of the body, but most often involves skin of the vulva, foreskin of the penis, or skin around the anus. There is often itching associated with this, which can result in areas of bleeding and irritation.
Urethral prolapse	A condition in which the urethra protrudes through the external meatus. It may have a swollen, reddened appearance.
Streptococcus infection	Group A streptococci are gram-positive bacteria that produce beta-hemolysis and appear usually as a chain of two or more bacteria and have molecules on their surface known as Lancefield group A antigens.

Anatomical Variations & Disease Processes	Common Findings Mistaken for Sexual Violence and Exploitation
Staphylococcus infection	Staphylococcal infections are caused by *Staphylococcus* bacteria, a bacteria commonly found on the skin or in the nose of even healthy individuals.
Straddle injury	Injury that can occur in the urogenital area from a fall, where the child "straddles" an object.

SEXUALLY TRANSMITTED INFECTIONS IN CHILDREN

Children being evaluated for sexual violence and exploitation may require diagnostic testing based on their presentation and physical assessment. Because prevalence of HIV and other STIs in prepubertal children who have experienced sexual violence and exploitation varies, testing for these infections is a reasonable approach (Kaplan et al. 2011). However, in geographic regions with high HIV prevalence and limited resources, HIV counseling and testing should be offered whenever possible. Providers will want to consider how and under what circumstance testing will occur.

In prepubertal children a "dirty urine" (or random voided urine specimen) or nucleic acid amplification test (NAAT) is superior to genital swabs (Black 2009). The NAAT is also appropriate for the adolescent population. In the absence of NAAT, genital swabs in prepubescent children should be taken from the vulva and beside the vaginal orifice. Cervical specimens are only required in adolescents (i.e., those at Tanner stage II of puberty or later, see Annex 3), as adolescents may have asymptomatic infections. Presumptive treatment for infection should be offered in children who have experienced sexual violence and exploitation according to local policies. Children and adolescents who test positive for STIs should be treated according to national protocols. Specimens may be required to test for STIs and pregnancy (in the case of the postpubertal female). If a provider tests for STIs, testing for HIV should also be offered.

The diagnosis of an STI in a prepubertal child or adolescent who has not become sexually active may be evidence that the child has experienced sexual violence and exploitation. Which diagnostic testing is necessary should be determined on a case-by-case basis. Which tests are performed and the results of any testing should be documented in the medical record. The following diagnostic tests may be necessary to complete in children:

- NAAT urine test for *Chlamydia trachomatis* and *Neisseria gonorrhea*. This specimen can be obtained as a "dirty" (a random voided, non–clean catch specimen) (Black 2009).
- Trichomoniasis testing of a portion of the "dirty" urine specimen.
- Human papilloma virus (HPV) testing using swabs of the vulva, perineum, and surrounding genital tissues. This may be done with or without the presence of warts (see general forensic considerations in Table 8) (Unger 2011).
- Herpes simplex virus (HSV) cultures may be obtained by unroofing a vesicle and sending the fluid for culture. Autoinoculation may occur, and may not be diagnostic for sexual abuse. Viral culture can distinguish between type 1 and type 2.

- Serologic baseline HIV testing should be offered at the time of the exam, and done if consent is given.
- Vertical transmission (acquired intrauterine) of HIV and other STIs can occur. Transmission can also occur from the birth process through cervical secretions of the mother (gonorrhea, chlamydia, HPV, HSV) (CDC 2010).
- Implications of commonly encountered STIs for diagnosis and reporting of sexual violence and exploitation among infants and prepubertal children (CDC 2010).

HEPATITIS B VIRUS (HBV)

When using diagnostic testing for STIs in children, it is important to know the timing of the sexual violence and exploitation, as STI cultures are likely to be negative, unless the child has a preexisting infection. Follow-up testing may be necessary in acute sexual violence and exploitation cases to repeat testing done at the initial examination.

There is no information on the incidence of HBV following sexual violence and exploitation. However, HBV is present in semen and vaginal fluid and is sexually transmitted. If possible, the hepatitis B vaccination should be administered to unvaccinated children who have experienced sexual violence and exploitation within 6 weeks of the last incident (Rogstad et al. 2010). Children who have experienced sexual violence and exploitation are at increased risk of contracting HBV if they have not been immunized against it. If there is vaccine available, and the child has not been immunized, they should be treated with the appropriate type of vaccine and dosage. The first dose should be given at the time of the examination, as a component of the treatment. Once the vaccine is initiated, then the child (or caregiver as appropriate) should be instructed to complete the series of three doses and encouraged to have a booster after one year.

Treatment

Evaluation and treatment for exposure to STIs, pregnancy, and injuries should be completed at the time of the examination. Examples of treatments that should be anticipated are:

- HIVnPEP
- STI prophylaxis and treatment
- Pregnancy prevention
- Injury treatment

HIV NON-OCCUPATIONAL POST-EXPOSURE PROPHYLAXIS (HIVnPEP)

Children might be at higher risk for HIV transmission than adults because the sexual violence and exploitation of children is frequently associated with multiple episodes of violence and might result in mucosal trauma. Specific circumstances of sexual violence and exploitation (e.g., bleeding, which often accompanies trauma) might increase risk for HIV transmission in cases involving vaginal, anal, or oral penetration. Site of exposure to ejaculate, viral load in ejaculate, and the presence of an STI or genital lesions in the assailant or child who has experienced sexual violence and exploitation also might increase the risk for HIV infection (CDC 2005).

Several factors impact the medical recommendation for HIVnPEP and affect the child's acceptance of that recommendation, including:

- The likelihood of the assailant having HIV
- Any exposure characteristics that might increase the risk for HIV transmission
- The time elapsed after the event
- The potential benefits and risks associated with the HIVnPEP

Determination of the assailant's HIV status at the time of the examination is usually not possible. Therefore, the health care provider should assess any available information concerning local HIV epidemiology and exposure characteristics of the sexual violence and exploitation.

When an assailant's HIV status is unknown, factors that should be considered in determining whether an increased risk for HIV transmission exists include:

- Whether vaginal, anal, or oral penetration occurred
- Whether ejaculation occurred on mucous membranes
- Whether multiple assailants were involved
- Whether mucosal lesions are present in the assailant or child who experienced sexual violence and exploitation
- Any other characteristics of the violence, child, or assailant that might increase risk for HIV transmission

The risk factors for acquiring HIV from an act of sexual violence and exploitation will determine whether or not HIVnPEP should be offered to the child. Post-exposure prophylaxis for HIV is an area where practice and treatment modalities are changing frequently. For these reasons health workers are strongly urged to:

- Maintain knowledge of the current recommendations in this field
- Familiarize themselves with national policy and/or guidelines
- Ensure that they are aware of the risks, benefits, and costs of the various regimes so that they are able to fully inform children who have experienced sexual violence and exploitation, and their families, of these issues (ECSA-HC 2011)

The child, caregiver, and health worker must evaluate the risks and benefits of initiating or refraining from PEP treatment and decide together the best option for the child. If PEP is offered, the following information should be discussed with the child and caregiver:

- The unproven benefits of antiretrovirals
- The known toxicities of antiretrovirals
- The importance of close follow-up
- The benefit of adherence to recommended dosing
- The necessity of early initiation of PEP to optimize potential benefits (i.e., as soon as possible after and up to 72 hours after the assault)

Providers should emphasize that PEP appears to be well-tolerated in children and that severe adverse effects are rare (CDC 2010).

The sooner PEP is initiated after the exposure, the higher the likelihood that it will prevent HIV transmission, if HIV exposure occurred. However, distress after an assault also might prevent the child from accurately weighing exposure risks and benefits of PEP and from making an informed decision to start such therapy. If prescribed, PEP should be initiated within 72 hours of the sexual violence and exploitation and be given for 28 days. Patient liver enzyme levels and renal function should be measured and a complete blood count 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, children should have the test repeated at 6, 12, and 24 weeks after the assault**. If the initial testing was not accepted at the time of the examination, the child should still be told that they can return for testing. If available, a professional specializing in HIV infection in children should be consulted prior to prescribing PEP.

RECOMMENDED HIVnPEP REGIMEN FOR CHILDREN

Recommended drug regimens for PEP in children will depend on local or national protocols. These medications and dosing information for children should be readily available and easily accessible.

Providers need to be familiar with local protocols and available medication given the changing nature of antiretroviral therapies. According to WHO, PEP should be broadly available for children, and the challenges of ensuring children's access to it and of follow-up should be addressed, see Box 8. Poor follow-up rates and testing uptake are reported, and strategies to address children's needs for PEP require more attention. Consultation with an infectious disease specialist should be done, if available, as soon as possible if PEP is being considered, and formulations and dose information appropriate for children should be made available to the clinicians. The availability of an infectious disease consultant should not delay or prevent provision of HIVnPEP. Appropriate counseling and consent should be obtained at the time the testing is offered, and if PEP is being given.

Common side effects include nausea, vomiting, diarrhea, headaches, fatigue, and general body malaise. Despite the benign nature of the side effects listed, many can be severe, causing patients to

stop taking the medication. Additionally, people taking PEP risk liver and kidney toxicities that make baseline testing and follow-up an important consideration in care.

HIV counseling and testing (HCT) should always be offered as part of the PEP service package based on informed consent with standard pre-test and post-test counseling according to national or local protocols. HIV testing should not be mandatory or prerequisite for providing PEP, and the results should be treated in the strictest confidence (WHO/ILO 2008). If HCT is not available at the service site and the child falls within the guidelines for PEP, then the medications should be started as soon as possible. It is not recommended that children be referred to programs for preventing mother-to-child transmission, as the drug regimens prescribed in such circumstances are inappropriate for PEP (WHO/ILO, 2008).

Whenever possible, confidential HCT should be done on-site. In the absence of this option, the child should be referred to an HCT center. Regardless of where the child is tested, appropriate counseling services should be made available before and after HIV testing.

Box 8:
THE OPTIONS FOR DISPENSING PEP AT THE INITIAL CONSULTATION ARE AS FOLLOWS:

- An initial supply of medicine to last 1–7 days (starter packs)
- Medicine provided every week or two weeks to encourage follow-up and to minimize possible waste of medicine (incremental dosing)
- The full 28-day course of medicine supplied at the initial visit (maximizing the likelihood of completion if follow-up is a concern) (WHO/ILO 2008)

EMERGENCY CONTRACEPTION (EC)

It is imperative that the health care provider understand the laws that exist in the country in which the care is being provided. This includes national statutes, civil, religious, and health care policies in place. The health care provider's role is to provide the necessary information and options available for pregnancy prevention to the female child who has experienced sexual violence and exploitation or may be returning to a situation that would require such prevention. This information and options much be based on national protocols and laws, particularly as they relate to minors.[15]

Pregnancy as a consequence of sexual violence and exploitation should be a concern for any female child (Tanner stage III or above, see Annex 3), irrespective of menarche. Even a single exposure can result in pregnancy. Depending on the legality, as well as national protocols that guide the provision to minors, EC should be offered up to five days (120 hours) after the sexual violence and exploitation. Recommended dosage is 1.5 mg of progestin-only contraceptive in a single dose. The efficacy of this regimen is best if used within 72 hours; however, it can be administered up to 120 hours. If the assault occurred outside the 120-hour window for EC, then pregnancy testing can be offered. An alternative EC regimen that is effective up to 120 hours post-exposure is ulipristal acetate, 30 mg orally as a one-time dosage. It has been found to be more effective than levonorgestrel, especially up to the 120 hour limits (Glasier et al. 2010).

There are limited side effects to EC. Nausea and vomiting may occur, but is more likely to be encountered in the estrogen-based medications no longer recommended. Other side effects may

[15] Consistent with U.S. Government policy and PEPFAR's FY 2013 Country Operational Plan Guidance (PEPFAR 2012). PEPFAR upholds the right of individuals to voluntarily decide the number, timing, and spacing of their children and to have the information and means to do so, and the right to make these decisions voluntarily within a context free of discrimination, stigma, coercion, duress, or deceit. PEPFAR funds cannot be used to procure contraceptive commodities other than male and female condoms, which also protect against HIV.

include breast tenderness, spotting or bleeding, and menstrual irregularities. Antiemetic medications can be offered if the patient is experiencing nausea prior to taking EC.

Children who are pregnant at the time of the examination should be offered information on any options available to her.

INJURY TREATMENT

Although rare, there may be physical and/or genital injury that occurs as a result of sexual violence and exploitation. All injuries should be treated at the time of the exam. Any suturing, splinting, pain management, or wound care should be initiated with appropriate medical treatment. If there is any disruption in mucous membranes or skin integrity, then appropriate tetanus toxoid (td) therapy should be administered. In a previously unvaccinated child, it may be necessary to administer antitetanus serum and start a course of tetanus toxoid vaccine (WHO 2008). For children younger than 7 years old, Diptheria, Tetanus and pertussis (DPT) or Diptheria and Tetanus (DT) is preferred to tetanus toxoid alone. For children 7 years and older, Td is preferred to tetanus toxoid alone (WHO 2008).

There are occasions when the injuries are significant enough to require surgical intervention. When surgery is necessary, providers should make every attempt to collect evidence prior to the surgical procedure while the patient is anesthetized.

FOLLOW-UP TREATMENT

See Chapter 4.

MANDATORY REPORTING

Many countries lack a reliable reporting system for children who have experienced sexual violence and exploitation, and there are differing definitions of child violence and exploitation between countries (WHO 2003). Mandatory crime reporting requirements and the age groups these requirements apply to will vary. It is essential that the health care provider is aware of existing laws regarding mandatory reporting of child sexual violence and exploitation. PEPFAR standards are that each agency has a policy in place at the clinic level to guide providers through the reporting process.

Mandatory reporting *is not the same thing* as referring a child for immediate protection if they are in imminent danger.

If mandatory reporting is required, then the child and caregiver must be informed of the reporting responsibilities of the provider, and this can be done in conjunction with the initial informed consent process. The following information should be shared with the child (if appropriate for developmental age) and the caregiver:

- The agency/person to which/whom the medical provider will report
- The specific information being reported
- How the information must be reported (written, oral, etc.)

- The likely outcome of the report
- The child's and family's rights in the process

In this case, there should be immediate action taken to ensure the child's safety (through referral to local police or child protection agencies), prior to making the designated mandatory report. Once the child is safe, the mandatory reporting procedures can be implemented (IRC/UNICEF 2012).

