



STRENGTHENING THE
MEDICO-LEGAL
RESPONSE TO
SEXUAL VIOLENCE



UNODC

United Nations Office on Drugs and Crime



STOP RAPE NOW

UN ACTION AGAINST SEXUAL VIOLENCE IN CONFLICT



**World Health
Organization**



Introduction to the toolkit

Background

In the past 20 years, increasing attention has been paid to ending impunity for perpetrators of sexual violence in conflict-affected settings and to achieving assistance and justice for victims. It is acknowledged that this is an important part of the response to sexual violence. While there have been significant advances, there remains a lack of clarity about what medico-legal evidence should be collected to support national and international criminal justice processes.

Medico-legal evidence is at the intersection of medical and justice processes and appropriate implementation requires coordination between the range of actors and sectors involved in prevention of, and response to, sexual violence; these include health services, social services, forensic medicine, forensic lab services, police/investigation, and the legal system, including lawyers and judges.

This toolkit is practitioner focused and addresses key knowledge gaps within and between sectors, to help support service provision and coordination in low-resource settings. It is part of a World Health Organization (WHO) and United Nations Office on Drugs and Crime (UNODC) Project on Strengthening Medico-Legal Services for Sexual Violence Cases in Conflict-Affected Settings, supported by United Nations Action against Sexual Violence in Conflict (UN Action)

How to use the tools

- These job aids are intended to provide basic and key information to a range of actors involved in the medico-legal care system in conflict-affected low-resource settings.
- Key categories of actors for whom these job aids are designed include those in the following sectors: health, social services, forensics, police/investigation, law, and those engaged in the process of coordination between these sectors.
- The primary and secondary audiences for each of the job aids are designated at the top of each factsheet.
- The job aids are one page each, to enable quick reference to the most important information.
- There is a limit to how much can be included on one page. The factsheets only address the key considerations and additional references and/or resources are provided at the end of each factsheet.
- Relevant related job aids are noted at the top of each factsheet.
- It is recommended that someone working in a more central role within the system, or who is responsible for coordinating with other parts of the medico-legal system, reads all of the job aids as well as the background paper and policy note.
- Labelled diagrams of female and male genitalia are included in this toolkit. These are intended to help all actors, especially those without training in human anatomy, to use more precise and accurate terminology when requesting examinations and reviewing and interpreting evidence.
- The establishment of health and psychosocial services for those who experience sexual violence is of primary importance to their well-being. The collection of medico-legal evidence should not be done in the absence of, or at the expense of, this service provision.
- For clarity and consistency, the term “victim” is used to designate those who have experienced sexual violence. This is not intended to imply any lack of agency or empowerment.
- This toolkit is designed for use in resource-poor settings. Hence, although the general principles apply to all settings, the interventions available may vary, depending on the setting.

Also relevant to: Media

See also: Competencies, Support and protection, Special considerations for children



Facts about sexual violence

Background/rationale

Any person who works with individuals who have experienced sexual violence, or who is part of the medical, criminal justice or legal system response to sexual violence, must have a good understanding of sexual violence.

Key points

- Sexual violence is “any sexual act that is perpetrated against someone’s will” (1). It can be committed “by any person regardless of their relationship to the victim, in any setting” (2). It includes, but is not limited to, rape, attempted rape and sexual slavery, as well as unwanted touching, threatened sexual violence and verbal sexual harassment (3).
- Although national legal definitions may differ, rape is defined as “contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object” (1).
- The acts of sexual violence that are considered criminal offences may differ from jurisdiction to jurisdiction.
- In conflict-affected settings, sexual violence can include violence perpetrated by combatants, as well as violence within the community and family/intimate partnerships.
- Anyone can be a victim of sexual violence, including children and women and men of all ages.
- Sexual violence can occur anywhere (including in the home, workplace, school, place of detention or camps for refugees or the internally displaced).
- The vast majority of acts of sexual violence are perpetrated by someone known to the victim, including an intimate partner, even during conflict (4, 5).
- The majority of rape victims report that they were afraid of receiving serious injuries or of being killed and so offered little resistance to the attack. This does not mean they consented.
- Because many rapes do not involve a significant amount of physical force, in most cases of sexual violence there will not necessarily be any physical injuries. In non-conflict settings, only approximately one third of rape victims sustain visible physical injuries (6). There are no data about this for conflict settings.

