Medical Protocol/Guidelines for Management of Victims of Gender Based Violence (including sexual violence)

United Nations Population Fund

Ministry of Health & Population

وزارة الصحة والسكان

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RCT

REGIONAL CENTER FOR TRANING

IN FAMILY PLANNING & REPRODUCTIVE HEALTH

المركز الإكليمي للتدريب على تنظيم الأسرة والصحة الإنجابية

Medical Protocol/Guidelines for Management of Victims of Gender Based Violence *(including sexual violence)*

Service Provider's Manual

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Preface

In accordance with the constitution of the Arab Republic of Egypt, 18 January 2014, whereas it states in its introductory section that "Every citizen is entitled to live in his homeland safe and secure"; and as stipulated in article 11 of the constitution that "the State is committed to protect women against all forms of violence", a Protocol of Cooperation was signed between the Ministry of Health and Population and the National Council for Women, to develop a national strategy to combat gender-based violence and to develop a five-year plan for the implementation of the strategy.

Considering the State's political direction, coupled with the national efforts of various sectors concerned, in protecting women and providing services to victims of violence, the Ministry of Health and Population, in cooperation with the United Nations Population Fund (UNFPA), as well as, concerned national authorities, consolidated its efforts to establish a comprehensive programme, aiming at integrating a Gender Based Violence services package within the health care services provided by the Ministry of Health and Population.

In light of the above, a Supreme Consultative Committee was established to develop a comprehensive Medical Guideline for the treatment of victims of violence, in partnership with concerned specialized authorities such as: the Ministry of Health and Population with its various sectors; the Ministry of Justice, represented by its Human rights Sector and the Forensic Medicine Sector; the Ministry of Interior, represented by its affiliated Violence against Women's Unit; the Ministry of Social Solidarity; the National Council for Women; the National Council for Population; the National Council for Childhood and Motherhood; the United Nations Population Fund (UNFPA); and the relevant United Nations Agencies.

The Ministry of Health and Population is pleased to introduce the Medical Guidelines, which outlines a systematic approach for dealing with victims of gender-based violence. The manual comprises first, comprehensive definitions of all forms of violence and the various international and national legislations addressing violence; second, role of health service providers in identifying violence and assaults with their various forms, providing preliminary psychological/medical treatment; documenting, reporting, and referring cases to receive further more specialized services; third, dealing with victims of physical and domestic violence; fourth, dealing with victims of sexual assaults, including rape; and last, the annexes referred to in the manual.

Additionally, the Supreme Consultative Committee developed a number of significant recommendations which were adopted by both the Ministry of Health and Population and the Ministry of Justice (with respect to collection and safeguarding of forensic evidences), to ensure delivery of high quality services to victims of violence and to protect their rights. The key recommendations are:

- To overcome the scarcity of forensic specialists, through training of selected healthcare service providers on gathering forensic evidences in cases of physical and sexual assaults as soon as received at the healthcare facilities, to ensure that evidences are promptly submitted to the Prosecution, for the preservation of the victim's rights, noting that training will be conducted by the Forensic Medicine Sector at the Ministry of Justice.

- Launching a unified updated form for the preliminary medical report, more precise and detailed, in terms of providing information about the injuries and the treating physician for future reference, whenever needed.

- Launch and Integration of a GVB logbook in all hospitals to register gender based violence cases received and services provided, as well as referral of cases to other services.

We hope that this guideline will serve as a tool that helps in identifying, tracing cases of violence against women, as well as providing appropriate support to women, while preserving their full rights; which will consequently have a positive impact towards improving the status of women in particular and the society in general.

We wish to acknowledge our appreciation to all partners for their efforts in developing this guideline/ manual and making it operational.

Dr. Adel Adawy

Minister of Health and Population

Ambassador Mervat Tallawy

President of the National Council for Women

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Content Index

Part 1 Overview and basic information about Gender-Based Violence Protecting human rights **9**

What is Gender-Based Violence? 14

Defining Key Concepts. 16

Types of Gender-Based Violence. 19

When and where does Gender-Based Violence Occur? 23

Causes and Consequences of Gender-Based Violence 24

Legal and security safeguards in Egypt against Gender based violence 28

Key Points to Remember 32

Part 2 Guiding Principles for Management of GBV **33**

Roles and responsibilities of health care provider 37

The Relevance of Screening for GBV 39

How to overcome barriers? 42

Challenges Preventing Women from Disclosing GBV. 46

Part 3 Provider's Guide for Management of Domestic Violence (DV) **51**

Guidelines step by step 55

Tactics and clinical cues 56

When to consider domestic violence even if the patient does not disclose abuse 58

Sample Screening Tool for Suspected Cases 59

Medical history and examination form 60

Danger assessment instrument 64

Safety plan 65

Medical report form 66

Part 4 Provider's guide for clinical management of rape/sexual violence 69

Introduction 73

Preparations required to offer appropriate medical care to victims of rape 76

Steps to deal with a sexually abused person 78

STEP 1 – Preparing the victim for the examination 78

STEP 2 – Taking the history 79

STEP 3 – Collecting forensic evidence 81

STEP 4 – Performing the physical and genital examination 84

STEP 5 – Prescribing treatment 87

STEP 6 – Counseling the patient 93

STEP 7 - Follow-up care of the survivor 95

Care of child survivor 95

Part 5 Appendix

Annex 1 Legal and security safeguards in Egypt against GBV

Annex 2 History and examination form and Pictogram

Annex 3 Psychological First Aid

Annex 4 Medical report form and ethics (Arabic)

Annex 5 Sexual Assault Forensic Examiner (SAFE) training

Annex 6 Consent form

Annex 7 STDs protocol

Annex 8 PEP (Post Exposure Prophylaxis to HIV) protocol

Annex 9 EC (Emergency Contraception) protocol

Annex 10 Referral Networks

Annex 11 Adult medical certificate model

Annex 12 Violence against woman in Egypt's Law

Annex 13 Forensic Evidence Collection

Annex 14 Danger assessment instrument

Part 1: Overview and basic information about Gender-Based Violence (including sexual violence)

Part 1: Overview and basic information about Gender-Based Violence (including sexual violence)

Contents

- Protecting human rights
- What is Gender-Based Violence?
- Defining Key Concepts.
- Types of Gender-Based Violence.
- When and where does Gender-Based Violence Occur?
- Causes and Consequences of Gender-Based Violence
- Key Points to Remember.

Gender-based violence is a violation of human rights. This kind of violence perpetuates the stereotyping of gender roles that denies human dignity of the individual and stymies human development. The overwhelming majority of the victims/survivors of gender-based violence (including sexual violence) are women and girls.

Gender-based violence includes much more than sexual assault and rape. Although it may occur in public contexts, it is largely rooted in individual attitudes that condone violence within the family, the community and the State. The root causes and consequences of gender-based violence must be understood before appropriate programmes to prevent and respond to this violence can be planned.

A Few Facts about Gender-Based Violence

World-wide, an estimated 40 to 70 per cent of homicides of women are committed by intimate partners, often in the context of an abusive relationship.

Around the world, at least one in every three women has been beaten, coerced into sex, or otherwise abused in her lifetime.

Trafficking of humans world-wide grew almost 50 percent from 1995 to 2000 and the International Organization for Migration (IOM) estimates that as many as 2 million women are trafficked across borders annually.

More than 90 million African women and girls are victims of female genital mutilation.

At least 60 million girls who would otherwise be expected to be alive are missing from various populations, mostly in Asia, as a result of sex-selective abortions, infanticide or neglect.[1]

Domestic Violence is worldwide spread

Between 21% and 37% of women experience domestic violence during their lifetimes.[2]

Research in primary care settings indicates that 3.4-5.5% of patients have experienced domestic violence within the last year.[3]

Women aged 16 to 24 experience the highest rate of partner violence per capita.[4]

The reported rate of teen dating violence among adolescents varies from 25-60%.[5]

A national survey of 6,000 American families revealed that 50% of the men who frequently assaulted their wives, also frequently abused their children.[6]

Approximately 14% of women being treated in emergency departments were victims of domestic violence within the last year.[7]

Studies estimate that between 3% and 5% of the elderly population have been abused. The Senate Special Committee on Aging estimates that there may be as many as 5 million elders abused every year.[8]

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1) Violence Against Women: The Hidden Health Burden (World Bank 1994) Fact Sheet on Gender Violence: A Statistics for Action Fact Sheet (L. Heise, IWTC, 1992 and Progress of the World's Women (UNIFEM, 2000)
2) Campbell AS, Schollenberger J, Gielen, AC et al. 1999. Annual and lifetime prevalence of partner abuse in a sample of female HMO enrollees. Women's Health Issues 9(6): 295-305.
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4) Rennison M. 2001. Intimate Partner Violence and Age of Victim, 1993-1999. Bureau of Justice Statistics: Special Report. Washington, DC: U.S. Department of Justice. Publication NCJ 187635.
5) Cohall A, Cohall R, Banniester H et al. 1999. Love shouldn't hurt: Strategies for healthcare providers to address adolescent dating violence. J Am Med Women's Assoc54(3):144-8.
6) Strauss, M, Gelles R, Silverman J, and Smith C. 1990. Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families. New Brunswick: Transaction Publishers.
7) Dearwater SR, Coben JH, Campbell JC et al. 1998. Prevalence of intimate partner abuse in women
8) National Center on Elder Abuse. 2003. (http://www.elderabusecenter.org/default.cfm?p=faqs.cfm#seven).

The situation in Egypt

- Data from recent DHS 2005 showed that one in every three women is a victim of domestic violence. Approximately 91% of married females are subjected to FGM/C in their early adulthood. Harassments in public places are progressively increasing and becoming a phenomenon.[9]
- 47% of married women surveyed report having experienced physical violence and 33% at the hands of current or former husbands while only 1.3% of harmed women requested help from the police[10]
- 57% of unmarried female youth in Egypt report being subject to physical violence by their fathers and brothers. A public opinion poll on 13,500 female was conducted by the National Council for Women (NCW) showed that 88% are circumcised, 38% forced to early marriage, and 82% were subject to harassment[11].

Human Rights

Prevention of and response to gender-based violence (including sexual violence) are directly linked to the protection of human rights.

Human rights are universal, inalienable, indivisible, interconnected and interdependent. Every individual, without regard to race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or status, is entitled to the respect, protection, exercise and enjoyment of all the fundamental human rights and freedoms.

Governments are obliged to ensure the equal enjoyment of all economic, social, cultural, civil and political rights for women and men, girls and boys.

Acts of gender-based violence violate a number of human rights principles enshrined in international human rights instruments

Among others, these include:

- The right to life, liberty and security of the person.
- The right to the highest attainable standard of physical and mental health.
- The right to freedom from torture or cruel, inhuman, or degrading treatment or punishment.
- The right to freedom of movement, opinion, expression, and association.
- The right to enter into marriage with free and full consent and the entitlement to equal rights to marriage, during marriage and at its dissolution.
- The right to education, social security and personal development.
- The right to cultural, political and public participation, equal access to public services, work and equal pay for equal work.

International Criminal Court defines rape, sexual slavery, enforced prostitution, forced pregnancy, enforced sterilization or any other form of sexual violence of comparable gravity as a crime against humanity.

What is Gender-Based Violence?

Sexual violence, gender-based violence and violence against women are terms that are commonly used interchangeably. All these terms refer to violations of fundamental human rights that perpetuate sex-stereotyped roles that deny human dignity and the self-determination of the individual and hamper human development.

9) Demographic and Health Survey Egypt 2005
10) Study on Violence against women in Egypt –NCW 2009
11) National Council for Women (NCW) 2012

They refer to physical, sexual and psychological harm that reinforces female subordination and perpetuates male power and control.

While gender based violence has a devastating impact on the lives of women and girls who are the majority of victims/survivors, it also hinders the development of men and boys. Eliminating gender based volence and gender inequalities helps to strengthen entire communities.

The term **gender-based violence (GBV)** is used to distinguish common violence from violence that targets individuals or groups of individuals on the basis of their gender. Gender-based violence has been defined by the CEDAW[12] Committee as violence that is directed at a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threat of such acts, coercion and other deprivations of liberty.

GBV shall be understood to encompass, but not be limited to the following:

a) Physical, sexual and psychological violence occurring **in the family**, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.

b) Physical, sexual and psychological violence occurring **within the general community**, including rape, sexual abuse, sexual harassment and intimidation at work, in educational institutions and elsewhere trafficking in women and forced prostitution.

c) Physical, sexual and psychological violence **perpetrated or condoned by the State and institutions**, wherever it occurs.

The term **violence against women** refers to any act of gender-based violence that results in, or is likely to result in, physical, sexual and psychological harm to women and girls, whether occurring in private or in public. Violence against women is a form of gender-based violence and it includes sexual violence.

Sexual violence, including **exploitation and abuse**, refers to any act, attempt or threat of a sexual nature that results, or is likely to result, in physical, psychological and emotional harm. Sexual violence is a form of gender-based violence.

Some organizations employ an inclusive conception of **sexual and gender-based violence** that recognizes that, although the majority of victims/survivors are women and children, boys and men are also targets of sexual and gender-based violence.

Sexual and gender-based violence is largely rooted in unequal power relations. These perpetuate and condone violence within the family, the community and the State. The distinction made between public and private spheres should not serve as an excuse for not addressing domestic violence as a form of SGBV. The exclusion of women and girls from the public arena only increases their vulnerability to violence within the family. **Domestic violence** reinforces gender-based discrimination and keeps women subordinate to men.

Trafficking in persons shall mean the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labor or services, slavery or practices similar to slavery, servitude or the removal of organs.[13]

12) CEDAW: Convention on Elimination of All Forms of Discrimination Against Women UN 1979

13) Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime, November 2000

Defining Key Concepts

Sexual and gender-based violence includes much more than sexual assault and rape. To understand its root causes and consequences, it is essential to define and distinguish between the terms gender and sex.

The term **sex** refers to the biological characteristics of males and females. These characteristics are congenital and their differences are limited to physiological reproductive functions.

Gender is the term used to denote the social characteristics assigned to men and women. These social characteristics are constructed on the basis of different factors, such as age, religion, national, ethnic and social origin. They differ both within and between cultures and define identities, status, roles, responsibilities and power relations among the members of any society or culture. Gender is learned through socialization. It is not static or innate, but evolves to respond to changes in the social, political and cultural environment.

Gender is learned and therefore changeable.

People are born female or male (sex); they learn how to be girls and boys, and then become women and men (gender). Gender refers to what it means to be a boy or girl, woman or man, in a particular society or culture. Society teaches expected attitudes, behaviors, roles and activities. Gender defines the roles, responsibilities, constraints, opportunities and privileges of men and women in any context. This learned behavior is known as **gender identity**. Women around the world are usually in a disadvantaged position compared to men of the same social and economic levels. Gender roles and identities usually involve inequality and power imbalance between women and men. Violence against women, and its acceptance within society and cultures, is one of the manifestations of this inequality and power imbalance.

A comprehensive prevention and response plan should focus on the roles and needs of both women and men and how both can become agents of change.

Focusing only on women when addressing sexual and gender-based violence tends to place the responsibility for prevention and response on the victims/survivors.

Violence is a means of control and oppression that can include emotional, social or economic force, coercion or pressure, as well as physical harm. It can be overt, in the form of a physical assault or threatening someone with a weapon; it can also be covert, in the form of intimidation, threats, persecution, deception or other forms of psychological or social pressure. The person targeted by this kind of violence is compelled to behave as expected or to act against her will out of fear. An incident of violence is an act or a series of harmful acts by a perpetrator or a group of perpetrators against a person or a group of individuals. It may involve multiple types and repeated acts of violence over a period of time, with variable durations. It can take minutes, hours, days or a lifetime.

Abuse is the misuse of power through which the perpetrator gains control or advantage of the abused, using and causing physical or psychological harm or inciting fear of that harm. Abuse prevents persons from making free decisions and forces them to behave against their will.

Coercion is forcing, or attempting to force, another person to engage in behaviors against her will by using threats, verbal insistence, manipulation, deception, cultural expectations or economic power.