Best practices, as recommended by UNICEF and the International Rescue Committee, for reporting cases of child sexual violence and exploitation in settings where mandatory reporting systems function are (IRC/UNICEF 2012):

- Including protocols for maintaining the discretion and confidentiality of children who have experienced sexual violence and exploitation
- Knowing the case criteria that warrant a mandatory report
- Making the verbal and/or written reports (as indicated by law) within a specified time frame (usually 24 to 48 hours)
- Reporting only the minimum information needed to complete the report
- Explaining to the child and caregiver what is happening and why
- Documenting the report in the child's file and following up with the family and relevant authorities.

The older the child, the more he or she needs to be actively involved in the considerations surrounding reporting. This does not mean the child can determine if a report is made, but rather acknowledges their ability to understand what may be best in their circumstance with regard to how and when the report is made.

DOCUMENTATION

The child or adolescent who reports to the clinic for care should have a written record of the encounter. This record should include a medical forensic report, diagrams or body maps of any findings, and, if available, photographs. All aspects of the care should be documented including consent forms, the medical forensic history, findings from the physical assessment, evidence collected, any testing or treatment rendered, photographic images obtained during the examination, and any follow-up care and referrals given. If the health care provider is called to testify in any criminal justice proceedings, they may use this report to recall the patient encounter.

The written record should accurately reflect the child's demeanor, any statements made by the child during the course of treatment, and any caretaker history of events. All information documented should be legible and accurate. Any statements made by the child should be put in quotations, verbatim, rather than making an interpretation of what is said. It is generally preferable to use a standard form to document the examination, for convenience and reliability (WHO 2003). A sample form is included in Annex 10.

All injuries should be documented clearly, using standard terminology and descriptive language. At a minimum all injury or wound descriptions should include the type of injury (bruise, laceration, etc.), the size of the injury, the color, and the location. Information on describing features of physical injuries can be found in Annex 7. All findings should also be noted on body maps or pictograms (samples can be found in Annex 10), and also photo-documented when equipment is

available. Describe the injury without making speculation on the cause of the injury; however, if the child details where the injury is from, it is appropriate to document their words, in quotations. Make note of any samples collected from injuries. Wounds should be photographed prior to interventions such as cleaning or suturing.

When care is provided to a child who has experienced sexual violence and exploitation, the possibility exists that the health care provider may need to produce documentation and testimony regarding that care. The following chart provides a list of "Do's and Don'ts" with regard to documentation that providers may find useful in practice.

Documentation Do's and Don'ts

DO	DON'T
Write or type legibly	Leave blank sections
Complete all aspects of the chart	Cross out previously documented information
Record the date and time of examination	Use unauthorized abbreviations
Record the history and source	Draw unfounded conclusion
Make sure all duplicate copies are legible	Draw legal conclusions
If you did not examine something, write *Not Examined*	Fill in the form if you are not the person who completed the examination
Put patient statements in quotation marks	
Sign every page	
Complete all legally required paperwork	

PSYCHOSOCIAL INTERVENTIONS, FOLLOW-UP CARE, AND REFERRALS

The long-term health consequences associated with child or adolescent sexual violence and exploitation, particularly mental health consequences and the risk of acquiring HIV, underscore how important it is that providers understand their role in securing appropriate psychosocial interventions, referrals, and follow-up for children who have experienced sexual violence and exploitation. Provider responsibilities include:

- Immediate and emergent health interventions
- Disease prevention or treatment
- Safety of the child within and upon discharge from the health facility
- Referral to appropriate ongoing resources and services.

Because sexual violence and exploitation can impact a child at varying stages throughout their growth and development, ongoing counseling and intervention of key services should be a strong component of all initial and follow-up interventions. The provider is well positioned to ensure effective wrap around services.

Providers are encouraged to bring together the following services in individual communities, taking the lead to establish a list of existing resources, and how those services can work collaboratively to improve both initial and long-term responses to sexual violence and exploitation:

- Emergency medical
- Clinic
- Surgery
- Maternity
- Advocacy
- Counseling
- Social welfare services including child protective services
- HIV
- Community health
- Pharmacy
- Laboratory (testing and evidentiary)

Additionally, providers will want to enable their facilities to improve overall response through routine meetings with entities involved in responding to sexual violence and exploitation against children. Development and implementation of policies addressing the appropriate response to children, including educating involved providers so that the response to children is both medically appropriate and sensitive to the issues surrounding sexual violence and exploitation is critical.

The goal of collaboratively engaging community resources is to identify and better address the needs and rights of children who have experienced sexual violence and exploitation.

The possibility of criminal justice system involvement also underscores the provider's responsibility in relation to communication with law enforcement and provision of appropriate evidence collection and release. If it is obligatory to report cases of child sexual violence and exploitation in the provider's setting, the provider should obtain a copy of the national child sexual violence and exploitation management protocol and information on customary police and court procedures. Evaluate each case individually. In some settings, reporting suspected child sexual violence and exploitation can be harmful to the child if protection measures are not possible (WHO/UNHRC 2004).

ROLE OF THE MEDICAL PROVIDER IN FOLLOW-UP CARE

Medical providers will see children who have been acutely assaulted as well as those who have been experiencing sexual violence and exploitation in a chronic way, so they must be prepared to engage appropriate health and community-based services. The following chart outlines typical follow-up services following acute or nonacute sexual violence and exploitation.

Acute	Nonacute
• Advocacy • Social welfare including child protective services • Counseling • Laboratory (crime lab) • Laboratory (testing) • HIV • Pharmacy • Surgery • Community health	• Advocacy • Social welfare including child protective services • Counseling • Laboratory (testing) • HIV • Pharmacy • Maternity • Community health

Health care providers, as professionals with an established infrastructure and scientific base, must take the lead in educating community partners and referral resources on the well-rooted stigma, discrimination, myths, and silence regarding sexual violence and exploitation against children and its life-threatening health consequences.

Acute medical forensic examination and treatment can effectively address prevention of pregnancy, STIs, and HIV, but much of the child's psychological recovery will occur in the months and

sometimes years following the sexual violence and exploitation through their ongoing work with advocacy, social welfare, and counseling services.

The following list outlines suggested interventions to be implemented by health service providers in order to establish or strengthen referral linkages to existing community-based psychological and social support services.

- Encourage and provide routine exchange visits with expert providers in child sexual violence and exploitation with the goal of improving the health response.
- Conduct participatory community mapping to identify service providers in the community to whom and from whom children who have experienced sexual violence and exploitation can be referred for services.
- Develop a formal community directory for sexual violence and exploitation services for children and distribute copies to all health providers working with children.
- Build and formalize relationships with referral institutions, including setting up formal referral and counter-referral systems.
- Develop formal and informal protocols regarding standards for confidentiality, service delivery, data collection, and/or collaborating more closely on projects and activities.
- Set up formal referral systems with built in tracking mechanisms.
- Develop algorithms of care that include follow-up appointments and referrals to external service providers.
- Develop referral systems to facilitate and track use of referral services.
- Conduct community outreach activities to ensure that communities are aware of services available to children who have experienced sexual violence and exploitation and how to access them.
- Develop communication material for community and clinic-based awareness.
- Create community and service provider education to increase sensitivity and understanding of appropriate response.

Health providers serve as gatekeepers for children who have experienced sexual violence and exploitation. These children require intervention from a coordinated and skilled team of health professionals, social workers, and nongovernmental organizations, including organizations representing people with disabilities, staff, and volunteers for psychological and social support.

ROLE OF THE COMMUNITY IN FOLLOW-UP CARE

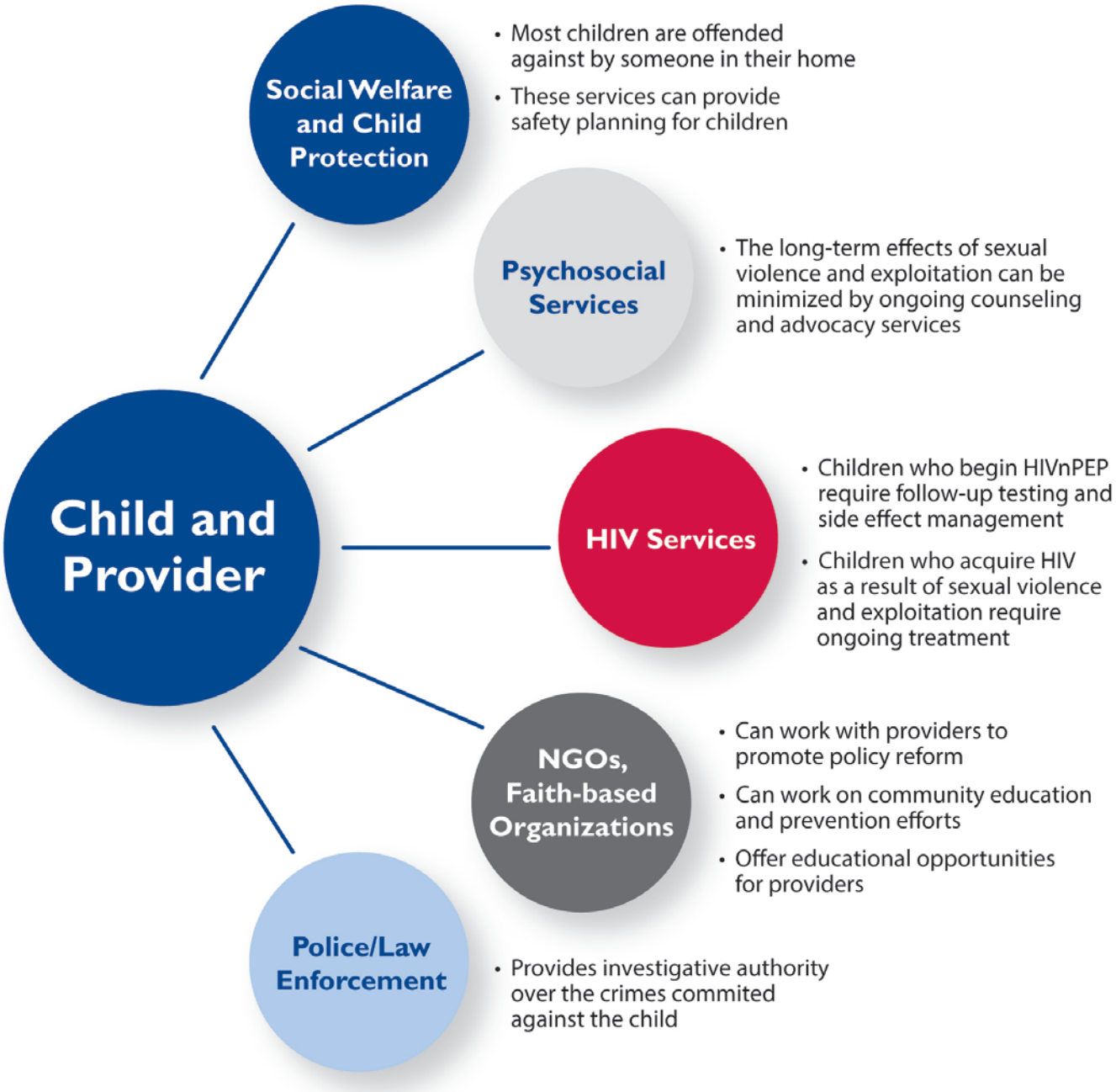
Although the main role of health service providers is to lead medical management for the child, making sure children and families are aware of, appropriately referred to, and able to access additional support services located outside of the health facility is also an important responsibility.

Community support services are often provided by a variety of sources including nongovernmental organizations, organizations representing people with disabilities, and faith-based organizations. They may be individuals who provide direct services to children who have experienced sexual violence and exploitation and their families, including police, prosecutors, social services, community shelters and safe havens, legal advice centers, local clinics, women's organizations, and

organizations providing psychosocial care. Ensuring strong referral linkages to and from these providers is a critical, yet often underdeveloped element of clinical post-rape care services.

Communication and referral between health care and community resources is depicted in the illustration here.

Figure 3. Communications and Referral Between Health Care and Community Resources



FOLLOW-UP TREATMENT

Opportunities for follow-up care of children who have experienced sexual violence and exploitation may be difficult. Therefore, it is essential that treatment delivered at the time of the examination be as complete as possible.

Follow-up STI testing may be necessary if the initial visit was acutely following the sexual violence and exploitation. The timing for any follow-up examinations or treatment should be individualized for each child. Repeat pregnancy, HIV, HBV, and syphilis testing may be necessary depending on initial treatment. The health care provider should ensure that the child or caregiver understands the need for and timing of any follow-up visits.

Follow-up visits also allow observation and documentation of any healing or healed trauma observed during the initial exam. Healing in children occurs fairly rapidly, so it is expected that genital and physical injuries should be resolving or healed at follow-up appointments. The follow-up examination can also be used to ensure that there has been adequate psychological support for the child and family where necessary.

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ANNEX 1

GLOSSARY OF TERMS (GENERAL)

Common terms and definitions used throughout this document are described below.

ADOLESCENCE: The period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioral, and psychosocial spheres.

ADOLESCENT: Any person between the ages of 10 and 19 years old.

ADULT: Any person 18 years and older.

CAREGIVER: The person who is exercising day-to-day care for a child or children. He or she can be a caregiver, relative, sibling, family friend, or other guardian; it does not necessarily imply legal responsibility. This may apply to foster parents, including those who "adopt" a child spontaneously as well as those who do so formally.

CHAIN OF CUSTODY: A formal chronological documentation of the custody and possession of evidence. It is used to establish the integrity of the evidence collection in a court of law.

CHILD: Any person under the age of 18 years. Children have evolving capacities depending on their age and developmental stage. In working with children, it is critical to understand these stages as it will determine the method of communication with individuals. It will also allow the provider to establish an individual child's level of understanding and their ability to make decisions about their care. As a result, the provider will be able to make an informed decision about which intervention is most appropriate for each individual child.

The following definitions clarify the term "child" with regard to age and developmental stages for guiding interventions and treatment:

- Children = 0–18, as per the Convention on the Rights of the Child
- Young children = 0–9
- Early adolescence = 10–14
- Later adolescence = 15–18

CHILD WHO HAS EXPERIENCED SEXUAL VIOLENCE AND EXPLOITATION: A person under the age of 18 years who has experienced an act of sexual abuse. Child exploitation is the use of children for someone else's economic or sexual advantage, gratification, or profit, often resulting in unjust, cruel, and harmful treatment of the child (Save the Children UK 2007). This is the predominant term found throughout this document.