Power is understood as the capacity to make decisions. All relationships are affected by the exercise of power. When power is used to make decisions regarding one's own life, it becomes an affirmation of self-acceptance and self-respect that, in turn, fosters respect and acceptance of others as equals. When used to dominate, power imposes obligations on, restricts, prohibits and makes decisions about the lives

of others. To prevent and respond to sexual and gender-based violence effectively, the power relations between men and women, women and women, men and men, adults and children, and among children must be analyzed and understood.

Exploitation and abuse occurs when this disparity of power is misused to the detriment of those persons who cannot negotiate or make decisions on an equal basis. Exploitation and abuse can take the form of physical and psychological force or other means of coercion (threats, inducements, deception or extortion) with the aim of gaining sexual or other favors in exchange for services.

Consent is when a person makes an informed choice to agree freely and voluntarily to do something. The phrase against her will is used to indicate an absence of informed consent. There is no consent when agreement is obtained through the use of threats, force or other forms of coercion, abduction, fraud, deception, or misrepresentation.

The use of a threat to withhold a benefit, or a promise to provide a benefit, in order to obtain the agreement of a person is also an abuse of power; any agreement obtained this way is not considered to be consensual. There is also no consent if the person is below the legal (statutory) age of consent or is defined as a child under applicable laws.

A **perpetrator** is a person, group, or institution that directly inflicts, supports and condones violence or other abuse against a person or a group of persons. Perpetrators are in a position of real or perceived power, decision-making and/or authority and can thus exert control over their victims.

It is a myth that sexual and gender-based violence is usually perpetrated by strangers. In fact, most acts of sexual and gender-based violence are perpetrated by someone known to the survivor, and many violent incidents are planned in advance.

Sexual and gender-based violence can also be perpetrated by family and community members. States and institutions condone and perpetrate sexual and gender-based violence when discriminatory practices are not challenged and prevented, including through the use of legal and policy instruments. During war and conflict, sexual and gender-based violence is frequently perpetrated by armed members from warring factions.

Perpetrators of sexual and gender-based violence are sometimes the very people upon whom survivors depend to assist and protect them.

Most cases of sexual and gender-based violence involve a female victim/survivor and a male perpetrator. Most acts of sexual and gender-based violence against boys and men are also committed by male perpetrators.

Intimate partners (husband, fiancée): In most societies, the accepted gender role for male intimate partners is one of decision-making and power over the female partner. Unfortunately, this power and influence is often exerted through discrimination, violence, and abuse.

Family members, close relatives and friends: Girls are far more likely to suffer sexual and gender-based violence within the domestic sphere. From neglect to incest, these human rights violations are not always reported, since they involve fathers, stepfathers, grandfathers, brothers and/or uncles as perpetrators. Harmful traditional practices also take place with the knowledge and sometimes the participation of family members and close relatives and friends.

Influential community members (teachers, leaders, politicians, employers):

Leaders and other community members in positions of authority can abuse that power through acts of sexual and gender-based violence. The victim/survivor in these situations is even more reluctant to report the violence because of the perpetrator's position of trust and power within the community.

Institutions: Discriminatory practices in the delivery of social services help maintain and increase gender inequalities. Withholding information, delaying or denying medical assistance, offering unequal salaries for the same work and obstructing justice are some forms of violence perpetrated through institutions.

TYPES OF POWER AND CONTROL

Physical violence

- Hitting, punching, kicking
- Withholding medications
- Attempting to force miscarriage

Sexual violence

- Forced sexual activities
- Forced prostitution or exotic dancing
- Threatening to sexually abuse children

Using coercion or threats

- Making and/or carrying out threats to hurt her
- Threatening to leave her, to commit suicide,
- Making her drop existing charges

Using intimidation

- Making her afraid by using looks, actions or gestures
- Smashing things and destroying her property
- Displaying weapons as a threat to harm her

Using emotional abuse

- Putting her down and making her feel bad about herself
- Making her think that she is "crazy"
- Humiliating her and calling her names including racial slurs

Using isolation

- Controlling what she does, who she sees,
- who she talks to and where she goes
- Limiting her involvement with others
- Using jealousy to justify his actions

Using economic abuse

- Preventing her from getting or keeping a job
- Forcing the victim to work "under the table"
- Taking the victim's earned income

Using children

- Using children to relay intimidating or
- Threatening messages to her
- Threatening to take children away from her
- Using visitation to harass her

Minimizing, denying and blaming

- Saying the abuse didn't happen
- Saying she caused the abuse
- Making light of the abuse

Using assumed male privilege

- Expecting subservience based on her
- perceived status as a woman
- Treating her like a servant
- Making relevant decisions unanimously
- Being the one to define the male and female roles in their relationship

Types of Gender-Based Violence (including sexual violence)

The following table describes some of the more common forms of sexual and gender-based violence. The list is neither exhaustive nor exclusive. It is a practical tool that can be used in each location to help identify the different forms of sexual and gender-based violence that exist. Acts of sexual and gender-based violence have been grouped into five categories:

- Sexual violence.
- Physical violence.
- Emotional and psychological violence.
- Harmful traditional practices.
- Socio-economic violence.

Sexual Violence

Type of act	Description/Examples	Can be perpetrated by
Rape	The invasion of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body by force, threat of force, coercion, taking advantage of a coercive environment, or against a person incapable of giving genuine consent (International Criminal Court).	Any person in a position of power, authority and control, including, intimate partner, caregiver and stranger.
Child sexual abuse, defilement and incest	Any act where a child is used for sexual gratification. Any sexual relations/ interaction with a child.	Someone the child trusts, including parent, sibling, extended family member, friend or stranger, teacher, elder, leader or any other caregiver, anyone in a position of power, authority and control over a child.
Forced sodomy/ anal rape	Forced /coerced anal intercourse, usually male-to-male or male-to-female.	Any person in a position of power, authority and control.
Attempted rape or attempted forced sodomy /anal rape	Attempted forced/coerced intercourse; no penetration.	Any person in a position of power, authority and control.
Sexual abuse	Actual or threatened physical intrusion of a sexual nature, including inappropriate touching, by force or under unequal or coercive conditions.	Any person in a position power, authority and control, family/ community members, co-workers, including supervisors, strangers.
Sexual exploitation	Any abuse of a position of vulnerability, differential power, or trust for sexual purposes; this includes profiting momentarily, socially or politically from the sexual exploitation of another (IASC); Sexual exploitation is one of the purposes of trafficking in persons (performing in a sexual manner, forced undressing and/ or nakedness, coerced marriage, forced childbearing, engagement in pornography or prostitution, sexual extortion for the granting of goods, services, assistance benefits, sexual slavery).	Anyone in a position of power, influence, control, including humanitarian aid workers, soldiers/officials at checkpoints, teachers, smugglers, trafficking networks.
Forced prostitution (also referred to as sexual exploitation)	Forced/coerced sex trade in exchange for material resources, services and assistance, usually targeting highly vulnerable women or girls unable to meet basic human needs for themselves and/or their children.	Any person in a privileged position, in possession of money or control of material resources and services, perceived as powerful.

Sexual harassment	Any unwelcome, usually repeated andmunreciprocated sexual advance, unsolicited sexual attention, demand for sexual access or favors, sexual innuendo or other verbal or physical conduct of a sexual nature, display of pornographic material, when it interferes with work, is made a condition of employment or creates an intimidating, hostile or offensive work environment.	Employers, supervisors or colleagues, any person in a position of power, authority, or control.
Sexual violence as a weapon of war and torture	Crimes against humanity of a sexual nature, including rape, sexual slavery, forced abortion, sterilization, or any other forms to prevent birth, forced pregnancy, forced delivery, and forced child rearing, among others. Sexual violence as a form of torture is defined as any act or threat of a sexual nature by which severe mental or physical pain or suffering is caused to obtain information, confession or punishment from the victim or third person, intimidate her or a third person or to destroy, in whole or in part, a national, ethnic, racial or religious group.	Often committed, sanctioned and ordered by military, police, armed groups or other parties in conflict.

Physical Violence

Type of act	Description/Examples	Can be perpetrated by
Physical assault	Beating, punching, kicking, biting, burning, maiming or killing, with or without weapons; often used in combination with other forms of sexual and gender-based violence.	Spouse, intimate partner, family member, friend, acquaintance, stranger, anyone in position of power, members of parties to a conflict.
Trafficking, Slavery	Selling and/or trading in human beings for forced sexual activities, forced labor or services, slavery or, servitude or removal of organs.	Any person in a position of power or control.

Emotional and Psychological Violence

Type of act	Description/Examples	Can be perpetrated by
Abuse/Humiliation	Non-sexual verbal abuse that is insulting, degrading, demeaning; compelling the victim/survivor to engage in humiliating acts, whether in public or private; denying basic expenses for family survival.	Anyone in a position of power and control, often perpetrated by spouses, intimate partners or family members in a position of authority.

Confinement	Isolating a person from friends/family restricting movements, deprivation of liberty or obstruction/restriction of the right to free movement.	Anyone in a position of power and control; often perpetrated by spouses, intimate partners or family members in a position of authority.

Harmful Traditional Practices

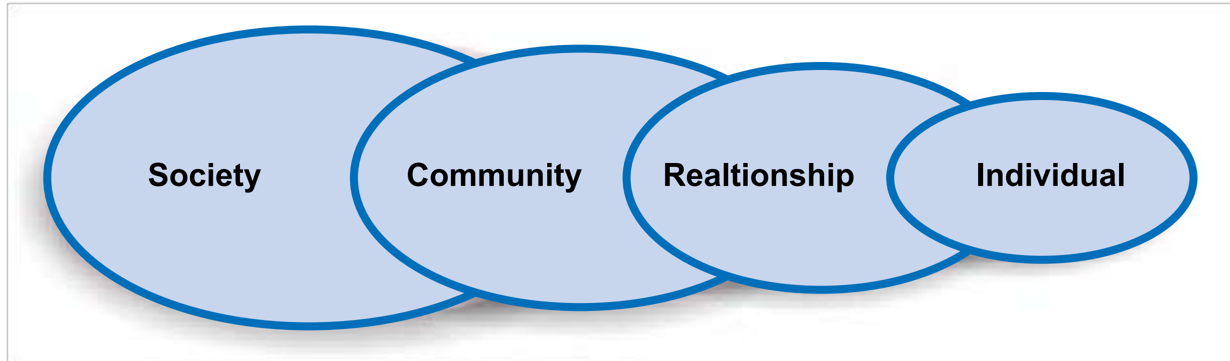
Type of act	Description/Examples	Can be perpetrated by
Female genital mutilation (FGM)	Cutting of genital organs for non-medical reasons, usually done at a young age; ranges from partial to total cutting, removal of genitals, stitching whether for cultural or other non-therapeutic reasons; often undergone several times during life-time, i.e., after delivery or if a girl/woman has been victim of sexual assault.	Traditional practitioners, health providers (in some countries), supported, condoned, and assisted by families, religious groups, entire communities and some States.
Early marriage	Arranged marriage under the age of legal consent (sexual intercourse in such relationships constitutes statutory rape, as the girls are not legally competent to agree to such unions)	Parents, community and State.
Forced marriage	Arranged marriage against the victim's/ survivor's wishes; often a dowry is paid to the family; when refused, there are violent and/or abusive consequences.	Parent, family members.
Honor killing and maiming	Maiming or murdering a woman or girl as punishment for acts considered inappropriate for her gender that are believed to bring shame on the family or community (e.g., pouring acid on a young woman's face as punishment for bringing shame to the family for attempting to marry someone not chosen by the family), or to preserve the honor of the family (i.e., as a redemption for an offence committed by a male member of the family).	Parent, husband, other family members or members of the community.
Infanticide and/or neglect	Killing, withholding food, and/or neglecting female children because they are considered to be of less value in a society than male children are.	Parent, other family members.
Denial of education for girls or women	Removing girls from school, prohibiting or obstructing access of girls and women to basic, technical, professional or scientific knowledge	Parents, other family members, community, some States.

Socio-Economic Violence

Type of act	Description/Examples	Can be perpetrated by
Discrimination and/or denial of opportunities, services	Exclusion, denial of access to education, health assistance or remunerated employment; denial of property rights.	Family members, society, institutions and organizations, government actors.
Obstructive legislative practice	Denial of access to exercise and enjoy civil, social, economic, cultural and political rights, mainly to women.	Family, community, institutions and State.

When and where does Gender-Based Violence Occur?

Gender-based violence can occur anywhere, at any time. It is used as a weapon of war; it is perpetrated in the supposed safety of one's home. Just as the laws and structures that govern a society influence the behavior of individuals, so, too, can individual attitudes influence the way families, communities and societies respond to certain types of behavior. The diagram represents the clear linkages between the individual and the society.



At the *individual level*, the degree of knowledge, personal security, access to and control of resources, services and social benefits, personal history and attitudes towards gender can influence whether a person will become a victim/survivor or a perpetrator of violence.

The second level, *relationship*, represents the immediate context in which abuse can occur: between individuals, even within families. At this level, existing power inequalities among individuals begin to reinforce subordinate/privileged positions.

The *community* level represents the dynamics between and among people that are influenced by socialization within such local structures as schools, health care institutions, peer groups and work relationships. Society includes the cultural and social norms about gender roles, attitudes towards children, women and men, the legal and political frameworks that govern behavior, and the attitude towards using violence as means of resolving conflicts. It is clear to see that changes in behavior and attitudes in any one of the areas can have an impact on all of them. Interventions to prevent or respond to sexual and gender-based violence should thus target all levels.

Gender based violence (including sexual violence) occurs in all classes, cultures, religions, races, gender and ages.

Gender-Based Violence during the Life Cycle

The following table describes the forms of violence to which women can be subjected to during the different **stages of their lives.**

Phase	Type of violence Present
Pre-birth	Sex-selective abortion; battering during pregnancy; coerced pregnancy.
Infancy	Female infaticide; emotional and physical abuse; differential access to food and medical care.
Girlhood	Child marriage; genital mutilation; sexual abuse by family members and strangers; differential access to food, medical care and education.
Adolescence	Violence during courtship; economically coerced sex (e.g. for school fees); sexual abuse in the workplace; rape; sexual harassment; arranged marriage; trafficking.
Reproductive age	Physical, psychological and sexual abuse by intimate male partners and relatives; forced pregnancies by partner; sexual abuse in the workplace; sexual harassment; rape; abuse of widows, including property grabbing and sexual cleansing practices.
Elderly	Abuse of widows, including property grabbing; accusations of witchcraft; physical and psychological violence by younger family members; differential access to food and medical care.

Causes and Consequences of Gender-Based Violence (including sexual violence)

To plan appropriate programmes to prevent and respond to sexual and gender-based violence, it is important to analyze the causes and consequences of such violence in each setting. Understanding the causes will help you to develop effective actions to prevent the violence; understanding the consequences allows you to develop appropriate response packages for victims/survivors.

CAUSES > Prevention activities

CONSEQUENCES > Response activities

Causes of Sexual and Gender-Based Violence

The root causes of sexual and gender-based violence lie in a society's attitudes towards and practices of gender discrimination, which place women in a subordinate position in relation to men. The lack of social and economic value for women and women's work and accepted gender roles perpetuate and reinforce

the assumption that men have decision-making power and control over women. Through acts of sexual and gender-based violence, whether individual or collective, perpetrators seek to maintain privileges, power and control over others. Gender roles and identities are determined by sex, age, socio-economic conditions, ethnicity, nationality and religion. Relationships between male and female, female and female, and male and male individuals are also marked by different levels of authority and power that maintain privileges and subordination among the members of a society. The disregard for or lack of awareness about human rights, gender equity, democracy and non-violent means of resolving problems help perpetuate these inequalities.

Contributing Risk Factors

While gender inequality and discrimination are the root causes of sexual and gender-based violence, various other factors determine the type and extent of violence in each setting. It is important to understand these factors in order to design effective strategies to prevent and respond to sexual and gender-based violence.

Equal access to and control of material resources and assistancebenefits and women's equal participation in decision making processes should be reflected in all programmes, whether explicitly targeting sexual and gender based violence or responding to the emergency, recovery or development needs of the population.

The following chart describes some causes or risk factors that can increase the risks of becoming a victim/ survivor or perpetrator of sexual and gender-based violence:

Causes or Risk Factors for SGBV

Individual risks	Loss of security Dependence Physical and mental disabilities Lack of alternatives to cope with changes in socio-economic status Alcohol, drug use/abuse Psychological trauma and stress of conflict, flight, displacement Disrupted roles within family and community Ignorance/lack of knowledge of individual rights Enshrined under national and international law
Social norms and culture	Discriminatory cultural and traditional beliefs and practices Religious beliefs

Legal framework and practices in host country and/or country of origin	Discrimination and condone sexual and gender-based violence Lack of legal protection for women's and children's rights Lack of laws against sexual and gender-based violence Lack of trust in the law enforcement authorities Application of customary and traditional laws and practices that enforce gender discrimination General insensitivity and lack of advocacy campaigns condemning and denouncing sexual and gender-based violence Discriminatory practice in justice administration and law enforcement Under-reporting of incidents and lack of confidence in the administration of justice Lack of willingness to effectively prosecute all cases reported to authorities Low number of prosecutions obtained in proportion to the number of cases reported Police and courts inaccessible because of remote location of camp Absence of female law enforcement officers Lack of administrative resources and equipment by local courts and security officials Laws or practices in the administration of justice that support gender
War and armed conflict	Breakdown of social structures Exertion of political power and control Ethnic differences Socio-economic discrimination
Refugee, returnee and internally displaced situations	Collapse of social and family support structures Geographical location and local environment (high crime area) Design and social structure of camp (overcrowded, multi- household dwellings, communal shelter) Design of services and facilities Predominantly male camp leadership; gender-biased decisions Unavailability of food, fuel, income generation, leading to movement in isolated areas Lack of police protection Lack of UNHCR/NGO presence in camp Lack of security patrols Lack of individual registration and identity cards Hostility of local population (refugees are considered materially privileged)

Consequences of Sexual and Gender-Based Violence

Rape or sexual assault is a traumatic experience, both emotionally and physically. Survivors may have been raped by a number of people in a number of different situations; they may have been raped by strangers, friends, fathers, uncles or other family members; they may have been raped while working in field, using the latrine, in their beds or visiting friends.

They may have been raped by one, two, three or more people, by men or boys, or by women. They may have been raped once or a number of times over a period of months. Survivors may be women or men, girls or boys; but they are most often women and girls, and the perpetrators are most often men.

Survivors may react in any number of ways to such a trauma; whether their trauma reaction is long-lasting or not depends, in part, on how they are treated when they seek help. By seeking medical treatment, survivors are acknowledging that physical and/or emotional damage has occurred. They most likely have health concerns. The health care provider can address these concerns and help survivors begin the recovery process by providing compassionate, thorough and high-quality medical care, by centering this care around the survivor and her needs, and by being aware of the setting-specific circumstances that may affect the care provided.[14]

Victims/survivors of sexual and gender-based violence are at high risk of severe health and psycho-social problems, sometimes death, even in the absence of physical assault.

The potential for debilitating long-term effects of emotional and physical trauma should never be underestimated. Understanding the potential consequences of sexual and gender-based violence will help actors to develop appropriate strategies to respond to these after effects and prevent further harm. A sectoral breakdown is used in the following summary of consequences.

Health

There are serious and potentially life threatening health outcomes with all types of sexual and gender-based violence.

Fatal Outcomes	Homicide Suicide Maternal mortality Infant mortality AIDS-related mortality

Non-Fatal Outcomes	Acute Physical	Chronic Physical	Reproductive
	Injury Shock Disease Infection	Disability Somatic complaints Chronic infections Chronic pain Gastrointestinal problems Eating disorders Sleep disorders Alcohol/drug abuse	Miscarriage Unwanted pregnancy Unsafe abortion STIs, including HIV/ AIDS Menstrual disorders Pregnancy complications Gynecological disorders Sexual disorders

14) Center for Health and Gender Equity (CHANGE)

Psycho-Social

Emotional & Psychological Consequences	Social Consequences
Post traumatic stress Depression Anxiety, fear Anger Shame, insecurity, self-hate, self-blame Mental illness Suicidal thoughts, behavior	Blaming the victim/survivor Loss of role/functions in society (e.g. earn income, child care) Social stigma Social rejection and isolation Feminization of poverty Increased gender inequalities

- Most societies tend to blame the victim/survivor. This social rejection results in further emotional damage, including shame, self-hate and depression.
- As a result of the fear of social stigma, most victims/survivors never report the incident. Indeed, most incidents of sexual and gender-based violence go unreported.

Legal/Justice

- If national laws do not provide adequate safeguards against sexual and gender-based violence, or if practices in the judicial and law enforcement bodies are discriminatory, this kind of violence can be perpetrated with impunity.
- Community attitudes of blaming the victim/survivor are often reflected in the courts. Many sexual and gender-based crimes are dismissed or guilty perpetrators are given light sentences. In some countries, the punishment meted out to perpetrators constitutes another violation of the victim's/survivor's rights and freedoms, such as in cases of forced marriage to the perpetrator. The emotional damage to victims/survivors is compounded by the implication that the perpetrator is not at fault.

Safety/Security

- The victim/survivor is insecure, threatened, afraid, unprotected and at risk of further violence.
- When dealing with incidents of trafficking in persons, police and security workers are at risk of retaliation.
- If police and security workers are not sensitive to the victim's/survivor's needs for immediate care, dignity and respect, further harm and trauma may result because of delayed assistance or insensitive behavior.

Legal and security safeguards in Egypt against Gender based violence

International conventions ratified by Egypt addressing GBV (please see annex 1)

Convention on Elimination of All Forms of Discrimination Against Women – ratified by Egypt in 1981

Article 2

States Parties condemn discrimination against women in all its forms, agree to pursue by all appropriate means and without delay a policy of eliminating discrimination against women and, to this end, undertake:

(a) To embody the principle of the equality of men and women in their national constitutions or other appropriate legislation if not yet incorporated therein and to ensure, through law and other appropriate means, the practical realization of this principle;

(b) To adopt appropriate legislative and other measures, including sanctions where appropriate, prohibiting all discrimination against women;

(c) To establish legal protection of the rights of women on an equal basis with men and to ensure through competent national tribunals and other public institutions the effective protection of women against any act of discrimination;

(f) To take all appropriate measures, including legislation, to modify or abolish existing laws, regulations, customs and practices which constitute discrimination against women;

Convention on the Rights of the Child – CRC, ratified by Egypt in 1990 (Egypt was one of the first 20 states to ratify the CRC)

Article (19)

1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent

2. Treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child.

International Conference on Population and Development- ICPD, hosted in Egypt in 1994.

4.9. Countries should take full measures to eliminate all forms of exploitation, abuse, harassment and violence against women, adolescents and children. This implies both preventive actions and rehabilitation of victims. Countries should prohibit degrading practices, such as trafficking in women, adolescents and children and exploitation through prostitution, and pay special attention to protecting the rights and safety of those who suffer from these crimes and those in potentially exploitable situations, such as migrant women, women in domestic service and schoolgirls. In this regard, international safeguards and mechanisms for cooperation should be put in place to ensure that these measures are implemented.

4.10. Countries are urged to identify and condemn the systematic practice of rape and other forms of inhuman and degrading treatment of women as a deliberate instrument of war and ethnic cleansing and take steps to assure that full assistance is provided to the victims of such abuse for their physical and mental rehabilitation.

Geneva Convention IV- ratified by Egypt in 1952.

Article (27)“…. Women shall be especially protected against any attack on their honor, in particular against rape, enforced prostitution, or any form of indecent assault…”

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment – ratified by Egypt in1986

Article (1) “ …… the term «torture» means any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is inflicted by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity”

Gender based violence in the Egyptian constitution of 2014
(please refer to annex 1)

Article (11)"…… The State shall protect women against all forms of violence and ensure enabling women to strike a balance between family duties and work requirements. The state shall provide care to and protection of motherhood and childhood, female heads of families, and elderly and neediest women."

The articles of criminal law on sexual assaults, rape, physical violence, FGM/C, sexual harassment and Human Trafficking.(please refer to annex 1)

The Egyptian law criminalizes **FGM/C**, it enforces a prison sentence of 3 months - 2 years or a monetary penalty on the persons who perform FGM/C and/or the parent of the victim of FGM/C, as per "Article 242 repeated" of the criminal law.

The Egyptian law criminalizes verbal and physical acts of **sexual harassment** with a prison sentence of 6months- 2 years and/or a monetary penalty, as per "Article 306 repeated" of the criminal Law.

Sexual assaults of males and females are criminalized with a prisoning sentence of 7 years up to life in prison, if the victim is below the age of 18 years old, as per "Article 268" of the Egyptian criminal law.

Rape is criminalized in the Egyptian criminal law by a sentence of life in prison or execution as per "Articles 267 and 269"

All forms of **Human trafficking** are criminalized under the special law on Human Trafficking 2010 as per the legal definition in Article 2 of the same law.

The Egyptian Law criminalizes **all acts of violence**, as per "Article 241" of the criminal law by a prison sentence of maximum of 2 years or a monetary penalty in cases where the assault results in more than 20 days of hospitalization. The prison sentence is obligatory in the case of use of tools or weapons. According to "Article 240", violent acts resulting in the loss of body functions or loss of body organs leading to a permanent disability, the perpetrator shall be subject to a prison sentence of 3-5 years. Domestic Violence or violence inside the household is not addressed in specific in the Egyptian criminal law other than in the above Articles.

The role of the Department of the Human Rights at the Ministry of Justice

The unit of "Combating Violence against Women" pertaining to the Department of the Human Rights at the Ministry of Justice was established by a ministerial decree. The unit is taking the lead in strengthening collaboration between the various justice and law enforcement departments and agencies to ensure adequate timely response through providing victims with access to justice, as well as, bringing perpetrators to justice.

The role of the VAW Unit at the Ministry of Interior

The "Violence against Women" unit at the Ministry of Interior has been established by the ministerial decree No. 2285 for the year 2013. The unit is mandated to follow-up on cases where women are subject to violence to ensure that all adequate legal proceedings have been taken and to provide the required psychological and social support for the victims to overcome the effects of the attack. An additional extension of the central VAW unit in August 2014 has approved the establishment of a VAW unit in every governorate.

The main role of the Unit is:

- To conduct research and investigation on cases of violence against women,
- To provide victims of violence with adequate support and protection throughout the various steps of the investigation process, including legal literacy (providing legal information) throughout the stages of proceedings,

- To raise community awareness on the harms of violence against women and work on promoting a conducive culture that encourages reporting of cases of violence.

The social protection networks available (Shelters, Ombudsman offices, etc.)
(please refer to annex 10 Referral networks)

Governmental and non-governmental entities providing various types of support services to victims of violence which include but are not limited to: legal counseling, legal literacy, legal assistance, psycho-social support, shelters for women who are facing severe violence or danger in their homes, ..etc.

Key Points to Remember

- Sexual and gender-based violence violates human rights. Preventing and responding to sexual and gender-based violence against people is thus part of the overall strategy to protect human rights.
- Women and girls make up the vast majority of victims/survivors of sexual and gender-based violence, although boys and men can also be victims/survivors.
- Gender refers to what it means to be a boy or girl, woman or man, in a particular society or culture.
- A comprehensive prevention and response plan should focus on the roles and needs of both women and men and how both can become agents of change.
- Most acts of sexual and gender-based violence are perpetrated by someone known to the survivor.
- Perpetrators of sexual and gender-based violence are sometimes the very people upon whom survivors depend to assist and protect them.
- Sexual and gender-based violence occurs in all classes, cultures, religions, races, gender and ages. Interventions to prevent or respond to sexual and gender-based violence should target individuals, close relationships, the community and society, in general.
- Understanding the causes of sexual and gender-based violence will help us to develop effective actions to prevent it; understanding the consequences of sexual and gender-based violence allows us to develop appropriate response packages for victims/survivors.
- Gender inequality and discrimination are the root causes of sexual and gender-based violence.
- Equal access to and control of material resources and assistance benefits and women's equal participation in decision-making processes should be reflected in all programmes, whether explicitly targeting sexual and gender-based violence or responding to the emergency, recovery or development needs of the population.
- The potential for debilitating long-term effects of emotional and physical trauma should never be underestimated.
- The Egyptian laws and International conventions ratified by Egypt criminalize GBV.

*The main source of this chapter is **"Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons"**, a product of UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES May 2003*

Part 2 Guiding Principles for Management of GBV

Part 2: Guiding Principles for Management of GBV

Contents

- Roles and responsibilities of health care provider.
- The Relevance of Screening for GBV.
- How to overcome barriers?
- Challenges Preventing Women from Disclosing GBV.

Role of health care provider

Healthcare professionals play a crucial role in identifying victims of GBV because they have a regular opportunity to ask patients about GBV, regardless of the reason for the medical visit. By screening patients for GBV, healthcare professionals can assist victims who may not seek assistance elsewhere. By directly asking patients about violence, regardless of symptoms, injuries or reason for the visit, there is an increased likelihood that victims will disclose abuse.

Given medical practitioners' specific roles and time constraints, responding to GBV can be challenging. This guide explores methods of overcoming these challenges and intends to assist practitioners to efficiently identify GBV victims, intervene effectively, and provide meaningful referrals. It is key that each GBV case is approached systemically while having each professional limit his/her role by area of expertise.

What Health Care Provider Should Know

How to manage the screening process for suspected cases in a time efficient manner

How to manage the care of a patient who discloses GBV and/or DV (Domestic Violence)

How to screen a patient when the abuser accompanies her to the appointment

Challenges that prevent women from disclosing abuse

The importance of documentation for a complete diagnosis

The importance of effective referral system and networking with other support and safety services

Roles & Responsibilities Matrix[15]

Health care provider	Physician at primary health care center	Physician at district or governorate hospital	Nurse	Social worker
Preparing the victim for the examination	√	√	√	√
First aid psychological support	√	√	√	√
Taking the history including screening questions for suspected cases	√	√	√ Attendance required	
Collecting forensic evidence[16]		√	√	
Performing general physical examination	√	√	√ Attendance required	

15) Identification of roles and responsibilities of service providers at various levels as per the recommendations of the High Committee developing the GBV Medical Protocol and validated by the Ministry of Health and Population in Egypt – MOHP

16) Trained MOHP health service providers on Sexual Assault Forensic Examiner (SAFE) training conducted by Forensic Medicine Department at Ministry of Justice

Performing genital examination (inspection)	√	√	√ Attendance required	
Performing genital examination (internal)		Call gynecologist		
Laboratory testing		Referral		
Prescribing treatment				
First aid treatment: suturing wounds, support vital function, ….	√	√	√ assistance	
Tetanus toxoid	√	√	√ assistance	
Hepatitis B vaccine		√	√ assistance	
Emergency contraception	√ oral	√ + IUCD	√ assistance	
Prophylactic STDs	√	√		
PEP for HIV		√ or Referral		
Psychological first aid	√	√	√	√
Psychological counselling		Referral		
Documentation and registration in GBV logbook	√	√		
Medical certificate		√		
Reporting to legal authorities	√	√	√	√

The Relevance of Screening for GBV[17]

Screening is critical for the prevention and detection of GBV as well as the effective management of patient care.

Failure to identify GBV may have serious consequences

Possible negative health outcomes

- Unnecessary testing and misdiagnoses.
- Complications during pregnancy.
- Increased risk of chronic illness such as abdominal pain, migraines, sexually transmitted infections, HIV, depression and other conditions.

Victims are unlikely to voluntarily disclose their abuse

In America, 57% of abused women have never told anyone about their abusive situation. Of the women who received domestic violence services in a large healthcare network, 95% had not previously sought treatment from any other organization.

√ You may be the only person to inquire about the abuse before it results in adverse health consequences.

Opportunity for the healthcare provider to intervene

You may be seeing patients who are victims of abuse, but are seeking medical care for other reasons.

- Researchers concluded that prenatal and postpartum clinic visits present an ideal situation for the doctor to prevent injury to pregnant women.
- Women who are battered during pregnancy are more likely to seek healthcare for injuries than women battered before pregnancy.

√ When you pick up a case of GBV and make referrals to relevant providers, you communicate your concern about this issue, validate the victim's experience and provide an opportunity for her to legitimately seek help.