CHILD SEXUAL ABUSE: The World Health Organization defines child sexual abuse as "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 performances and materials." (WHO 1999)

CONFIDENTIALITY: Confidentiality is an ethical principle that is associated with medical and social services professions. Maintaining confidentiality requires that service providers protect information gathered about clients and agree only to share information about a client's case with their explicit permission. All written information should be maintained in a confidential place in locked files. There may be limits to confidentiality while working with children (e.g., there may be mandatory reporting requirements for assault and/or abuse or children).

DISCLOSURE: The process of revealing information. In reference to this document, disclosure in the context of sexual abuse refers specifically to how a person learns about a child's experience with sexual abuse. Disclosure about sexual abuse can be directly or indirectly communicated, voluntarily or involuntarily.

GENDER-BASED VIOLENCE (GBV): In the broadest terms, "gender-based violence" is violence that is directed at an individual based on his or her biological sex, gender identity, or his or her perceived adherence to socially defined norms of masculinity and femininity. It includes physical, sexual, and psychological abuse; threats; coercion; arbitrary deprivation of liberty; and economic deprivation, whether occurring in public or private life.

- GBV takes on many forms and can occur throughout the lifecycle, from the prenatal phase through childhood and adolescence, the reproductive years, and old age (Moreno 2005). Types of GBV include female infanticide; harmful traditional practices such as early and forced marriage, "honor" killings, and female genital cutting; child sexual abuse and slavery; trafficking in persons; sexual coercion and abuse; neglect; domestic violence; and elder abuse.
- Women and girls are the most at risk and most affected by GBV. Consequently, the terms "violence against women" and "gender-based violence" are often used interchangeably. However, boys and men can also experience GBV, as can sexual and gender minorities, such as men who have sex with men and transgender persons. Regardless of the target, GBV is rooted in structural inequalities between men and women and is characterized by the use and abuse of physical, emotional, or financial power and control

LOCARD'S EXCHANGE PRINCIPLE: A principle of forensic science, developed by Edmund Locard in which he found that every contact, no matter how slight, between two items will result in an exchange between the two. Any contact between an offender and child, as well as the crime scene itself, may have potential corroborating evidence left behind. This evidence may be in the form of trace materials and/or body fluids from the offender. As the body of the child is assessed, forensic samples should be taken from the areas where possible evidence may exist.

MANDATORY REPORTING: This refers to country or jurisdictional laws and policies, which mandate certain agencies and/or persons in helping professions (teachers, social workers, health staff, etc.) to report to child protection and/or criminal justice authorities actual or suspected child abuse (e.g., physical, sexual, neglect, emotional and psychological abuse, unlawful sexual intercourse).

PERPETRATOR: A person who directly inflicts or supports violence or other abuse on another against their will.

The perpetrators of violence against children may be adults or children, including:

- Parents, guardians, and other caregivers
- Other family members living in the home (adults and children)
- Other nonresident relatives (uncles/aunts, grandparents, cousins)
- Boyfriend/girlfriend, romantic partner, fiancé, or husband/wife in the case of child marriage)
- Friends, acquaintances, neighbors (both family friends, but also peers)
- Unknown adults/ strangers
- Public authority figures (teachers, soldiers, police officers, clergy, health care workers, youth group leaders, and adults from organizations working with children)

RAPE: Physically forced or otherwise coerced penetration—even if slight—of the vulva or anus, using a penis, other body parts or an object (Jewkes, Sen, and Garcia-Moreno 2002). Penetration of the vulva or anus or mouth with another body part or object without consent.

SERVICE PROVIDER: Health and psychosocial service providers charged with providing direct services to child survivors of gender-based violence. These professionals include caseworkers, social workers, health workers, and child protection workers. Note: this term does not refer to police or law enforcement officers, although much of the guidance in the communication sections can apply to police and law enforcement professionals as well.

SEXUAL EXPLOITATION: Any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes. This includes profiting monetarily, socially, or politically from the sexual exploitation of another (see also child sexual abuse).[16]

SURVIVOR/VICTIM: The term "survivor" in this document implies women, girls, men, and boys, unless indicated otherwise. Most individuals who present themselves for sexual and gender-based violence interventions are women and girls. It is also recognized that even men and boys can be victims. The guidelines refer to the abused person as a survivor, victim, client, or patient. The words survivor, victim, client, and patient shall be used interchangeably.

VIOLENCE AGAINST CHILDREN: All forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse (UN 1989).

- ***Physical Violence against Children:*** comprises fatal and nonfatal physical violence. It can be defined as the intentional use of physical force against a child that results in, or has a high likelihood of, resulting in harm to the child's health, survival, development, or dignity. It includes all corporal punishment and all forms of torture, cruel, inhuman, or degrading treatment or punishment, and physical bullying and hazing by adults and by other children. "Corporal" or "physical" punishment is any punishment in which physical force is used and intended to cause some degree of pain or discomforts, however light. This includes hitting (with the hand or with an implement), kicking, shaking or throwing, scratching, pinching, biting,

[16] http://europeandcis.undp.org/files/hrforms/STSGB200313%20-%20Measures%20for%20Protection%20from%20Sexual%20Exploitation%20and%20Sexual%20Abuse.pdf

pulling hair or boxing ears, caning, forcing children to stay in uncomfortable positions, scalding, or forced ingestions (Pinheiro 2006).

- ***Emotional Violence against Children:*** a pattern of failure over time or an isolated incident provide a developmentally appropriate and supportive environment that has a high probability of damaging the child's physical or mental health, or its physical, mental, spiritual, moral, or social development. It can include:
  - All forms of persistent harmful interactions with the child, for example, conveying to children that they are worthless, unloved, unwanted, endangered, or only of value in meeting another's needs
  - Scaring, terrorizing, and threatening; exploiting and corrupting; spurning and rejecting; isolating, ignoring, and favoritism
  - Denying emotional responsiveness; neglecting mental health, medical, and educational needs
  - Insults, name-calling, humiliation, belittling, ridiculing
  - Exposure to domestic violence
  - Placement in solitary confinement, isolation, or humiliating or degrading conditions of detention
  - Psychological bullying and hazing by adults or other children, including via information and communication technologies (including 'cyber bullying').[6]
- ***Sexual Violence against Children:*** All forms of sexual abuse and sexual exploitation of children (see child sexual abuse).

ANNEX 2

SEXUAL BEHAVIOR IN YOUNG CHILDREN[17]

Examples of Sexual Behaviors in Children 2 to 6 Years of Age

Normal, Common Behaviors	Less Common Normal Behaviors	Uncommon Behaviors in Normal Children	Rarely Normal
Touching/masturbating genitals in public/private Viewing/touching peer or new sibling genitals Showing genitals to peers Standing/sitting too close Trying to view peer/adult nudity Behaviors are transient, few, and distractible	Rubbing body against others Trying to insert tongue in mouth while kissing Touching peer/adult genitals Crude mimicking of movements associated with sexual acts Sexual behaviors that are occasionally, but persistently, disruptive to others Behaviors are transient and moderately responsive to distraction	Asking peer/adult to engage in specific sexual act(s) Inserting objects into genitals Explicitly imitating intercourse Touching animal genitals Sexual behaviors that are frequently disruptive to others Behaviors are persistent and resistant to parental distraction	Any sexual behaviors that involve children who are 4 or more years apart A variety of sexual behaviors displayed on a daily basis Sexual behavior that results in emotional distress or physical pain Sexual behaviors associated with other physically aggressive behavior Sexual behaviors that involve coercion Behaviors are persistent and child becomes angry if distracted

[17] American Academy of Pediatrics. http://www2.aap.org/pubserv/PSVpreview/pages/behaviorchart.html

ANNEX 3

TANNER STAGES OF SEXUAL MATURATION[18]

In young women, the Tanner stages for breast development are as follows (Fig 9 – 24, C)

- Stage I (Preadolescent) – Only the papilla is elevated above the level of the chest wall.
- Stage II (Breast Bubbling) – Elevation of the breasts and papillae may occur as small mounds along with some increased diameter of the areolae.
- Stage III – The breasts and areolae continue to enlarge, although they show no separation of contour
- Stage IV – The areolae and papillae elevate above the level of the breasts and form secondary mounds with further development of the overall breast tissue.
- Stage V – Mature female breasts have developed. The papillae may extend slightly above the contour of the breasts as a result of the recession of the areolae.

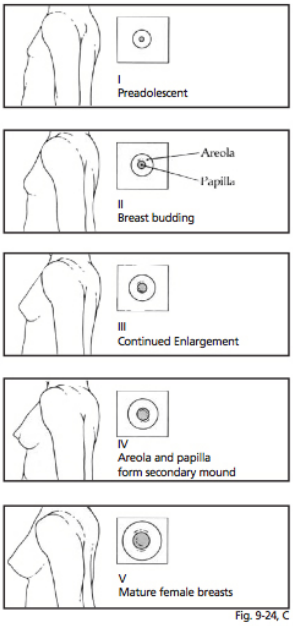


Fig. 9-24, C

The stages for male genitalia development are as follows: (Fig. 9 – 24, A):

- Stage I (Preadolescent) – The testes, scrotal sac, and penis have a size and proportion similar to those of early childhood.
- Stage II – There is enlargement of the scrotum and testes and a change in the texture of the scrotal skin. The scrotal skin may also be reddened, a finding not obvious when viewed on a black and white photograph.
- Stage III – Further growth of the penis has occurred, initially in length, although with some increase in circumference. There is also increased growth of the testes and scrotum.
- Stage IV – The penis is significantly enlarged in length and circumference with further development of the glans penis. The testes and scrotum continue to enlarge, and there is distinct darkening of the scrotal skin. This is difficult to evaluate on a black and white photograph.
- Stage V – The genitalia are adult with regard to size and shape.

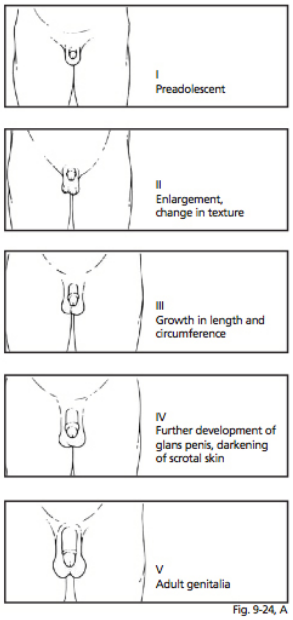


Fig. 9-24, A

[18] Vermont Department of Health. http://healthvermont.gov/family/toolkit/tools%5CJ-1%20CARD%20Tanner%20Stages.pdf

Because the onset and progression of puberty are so variable, Tanner has proposed a scale now uniformly accepted, to describe the onset and progression of pubertal changes (Fig. 9 – 24). Boys and girls are rated on a 5 point scale. Boys are rated for genital development and pubic hair growth, and girls are rated for breast development and pubic hair growth.

Pubic hair growth in females is staged as follows (Fig 9 – 24, B):

- Stage I (Preadolescent) – Vellos hair develops over the pubes in a manner not greater than that over the anterior wall. There is no sexual hair.
- Stage II – Sparse, long, pigmented, downy hair, which is straight or only slightly curled, appears. These hairs are seen mainly along the labia. This stage is difficult to quantitate on black and white photographs, particularly when pictures are of hair-haired subjects.
- Stage III – Considerably darker, coarser, and curlier sexual hair appears. The hair has now spread sparsely over the junction of the pubes.
- Stage IV – The hair distribution is adult in type but decreased in total quantity. There is no spread to the medial surface of the thighs.
- Stage V – Hair is adult in quantity and type and appears to have an inverse triangle of the classically feminine type. There is spread to the medial surface of the thighs but not above the base of the inverse triangle.

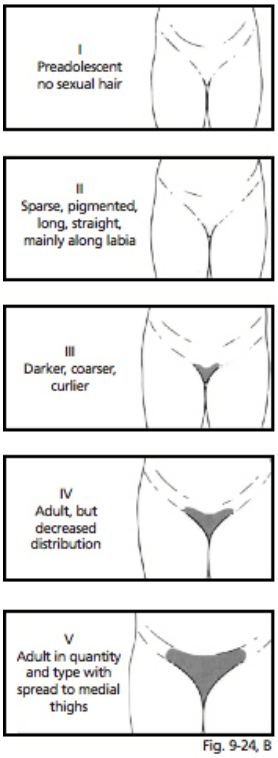


Fig. 9-24, B

The stages in male pubic hair development are as follows (Fig. 9-24, D):

- Stage I (Preadolescent) – Vellos hair appears over the pubes with a degree of development similar to that over the abdominal wall. There is no androgen-sensitive pubic hair.
- Stage II – There is sparse development of long pigmented downy hair, which is only slightly curled or straight. The hair is seen chiefly at the base of penis. This stage may be difficult to evaluate on a photograph, especially if the subject has fair hair.
- Stage III – The pubic hair is considerably darker, coarser, and curlier. The distribution is now spread over the junction of the pubes, and at this point that hair may be recognized easily on black and white photographs.
- Stage IV – The hair distribution is now adult in type but still is considerably less that seen in adults. There is no spread to the medial surface of the thighs.
- Stage V – Hair distribution is adult in quantity and type and is described in the inverse triangle. There can be spread to the medial surface of the thighs.

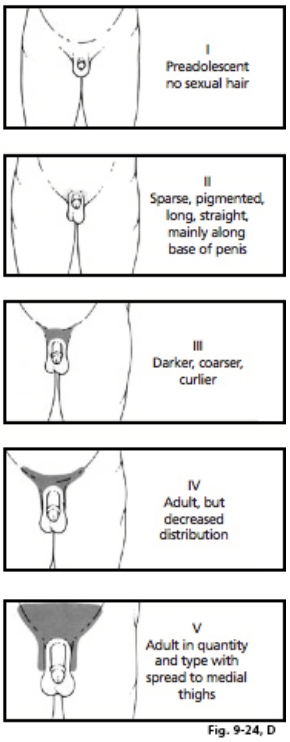


Fig. 9-24, D

ANNEX 4

CLINICAL SITE PREPARATION AND SET-UP JOB AID

This job aid can be used as a checklist to assist the clinical site (facility administrators and providers) in determining its readiness for an effective response to medical management of children who have experienced sexual violence and exploitation. Specific priority consideration should be given to the education of the clinical staff on-site.

Medical forensic examinations should take place at a medical site where there is optimal access to the full range of services that may be required by the child. Ideally this would be a hospital or clinic setting. Children should be able to access services 24 hours a day. If that is not feasible, they should access the clinic during hours of operation. Care should be ethical, compassionate, objective, and child-centered. Resource constraints may preclude the possibility of service provision in an ideal facility, but it is possible to improve the quality of existing facilities by ensuring they are accessible, secure, clean and private (WHO 2003).