Relevance of screening for GBV

Those who favors routine screening for GBV say that by asking your patient about possibility of violence, you may achieve the following positive outcomes:

- Prevent physical and mental health problems caused by GBV;
- Improve the quality of life of the victim's children;
- Protect the victim's friends, family and coworkers from harm by the abuser;
- Prevent the cycle of violence from damaging another generation;
- Affirm the significance of GBV as a public health issue; and
- Reduce sick days and lost productivity in the workplace.
- Selective screening for GBV can save the life of a victim of abuse.

17) *This section is mainly adapted from MEDICAL PROVIDERS' GUIDE TO MANAGING THE CARE OF DOMESTIC VIOLENCE PATIENTS WITHIN A CULTURAL CONTEXT 2nd edition. Product of the New York City Mayor's Office to Combat Domestic Violence 2004*

Prevalence of DBV during pregnancy

A substantial number of pregnant women are victims of GBV.

- Approximately 240,000 pregnant women (6%) in the U.S. are abused by an intimate partner annually.
- Battering during pregnancy is associated with greater severity than battering that occurred before pregnancy.
- Abuse during pregnancy seems to be recurrent, with 60% of abused women reporting two or more episodes of assault.

GBV risk factors can be identified in pregnant women

Research indicates an association between GBV and various risk factors.

- Lack of effective social support is more common among pregnant victims of GBV.
- Women with inadequate access to prenatal care are more likely to be battered during pregnancy.
- Women who have fewer places to go for assistance are at greater risk of being assaulted.
- Women battered during pregnancy are more likely to have housing problems.

Possible Warning Signs of GBV in Pregnant Women

Medical care utilization	Pregnancy	Medical conditions	Mental health
Missed medical appointments	Late entry into prenatal care	Chronic pelvic pain	History of suicide Attempts
Repeated visits to the doctor	Young maternal age	Recurrent headaches	Depression and anxiety
Regular medical visits for injuries	History of abuse or assault	Irritable bowel syndrome	Unhappiness about being pregnant
Unscheduled visits to the doctor	Unintended pregnancy	Vaginitis	Substance abuse

√ However, GBV may exist in the absence of any obvious medical and behavioral warning signs, illustrating the relevance of routine screening.

GBV/DV is an obstetric risk factor

Various associations exist between GBV/DV and obstetric complications.

- Abused women are more likely to have a poor obstetric history than women who have not been abused.
- Abused adolescents are more likely to experience first or second trimester bleeding than adolescents who are not being abused.
- Physical violence during pregnancy is a significant predictor of premature labor or delivery.
- Women who are abused during pregnancy are at greater risk of miscarriage or neonatal death.

Association between maternal illness and abuse

There is a correlation between maternal morbidity and exposure to violence during pregnancy.

- Many women in abusive relationships also experience sexual assault, and are in turn at increased risk of contracting sexually transmitted infections.
- There is a significant association between physical violence and kidney infections in pregnant women.
- 83% of women who were battered during pregnancy reported symptoms of depression.
- 89% of women being abused during pregnancy suffer from symptoms of anxiety.
- Abused women are more likely to smoke, use drugs and use alcohol during their pregnancy than those who are not in abusive relationships. A possible explanation of these behaviors has been postulated as an attempt to manage the heightened stress or trauma associated with being abused.

Summary

√ A substantial percentage of women, including those who are pregnant, are victims of GBV.

√ Failure to identify GBV/DV as early as possible can result in negative health outcomes, costly medical care and legal implications.

√ Victims are unlikely to voluntarily disclose their abuse, reinforcing the relevance of selective screening.

√ Members of the public generally take a medical practitioner's opinion seriously, providing an opportunity for you to inquire about GBV/DV and to recommend interventions.

√ GBV/DV is a significant obstetric risk factor.

√ The majority of pregnant women receive prenatal care, enabling you to screen for GBV/DV during this time.

√ While there is a definite association between various risk factors and GBV, abuse may exist in the absence of observable medical and behavioral evidence.

How to Overcome self Barriers?

Techniques to Overcome Barriers that Healthcare Provider May Encounter

Concerns of Healthcare Practitioners and Techniques to Overcome Them

Is GBV/DV screening part of my job?

Despite time constraints and patient overload, GBV is an area of increasing concern, and the medical profession plays a central role in ending this problem.

- In many cases, you may be the only person who can provide help to the victim.
- Not asking about abuse can result in adverse health consequences or death for patients.
- Not asking about abuse can lead to costly testing and misdiagnoses.
- GBV is a public health issue.
- Many international medical organizations recommend screening for GBV/DV.

What is the medical provider's role in the screening and intervention process?

It is the practitioner's role to identify and recognize the presence of abuse, as well as to effectively manage patient care.

- Screen for abuse.
- Assess the medical context of the abuse (e.g. the severity and frequency of injuries; whether food or medication are being withheld from the patient).
- Provide medical treatment for the presenting injuries.
- Assess the safety of the victim.
- Briefly counsel the victim regarding available resources and management options.
- Document your findings and referrals.
- If the system permit take photos of the injuries.
- Refer the patient to relevant specialty whenever indicated

What should I do if my patient takes offense when I examine for abuse?

If a patient takes offense, explain that you ask all of your patients these questions and that there is nothing specific about her that is prompting you to screen.

- Include a few basic questions on GBV in a general health-status assessment, which is routinely provided to all patients prior to entering the practitioner's examination room.

How do I ensure privacy for examination?

Exclude all family members and friends during examination process since this may bias the victim's response.

- Privacy is essential (see next pages for issues related to privacy and screening)

How do I find the time for examination and intervention?

Include GBV assessment questions as part of the medical assessment and/or a general health status assessment

- Ask follow-up questions on GBV/DV during the medical examination (please refer to annex 2 History and Examination form). Ensure that no partner, child, family member or other patients are present during this time.
- Refer the victim to community-based organizations, and other resources for counseling, housing and other issues. , Give the victim the Domestic Violence Hotline number available in your area (please refer to annex10 Referral Networks)

Diagram for How to Approach Assessment for GBV

I don't know how to ask about GBV/DV. It is a personal issue, and I feel uncomfortable intruding on the patient's emotional privacy.

- Explain to the patient the purpose of asking questions about GBV. This can be achieved by universalizing the problem in order to provide a context that is less threatening.
- State that questions are asked routinely to all patients because of the prevalence of GBV and its potential to harm the victims.
- It may be uncomfortable at first, but with practice it will become easier. It is important for your patients' health and safety that you screen for GBV/DV.

How do I manage a patient if she discloses GBV/DV?

- Listen supportively and validate your patient's experience. You may be the first or only person that she tells about the abuse.
- Provide necessary medical treatment for the patient.
- Discuss various existing support services with the victim give her a general safety plan (p 8, part 3), or refer her.
- Make appropriate referrals based on the patient's needs:
  - Community based organizations
  - Counseling
  - Legal services
  - Medical services
  - Social services

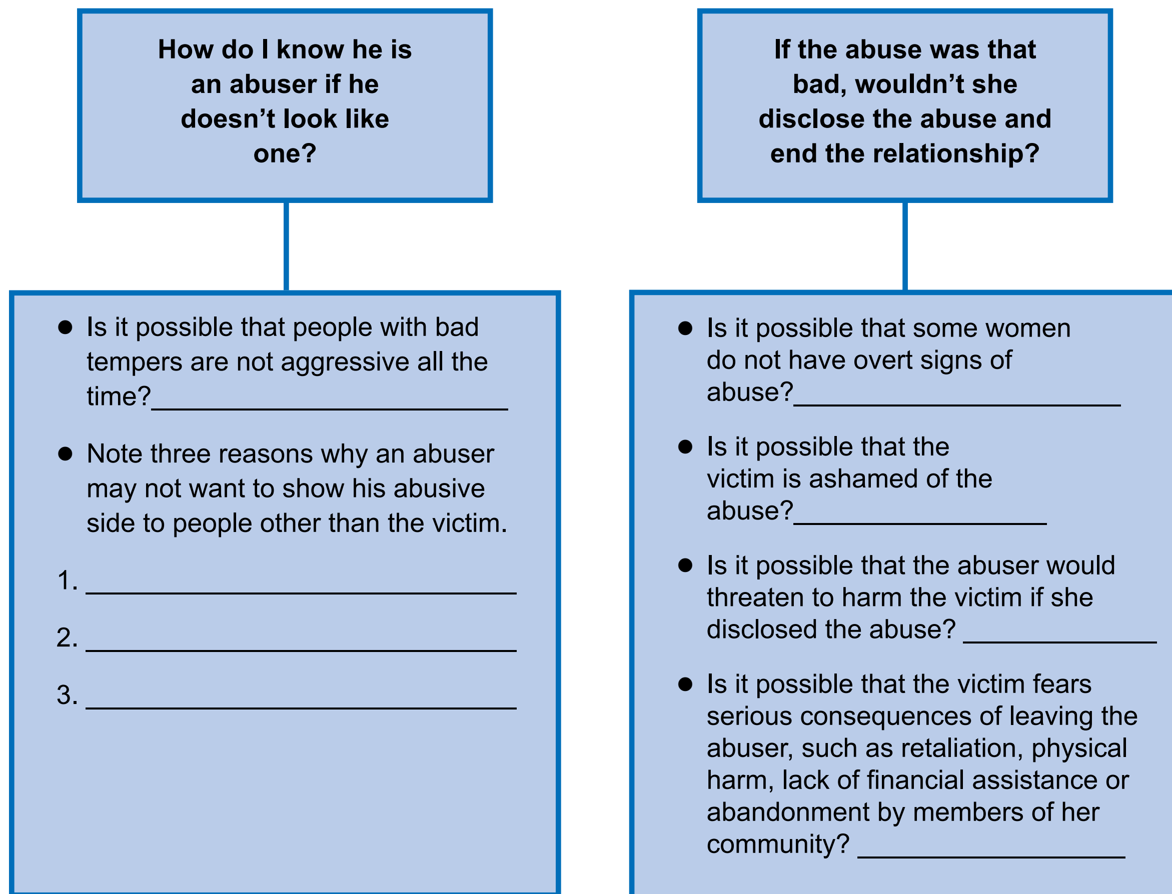
What if the patient is being abused but either denies the abuse or refuses help?

- You need to respect your patient's choice of whether to disclose abuse and/or to seek help.

  Attempting to leave an abusive relationship is frequently dangerous for a domestic violence victim.

  There may be financial and housing risks associated with leaving an abusive relationship and emergency shelter may not be immediately available.
- Discuss risk factors of further abuse with the patient. Inform her that women are at greater risk of harm when incidents of GBV/DV increase in frequency or intensity.
- Let your patient know that you are available in the future if she chooses to seek assistance for her situation.
- Document your concerns and treatment in the patient's medical record and make a notation to follow-up at future visits.
- Screen for medical and psychological indicators of abuse during subsequent visits, and offer feedback/suggestions to the patient in this regard.

Look beyond appearances of your patients and their partners



An abuser has the potential to be a "nice guy" to many people and still abuse his partner. A woman may not display obvious signs of abuse or she may hide the evidence for fear of adverse consequences. This illustrates the importance of routinely screening all patients for domestic violence.

Summary: AVDR

A = Ask patients about abuse

V = Validate, acknowledge abuse is wrong, confirm patient's worth

D = Document presenting symptoms and disclosures

R = Refer victims to specialists

Challenges Preventing Women from Disclosing GBV/DV

Overview of Challenges that Prevent Women From Disclosing Domestic Violence

An environment that is not conducive to disclosure	Fear for personal safety and pressure from the victim's support system	Fear of legal authorities	Factors complicating the diagnosis of GBV/DV
• Lack of selective screening • Lack of privacy from the abuser or family member during screening • Lack of privacy for screening in the waiting room • Lack of assessment beyond physical injuries	• Concern about bringing shame to her family and losing their support • Concern about being ostracized by her community	• Fear of the police • Mother's fear of having children removed from her care	• The victim being unaware that nonphysical abuse constitutes GBV/DV • The victim believing that abuse is an acceptable part of her culture or marital life • The victim's substance abuse inhibiting disclosure

AN ENVIRONMENT THAT IS NOT CONDUCIVE TO DISCLOSURE

Lack of selective screening

Approximately 92% of women who are physically abused do not voluntarily disclose abuse to physicians and 57% do not disclose the abuse to anyone.

Research indicates that the majority of female patients would disclose domestic violence if asked directly about it.

By screening, the practitioner can reduce a victim's feeling of isolation and provide meaningful information about her right to be free from abuse.

Lack of privacy from the abuser or family member during screening

A member of the victim's family (such as her mother), the abuser or his family member (such as his mother or sister), frequently accompanies the victim to her medical appointments. These family or extended family members may contribute to an environment that tolerates the abuse, complicating the victim's ability to seek help. If these people are present during the screening, it will decrease the likelihood of disclosure. It is crucial to speak to each patient privately in order to effectively screen her for domestic violence.

Lack of privacy for screening in the waiting room

A domestic violence victim is unlikely to disclose her abuse if she feels uncomfortable or unsafe doing so. Privacy for screening is essential.

Lack of assessment beyond physical injuries

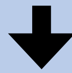
The majority of your domestic violence patients may be seeking medical care for reasons other than injuries related to abuse, such as an annual visit or prenatal care.

In addition to physical violence, abuse can be emotional, verbal, financial and sexual in nature.

FEAR FOR PERSONAL SAFETY AND PRESSURE FROM THE VICTIM'S SUPPORT SYSTEM

Concern about bringing shame to her family and losing their support

There may be significant pressure from immediate and extended family members, preventing the woman from disclosing abuse.



Some factors to consider when screening a patient for abuse:

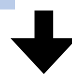
- She may not know that her mistreatment is abuse.
- Reporting abuse may imply that the woman has failed as a wife and mother because her role is to keep the family together at all costs.
- The woman may fear shame and abandonment for herself and her family.
- The woman may fear loss of emotional and financial support if she discloses the abuse or leaves the abuser.
- She may believe or be told not to discuss private issues with outsiders.
- She may not have told her family about the abuse.
- Family or extended family members may be present at medical appointments, inhibiting the process of disclosure.
- Some family or extended family members may condone and even participate in the abuse.
- A family's misinterpretation of religious text may sanction abuse.

Concern about being ostracized by her community

Community pressure may play a significant role in the patient's decision not to disclose abuse. Victims may be frightened or ashamed about their community's reaction to their domestic violence situation. Many women go to medical providers who have been recommended by members of their community. Also, certain doctors or facilities predominantly serve certain communities.

Some factors to consider when screening a patient for abuse:

- Community members may deny the prevalence of domestic violence.
- She may fear bringing shame to her community.
- A previous medical provider from the victim's community may have discouraged her from reporting the abuse.
- In certain cultures, family and community reputation is perceived as being more important than an individual's needs.
- She may not disclose the abuse for fear of losing her support system (her family and friends).
- She may fear being abandoned by members of her larger community if she leaves her partner.



WHAT YOU CAN DO

Screen the patient for GBV/DV in private and try not allowing family members to attend the interview.

Emphasize to the patient that you will respect her right to confidentiality.

Communicate effectively with patients from different populations as well as exploring various options of treatment with them. Explain legal options and rights and required procedures to protect and preserve these rights.

In case of disclosing GBV, going through the steps of examination, documentation, reporting ..etc.

Provide the Violence against women Hotline number and referral information to the patient, both within and outside of her community, depending on her preference.

FACTORS COMPLICATING THE DIAGNOSIS OF GBV/DV

The victim being unaware of nonphysical abuse

Many GBV/DV victims do not realize that they are in abusive relationships, particularly in the absence of serious physical injuries.

What you can do

- Briefly inform the patient about non-physical forms of domestic violence.
- Validate the victim's experience by reassuring her that her feelings and reactions are understandable.

The victim believing abuse to be an acceptable part of her culture or marital life

Many women believe that being a victim of GBV/DV is a normal part of their culture or marital life.

What you can do

- Explain to the victim that GBV/DV is a global problem that affects people from all cultures.
- Emphasize that no one deserves to be abused, irrespective of his/her culture.
- Tell the victim that GBV/DV is against the law in Egypt.

The victim, who is sexually assaulted in her relationship, is unlikely to seek medical attention

Forced sex is an independent risk factor for femicide. Research indicates that many women are raped within the context of their family life. There is a correlation between domestic violence and forced sexual activity. In general, women who are assaulted by a known perpetrator are less likely to seek assistance than those assaulted by a stranger.

What you can do

- Many victims do not disclose sexual assault either because of shame or because they perceive this to be part of the general abusive situation. Therefore, if GBV/DV is identified, assess the patient for sexual assault and vice versa.

The victim's use of substances making it less likely to seek assistance

After the first incident of GBV/DV, victims are nine times more likely to abuse drugs than non-battered women. This may be explained as self-medicating; a method of coping with the trauma of being abused."Many women experiencing both domestic violence and substance abuse feel that they have few places to turn where their co-occurring problems are recognized, understood and dealt with compassionately."

What you can do

- Assess for GBV/DV when working with patients who have a substance abuse problem and vice versa.
- Ensure that both domestic violence and substance abuse are addressed in an integrated treatment program for the patient.

Summary

- The practitioner should create an environment that is conducive to disclosure.
- Implement selective screening for GBV.
- Ensure privacy for screening patients.
- Ensure that neither the abuser nor a family member is with the patient during the screening.
- Pressure from the victim's social system may negatively impact disclosure.
- Concern about bringing shame to her family and losing their support may inhibit the victim's disclosure of domestic violence.
- Some family members may condone and even participate in the abuse.
- Concern about being ostracized by her community may inhibit disclosure.
- Victims may fear legal authorities such as the police .
- Victims may fear having their children removed from their care.
- Assess your patients for all types of abuse rather than just treating physical injuries.
- If appropriate, inform the patient about non-physical types of abuse.
- Inform the patient that abuse is unacceptable and against the law.
- Refer the victim to appropriate resources, both within and outside her community, depending on her preference.

Part 3: Provider's Guide for Management of Domestic Violence DV

Part 3: Provider's Guide for Management of Domestic Violence DV

Contents

- Guidelines step by step
- Tactics of control and clinical cues
- When to consider domestic violence even if the patient does not disclose abuse
- Sample Screening Tool for Suspected Cases
- Danger assessment instrument
- Safety plan
- Medical history and examination form

Guidelines and Tools for Assessment and Management of DV

Guidelines step by step

The following guidelines are designed to assist medical personnel in treating victims of domestic violence (DV).

1. Interview the patient in private. Ask any accompanying spouse, friend or family member to leave the treatment area. Questioning the patient about domestic violence in the presence of the abuser, suspected abuser or other family members may put the patient in extreme danger.

2. Convey an attitude of concern and respect for the patient and assure the confidentiality of any information provided. Provide psychological first aid (Annex 3 Psychological First Aid)

3. Explain to the patient why you are asking about domestic violence and ask the patient directly if the injuries or complaints are the result of abuse by someone they know.

4. If domestic violence is disclosed, communicate to the victim that they are not alone, they are not to blame for the abuse, and that help is available.

5. Take the patient’s history and conduct a thorough medical examination, with appropriate laboratory tests and x-rays. If the extent or type of injury is not consistent with the explanation the patient gives, note this in the medical record. A question to elicit information about site and cause of injury that might indicate domestic violence should be asked. Ask for specifics and document using the patient’s own words. *Keep results in confidential history and examination form* (Annex 2 History and Examination form) and *GBV log book*[18].

Examples:

“She threw a cup of coffee at me” is better than “We were arguing and things got out of hand.”

“Patient states that her husband, Adel Ibrahim, hit her with his belt” is better than “Patient has been abused.”

All emergency department logs should include a code for domestic violence.

6. Ask victim to preserve physical evidence such as blood stained clothing and/or weapon. It is recommended to apply the following: Allow evidence to be air dried. Mark forensic paper bag with patient’s name, date and name of person who collected evidence. Keep evidence under lock until it is turned over to the police, or forensic medicine.

N.B. MOHP health service providers trained on Sexual Assault Forensic Examiner (SAFE) conducted by Forensic Medicine Department at Ministry of Justice are illegible to collect forensic evidence as per the recommendations of the High Committee (including Ministry of Justice Representatives) which developed the GBV Medical Protocol validated by the Ministry of Health and Population in Egypt – MOHP

7. Help the victim assess their immediate safety and safety of the children. Respect and accept the victim’s evaluation of the situation. Offer your patient safety assessment and safety plans. If appropriate, offer to call the police. Tell the patient that battering is a crime and help is available. Support the patient’s decision.

8. Encourage the patient to call a local domestic violence program or Domestic Violence Hotline (08008883888 NCW[19]– 01126977222 MOI[20] - 01126977333 - 01126977444). Ensure access to a private telephone.

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18) GBV Log Book: anonymous based on serial numbering with the aim of tracking of GBV cases, referral and services provided. GBV log book to be integrated in registry system of the hospitals as per the recommendations of the High Committee developing the GBV Medical Protocol and validated by the Ministry of Health and Population in Egypt - MOHP

19) National Council for Women

20) Ministry of interior – Violence against women unit

9. Provide additional information and referrals for counseling, shelter, support groups and legal assistance in the community. Assure confidentiality (please refer to annex 10 Referral Networks).

10. Make safety the primary goal of all interventions. Victims are likely to be the best judge of what is safe for them. If it is necessary to follow-up with medical appointments, laboratory tests or prescriptions, ask directly if the victim can safely do so, or what could be done to make it possible for her to meet follow-up care needs.

11. Medical care of a victim of sexual assault include preparing a medical certificate. This is a main requirement to pursue further legal processes.[21] (please refer to annex 4 Medical certificate and guideline)

12. Mandatory reporting to police when the nature of injury indicate criminal act as per the Egyptian procedural criminal law article 25, 26 on mandatory reporting by civil servants (annex 1)

Tactics & Clinical Cues

Tactics of control may manifest in the following ways:

Tactics	Health Care Manifestations
Physical Abuse • Biting • Grabbing • Punching • Shoving • Kicking • Slapping • Shooting • Stabbing, etc. • Withholding medication, medical care, medical equipment, nutrition • Forcing use of alcohol or other drugs • Traditional practices : Female genital cutting (female circumcision)	• Ecchymosis (bruises) • Lacerations, often to arms & face • Headaches • Anxiety • Hyperventilation • Hypertension • Chest pains • Chronic pain • During pregnancy − Injury to abdomen, breasts, genitalia − Hemorrhaging, including placental separation − Uterine rupture − Miscarriage/stillbirth − Pre-term labor − Premature rupture of membranes • Delay in seeking prenatal care • Frequently missed appointments • Lack of attendance to prenatal education • Poor nutrition • Continued use of cigarettes, drugs and/or alcohol during pregnancy

21) Step 11 and 12 may alternate in order depending on the victim's first attempts to seek help

Psychological Abuse ● Instilling, or attempting to instill fear through ridiculing or humiliating the victim ● Destroying property ● Threatening to harm self or victim ● Blaming abuse on victim ● Injuring, killing, or threatening to injure or kill pets	● Depression ● Anxiety ● Hypertension ● Chronic muscle tension ● Psychosomatic illness ● Suicidal ideation ● Homicidal ideation ● Substance abuse
Sexual Abuse ● Coercing, or attempting to coerce any sexual activity without consent – Rape, sodomy, attacks on sexual parts of the body – Unprotected sex – Sex with others – Forced prostitution – Degrading, sexually explicit behavior toward victim – Taking/showing sexually explicit film or photos and using them against the victim • Attempts to undermine a person's sexuality – Treating partner in a sexually derogatory manner – Criticizing sexual performance and desirability – Accusations of infidelity – Withholding sex	● STD's ● HIV ● Multiple pregnancies ● Pregnancy-related injuries, usually around abdomen, breast and genitalia ● Spontaneous abortion ● Sexual assault injuries ● Depression ● Anxiety
Economic Abuse ● Making, or attempting to make a person financially dependent	● Depression ● Anxiety ● Migraines/headaches ● Reluctance to schedule additional tests, or accept needed prescriptions

Emotional Abuse	
• Undermining, or attempting to undermine, a person's self-worth – Constant criticism – Put downs – Insults – Name calling – Silent treatment – Manipulating feelings/emotions – Repeatedly making and breaking promises – Subverting partner's parenting and/or relationship with children – Threatening to harm, kill or abduct children – Using child visitation to harass victim	• Depression • Anxiety • Hypertension • Chronic muscle tension • Substance abuse • Suicidal ideation • Homicidal ideations • Psychosomatic illness ***NOTE: Any pre-existing conditions can be exacerbated by domestic violence

If the patient does not disclose abuse, consider domestic violence if any of the following is observed:

- Injuries to face, neck, throat, chest, abdomen or genitals
- Evidence of sexual assault; vaginal/anal injuries
- Bilateral or patterned injuries
- Injuries during pregnancy
- Delay between injury and treatment
- Multiple injuries in various stages of healing
- Injury inconsistent with patient's explanation
- Frequent use of emergency department services
- History of trauma related injury
- Chronic pain symptoms with no apparent etiology
- Repeated psychosomatic or emotional complaints
- Suicidal ideation or attempts
- An overly attentive or aggressive partner accompanying the patient
- Patient appears fearful of partner

According to MOJ consultants all physical injures require mandatory reporting.

Sample Screening Tool for Suspected Cases

(This screening tool is to be administered as an interview)

"Because many people experience violence by someone close to them, you have to ask your patients the following questions. We believe that no one should suffer from abuse. There are things that healthcare providers can do to help people who are being abused."

	Yes	No
1. Do you feel unsafe with anyone who lives with you or routinely stays in your home?		
2. Within the past year, has someone close to you:		
a) Hit, slapped, kicked, pushed or otherwise physically hurt you?		
b) Controlled your actions such as whom you see, whom you talk to, where you go or what you wear?		
c) Forced you to do something you don't want to do?		
d) Controlled your access to all finances?		
e) Prevented you from having access to your personal and legal documents?		
f) Threatened you?		
g) Intimidated you?		
h) Isolated you from friends and family?		
i) Constantly criticized you, called you names, or put you down?		
If yes, what is the relationship of that person to you?		
3. Within the past year, has anyone forced you to have unwanted sexual activity?		
If yes, what is the relationship of that person to you?		
4. Are you afraid of your husband, prevous husband or anyone who may be living in your home?		
If the person answers "yes" to question 1,2,3 or 4, ask:		
5. Would you like:		
a) To discuss your situation with someone who has expertise in these matters?		
b) Additional information on domestic violence?		

Comments: ____

____

Referrals made to: (Center)

____

Follow-up plan:

____

Completed by: ____________________ Date: ____________________

Medical History and Examination form[22]

(Victims of domestic and sexual violence)

CONFIDENTIAL CODE:

1. GENERAL INFORMATION

First Name Last Name

Address

Sex Date of birth 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 the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, any other sign or symptom.

22) Annex 2

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change cloth-ing?		
Defecate?			Wash or bathe		
Brush teeth?			Use tampon or pad		
Contraception use					
Pill		IUD		Sterilization	
Injectable		Condom		Other	

Menstrual/obstetric history

Last menstrual period 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:

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, petechiae, marks, etc. Document type, size, colour, form and other particulars. Be descriptive, do not interpret the 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

Vulva/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. COUNSELLING, REFERRALS, FOLLOW-UP

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

Name of health worker conducting examination/interview: ______________________________

Title: ____________________ ***Signature:*** ___________________________ ***Date:*** ____________

DANGER ASSESSMENT INSTRUMENT

This instrument could be used by health provider or victim

Several risk factors have been associated with homicides of battered women and their batterers in research conducted after the murders occurred. We cannot predict what will happen in your case, but we would like you to be aware of the homicide risk in situations of severe battering. Please answer the questions below to see how many of the homicide risk factors apply to your situation.

Please mark Yes or No for each of the following. ("He" refers to your husband, partner, ex-husband, or whoever is currently physically hurting you).

1	Has the violence increased in frequency over the past year?	**Yes**	**No**
2	Has he ever used a weapon against you or threatened you with a weapon?	**Yes**	**No**
3	Does he ever try to choke you?	**Yes**	**No**
4	Does he own a gun?	**Yes**	**No**
5	Has he ever forced you to have sex when you did not wish to do so?	**Yes**	**No**
6	Does he use drugs? By drugs, I mean happiness pills or Tramadol, sleeping pills, powders , "hashish ", street drugs or mixtures.	**Yes**	**No**
7	Does he threaten to kill you and/or do you believe he is capable of killing you?	**Yes**	**No**
8	Is he drunk every day or almost every day?	**Yes**	**No**
9	Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, how much money you can take with you shopping, or when you can take the car? (If he tries, but you do not let him, check here: _________)	**Yes**	**No**
10	Have you ever been beaten by him when you were pregnant? (If you have never been pregnant by him, check here: ________)	**Yes**	**No**
11	Is he violently and consistently jealous of you? (For instance, does he say, "If I can't have you, no one can.")	**Yes**	**No**
12	Have you ever threatened or tried to commit suicide?	**Yes**	**No**
13	Has he ever threatened or tried to commit suicide?	**Yes**	**No**
14	Does he threaten to harm your children?	**Yes**	**No**
15	Do you have a child that is not his?	**Yes**	**No**
16	Is he unemployed?	**Yes**	**No**
17	Have you left him during the past year? (If you never lived with him, check here:________)	**Yes**	**No**
18	Does he follow or spy on you, leave threatening notes, destroy your property, or call you when you don't want him to?	**Yes**	**No**

SAFETY PLAN

- Call **122** or **01126977222- 01126977333 (MOI VAW unit**) if you are in danger or have been hurt by your husband or whoever is physically hurting you. .
- Have a neighbor or friend call 122 on your behalf if they hear suspicious noises coming from your home.
- Teach your children to use the telephone to call the police.
- Teach your children to go to a safe place during a violent incident, for example, their bedroom or a neighbor's house.
- Gather important documents, including:

  - National ID or Passports (for you and your children)
  - Work permit
  - Marriage and birth certificates
  - Children's immunization and school records
  - Driver's license
  - Bank account details
  - Medical insurance card

- Keep these documents in a safe and immediately accessible place.
- Gather sentimental photographs (including photographs of the abuser) and other personal items.
- Hide some money, a checkbook, ATM card, spare keys, medications and a bag packed with necessities for you and your children.
- Identify a place to stay in case of an emergency.
- Know the location of your local police precinct.
- Memorize the number of a domestic violence agencies. The number for the Domestic Violence Hotline/s (please refer to annex 10 Referral Networks).
- Document your abuse. ; get copies of medical and police reports, .
- Obtain an Order of Protection (according to local legislations)and give a copy to your local police precinct and children's school or childcare provider.

(تقرير إصابي ابتدائي) Medical report form

(please see annex 4 in Arabic Part)

بمعرفتي أنا الطبيب... **(الاسم الرباعي بوضوح)**

الوظيفة .... رقم ترخيص مزاولة المهنة :

وبناء على طلب.**(جهة/شخص)** ....

بالخطاب رقم....................... بتاريخ / / الساعه......./٢٤

فإنه بتوقيع الكشف على ....**السن** .... **النوع** ....

الجنسية............ الحالة الاجتماعية............. العنوان...

رقم البطاقة/ جواز السفر / الرقم القومي : .... صادر من :

تذكرة استقبال رقم...................التاريخ. / / الساعة................./٢٤

فبناء علي ما صرح به المصاب أو مرافقه: ملخص الواقعة.

مكان حدوث الواقعة ....

التاريخ................الساعة......../٢٤

سرد الأحداث باختصار:

....

....

....

وبالفحص الطبي للحالة بعد أخذ الموافقة لوحظ ما يلي:

الحالة العامة

درجة الوعي....................النبض...............الضغط....................التنفس..................

الحرارة............... حاله الحدقتين ....

ملاحظات أخرى..

مناظرة الإصابة:

نوع الإصابة : قطعية.... رضية...... عيار ناري..... سجحات..... كدمات......

إصابات أخرى............................... عددها....................

وصفها:الحواف (منتظمة.......غير منتظمة.........) القاعدة مدممة.....يوجد بها جسم صلب............

ملاحظات أخرى...

الأبعاد: الطول...........العرض.................العمق...

وصف موضع الإصابة من الجسم..

(الرجاء تظليل الجزء المصاب على الرسم المرفق)

ترجيح نوع الآلة/الشيء المستخدم في إحداث الإصابة (حادة..... راضة..... عيار ناري.......