Overall Site Preparation
☐ Develop and implement written policies, procedures, and protocols in the language of care providers.
☐ Ensure provider education on child sexual violence and exploitation.
☐ Develop clinical documentation and physical assessment forms.
☐ Develop and implement a secure medical record storage system.
☐ Develop a data tracking system.

Examination Site Set-Up
☐ Determine appropriate location for private examination.
☐ Use available resources to create an aesthetically child-friendly environment.
☐ Ensure immediate access to proper lighting, soap and water, and toilet facilities.
☐ Develop a staffing plan that encourages the availability of trained health care professionals, 24 hours per day.
☐ Plan for the availability of a chaperone/companion to be present in the examination room during the ano-genital portion of the medical evaluation.

Equipment Needed
☐ Powder-free non-sterile examination gloves
☐ Examination table that allows for positioning for lithotomy
☐ Specula (for post-pubertal children ONLY)
☐ Culture supplies
☐ Lubricant
☐ Evidence collection kits
☐ Forensic supplies (see Chapter 2)
☐ Sharps disposal container
☐ Needles, syringes
☐ Sterile water, sterile normal saline
☐ Patient gowns, bed linens/sheets
☐ Basic medical supplies for injury treatment (sutures, bandages, splints, scissors)
☐ Patient comfort supplies such as feminine hygiene supplies, food, drink, toiletries, extra clothing/undergarments
☐ Resuscitation equipment
☐ Digital camera and related supplies, such as memory cards, batteries, flash, and photographic reference ruler/standard
☐ Handheld magnifying glass
☐ Access to autoclave for sterilizing equipment if necessary
☐ Laboratory facilities or testing access
☐ Scales, height chart, and measuring tape

ANNEX 5

UNDERSTANDING INFORMED CONSENT/ASSENT AND PATIENTS' RIGHTS

It is important for the health care provider to have a basic understanding of the information necessary to relay to the patient about the choices available to them during the examination, and obtain their consent or assent to care. Since the age of medical consent and consent for HIV testing varies by country, it is imperative that providers are aware of the national laws regarding consent, and understand those laws.

A child who is of the age of **consent** (which varies by country) should sign for permission for all treatment, including the medical forensic examination. A child who is below the age of consent for this treatment should still **assent** to care, and should be asked for permission to proceed. If the child is not of consent age, then the health care provider must obtain consent from either the parent/guardian or caregiver, in addition to obtaining assent from the child. The child should *never be forced* to undergo the medical forensic examination (e.g., a virginity check).

Health care providers need to know the following information in regard to children's legal rights in decision making:

- The person(s) responsible for providing permission (informed consent) for care and treatment of a child in the local context
- The age at which a child is able to independently consent to care and treatment in the local context
- The mechanisms for third-party individuals to provide consent if caregivers or parents are not available, or if a caregiver or parent is the suspected perpetrator.

Portion of the Examination	Necessary Consent
Medical forensic examination	written consent
Forensic sample collection	written consent
Release of information and documentation to police/other agencies (such as social work)	written consent
Photo-documentation of examination	written consent
HIV testing	written consent
Emergency contraception	written consent

Consent may be written, in a single document, and there may be a checklist of items, so consent is given to each individually. The patient may consent to each procedure and consent may be withdrawn at any point in the process (a sample consent form is included).

The child and caregiver should understand the need to protect the child from further harm, including making any mandatory reports that may be necessary in the case of child sexual violence or exploitation, suicidal or homicidal ideation, or exploitation. A child capable of giving their own history should do so one-on-one with the provider to ensure confidentiality and the ability of the child to speak openly when questions are asked (e.g., any consensual sexual activity).

Children should also understand that they are able to stop the exam process at any point, and ask for "time out" at any point. They may also have someone trusted with them during the exam (recognize that the caregiver/parent may not be the person the child prefers). The care provider should make it clear that it is all right for the child to ask questions if they are unclear about what they are being asked or if they do not understand something. The child should be asked during the examination if they have any further questions.

Informed Consent/Assent Guidelines (IRC/UNICEF 2012)

Age Group	Child	Caregiver	If No Caregiver or Not in Child's Best Interest	Means
0-5		Informed consent	Other trusted adult's or case-worker's informed consent	Written consent
6-11	Informed assent	Informed consent	Other trusted adult's or case worker's informed consent	Oral assent, written consent
12-14	Informed assent	Informed consent	Other trusted adults' or child's informed assent. Sufficient level of maturity (of the child) can take due weight).	Oral assent, written consent
15-18	Informed consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight.	Written consent

Patient rights vary according to country and sometimes even by jurisdiction. The health care provider should be aware of any existing national or local patient's rights policies, and utilize these when providing care to children who have experienced sexual violence and exploitation. If national or local guidelines do not exist, then the clinic providing post-rape care should develop policies for patient rights. Although we should strive to ensure that there is an appropriate criminal justice outcome for the child, it should be recognized that communities will have varying responses and infrastructure necessary to provide this outcome. Recognize that the most important aspect the health care provider can provide is that the health and well-being of the child at the episode of care will be priority, and that the child will be treated with dignity and compassion.

SAMPLE CONSENT FORM[19]

NAME OF FACILITY

Note to the health worker: Read the entire form to the child who has experienced sexual violence or exploitation and/or guardian, explaining that s/he 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 patient or parent/caregiver) authorize the above-named health facility to perform the following (tick the appropriate boxes) on my child: _____[insert name of child]:

Step	Yes	No
Conduct a complete medical examination, which may include a genital examination		
Collect samples for possible evidence which may include: collection of clothing, hair combings, swabs of finger nails, blood samples, and photographs		
Provide evidence and medical information to the police and law courts concerning my/my child's case; this information will be limited to this examination and any relevant follow-up care provided		

Signature_____

Date_____

Witness_____

[19] Source: National Guidelines on Management of Sexual Violence in Kenya, 2nd ed., 2009

ANNEX 6

THE "TOP-TO-TOE" PHYSICAL EXAMINATION

Below is detailed a systematic, head-to-toe physical examination of the child conducted in a step-wise manner. The examination should proceed affording as much dignity and privacy as possible. Limit exposure of the body to the area that is being examined (e.g., when observing the breast, only expose that particular area, draping the rest of the body to allow the child privacy).

Step	Observations	Other
Step 1	Note the child's general appearance, demeanor, and developmental stage.	Take vital signs, height, weight, and head circumference when appropriate.
Step 2	Inspect the head and scalp. Observe for areas of missing hair, and evidence of bruising/petechiae on the scalp.	Palpate the scalp for areas of tenderness. Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of hematoma. Hair loss due to hair pulling during the assault may cause loose hair to be collected in the gloved hands of the examiner or petechiae at the surface of the scalp; gentle palpation of jaw margins and orbital margins may reveal tenderness indicating bruising not yet visible.
Step 3	Inspect the eyes; observe for areas of bruising around the eyes (this may be subtle), and look for the presence of conjunctival petechiae or hemorrhage. Inspect all surfaces of the neck for injury.	Palpate the neck for subcutaneous emphysema. Any of these signs may indicate a strangulation event has occurred.
Step 4	Inspect the external and internal ears, not forgetting the area behind the ears, for evidence of shadow bruising or battle sign; this may be a sign that a skull fracture exists. Bleeding or leakage of cerebrospinal fluid (CSF) from the ear may also indicate skull fractures.	
Step 5	Inspect the nose and mouth; Look in the nose for signs of bleeding or leakage of CSF, or areas of bruising on the outside of the nose. The mouth should be	Collect oral swabs, as indicated.

Step	Observations	Other
	inspected carefully, include the lips, gums, and tongue, checking for injury of these structures and the buccal mucosa. Petechiae on the hard/soft palate may indicate oral penetration or strangulation. Check the area of the frenulum for tearing injuries and observe for broken teeth.	
Step 6	Injuries observed on the neck can indicate a possible strangulation event warranting further questions by the provider. Inspect all surfaces of the neck for injury.	Palpate the neck for subcutaneous emphysema and note any ligature marks. Any of these signs may indicate a strangulation event has occurred. Abrasions seen at the neck in cases of strangulation may be caused by the child as they try to protect themselves from strangulation. Petechiae or red bruising from bites or sucking should be noted and swabbed for saliva before being touched.
Step 7	Assess the child's hands inspecting all sides for injury, and observe general appearance; observe the wrists for signs of ligature marks.	Collect trace evidence from fingernails as appropriate.
Step 8	Inspect the forearms for injuries, appropriate circulation, sensation, and motion; any injuries or intravenous puncture sites should be noted.	Palpate for tenderness
Step 9	Inspect the inner surfaces of the upper arms and axilla for signs of injury appropriate circulation, sensation, and motion.	Children who have been restrained by hands may have "fingertip" bruising from the perpetrators hands on the arms.
Step 10	The breasts and trunk should be examined. Subtle obvious injury may be seen in a variety of places on the trunk. Breasts are frequently a target of assault in female patients, including sucking and bite marks.	Swab areas for saliva if indicated. Auscultate the lungs.
Step 11	Observe the back of the child, this can be accomplished at this time by rolling them over to complete the assessment, or by having them stand up at the exam completion to do a final observation of the back while standing up.	Observe for injury, bruising, and be sure to palpate for areas of tenderness.

Step	Observations	Other
Step 12	Complete the abdominal examination, including inspection, auscultation, and palpation to exclude any internal trauma.	If body fluid or saliva is suspected to be present, swab for evidence.
Step 13	Examine the anterior and posterior aspects of the legs paying special attention to the inner thighs for injury. Observe for injury, foreign materials, and assess for tenderness. Also assess the feet and ankles for similar injury, foreign materials, and tenderness including the soles of the feet.	Collect foreign materials if present, palpate for tenderness, limited range of motion.
Step 14	Inspection of the posterior aspects of the legs may be easier to achieve with the child standing or sitting on the parent's lap. Alternatively, the child may be examined in a supine position and asked to lift each leg in turn and then rolled slightly to inspect each buttock.	Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or gloved hands (for hair, fibers, grass, soil).
Step 15	Obvious physical deformities should be noted.	Notation of tattoos is generally unnecessary unless the presence of the tattoo is somehow related to the crime itself (i.e., the perpetrator tattooed the victim at the time of the crime).

ANNEX 7

DESCRIBING FEATURES OF PHYSICAL INJURIES (WHO/UNHCR 2004)

Feature	Notes
Classification/type	Use accepted terminology whenever possible; such as, abrasion, bruise, laceration, incised wound
Site	Record the location of the wound/injury
Size	Measure the wound (using a ruler or other standardized method such as a coin)
Shape	Describe the shape of the wound(s): linear, curved, irregular
Surrounds	Note the condition of nearby tissues: bruised, swollen, tender
Color	Observe any changes in color: redness, bruising, pallor
Contents	Note the presence of foreign material in the wound: dirt, debris, glass
Age	Note any healing injuries, such as cuts that are scabbed; use great caution in this area, do NOT date or attempt to date bruising
Borders	Characterize wound margins: ragged, smooth
Depth	Give an estimate of the depth of the wounds, if present

ANNEX 8

MEDICAL MANAGEMENT OF CHILD SEXUAL VIOLENCE AND EXPLOITATION JOB AID

Providers can use this job aid as a checklist reminder of what tasks should be completed when evaluating a child who has experienced sexual violence and exploitation.

- ☐ Obtain history from child without the caregiver present whenever possible.
- ☐ Document history obtained directly from child when appropriate, using verbatim quotes whenever possible (with children aged four and older).
- ☐ Obtain history from presenting caregiver without the child present whenever possible, unless the child is non-verbal.
- ☐ Document history obtained from the caregiver.
- ☐ Establish timeframe for last contact with offender (acute or non-acute exam).
- ☐ Identify and address safety issues if in-home offender identified.
- ☐ Identify and document any treatment rendered.
- ☐ Ensure evidence collection if assault is less than (<) 72 hours/3 days ago in pre-pubertal children.
- ☐ Ensure evidence collection if assault is less than (<) 168 hours/7 days ago in pubescent children.
- ☐ Identify and document body surface injury.
- ☐ Identify and document ano-genital injury.
- ☐ Offer pregnancy prevention when appropriate due to risk (penile/vaginal penetration reported or suspected) and stage of sexual development.
- ☐ Culture for sexually transmitted infections (STIs) when appropriate.
  - ☐ Urine NAAT testing in adolescent or prepubescent children
  - ☐ Swabs for anal and oral culture as required for gonorrhea or chlamydia
- ☐ Offer STI prevention in pubescent children.
- ☐ Offer HIVnPEP when appropriate and available.
- ☐ Meet mandatory reporting obligations when applicable.
- ☐ Provide community-based resources whenever possible.
- ☐ Plan and document follow-up care.

ANNEX 9

CLINICIAN'S ROLE IN EVIDENCE COLLECTION JOB AID

Providers can use this job aid to determine what type of evidence should be collected, how it should be collected, and in what timeframe following an incidence of sexual violence and exploitation.

- If a clinician sees a patient acutely following sexual violence and exploitation, evidence collection should be offered as part of the patient care standard.
- Evidence collection should occur in pre-pubertal children if the assault occurred in the past 72 hours/3 days.
- Evidence collection should occur in pubertal children if the assault occurred in the past 168 hours/7 days.

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
Penile/oral penetration with or without ejaculation	***Oral swabs***	Seminal fluid if oral penetration within two days	Sterile cotton-tip swabs	Use two dry swabs to swab/rub over the oral cavity (e.g., under tongue, around teeth, cheeks, and gums).
In all cases of evidence collection	***Buccal swabs***	Patient's reference DNA sample	Sterile cotton-tip swabs	Use two swabs to swab/rub over the inner aspect of each cheek at least 20 minutes after patient has had food or drink. This should be completed *after* **oral swabs.**
If drug facilitated-sexual assault is suspected If crime lab does not accept buccal swab for reference DNA sample	***Blood***	If drug-facilitated sexual violence and exploitation is suspected within 24 hours of the exam	Blood tube containing potassium oxalate OR at least 1.5% sodium fluoride + potassium oxalate or OR EDTA (ethylenediaminetetra-acetic acid) tube	Collect 10 ml of venous blood.