[خرطوش.....،رصاص حى.........، رصاص مطاطى.........]

أشياء أخرى...

يملأ هذا التقرير بخط واضح ويلغيه أي كشط أو تعديل بدون توقيع

الإصابات المشتبه في مصاحبتها للإصابة الأصلية:

كسور...................موضعها......................

ارتجاج بالمخ............غيبوبة.......صدمة عصبية..........نزيف داخلى.............تعاطي مواد مخدرة

الفحوص المطلوبة...

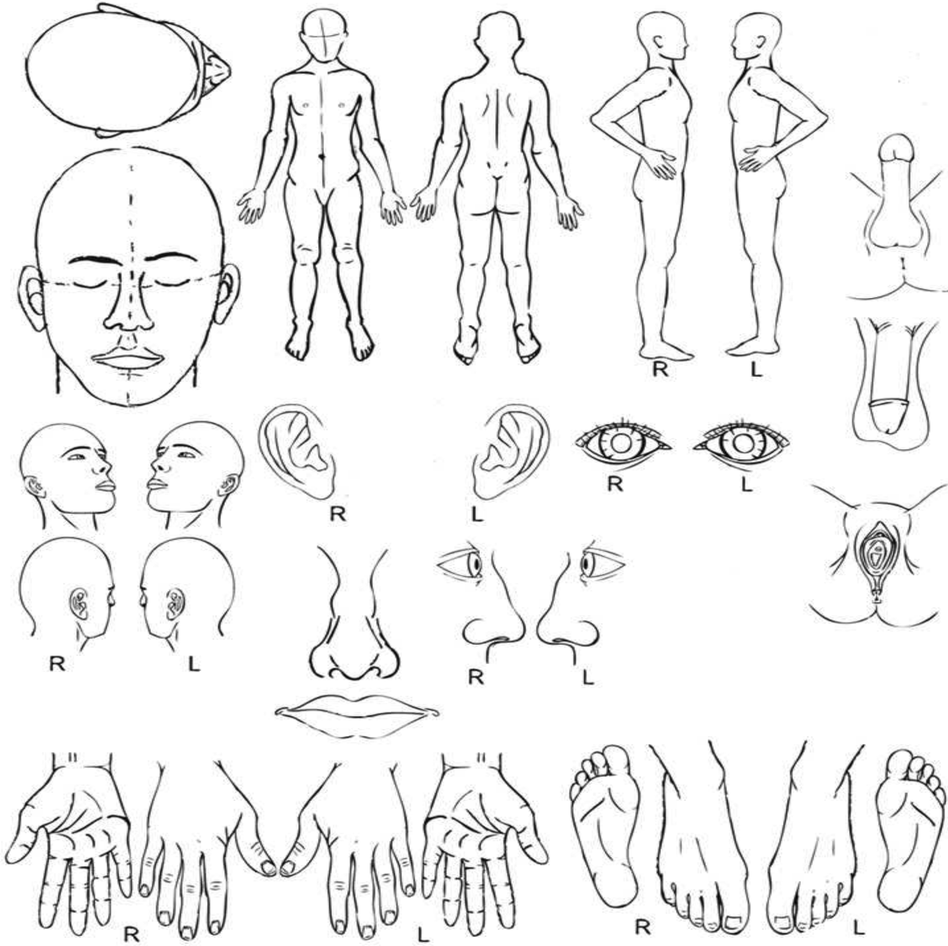
العلاج الموصوف أو أي إجراءات طبية أخري..

....

الوقت المتوقع للشفاء (اقل من ٢٠ يوم **أكثر** من ٢٠ يوم). **نسبة إعاقة** أو عجز.............

بصمه الإبهام اليسري للمصاب **أسم الطبيب الأخصائي**

ختم أدارة المستشفى التوقيع (علي صفحتي التقرير)



يملأ هذا التقرير بخط واضح ويلغيه أي كشط أو تعديل بدون توقيع

This form has been designed and developed By Prof. Dr. Dina Shokry – Forensic Medicine, Cairo University, member of the High Committee that developed the "Medical protocol/guideline for management of victims of Gender-based violence"

Part 4: Provider's guide for clinical management of rape/sexual violence

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Contents

- Introduction
- Preparations required to offer appropriate medical care to victims of rape
- Steps to deal with a sexually abused person
  - STEP 1 – Preparing the victim for the examination
  - STEP 2 – Taking the history
  - STEP 3 – Collecting forensic evidence
  - STEP 4 – Performing the physical and genital examination
  - STEP 5 – Prescribing treatment
  - STEP 6 – Counseling the patient
  - STEP 7 - Follow-up care of the survivor
- Care of child survivor

The essential components of medical care after a rape or sexual assault are:

- Documentation of injuries,
- Collection of forensic evidence,
- Treatment of injuries,
- Evaluation for sexually transmitted infections (STIs) and preventive care,
- Evaluation for risk of pregnancy and prevention,
- Psychosocial support, counseling and follow-up.
- Referral and reporting to legal authorities

Introduction

Rape or sexual assault is a traumatic experience, both emotionally and physically. Survivors may have been raped by a number of people in a number of different situations; they may have been raped by strangers, friends, , fathers, uncles or other family members; they may have been raped while working in field, using the latrine, in their beds or visiting friends.

"They may have been raped by one, two, three or more people, by men or boys, or by women. They may have been raped once or a number of times over a period of months. Survivors may be women or men, girls or boys; but they are most often women and girls, and the perpetrators are most often men.

Survivors may react in any number of ways to such a trauma; whether their trauma reaction is long-lasting or not depends, in part, on how they are treated when they seek help. By seeking medical treatment, survivors are acknowledging that physical and/or emotional damage has occurred. They most likely have health concerns. The health care provider can address these concerns and help survivors begin the recovery process by providing compassionate, thorough and high-quality medical care, by centering this care around the survivor and her needs, and by being aware of the setting-specific circumstances that may affect the care provided".[23]

Rape is considered the most severe form of sexual violence. It is a public health problem and a human rights violation. All individuals, including actual and potential victims of sexual violence, are entitled to the protection of, and respect for, their human rights, such as the right to life, liberty and security of the person, the right to be free from torture and inhuman, cruel or degrading treatment, and the right to health. Governments have a legal obligation to take all appropriate measures to prevent sexual violence and to ensure that quality health services equipped to respond to sexual violence are available and accessible to all. Health care providers should respect the human rights of people who have been raped.

What are preparations required to offer appropriate medical care to victims of rape?

The health care service must make preparations to respond thoroughly and compassionately to people who have been raped/sexually abused. The health system/institution should ensure that health care providers (doctors, medical assist, nurses, etc.) are trained to provide appropriate care and have the necessary equipment and supplies. Female health care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service providing care for survivors of rape/sexual violence.

In setting up a service, the following questions and issues need to be addressed, and standard procedures developed.

What should the community be aware of? (awareness raising at all levels)

Members of the community should know:

- ***what*** services are available for people who have been raped/sexually abused;
- ***why*** rape survivors would benefit from seeking medical care;
- ***where*** to go for services;
- ***that*** rape survivors should come for care immediately or as soon as possible after the incident, <u>without bathing or changing clothes</u>;
- ***that*** rape survivors can trust the service provider to treat them with dignity, maintain their security, and respect <u>their privacy and confidentiality;</u>
- ***when*** services are available; this should preferably be <u>24 hours a day,7 days a week</u>.

23) Health and Gender Equity (CHANGE)

What are the country's laws and policies?

- Legal and security safeguards in Egypt against Gender based violence (please refer to chapter one "Overview and basic information about Gender-Based Violence (including sexual violence)" page 21)
- According to this GBV medical protocol, the health service provider should provide the victim with the comprehensive care as detailed in chapter 2 "Guiding Principles for Management of GBV".
- If the person wishes to report the rape/sexual abuse officially to the authorities, according to the Egyptian laws and procedures, the health service provider examining the victim at the public hospital should provide the victim with the official medical certificate and keep the forensic evidence locked in a secure place until handed to the relevant authorities.
- If the service provider recognizes symptoms of rape/sexual abuse whether disclosed or not, he/she is required by law to report the case to legal authorities. Nonetheless the victim retain the right to confirm or deny without affecting her right in obtaining health services and without any liability on the service provider (please refer to annex 1: service providers' right of reporting and cases of mandatory reporting)

What are the legal requirements with regard to forensic evidence?

- In Egypt, collecting forensic evidence is the responsibility of the forensic medicine department pertaining to the Ministry of Justice. The step of collection of forensic evidence only takes place after the case has been referred to prosecution. The normal path to prosecution takes several days risking the loss of evidence. Efforts to expedite the process cannot be guaranteed, as forensic medicine specialists are few to be able to respond to on call requests to sites in 27 governorates of Egypt. Therefore, it has been recommended by the High Committee developing the GBV Medical Protocol (validated by the Ministry of Health and Population in Egypt – MOHP and the Ministry of Justice) that trained MOHP health service providers on Sexual Assault Forensic Examiner (SAFE annex 5) training can resume the preliminary role of forensic evidence collection.
- What are the national laws regarding management of the possible medical consequences of rape (e.g. emergency contraception, abortion, testing and prevention of human immunodeficiency virus (HIV) infection)?
- The Egyptian laws do not legalize abortion (despite the existence of approving Fatwa of abortion in case of rape). Emergency contraception and providing prophylaxis against STDs and HIV are part of this protocol and can be provided by the health service provider if identified as needed (annexes 7, 8&9)

Testing for HIV/AIDS is not mandatory by law; it is voluntary and needs victim consent.

What resources and capacities are available?

- Laboratory facilities for forensic testing (DNA analysis, acid phosphatase) are only available <u>at the forensic medicine laboratories and criminal evidence laboratories at ministry of interior</u>. HIV testing is only available at the central laboratory of MOHP, VCT centers, blood banks and some private labs.
- Counseling guidelines are available in the GBV management training package. Psychological first aid is available (annex 3) and advanced psychological counseling would be provided by a specialist at a referral point.(please refer to annex 10 Referral Networks)
- National STI treatment protocol, a post-exposure prophylaxis (PEP) protocol and vaccines for hepatitis B and Tetanus are available but not across all levels of health care.
- Referral of victim of GBV to a secondary health care facility (counseling services, surgery, pediatrics, or gynecology/obstetrics services) or additional psycho-social, protection and legal support services should be made available in hospitals as per this protocol.

Where should care be provided? (Please refer to chapter 2 "Guiding Principles for Management of GBV")

Generally, a clinic or outpatient service that already offers reproductive health services, such as antenatal care, normal delivery care, or management of STIs, can offer care for rape/sexual abuse survivors. Also emergency room at all selected hospitals should provide the service in case of referral to a hospital.

Who should provide care?(See chapter 2 page 2 "Roles and Responsibility of Health Care Provider Matrix")

All staff in health facilities dealing with rape/sexual abuse survivors, from reception staff to health care professionals, should be sensitized and trained. They should always be compassionate and respect confidentiality.

How should care be provided?

Care should be provided:

- according to a protocol that has been specifically developed for the situation. Protocols should include guidance on medical, psychosocial and ethical aspects, on collection and preservation of forensic evidence, and on referral to other more specialized protection (shelters), legal and social services; and on counseling/ psychological support options;

in a compassionate and non-judgmental manner;

with a focus on the survivor and her needs;

with an understanding of the provider's own attitudes and sensitivities, the socio-cultural context, and the community's perspectives, practices and beliefs.

What is needed?

- All health care for rape/sexual abuse survivors should be provided in one place within the health care facility so that the person does not have to move from place to place.
- Services should be available 24 hours a day, 7 days a week.
- All available supplies from the checklist below should be prepared and kept in a special box or place, so that they are readily available.
- One trained health care provider on sexual assault forensic evidence collection

How to coordinate with others

- Interagency and inter-sectoral coordination should be established to ensure comprehensive care for survivors of sexual violence.
- Be sure to include representatives of social and community services, protection, the police or legal justice system, and security. Depending on the services available in the particular setting, others may need to be included.
- As a multi-sectoral team, establish referral networks, communication systems, coordination mechanisms, and follow-up strategies. (Recommendations to MOHP system change)

Checklist of needs for clinical management of rape survivors

1) Protocol	Available
● Written medical protocol in language of provider*	
2) Personnel	**Available**
● Trained (local) health care professionals (on call 24 hours/day)*	
● For female survivors, a female health care provider speaking the same language is optimal. If this is not possible, a female health worker/social worker (or companion) should be in the room during the examination*	
3) Furniture/Setting	**Available**
● Room (private, quiet, accessible, with access to a toilet or latrine)*	
● Examination table*	
● Light, preferably fixed (a torch may be threatening for children)*	
● Magnifying glass (or colposcope)	
● Access to an autoclave to sterilize equipment*	
● Access to laboratory facilities/microscope/trained technician	
● Weighing scales and height chart for children	
4) Supplies Available	
● “Rape Kit” for collection of forensic evidence, could include:	
- Speculum* (preferably plastic, disposable, only adult sizes)	
- Comb for collecting foreign matter in pubic hair	
- Syringes/needles (butterfly for children)/tubes for collecting blood	
- Glass slides for preparing wet and/or dry mounts (for sperm)	
- Cotton-tipped swabs/applicators/gauze compresses for collecting samples	
- Laboratory containers for transporting swabs	
- Paper sheet for collecting debris as the survivor undresses	
- Tape measure for measuring the size of bruises, lacerations, etc*.	
- Paper bags for collection of evidence*	
- Paper tape for sealing and labeling containers/bags*	
● Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	

● Resuscitation equipment*	
● Sterile medical instruments (kit) for repair of tears, and suture material	
● Needles, syringes*	
● Cover (gown, cloth, sheet) to cover the survivor during the examination*	
● Spare items of clothing to replace those that are torn or taken for evidence	
● Sanitary supplies (pads or local cloths)*	
● Pregnancy tests	
● Pregnancy calculator disk to determine the age of a pregnancy	
5) Drugs	**Available**
● For treatment of STIs as per country protocol*	
● For post-exposure prophylaxis of HIV transmission (PEP)	
● Emergency contraceptive pills and/or copper-bearing intrauterine device (IUD)*	
● Tetanus toxoid, tetanus immuno-globulin	
● Hepatitis B vaccine	
● For pain relief* (e.g. paracetamol)	
● Anxiolytic (e.g. diazepam)	
● Sedative for children (e.g. diazepam)	
● Local anaesthetic for suturing*	
● Antibiotics for wound care*	
6) Administrative Supplies	**Available**
● Medical chart with pictograms*	
● Forms for recording post-rape care	
● Consent forms*	
● Information pamphlets for post-rape care (for survivor)*	
● Safe, locked filing space to keep records confidential*	
● Other medical documentation form (log book, Hist.& Exam. form……etc)	

Items marked with an asterisk * are the minimum requirements for examination and treatment of a rape survivor.

Steps to deal with a sexually abused person

STEP 1 – Preparing the victim for the examination

A person who has been raped/sexually abused has experienced trauma and may be in an agitated or depressed state. She often feels fear, guilt, shame and anger, or any combination of these. The health provider must prepare her and obtain her informed consent for the examination, and carry out the examination in a compassionate, systematic and complete fashion. Provide PFA(Psychological First Aid) early and maintain it all through examination

To prepare the victim for the examination:

- Introduce your-self.
- Ensure that a trained health worker of the same sex accompanies the victim throughout the examination.
- Explain what is going to happen during each step of the examination, why it is important, what it will tell you, and how it will influence the care you are going to give.
- Reassure the victim that she is in control of the pace, timing and components of the examination.
- Reassure her that the examination findings will be kept confidential unless she decides to bring charges (annex 6 consent form).
- Ask her if she has any questions.
- Ask if she wants to have a specific person present for support. Try to ask her this when she is alone.
- Review the consent form (annex 6 consent form) with her. Make sure she understands everything in it, and explain that she can refuse any aspect of the examination she does not wish to undergo. Explain to her that she can delete references to these aspects on the consent form. Once you are sure she understands the form completely, ask her to sign it. If she cannot write, obtain a thumb print together with the signature of a witness.
- Limit the number of people allowed in the room during the examination to the minimum necessary.
- Do the examination as soon as possible.
- Do not force or pressure her to do anything against her will. Explain that she can refuse steps of the examination at any time as it progresses.

STEP 2 – Taking the history

General guidelines

- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any documents or paper-work brought by the victim to the health centre.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Let the victim tell her story the way she wants to.
- Questioning should be done gently and at the victim's own pace. Avoid questions that suggest blame, such as "what were you doing there alone?"
- Take sufficient time to collect all needed information, without rushing.
- Do not ask questions that have already been asked and documented by other people involved in the case.
- Avoid any distraction or interruption during the history-taking.
- Explain what you are going to do at every step.
- Prepare for bringing on-board a female nurse or service provider during physical examination (advisable to be present at all times during examination). A female physician to perform the physical examination is recommended.
- A sample history and examination form is included in Annex 5. The main elements of the relevant history are described below.

General information

- Name, address, sex, date of birth (or age in years).
- Date and time of the examination and the names and function of any staff or support person (someone the survivor may request) present during the interview and examination.

Description of the incident

- Ask the victim to describe what happened. Allow her to speak at her own pace. Do not interrupt to ask for details; follow up with clarification questions after she finishes telling her story. Explain that she does not have to tell you anything she does not feel comfortable with.
- Victims may omit or avoid describing details of the assault that are particularly painful or traumatic, but it is important that the health provider understands exactly what happened in order to check for possible injuries and to assess the risk of pregnancy and STI or HIV. Explain this to her , and reassure her of confidentiality if she is reluctant to give detailed information. The form in Annex 5 specifies the details needed.

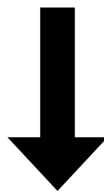
History

- If the incident occurred recently, determine whether the victim has bathed, urinated, defecated, vomited, used a vaginal douche or changed her clothes since the incident. This may affect what forensic evidence can be collected.
- Information on existing health problems, allergies, use of medication, and vaccination and HIV status will help you to determine the most appropriate treatment to provide, necessary counseling, and follow-up health care.

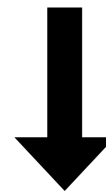
- Evaluate for possible pregnancy; ask for details of contraceptive use and date of last menstrual period.

In developed country settings, some 2% of survivors of rape have been found to be pregnant at the time of the rape. Some were not aware of their pregnancy. Explore the possibility of a pre-existing pregnancy in women of reproductive age by a pregnancy test or by history and examination. The following guide suggests useful questions to ask the survivor if a pregnancy test is not possible.

A guide for confirming pre-existing pregnancy		
No		**Yes**
	1) Have you given birth in the past 4 weeks?	
	2) Are you less than 6 months postpartum **and** fully breastfeeding **and** free from menstrual bleeding since you had your child?	
	3) Did your last menstrual period start within the past 10 days?	
	4) Have you had a miscarriage or abortion in the past 10 days?	
	5) Have you gone without sexual intercourse since your last menstrual period (apart from the incident)?	
	6) Have you been using a reliable contraceptive method consistently and correctly? (check with specific questions)	



If the survivor answers NO to all the questions, ask about and look for signs and symptoms of pregnancy. If pregnancy cannot be confirmed provide her with information on emergency contraception to help her arrive at an informed choice (see Step 7)



If the survivor answers YES to at least 1 question and she is free of signs and symptoms of pregnancy, provide her with information on emergency contraception to help her arrive at an informed choice (see Step 7)

STEP 3 – Collecting forensic evidence

The main purpose of the examination of a rape victim is to determine what medical care should be provided. Forensic evidence may also be collected to help the survivor pursue legal redress where this is possible. The survivor may choose not to have evidence collected. Respect her choice.

In Egypt, collecting forensic evidence is the responsibility of the forensic medicine department pertaining to the Ministry of Justice. The step of collection of forensic evidence only takes place after the case has been referred to prosecution. The normal path to prosecution takes several days risking the loss of evidence. Efforts to expedite the process cannot be guaranteed, as forensic medicine specialists are few to be able to respond to on call requests to sites in 27 governorates of Egypt. Therefore, it has been recommended by the High Committee developing the GBV Medical Protocol (validated by the Ministry of Health and Population in Egypt – MOHP and the Ministry of Justice) that trained MOHP health service providers on Sexual Assault Forensic Examiner (SAFE) (annex 5) training can resume the preliminary role of forensic evidence collection.

Referral to other entities for collection of forensic evidence in case no trained service provider is on duty at the time of receiving the case.

Reasons for collecting evidence

A forensic examination aims to collect evidence that may help prove or disprove a connection between individuals and/or between individuals and objects or places. Forensic evidence may be used to support a survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and possibly to identify the attacker. Proper collection and storage of forensic evidence can be key to a survivor's success in pursuing legal redress. Careful consideration should be given to the existing mechanisms of legal redress and the local capacity to analyze specimens when determining whether or not to offer a forensic examination to a survivor. The requirements and capacity of the local criminal justice system and the capacity of local laboratories to analyze evidence should be considered (please refer to annex 5)

Collect evidence as soon as possible after the incident

Documenting injuries and collecting samples, such as blood, hair, saliva and sperm, within 72 hours of the incident may help to support the survivor's story and might help identify the aggressor(s). If the person presents more than 72 hours after the rape, the amount and type of evidence that can be collected will depend on the situation. Whenever possible, forensic evidence should be collected during the medical examination so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic.

Documenting the case (please see annexes 2 & 4)

- Record the interview and your findings at the examination in a clear, complete, objective, non-judgmental way.
- It is not the health care provider's responsibility to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- Completely assess and document the physical and emotional state of the survivor.
- Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds (see Table 1). Record your findings on pictograms (please refer to annex 6). Health workers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible (see Table 1), without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.

- Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.
- Make note of any sample collected as evidence.

Table 1: Describing features of physical injuries[24]

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

Samples that can be collected as evidence

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

The medical certificate/report (please refer to annex 4)

Medical care of a victim of rape/sexual violence includes preparing a medical certificate. This is a legal requirement in most countries. It is the responsibility of the health care provider who examines the victim to make sure such a certificate is completed. (please refer to annex 2, 4)

The medical certificate is a confidential medical document that the doctor must hand over to the survivor The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story. The health care provider should keep one copy locked away with the

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

survivor’s file, in order to be able to certify the authenticity of the document supplied by the survivor before a court, if requested.

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

The medical certificate may be handed over to legal services or to organizations with a protection mandate only with the explicit agreement of the survivor.

N.B. The health service provider should register the GBV assault in the GBV Log Book: anonymous based on serial numbering with the aim of tracking of GBV cases, referral and services provided. GBV log book to be integrated in registry system of the hospitals as per the recommendations of the High Committee developing the GBV Medical Protocol and validated by the Ministry of Health and Population in Egypt - MOHP

If the service provider recognizes symptoms of rape/sexual abuse as stated below whether disclosed or not, he/she is required by law to report the case to legal authorities. Nonetheless the victim retain the right to confirm or deny without affecting her right in obtaining health services and without any liability on the service provider

(please see annex 1)

According to MOJ consultants all physical injuries require mandatory reporting.

A medical certificate must include:

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

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

STEP 4 – Performing the physical and genital examination

The primary objective of the physical examination is to determine what medical care should be provided to the victim.

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

General guidelines

- Make sure the equipment and supplies are prepared.
- Always look at the survivor first, before you touch her, and note her appearance and mental state; some cases may need a specialist ; if available in your area call him/her.
- Always tell her what you are going to do and ask her permission before you do it.
- Assure her that she is in control, can ask questions, and can stop the examination at any time.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate and temperature).
- The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications might include:
  - extensive trauma (to genital region, head, chest or abdomen),
  - asymmetric swelling of joints (septic arthritis),
  - neurological deficits,
  - respiratory distress.
- The treatment of these complications is not covered here.
- Obtain voluntary informed consent for the examination and to obtain the required samples for forensic examination
- Prepare for bringing on-board a female nurse or service provider during physical examination
- Record all your findings and observations as clearly and completely as possible on a standard examination form (please refer to annex 5).

Part A:
Victim presents within 72 hours of the incident
Physical examination

- Never ask the survivor to undress or uncover completely. Examine the upper half of her body first, then the lower half; or give her a gown to cover herself.
- Minutely and systematically examine the patient's body. Start the examination with vital signs and hands and wrists rather than the head, since this is more reassuring for the victim. Do not forget to look in the eyes, nose, and mouth (inner aspects of lips, gums and palate, in and behind the ears, and on the neck. Check for signs of pregnancy. Take note of the pubertal stage.

- Look for signs that are consistent with the victim's story, such as bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or torn eardrums, which may be a result of being slapped. If the survivor reports being throttled, look in the eyes for petechial haemorrhages. Examine the body area that was in contact with the surface on which the rape occurred to see if there are injuries.
- Note all your findings carefully on the examination form and the body figure pictograms (please refer to annex 6), taking care to record the type, size, colour and form of any bruises, lacerations, ecchymoses and petechiae.
- Take note of the survivor's mental and emotional state (withdrawn, crying, calm, etc.).
- Take samples of any foreign material on the survivor's body or clothes (blood, saliva, and semen), fingernail cuttings or scrapings, swabs of bite marks, etc., according to the local evidence collection protocol. (Function of forensic medicine in Egypt)

Examination of the genital area, anus and rectum

Even when female genitalia are examined immediately after a rape, there is identifiable damage in less than 50% of cases. Carry out a genital examination as indicated below. Note the location of any tears, abrasions and bruises on the pictogram and the examination form.

- Systematically inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen:
  - Note any scars from previous female genital mutilation or childbirth.
  - Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
  - Look for any sign of infection, such as ulcers, vaginal discharge or warts.
  - Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and adolescents
  - Take samples according to your local evidence collection protocol. If collecting samples for DNA analysis, take swabs from around the anus and perineum before the vulva, in order to avoid contamination. (forensic medicine function in Egypt)
- For the anal examination the patient may have to be in a different position than for the genital examination. Write down her position during each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination).
  - Note the shape and dilatation of the anus, anal reflex, and mucosal corrugations. Note any fissures around the anus, the presence of faecal matter on the perianal skin, and bleeding from rectal tears.
  - If indicated by the history, collect samples from the rectum according to the local evidence collection protocol. (Forensic medicine)
  - If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline *(**do not** use a speculum when examining children. (postpone that step if referral to forensic is mandatory)*
  - Under good lighting inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
  - Take swabs and collect vaginal secretions according to the local evidence collection protocol. *(postpone that step if referral to forensic is mandatory)*
- If indicated by the history and the rest of the examination, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection. (referral to specialist)

- If indicated, do a recto-vaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge. Note the sphincter tone. If there is bleeding, pain or suspected presence of a foreign object, refer the patient to a hospital.(referral to specialist)

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

Laboratory testing (forensic medicine function and/or trained health service provider on forensic evidence collection)

Only the samples mentioned in Step 4 need to be collected for laboratory testing. indicated by the history or the findings on examination, further samples may be collected for medical purposes. If the survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and possible for culture. Do a pregnancy test, if indicated and available. Other diagnostic tests, such as X-ray and ultrasound examination, may be useful in diagnosing fractures and abdominal trauma.

Part B:

Victim presents more than 72 hours after the incident

Physical examination

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

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

Examination of the genital area

If the assault occurred more than 72 hours but less than a week ago, note any healing injuries to genitalia and/or recent scars. If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal dischargeor ulcers), there is little indication to do a pelvic examination. Even when one might not expect to find injuries, the survivor might feel that she has been injured. A careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the patient and might be the main reason she is seeking care.

Laboratory screening

Do a pregnancy test, if indicated and available (see Step 3). If laboratory facilities are available, samples may be taken from the vagina and anus for STI screening for treatment purposes.

Screening might cover:

- rapid plasma reagin (RPR) test for syphilis or any point of care rapid test;
- Gram stain and culture for gonorrhoea;
- culture or enzyme-linked immunosorbent assay (ELISA) for Chlamydia or any point of care rapid test;
- wet mount for trichomoniasis;
- HIV test (only on a voluntary basis and after counselling).

STEP 5 – Prescribing treatment

Treatment will depend on how soon after the incident the victim presents to the health service. Follow the steps in Part A if she presents within 72 hours of the incident; Part B is applicable to victims who present more than 72 hours after the incident. Male victims require the same vaccinations and STI treatment as female survivors.

Part A: Survivor presents within 72 hours of the incident

Prevent sexually transmitted infections

- Survivors of rape should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis (please refer to annex 9). If you know that other STIs are prevalent in the area (such as trichomoniasis or chancroid), give preventive treatment for these infections as well.
- Give the shortest courses available in the local protocol, which are easy to take. For instance: 400 mg of cefixime plus 1 g of azithromycin orally will be sufficient presumptive treatment for gonorrhoea, chlamydial infection and syphilis.
- Be aware that women who are pregnant should not take certain antibiotics, and modify the treatment accordingly (annex 7).
- Examples of WHO-recommended STI treatment regimens are given in Annex 7.
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV/AIDS (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

Prevent HIV transmission

- PEP should be offered to survivors according to the health care provider's assessment of risk, which should be based on what happened during the attack (i.e. whether there was penetration, the number of attackers, injuries sustained, etc.) and HIV prevalence in the region. Risk of HIV transmission increases in the following cases: If there was more than one assailant; if the survivor has torn or damaged skin; if the assault was an anal assault; if the assailant is known to be HIV-positive or an injecting drug user. If the HIV status of the assailants is not known, assume they are HIV-positive, particularly in countries with high prevalence.
- PEP usually consists of 2 or 3 antiretroviral (ARV) drugs given for 28 days There are some problems and issues surrounding the prescription of PEP, including the challenge of counselling the survivor on HIV issues during such a difficult time.
- If it is not possible for the person to receive PEP in your setting refer her as soon as possible (within 72 hours of the rape) to a service centre where PEP can be supplied. If she presents after this time, provide information on voluntary counselling and testing (VCT) services available in your area.
- PEP can start on the same day as emergency contraception and preventive STI regimens, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Prevent pregnancy

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

- Progestogen-only pills are the recommended ECP regimen. They are more effective than the combined estrogen-progestogen regimen and have fewer side-effects(annex 9).
- Emergency contraceptive pills work by interrupting a woman's reproductive cycle - by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. ECPs do not interrupt or damage an established pregnancy and thus WHO does not consider them a method of abortion.
- The use of emergency contraception is a personal choice that can only be madeby the woman herself. Women should be offered objective counselling on this method so as to reach an informed decision. A health worker who is willing to prescribe ECPs should always be available to prescribe them to rape survivors who wish to use them.
- If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian, who can help her to understand and take the regimen as required.
- If an early pregnancy is detected at this stage, either with a pregnancy test or from the history and examination (see Steps 3 and 5), make clear to the woman that it cannot be the result of the rape.
- There is no known contraindication to giving ECPs at the same time as antibiotics and PEP, although the doses should be spread out and taken with food to reduce side-effects, such as nausea.

Provide wound care

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

Prevent tetanus

Good to know

Tetanus toxoid is available in several different preparations. Check local vaccination guide lines for recommendations.

Anti-tetanus immunoglobulin (antitoxin) is expensive and needs to be refrigerated. It is not avail able in low-re source settings.

- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
- Use Table 2 to decide whether to administer tetanus toxoid (which gives active protection) and Anti-tetanus immunoglobulin, if available (which gives passive protection).
- If vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.
- Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

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

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

TT - tetanus toxoid

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

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

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

TIG – anti-tetanus immunoglobulin

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

For persons 7 years and older, Td is preferred to tetanus toxoid alone.

Adapted from: Benenson, A.S. Control of communicable diseases manual.

Washington DC, American Public Health Association, 1995.

Prevent hepatitis B

Good to know

Find out the prevalence of hepatitis B in your setting, as well as the standardized MOH vaccination schedules.

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

- Whether you can provide post-exposure prophylaxis against hepatitis B will depend on the setting you are working in. The vaccine may not be available as it is relatively expensive and requires refrigeration.
- HBV is present in semen and vaginal fluid and is efficiently transmitted by sexual intercourse. If possible, survivors of rape should receive hepatitis B vaccine within 14 days of the incident.
- In countries where the infant immunization programmes routinely use hepatitis B vaccine, a survivor may already have been fully vaccinated. If the vaccination record card confirms this, no additional doses of hepatitis B vaccine need be given.