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
If drug-facilitated sexual assault is suspected	***Urine***	If drug-facilitated sexual violence and exploitation is suspected within 120 hours of the exam[20]	Appropriate sterile container with at least 1.5% sodium fluoride preservative	Collect a minimum of 90 ml of urine.
If the patient broke a fingernail during the assault or scratched or dug at the body of the assailant	***Fingernails, swabs***	Skin, blood, fibers, etc. (from assailant); and for comparison with any broken nails found at scene	Sterile cotton-tip swabs x 2 Sterile water	Moisten first swab with sterile water and clean under fingernails. Repeat with the second dry swab. (Use two swabs for each hand.) Only collect fingernail clippings if a nail was broken during the assault.
If the assailant put their mouth anywhere on the patient, collect a specimen; if foreign material or debris is seen during exam, collect specimen.	***Other body surface specimens***	Body fluids/DNA; other possible foreign materials (skin within 48 hours) Foreign material (e.g., vegetation, matted hair, or foreign hairs)	Sterile cotton-tip swabs x 2 per site Sterile water Bindle/pharmacy fold	Moisten first swab with water and swab/rub over sites where semen, body fluids, or DNA may be present. Repeat with the second dry swab. Place foreign material in bindle, and enclose and seal in evidence envelope.
Vaginal/penile penetration or other genital-to-genital contact	***Genitalia: Pre-pubertal*** External genital	Body fluids/DNA; other possible foreign material	Sterile cotton-tip swabs Sterile water	Moisten first swab with sterile water and thoroughly swab/rub over the external genitalia. Repeat with the second dry swab.
Vaginal/penile penetration or other genital-to-genital contact	***Genitalia: Pubertal*** External genital Low vaginal	Body fluids/DNA; other possible foreign material	Sterile cotton-tip swabs Sterile water	Moisten first swab with sterile water and thoroughly swab/rub over the external genitalia. Repeat with a second dry swab. Insert a dry swab into the lower one-third of the vagina (approximately 2–4

[20] Society of Forensic Toxicologists Drug-Facilitated Sexual Assaults Fact Sheet: http://soft-tox.org/sites/default/files/DFSA-Fact-Sheet.pdf

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
				cm beyond the vaginal orifice) and use a gentle rotational movement to obtain a sample. Repeat with a second dry swab.
	High vaginal		Speculum and water-based lubricant (e.g., K-Y®, Pedicat®, Gelcat®)	Pass a lubricated sterile speculum into the vagina. Insert a dry swab and swab/rub over the mucosal lining of the upper two-thirds and fornices of the vagina. Repeat with a second dry swab. If it is not possible to pass a speculum, attempt to obtain two vaginal swabs.
	Cervical			With the speculum in place, use two dry swabs, one at a time, to swab the face of the cervix.
Anal/penile penetration; rectal/penile penetration; oral/anal penetration or contact	***Ano-rectal:*** Peri-anal area Anal canal	Body fluids/DNA; other material	Sterile cotton-tip swabs Sterile water	Moisten first swab with water and swab/rub over peri-anal area/folds. Repeat with the second dry swab. Using another two swabs, repeat the same procedure for the anal canal.
Oral contact; anal or rectal contact; foreign material suspected (ie.lubricant)	***Penile swabs:*** Penile shaft and prepuce (foreskin) Glans	Body fluids/DNA; other material	Sterile cotton-tip swabs Sterile water	Moisten first swab with water and swab/rub over the shaft of the penis and prepuce/ foreskin (when present). Repeat with the second dry swab. Repeat the same procedure for the glans—avoiding the urethra. (Swabbing the urethra will result in the patient's own DNA being obtained.)

Type/Nature of Assault	Evidence Sample	Possible Material	Equipment	Sampling Instructions
If the patient is wearing the same clothes as at the time of the assault; collect the underpants only if the patient has changed clothes since the assault.	***Clothing***	Adherent foreign material (e.g., semen, blood, hair, fibers)	Paper bags	Clothing worn at the time of the assault should be placed in a paper bag. Wet items should be dried if possible. All items should be bagged separately.
If the patient was wearing a tampon/pad/diaper at the time of the assault or immediately following; if a condom is found in or on the patient's body from the assault	***Sanitary pads, tampons, panty liners, diapers, condoms***	Body fluids/DNA; other foreign material (e.g., semen, blood, hair)	Appropriate sterile container Small clamp	Collect if used during or after vaginal or anal penetration. For condoms: use small clamp to close off open end and place in sterile container.

ANNEX 10

SAMPLE HISTORY, EXAM FORM (WHO/UNHCR 2004), AND BODY MAPS[21]

Medical History and Examination Form – Sexual Violence

1. GENERAL INFORMATION

First Name	Last Name	
Address		
Sex	Date of Birth (dd/mm/yy)	Age
Date/time of examination /	In the presence of	

In case of a child include: name of school, name of parents or guardian.

2. THE INCIDENT

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

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

[21] www.ou.edu/cwtraining/assets/pdf/.../Anatomical%20Drawings.doc

3. MEDICAL HISTORY

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

Contraception use					
Pill		IUD		Sterilization	
Injectable		Condom		Other	

Menstrual/obstetric history	
Last menstrual period (dd/mm/yy)	Menstruation at time of event Yes □ No □
Evidence of pregnancy Yes □ No □	Number of weeks pregnant _____weeks
Obstetric history	

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date (dd/mm/yy)	Name of individual:

Existing health problems
History of female genital mutilation, type
Allergies
Current medication

Vaccination status	Vaccinated	Not Vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				

HIV/AIDS Status	Known	Unknown

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)			
Mental state (calm, crying, anxious, cooperative, depressed, other)			
Weight:	Height:	Pubertal stage (pre-pubertal, pubertal, mature):	
Pulse rate:	Blood pressure:	Respiratory rate:	Temperature:

Physical findings

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

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

5. GENITAL AND ANAL EXAMINATION

Vulvas/scrotum	Introitus and hymen	Anus
Vagina/penis	Cervix	Bimanual/recto vaginal examination

Position of patient (supine, prone, knee-chest, lateral, mother's lap)

For genital examination:	For anal examination:

6. INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result

7. EVIDENCE TAKEN

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

8. TREATMENTS PRESCRIBED

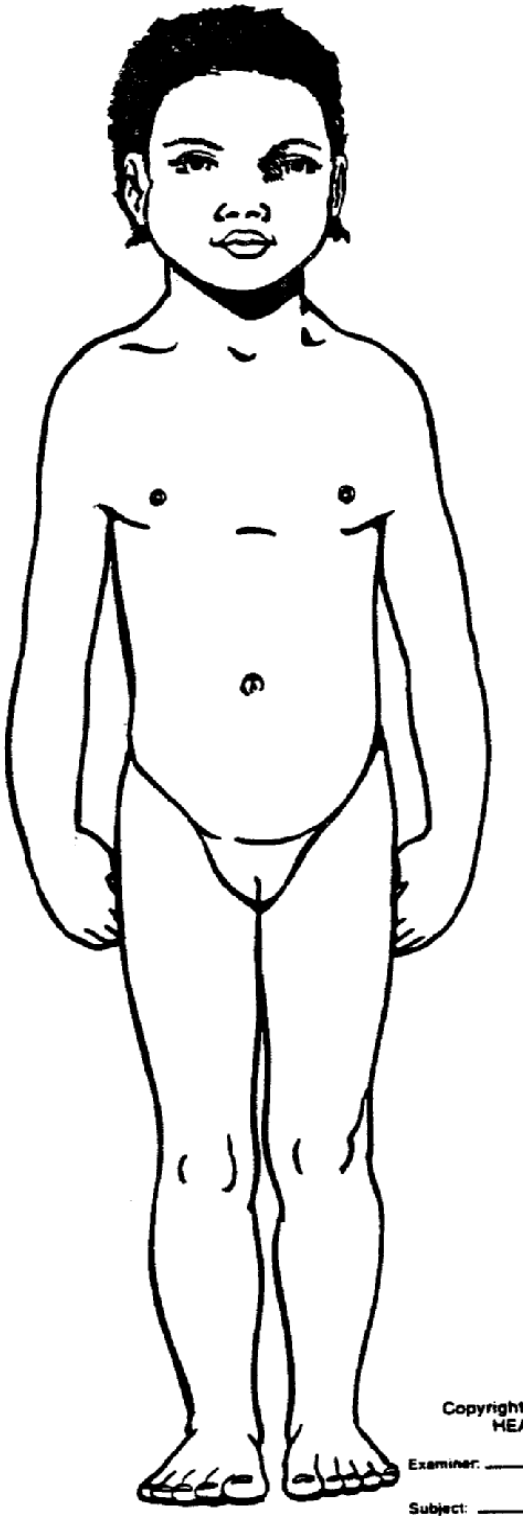
Treatment	Yes	No	Type and Comments
STI Prevention/treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Other			

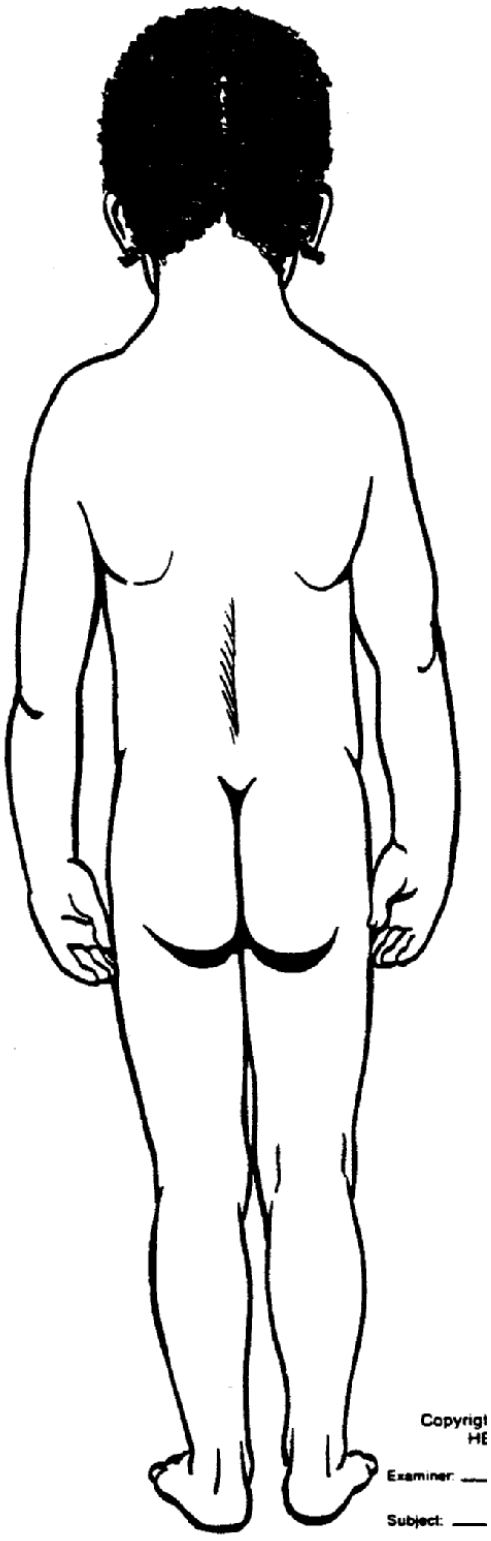
9. COUNSELING, REFERRALS, FOLLOW-UP

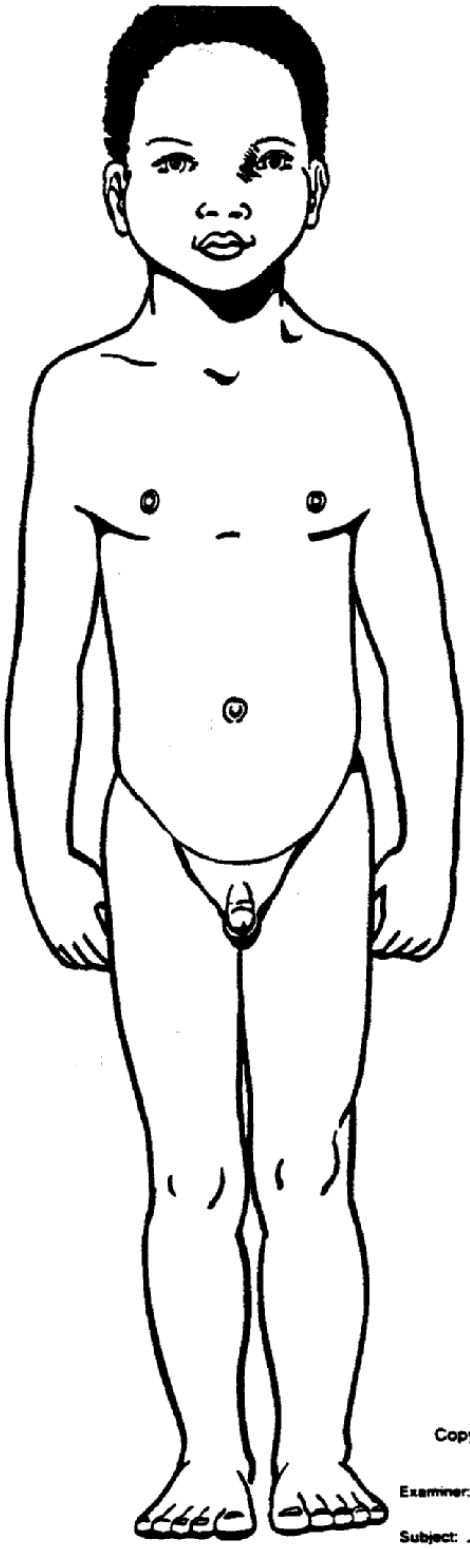
General psychological status	
Survivor plans to report to police OR has already made report Yes □ No □	
Survivor has a place to go to Yes □ No □	Has someone to accompany her/him Yes □ No □
Counseling provided:	
Referrals	
Follow-up required Date need visit	

Name of health worker conducting examination/interview: _____

BODY MAPS







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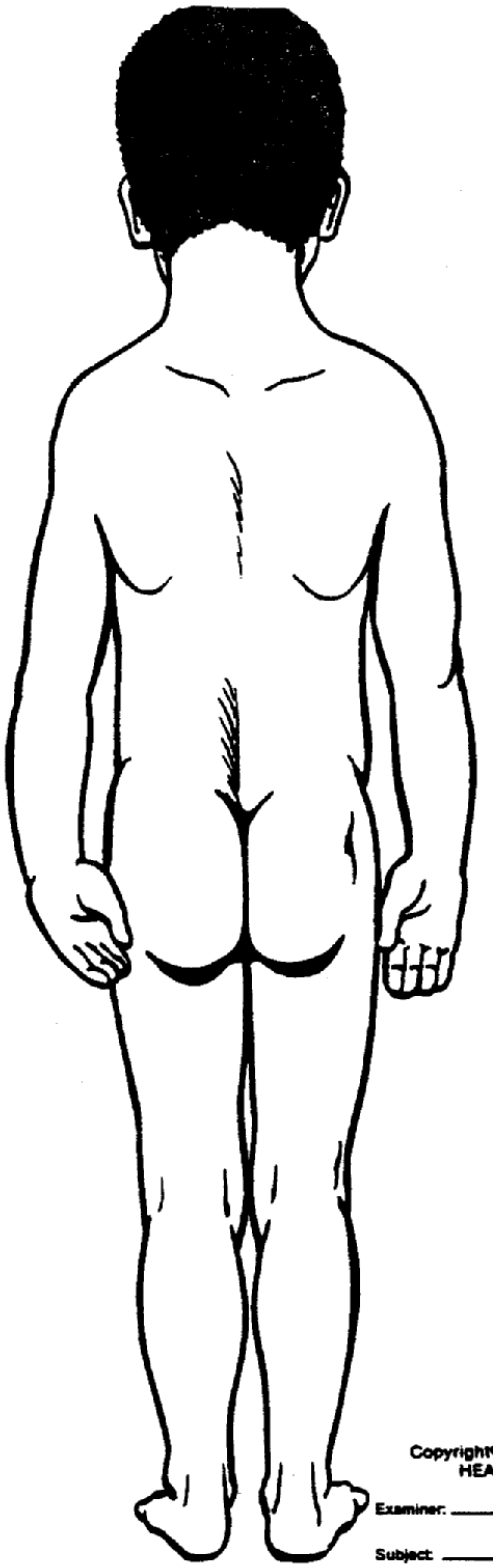

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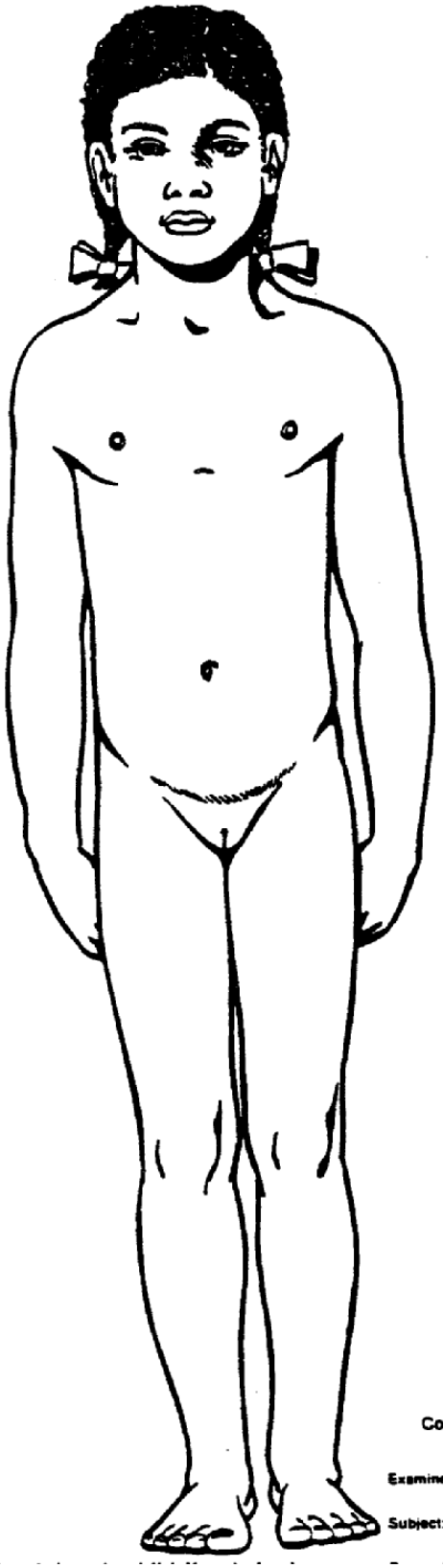

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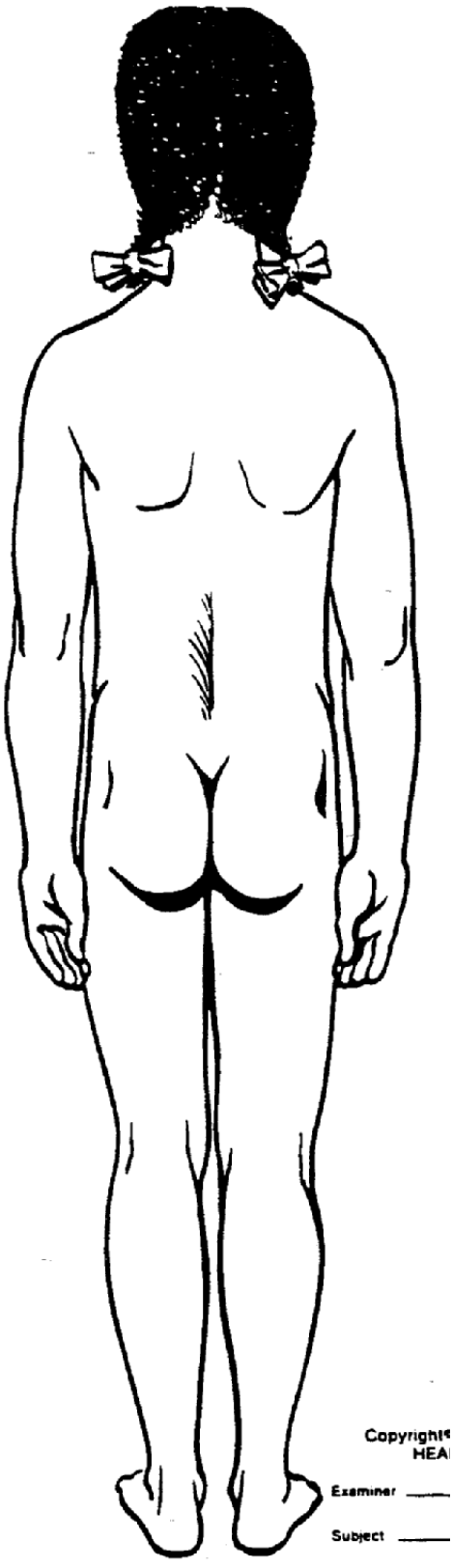

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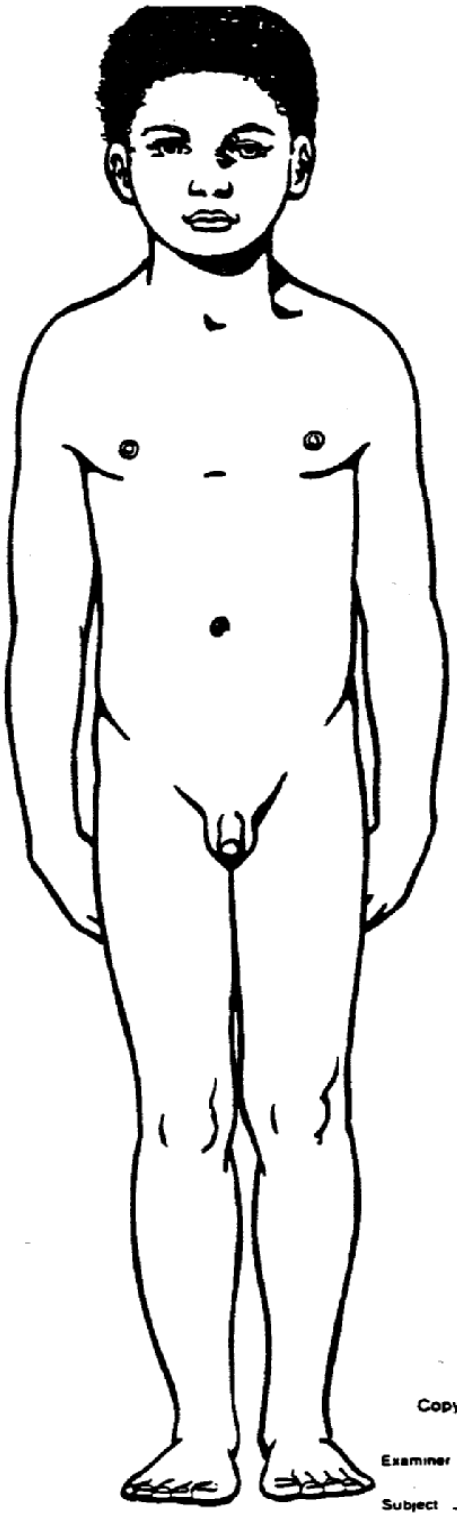
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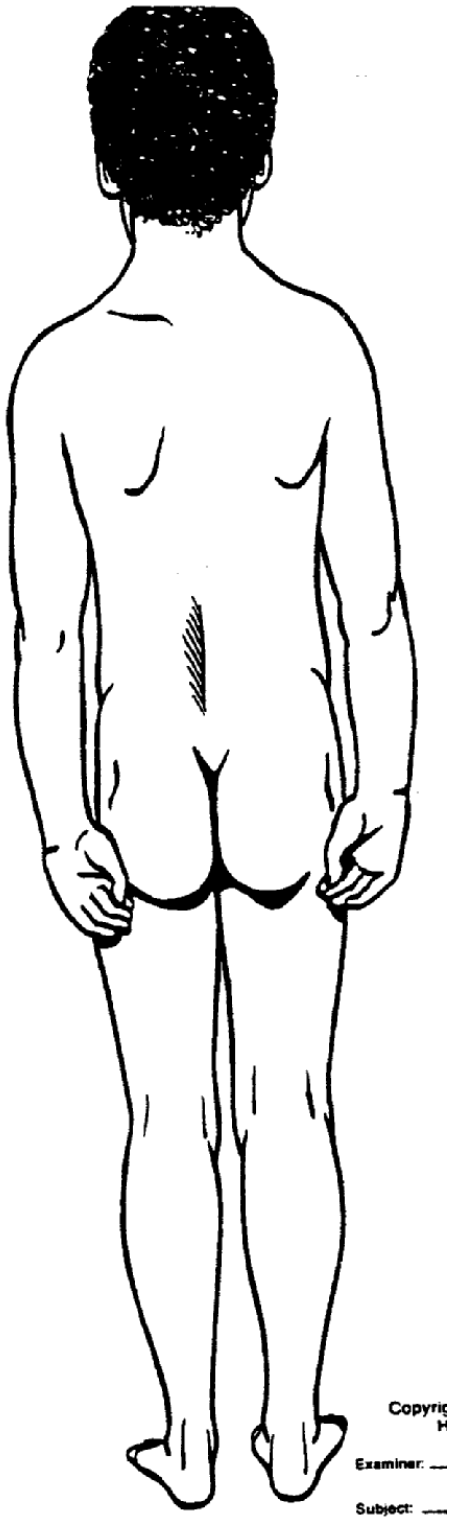
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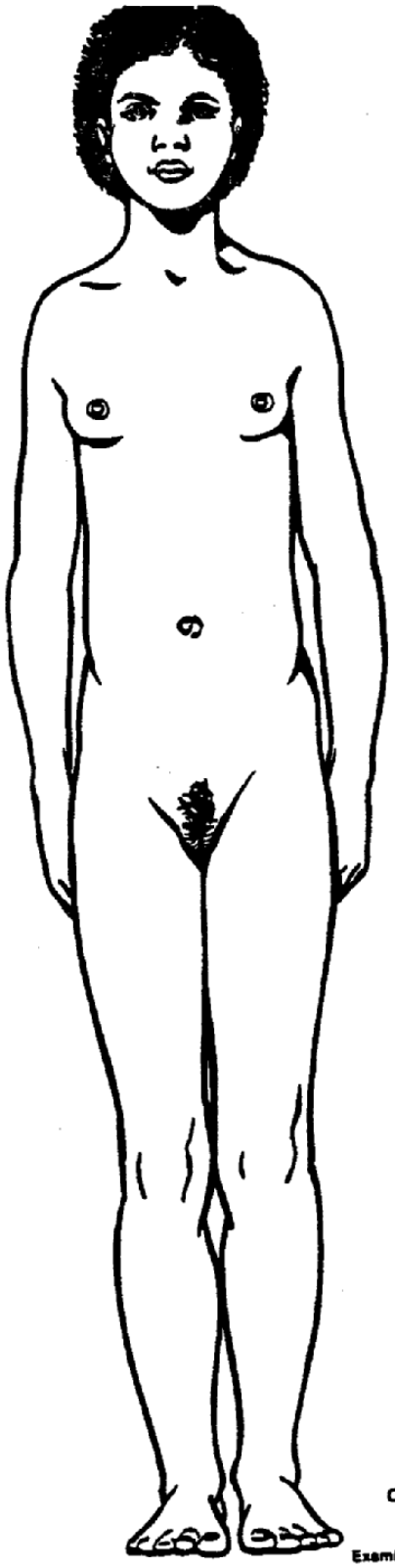

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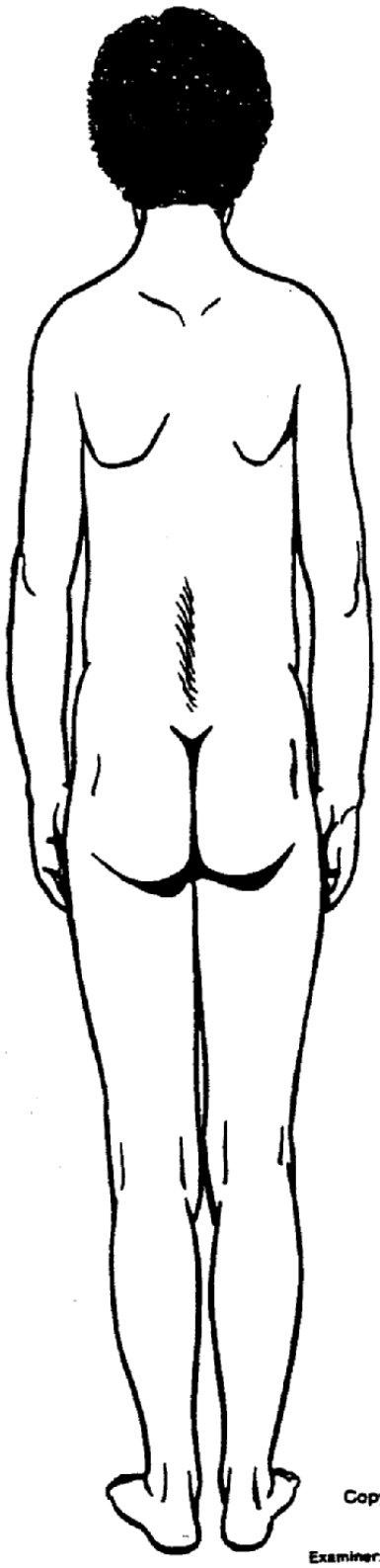