- The usual vaccination schedule is at 0, 1 and 6 months. However, this may differ for different products and settings. Give the vaccine by intramuscular injection in the deltoid muscle (adults) or the antero-lateral thigh (infants and children). Do not inject into the buttock, because this is less effective.
- The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It may be given at the same time as tetanus vaccine.

Provide mental health care

- Social and psychological support, including counselling (see Step 7) are essential components of medical care for the rape/sexual violence victim. Most victims of rape will regain their psychological health through the emotional support and understanding of people they trust, community counselors, and support groups. At this stage, do not push the survivor to share personal experiences beyond what she wants to share. However the survivor may benefit from counselling at a later time, and all survivors should be offered a referral to the community focal point for sexual and gender-based violence if one exists.
- If the victim has symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations, that cannot be medically explained (i.e. without an organic cause), explain to her that these sensations are common in people who are very scared after having gone through a frightening experience, and that they are not due to disease or injury.[25] The symptoms reflect the strong emotions she is experiencing, and will go away over time as the emotion decreases.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of the symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose may be repeated for a few days with daily assessments.
- Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivors.

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

Sexually transmitted infections

If laboratory screening for STIs reveals an infection, or if the person has symptoms of an STI, follow local protocols for treatment.

HIV transmission

In some settings testing for HIV can be done as early as six weeks after a rape. Generally, however, it is recommended that the survivor is referred for voluntary counselling and testing (VCT) after 3-6 months, in order to avoid the need for repeated testing. Check the VCT services available in your setting and their protocols.

25) Resnick H, Acierno R, Holmes M, Kilpatrick DG, Jager N. Prevention of post-rape psychopathology: preliminary findings of a controlled acute rape treatment study. Journal of anxiety disorders, 1999, 13(4):359-70.

Pregnancy

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

If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, taking progestogen-only emergency contraceptive pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72 hours, but it is still moderately effective within 120 hours after unprotected intercourse (annex 9).

There are no data on effectiveness of emergency contraception after 120 hours.

If the survivor presents within five days of the rape, insertion of a copper-bearing IUD is an effective method of preventing pregnancy (it will prevent more than 99% of subsequent pregnancies). The IUD can be removed at the time of the woman's next menstrual period or left in place for future contraception. Women should be offered counselling on this service so as to reach an informed decision. A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full STI treatment to prevent infections of the upper genital tract. (annex 7).

Bruises, wounds and scars

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

Tetanus

Tetanus usually has an incubation period of 3 to 21 days, but it can be many months. Refer the survivor to the appropriate level of care if you see signs of a tetanus infection. If she has not been fully vaccinated, vaccinate immediately, no matter how long it is since the incident. If there remain major, dirty, unhealed wounds, consider giving antitoxin if this is available.

Hepatitis B

Hepatitis B has an incubation period of 2-3 months on average. If you see signs of an acute infection, refer the person if possible or provide counselling. If the person has not been vaccinated and it is appropriate in your setting, vaccinate, no matter how long it is since the incident.

Mental health

- Social support and psychological counselling (see Step 7) are essential components of medical care for the rape survivor. Most survivors of rape will regain their psychological health through the emotional support and understanding of people they trust, community counselors, and support groups. All survivors should be offered a referral to the community focal point for sexual and gender-based violence if one exists.
- Provide medication only in exceptional cases, when acute distress is so severe that it limits basic functioning, such as being able to talk to people, for at least 24 hours. In this case, and only when the survivor's physical state is stable, give a 5 mg or 10 mg tablet of diazepam, to be taken at bedtime, no more than 3 days. Refer the person to a professional trained in mental health for reassessment of symptoms the next day. If no such professional is available, and if the severe symptoms continue, the dose of diazepam may be repeated for a few days with daily assessments.
- Be very cautious: benzodiazepine use may quickly lead to dependence, especially among trauma survivors.

- Many symptoms will disappear over time without medication, especially during the first few months. However, if the assault occurred less than 2 to 3 months ago and the survivor complains of sustained, severe subjective distress lasting at least 2 weeks, which is not improved by psychological counselling and support (see Step 7), and if she asks repeatedly for more intense treatment and you cannot refer her, consider a trial of imipramine, amitriptyline or similar antidepressant medicine, up to 75-150 mg at bedtime. Start by giving 25 mg and, if needed, work up to higher doses over a week or so until there is a response. Watch out for side-effects, such as a dry mouth, blurred vision, irregular heartbeat, and light-headedness or dizziness, especially when the person gets out of bed in the morning. The duration of the treatment will vary with the medication chosen and the response.
- If the assault occurred more than 2 to 3 months ago and psychological counselling and support (see Step 7) are not reducing highly distressing or disabling trauma-induced symptoms, such as depression, nightmares, or constant fear, and you cannot refer her; consider a trial of antidepressant medication (see the bullet above).

STEP 6 – Counselling the patient

Survivors seen at a health facility immediately after the rape are likely to be extremely distressed and may not remember advice given at this time. It is therefore important to repeat information during follow-up visits. It is also useful to prepare standard advice and information in writing, and give the survivor a copy before she leaves the health facility (even if the survivor is illiterate, she can ask someone she trusts to read it to her later). Give the survivor the opportunity to ask questions and to voice her concerns. Practice psychological first aid.(Annex 3)

Psychological and emotional problems

- Medical care for survivors of rape includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, substance abuse, risk-taking behaviour, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to a specialist. A coordinated integrated referral system should be put in place as soon as possible. (Recommendation to MOHP)[26]
- The majority of rape survivors never tell anyone about the incident. If the survivor has told you what happened, it is a sign that she trusts you. Your compassionate response to her disclosure can have a positive impact on her recovery.
- Provide basic, non-intrusive practical care. Listen but do not force her to talk about the event, and ensure that her basic needs are met. Because it may cause greater psychological problems, do not push survivors to share their personal experiences beyond what they would naturally share.
- Ask the survivor if she has a safe place to go to, and if someone she trusts will accompany her when she leaves the health facility. If she has no safe place to go to immediately, efforts should be made to find one for her. See Arabic appendix for shelters supervised by Ministry of Social Solidarity.
- Enlist the assistance of the counseling services, community services provider, and law enforcement authorities, including police or security officer as appropriate (See referral list). If the survivor has dependants to take care of, and is unable to carry out day-to-day activities as a result of her trauma, provisions must also be made for her dependants and their safety.
- Survivors are at increased risk of a range of symptoms, including:
  - feelings of guilt and shame;
  - uncontrollable emotions, such as fear, anger, anxiety;
  - nightmares;
  - suicidal thoughts or attempts;
  - numbness;
  - substance abuse;
  - sexual dysfunction;
  - medically unexplained somatic complaints;
  - social withdrawal.
- Tell the survivor that she has experienced a serious physical and emotional event. Advise her about the psychological, emotional, social and physical problems that she may experience. Explain that it is common to experience strong negative emotions or numbness after rape.
- Advise the survivor that she needs emotional support. Encourage her – but do not force her - to confide in someone she trusts and to ask for this emotional support, perhaps from a trusted family member or friend. Encourage active participation in family and community activities.

26) MOHP referral chain is under-construction and validation

- Involuntary orgasm can occur during rape, which often leaves the survivor feeling guilty. Reassure the survivor that, if this has occurred, it was a physiological reaction and was beyond her control.
- In most cultures, there is a tendency to blame the survivor in cases of rape. If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her that she did not deserve to be raped, that the incident was not her fault, and that it was not caused by her behaviour or manner of dressing. Do not make moral judgments of the survivor.

Pregnancy

- Emergency contraceptive pills cannot prevent pregnancy resulting from sexual acts that take place after the treatment. If the survivor wishes to use a hormonal method of contraception to prevent future pregnancy, counsel her and prescribe this to start on the first day of her next period or refer her to the family planning clinic.
- Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of the rape. Emotional support and clear information are needed to ensure that they understand the choices available to them if they become pregnant:
- Women who are pregnant at the time of a rape are especially vulnerable physically and psychologically. In particular they are susceptible to miscarriage, hypertension of pregnancy and premature delivery. Counsel pregnant women on these issues and advise them to attend antenatal care services regularly throughout the pregnancy. Their infants may be at higher risk for abandonment so follow-up care is also important.

HIV/STIs

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

- The survivor may be referred to an HIV/AIDS counselling service if available.(See sites of VCT centers in Egypt at referral list)
- The survivor should be advised to use a condom with her partner for a period of 6 months (or until STI/HIV status has been determined).
- Give advice on the signs and symptoms of possible STIs, and on when to return for further consultation.

Other

- Give advice on proper care for any injuries following the incident, infection prevention (including perineal hygiene, perineal baths), signs of infection, antibiotic treatment, when to return for further consultation, etc.
- Give advice on how to take the prescribed treatments and on possible side-effects of treatments.

Follow-up care at the health facility

Tell the survivor that she can return to the health service at any time if she has questions or other health problems. Encourage her to return in two weeks for follow-up evaluation of STI and pregnancy (see Step 7).

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

STEP 7 - Follow-up care of the survivor

It is possible that the survivor will not or cannot return for follow-up. Provide maximum input during the first visit, as this may be the only visit.

Follow-up visits for survivors <u>who do not receive</u> post-exposure prophylaxis

Two-week follow-up visit

- Evaluate for pregnancy and provide counselling (see Steps 2, 5, and 6).
- Check that survivor has taken the full course of any medication given for STIs.
- If prophylactic antibiotics were not given, evaluate for STI, treat as appropriate, and provide advice on voluntary counselling and testing for HIV (see Steps 5 and 6).
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Three-month follow-up visit

- Evaluate for STIs, and treat as appropriate.
- Assess pregnancy status, if indicated.
- Test for syphilis if prophylaxis was not given.
- Provide advice on voluntary counselling and testing for HIV.
- Evaluate mental and emotional status; refer or treat as needed (see Step 6).

Care for child[27] survivors

Good to know

If it is obligatory to report cases of child abuse in your setting. Evaluate each case individually in some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.

- **Find out about specific laws in your setting that determine who can give consent for minors and who can go to court as an expert witness.[28]**
- **Health care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that health care staff receive special training in examining children who may have been abused.**

General

A parent or legal guardian should sign the consent form for examination of the child and collection of forensic evidence, unless he or she is the suspected offender. In this case,

a representative from the police, the community support services or the court may sign the form. Adolescent minors may be able to give consent themselves. The child should never be examined against his or her will, whatever the age, unless the examination is necessary for medical care.

27) The United Nations Convention on the Rights of the Child (1989) defines a child as any individual below the age of eighteen years.
28) National Council for Childhood and Motherhood Hot line 16000

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

- convulsions;
- persistent vomiting;
- stridor in a calm child;
- lethargy or unconsciousness;
- inability to drink or breastfeed.

In children younger than 3 months, look also for:

- fever;
- low body temperature;
- bulging fontanelle;
- grunting, chest in-drawing, and a breathing rate of more than 60 breaths/minute.

Create a safe environment

- Take special care in determining who is present during the interview and examination (remember that it is possible that a family member is the perpetrator of the abuse). It is preferable to have the parent or guardian wait outside during the interview and have an independent trusted person present. For the examination, either a parent or guardian or a trusted person should be present. Always ask the child who he or she would like to be present, and respect his or her wishes.
- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that he or she is not in any trouble.
- Ask a few questions about neutral topics, e.g., school, friends, who the child lives with, favorite activities.

Take the history

- Begin the interview by asking open-ended questions, such as “Why are you here today?” or “What were you told about coming here?”
- Avoid asking leading or suggestive questions.
- Assure the child it is okay to respond to any questions with “I don’t know”.
- Be patient; go at the child’s pace; do not interrupt his or her train of thought.
- Ask open-ended questions to get information about the incident. Ask yes-no questions only for clarification of details.
- For girls, depending on age, ask about menstrual and obstetric history. The pattern of sexual abuse of children is generally different from that of adults. For example, there is often repeated abuse.
- To get a clearer picture of what happened, try to obtain information on:
  - the home situation (has the child a secure place to go to?);

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

Prepare the child for examination

- As for adult examinations, there should be a support person or trained health worker whom the child trusts in the examination room with you.
- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.

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

- It is possible that the child cannot relax because he or she has pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety and worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

Conduct the examination

- Conduct the examination in the same order as an examination for adults. Special considerations for children are as follows:
- Note the child's weight, height, and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed.
- Check the hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Note the location of any fresh or healed tears in the hymen and the vaginal mucosa. The amount of hymenal tissue and the size of the vaginal orifice are not sensitive indicators of penetration.
- Do not carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size).
- Look for vaginal discharge. In pre-pubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
- Do not use a speculum to examine pre-pubertal girls; it is extremely painful and may cause serious injury.
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a pre-pubertal child is usually done under general anesthesia.

Depending on the setting, the child may need to be referred to a higher level of health care.

- In boys, check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- All children, boys and girls, should have an anal examination as well as the genital examination. Examine the anus with the child in the supine or lateral position. Avoid the knee-chest position, as assailants often use it.
- Record the position of any anal fissures or tears on the pictogram.
- Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Do not carry out a digital examination to assess anal sphincter tone.

Laboratory testing

Testing for sexually transmitted infections should be done on a case-by-case basis and is strongly indicated in the following situations:[29]

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

In some settings, screening for gonorrhea and Chlamydia, syphilis and HIV is done for all children who may have been raped. The presence of any one of these infections may be diagnostic of rape (if the infection is not likely to have been acquired perinatally or through blood transfusion).[30] Follow your local protocol.

If the child is highly agitated

In rare cases, a child cannot be examined because he or she is highly agitated. Only the child cannot be calmed down, and physical treatment is vital, the examination may be performed with the child under sedation, using one of the following drugs:

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg; or
- promethazine hydrochloride, syrup, by mouth;

- 2-5 years: 15-20 mg
- 5-10 years: 20-25 mg

These drugs do not provide pain relief. If you think the child is in pain, give simple pain relief first, such as paracetamol (1-5 years: 120-250 mg; 6-12 years: 250-500 mg). Wait for this to take effect. Oral sedation will take 1-2 hours for full effect. In the meantime allow the child to rest in a quiet environment.

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29) From Guidelines for the management of sexually transmitted infections, revised version. Geneva, World Health Organization, 2003 (WHO/RHR/01.10).
30) American Academy of Pediatrics Committee on Child Abuse and Neglect. Guidelines for the evaluation of sexual abuse of children: subject review. Pediatrics, 1999,103:186-191.

Treatment

With regard to STIs, HIV, hepatitis B, and tetanus, children have the same prevention and treatment needs as adults but may require different doses. Special protocols for children should be followed for all vaccinations and drug regimens. Routine prevention of STIs is not usually recommended for children. However, in low-resource settings with a high prevalence of sexually transmitted diseases, presumptive treatment for STIs should be part of the protocol (annex7).

Follow-up

Follow-up care is the same as for adults. If a vaginal infection persists, consider the possibility of the presence of a foreign body, or continuing sexual abuse.

Referral

Specialized services for children and child abuse including physical, psychological and social services are listed at referral list in the appendix

Chapter 4 is mainly adopted from Clinical Management of Rape Survivors - Developing protocols for use with refugees and internally displaced persons WHO 2004

Main Resources of the medical protocol for Management of GBV

APPENDIX O -Special Considerations for Caring for Diverse Populations Domestic Violence Intervention: A Guide for Health Care Professionals

Responding to Family & Domestic Violence - A Guide for Health Care Professionals in Western Australia December 2001

Responding to intimate partner violence and sexual violence against women- WHO clinical and policy guidelines   WHO 2013

Sexual and Gender-Based Violence against Refugees, Returnees and Internally Displaced Persons

Guidelines for Prevention and Response - UNITED NATIONS HIGH COMMISSIONER FOR REFUGEES May 2003

Medical providers' guide to managing the care of domestic violence patients within a cultural context 2ND Edition New York 2004

Improving the Health Sector Response to Gender Based Violence - A Resource Manual for Health Care Professionals in Developing Countries- IPPF/WHR Tools | 2010

Clinical Management of Rape Survivors - Developing protocols for use with refugees and internally displaced persons WHO 2004