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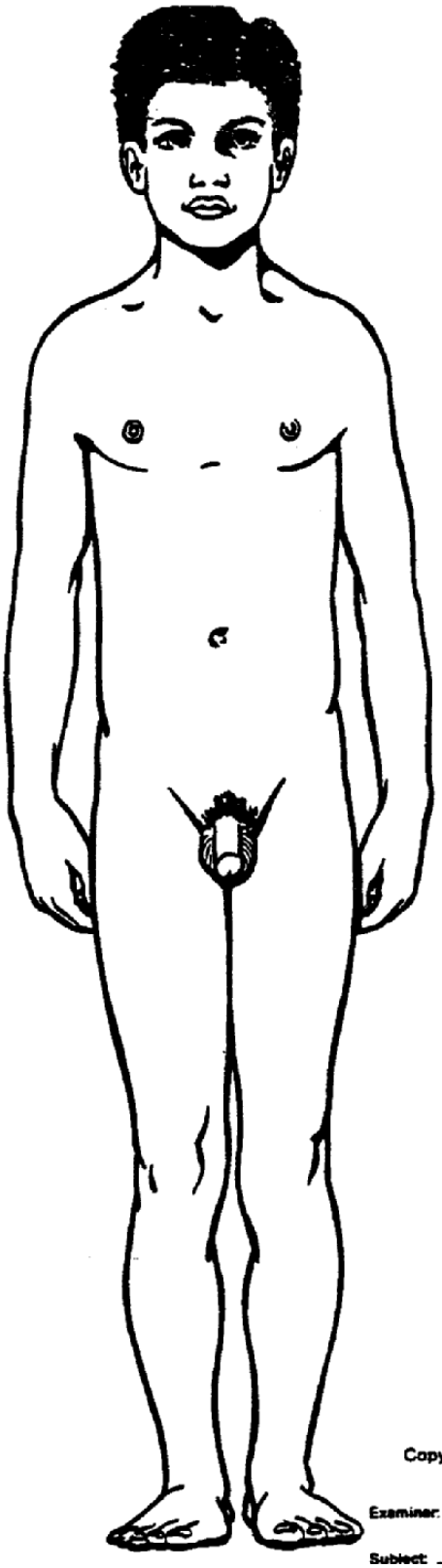

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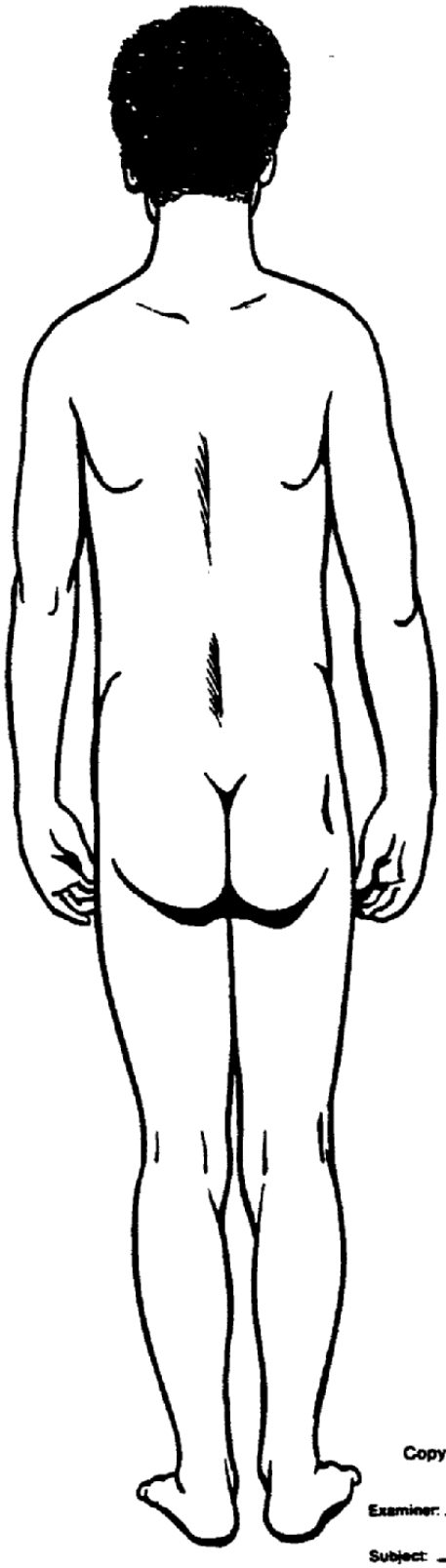

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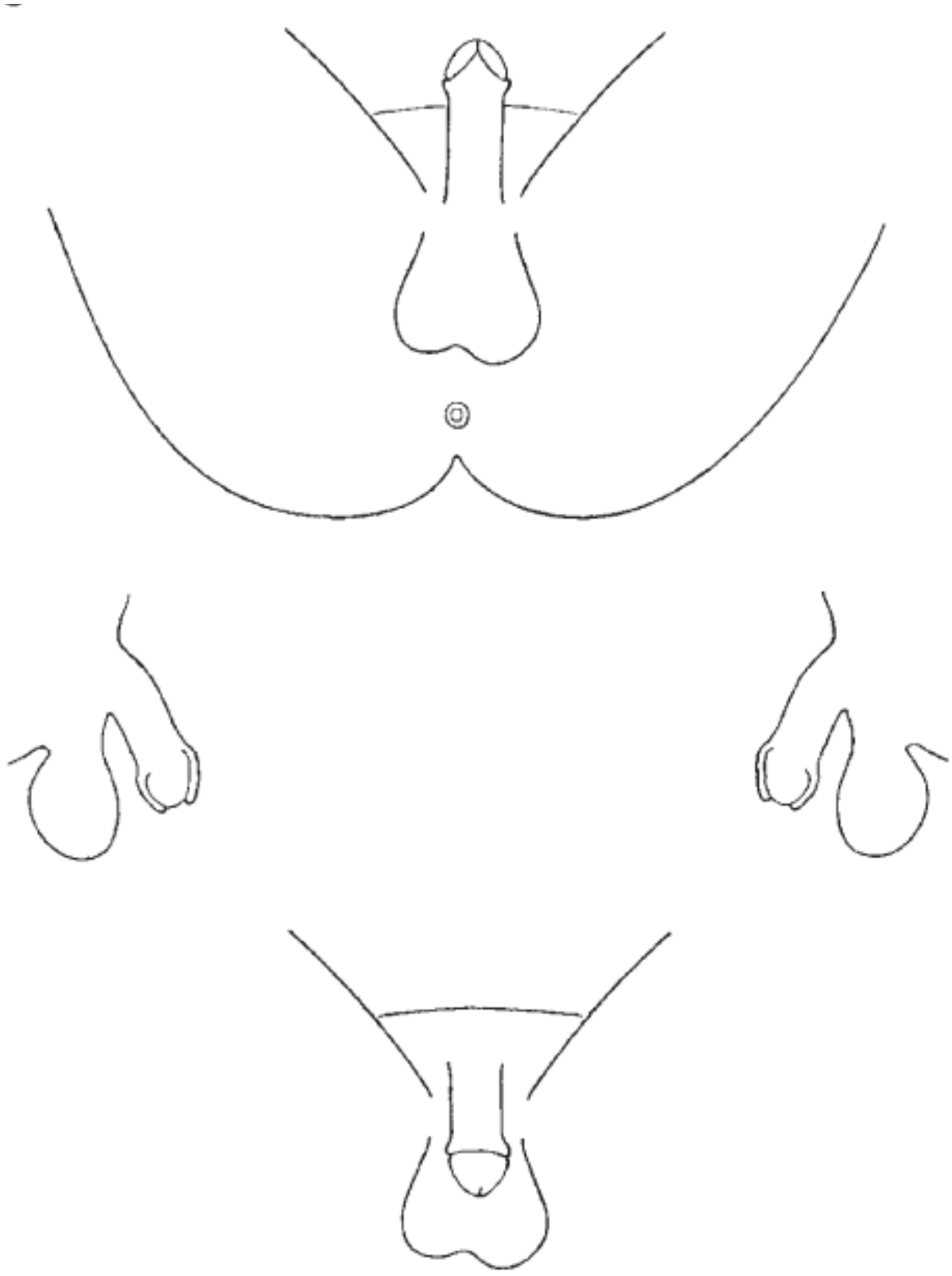

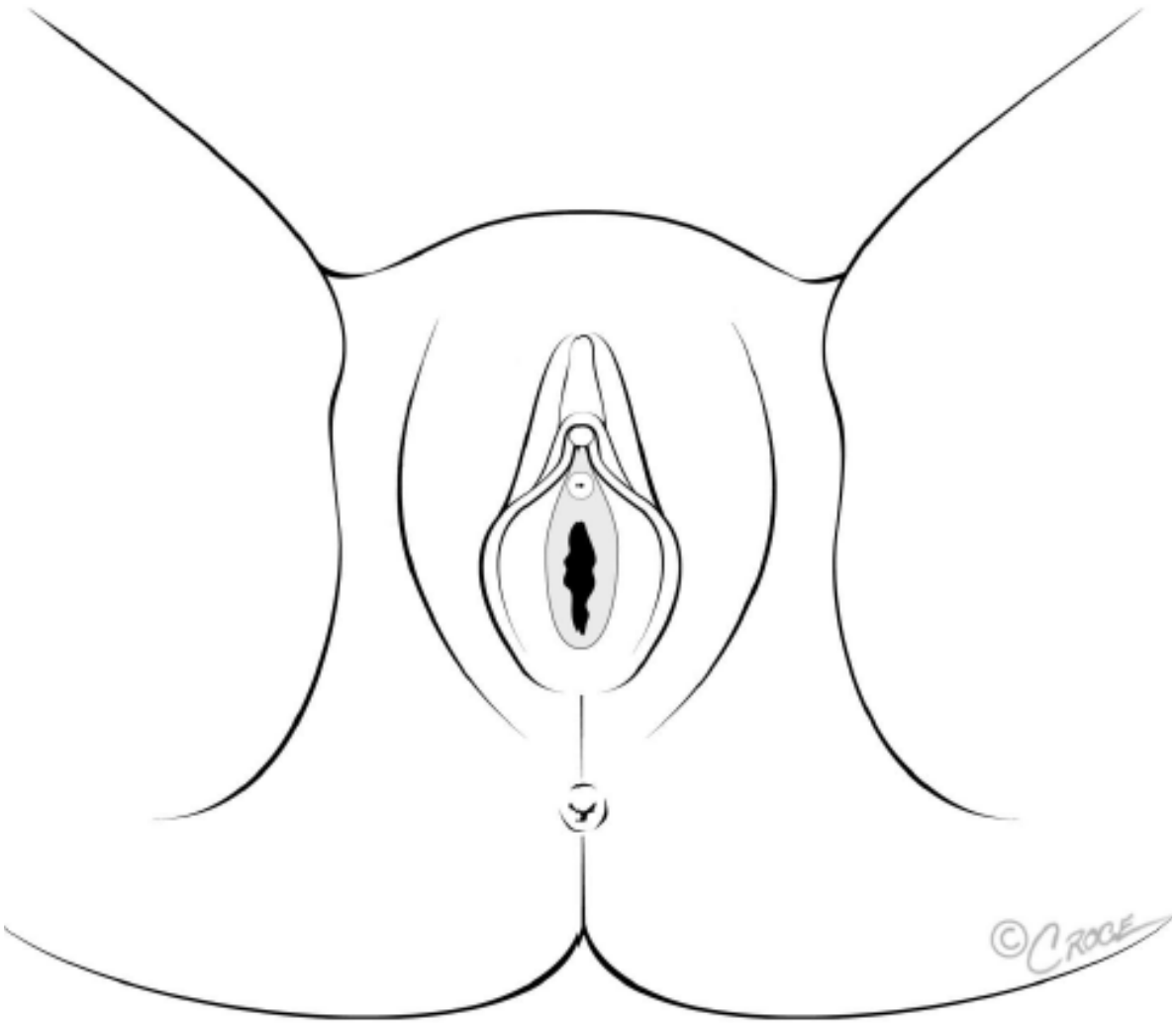
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ANNEX 11

NURSE'S CHECKLIST

TRIAGE

HISTORY TAKING

- Forensic history
  - Assess developmental level
  - Do not attempt for children younger than 5 years
  - Ask open-ended questions (avoid "yes/no" questions)
    - "Tell me about what happened"
    - DO NOT pressure a child to speak
  - Attempt to speak with the patient and caregiver separately and in private
  - Write the history in the patient's (or caregiver's) exact words when possible (use quotes)
  - Get other important information
    - When the rape occurred
    - How many times rape occurred
    - Type of penetration
    - Condom use (etc.)
  - Medical history
    - Any pain, bleeding, or injuries
    - Last menses
    - Last intercourse
    - Birth control method
    - Other medical history or diagnoses

DISCHARGE CONSIDERATIONS

- Review exam findings
  - Injury vs. no injury (what does it mean)
  - What we can and can't tell from an exam
    - Can tell if there is injury or infection
    - Cannot tell if there was penetration or by what mechanism
    - Cannot provide virgin checks
  - Signs and symptoms to return for
  - Medications
- Safety planning
  - Where is the child going?
  - Who will be there to protect the child?

*REMEMBER THERAPEUTIC COMMUNICATION

- "This is not your fault."
- "I believe you."
- Explain what is going to happen during the exam
- Offer the patient choices throughout the exam
- Offer the patient support and encouragement throughout the exam!

(Lechner and Nash 2012)

ANNEX 12

DOCTOR'S CHECKLIST

HISTORY TAKING (MAY ALREADY BE COMPLETED BY THE NURSE)

- Forensic history
  - Assess developmental level
  - Do not attempt for children younger than 5 years
  - Ask open-ended questions (avoid "yes/no" questions)
    - "Tell me about what happened"
    - DO NOT pressure a child to speak
    - Refer to the chart for rape details
      - Do not ask questions that have already been asked and documented
      - Avoid questions that suggest blame
        - "What were you doing there alone?"
  - Attempt to speak with the patient and caregiver separately and in private
  - Write the history in the patient's (or caregiver's) exact words when possible (use quotes)
  - Get other important information
    - When and where the rape occurred
    - How many times rape occurred
    - Type of penetration
    - Condom use
    - Is the perpetrator a known person or stranger?
    - Is the perpetrator's HIV status known?

MEDICAL HISTORY

- Any pain, bleeding, discharge, or injuries
- Last menses
- Last intercourse
- Birth control method
- Gravida/para
- Other medical history or diagnoses
- Family and social history

MEDICAL FORENSIC EXAM

- Complete physical assessment
  - Assess for overall health
  - Assess for body surface injuries

- Assess maturation level (Tanner staging)
- This may be the only physical exam the patient has for a long time

- Genital assessment
  - Positioning
    - "Frog-leg" position
    - "Knee-chest" position (supine and prone)
  - Separation and traction of labia
    - Allows full visualization of the hymen edges, fossa navicularis, and posterior fourchette
    - Hymen assessment
      - Estrogenized
        - Appears in newborns (estrogen remains from mother) to approximately 4 years (may vary)
        - Appears thicker, redundant
      - Unestrogenized
        - Appears in young children (approximately 4 years) to onset of puberty
        - Appears thinner, translucent
        - Painful to touch
        - NEVER insert any digits, swabs, or instruments
      - Estrogenized
        - Appears with the onset of puberty
        - Appears thicker, redundant
        - Preparing the body for reproduction and childbirth
        - ALL hymens have an opening
        - If the hymen is completely closed off, this is a medical condition that warrants attention
      - Speculum exams
        - Only done on post-menarcheal patients
        - Assess vagina and cervix (for injury and infection)
      - Anal assessment
        - Assess on all patients (for injury and infection)

MEDICATION CONSIDERATIONS

- STI prophylaxis
  - Consider for all patients raped within a 4-week timeframe
    - Even if it was considered consensual
- PEP prophylaxis
  - Consider for ALL patients raped within 72 hours (with negative test results)
  - Injury does not have to be present
  - Proof of rape does not have to be present
- Pregnancy prophylaxis
  - Consider for all pubertal patients raped within 120 hours

- Pregnancy testing should be done on all pubertal patients
- Immunizations
  - Discuss status with patients and caregivers
  - Consider tetanus with injury!

DISCHARGE CONSIDERATIONS

- Review exam findings
  - Injury vs. no injury (what does it mean)
  - What we can and can't tell from an exam
    - Can tell if there is injury or infection
    - Cannot tell if there was penetration and by what mechanism
    - Cannot provide virgin checks
  - Signs and symptoms to return for
  - Medications
- Safety planning
  - Where is the child going?
  - Who will be there to protect the child?

* REMEMBER THERAPEUTIC COMMUNICATION

- "This is not your fault."
- "I believe you."
- Explain what is going to happen during the exam
- Offer the patient choices throughout the exam
- Offer the patient support and encouragement throughout the exam

(Lechner and Nash 2012)

ANNEX 13

SOCIAL WORKER'S CHECKLIST

THERAPEUTIC COMMUNICATION IS KEY

- Discussing the rape
  - Assess developmental level
  - Do not ask children younger than 5 years questions about the rape
  - Allow the patient to lead the conversation (if they wish to talk about it)
    - Ask the patient if they want to talk about it, if so
      - Ask open-ended questions (avoid "yes/no" questions)
        - "Tell me about what happened"
        - Let the patient tell his or her story the way they want to
        - DO NOT pressure a child to speak
        - Refer to the chart for rape details
          - Do not ask questions that have already been asked and documented
            - Avoid questions that suggest blame
              - "What were you doing there alone?"
  - Attempt to initially speak with the patient and caregiver separately and privately
    - Speak to the patient and caregiver together if that is what is desired
  - Encourage and support the patient and caregiver
    - "I believe you."
    - "I am proud of you for talking about this."
    - "This is not your fault."
    - "You did what you had to do to survive the rape."
    - "You did nothing wrong."
    - "No one deserves to be raped."

DISCHARGE CONSIDERATIONS AND SAFETY PLANNING

- Discuss possible trauma related symptoms
  - Feelings of guilt and shame
  - Uncontrolled emotions such as fear, anger, and anxiety
  - Nightmares
  - Suicidal thoughts or attempts
  - Numbness
  - Substance abuse
  - Sexual dysfunction
  - Medically unexplained somatic symptoms

- Social withdrawal

- Where is the patient being discharged to?
  - Does the perpetrator live in the home?
  - Can the perpetrator leave the home?
  - Is there another place the child can live?
  - Who will protect the child?
  - What to do if the child feels threatened or the abuse reoccurs

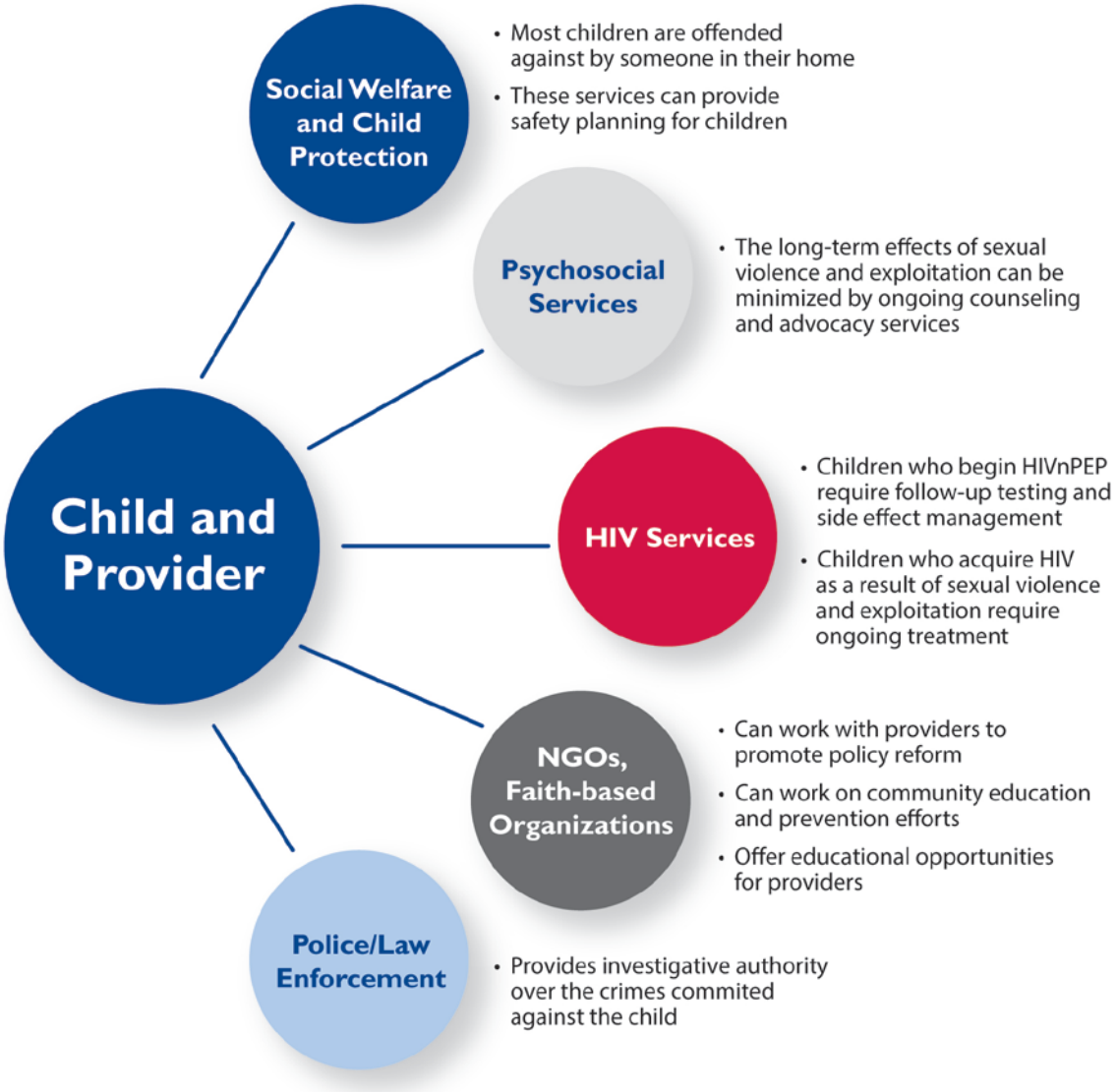
(Lechner and Nash 2012)

ANNEX 14

PROVIDER'S ROLE IN LINKING TO COMMUNITY RESOURCES JOB AID

Medical providers who see children who have experienced sexual violence and exploitation must be prepared to engage appropriate health and community-based services in an effort to give children the best-possible chance at recovery and reintegration, as well as to provide follow-up support for caregivers/families. The illustration below identifies community-based linkages the provider should connect the child or adolescent and caregiver/family member to, and explains the rationale behind each linkage.

Communication and referral between health care and community resources is depicted in the illustration here. *This may also be appropriate for facility managers/directors.



ANNEX 15

PROMISING PRACTICES

MODEL 1: ONE-STOP CENTERS

The idea of the "one-stop center" model is to bring multi-sectoral stakeholders together to provide all essential sexual violence services in one place. In addition to offering clinical services, the one-stop typically has a police officer on-site or on call to open dockets and/or take statements at the center; a social worker, nurse, and/or lay counselors to provide crisis counseling and psychosocial support; and, ideally, someone to liaise with the prosecutor and monitor the cases going to trial. The one-stop may also provide or refer clients for additional services such as psychological counseling, emergency shelter, and health care needs. This model center tends to be co-located inside or on the grounds of existing hospitals or health centers, although there are some examples of "stand-alone" clinics or community-based sites.

Livingstone General Hospital in Zambia has such a model set up, which opened in 2008, located under Livingstone Paediatric Centre of Excellence. The advantage of the one-stop model is that it can potentially provide more efficient and coordinated services, and a full range of services necessary for comprehensive care.[22]

Potential challenges are that these types of centers tend to require significantly more space and resources to operate, including dedicated staff and a site manager or services coordinator. In addition, questions about cost-effectiveness and sustainability remain unanswered, particularly in rural areas where the client load is generally small.

MODEL 2: FAMILY JUSTICE CENTER MODEL

The Family Justice Center model also provides a "one-stop" service where multidisciplinary stakeholders share common space providing all essential sexual violence services. In addition to offering health services, the center may have a law enforcement investigator on-site, a forensic interviewer, counselor, and social service support. Often the center is connected to available community resources should shelter or ongoing counseling be necessary. The center may be co-located within a health facility, or stand alone in the community.[23]

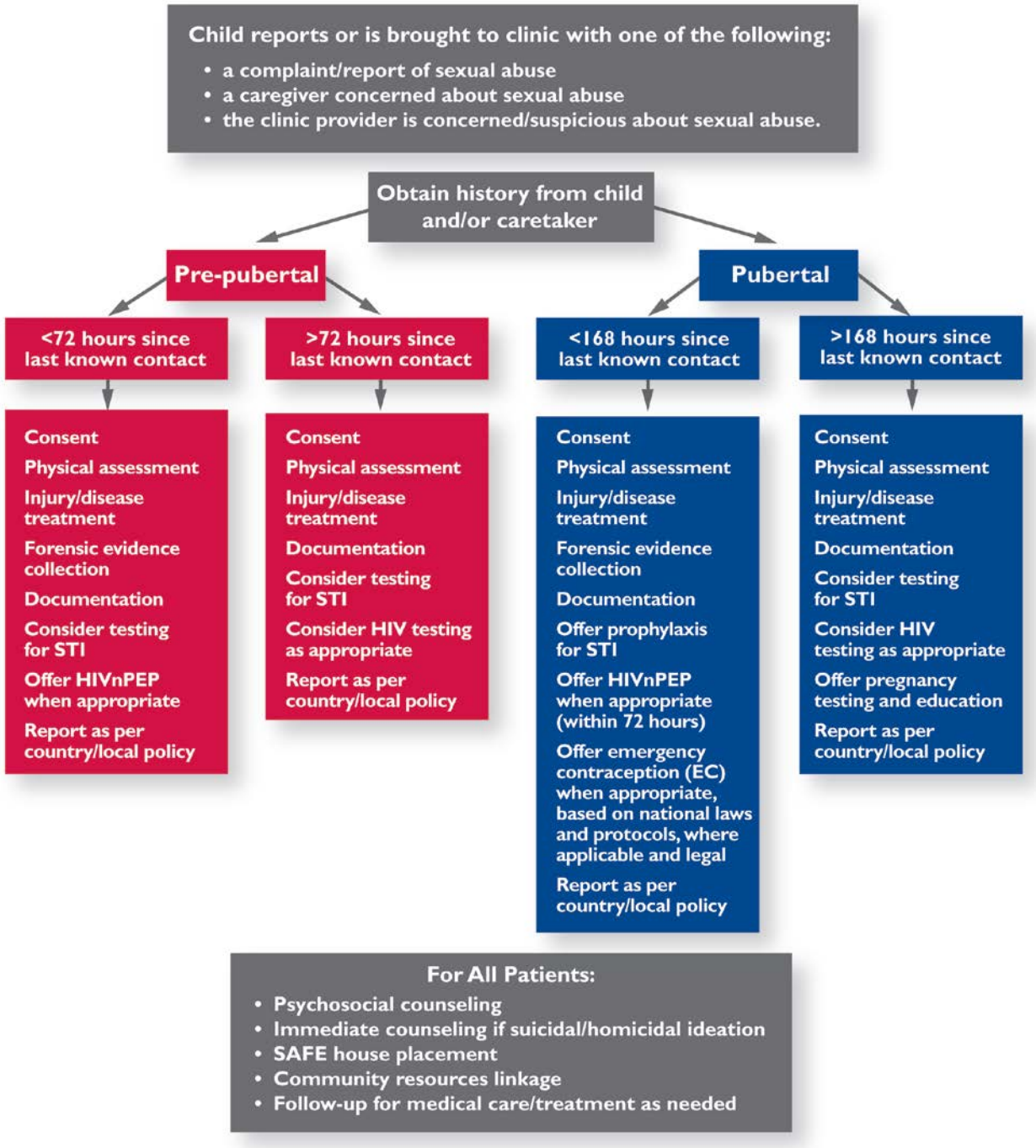
22 AIDSTAR One. http://www.aidstar-one.com/sites/default/files/PRC%20Panel%20Presentation.pdf

23 Family Justice Center Alliance. http://www.familyjusticecenter.org/

ANNEX 16

CARE ALGORITHM

The algorithm below illustrates the typical process and care considerations when sexual violence and exploitation is suspected.



For more information, please visit aidstar-one.com.

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