- The absence of physical injuries does not mean that a rape did not occur.
- Sexual violence can have short- and long-term physical, psychological and social impacts on the victim.
- A victim's previous or current involvement in commercial sex work does not mean that he or she was not raped.
- Although national laws may not recognize it in all settings, rape can also occur between spouses and other intimate partners, and this is a common form of violence even in conflict-affected settings (4).
- Even in peaceful and high-resource settings, the majority of rapes are never reported to the police, owing to shame, stigma, fear of negative repercussions, or knowledge that the response will be limited.

References

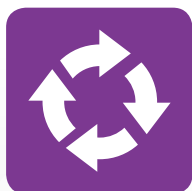
1. Centers for Disease Control and Prevention. Injury prevention and control. Sexual violence: definitions (<http://www.cdc.gov/violenceprevention/sexualviolence/definitions.html> , accessed 8 May 2014).
2. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002 (http://whqlibdoc.who.int/publications/2002/9241545615_eng.pdf?ua=1, accessed 8 May 2014).
3. Rome statute of the ICC http://www.icc-cpi.int/nr/rdonlyres/ea9aef7-5752-4f84-be94-0a655eb30e16/0/rome_statute_english.pdf
4. Stark L, Ager A. A systematic review of prevalence studies of gender-based violence in complex emergencies. *Trauma Violence Abuse*. 2011;12:127–34. doi:10.1177/1524838011404252.
5. Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, Glass N et al. The prevalence of sexual violence among female refugees in complex humanitarian emergencies: a systematic review and meta-analysis. *Plos Current Disasters*. 2014 March 18. doi:10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7 (<http://currents.plos.org/disasters/article/the-prevalence-of-sexual-violence-among-female-refugees-in-complex-humanitarian-emergencies-a-systematic-review-and-meta-analysis/>, accessed 8 May 2014).
6. Tjaden PG, Thoennes N. (2000). Full report of the prevalence, incidence, and consequences of violence against women. Research report. Findings from the National Violence Against Women Survey. Washington, DC: National Institute of Justice and Centers for Disease Control and Prevention; 2000 (<https://www.ncjrs.gov/pdffiles1/nij/183781.pdf>, accessed 8 May 2014).

Additional resources

- Guidelines for medico-legal care of victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf?ua=1>, accessed 8 May 2014).
- Understanding and addressing violence against women. Sexual violence. Geneva: World Health Organization; 2012 (http://apps.who.int/iris/bitstream/10665/77434/1/WHO_RHR_12.37_eng.pdf, accessed 8 May 2014).
- World Health Organization, London School of Hygiene and tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women. Prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: World Health Organization; 2013 (http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf?ua=1, accessed 8 May 2014).
- Stop rape now. UN Action against Sexual Violence in Conflict (<http://www.stoprapenow.org/>, accessed 8 May 2014).

Also relevant to: Media

See also: Key stakeholders, Ethics, Competencies



Coordination and cooperation

Background/rationale

The provision of medico-legal services to victims of sexual violence requires the involvement of a range of systems and professions, including health and social service providers, forensic medicine, forensic lab services, police, and the legal system, including lawyers and judges. When collaboration and coordination occur at different levels (case management, service provision, planning and policy development), there is more likely to be a service that is efficient, timely and of good quality, that encourages victims to access services and report cases, and that is more effective in holding offenders accountable.

In settings affected by conflict, it is also important to establish good coordination between national and international actors such as the United Nations and international nongovernmental organizations and, where relevant, international criminal tribunals.

Key points

- Coordination is more than just holding meetings or sharing information; it is about working together in a way that brings coherence across sectors, to develop and enhance the functioning of services and improve outcomes for victims.
- Coordination requires commitment and engagement from all relevant entities (e.g. organizations, departments and services) and dedicated staff – with sufficient time to ensure coordination and participation.
- A critical first step to coordination is to identify which entities need to be involved.
- These should be represented by individuals who are knowledgeable about their discipline and empowered to make decisions for their entities.
- Meetings should include both female and male representatives and participating entities should aim for equal representation and ensure that women's voices are heard.
- It is useful to identify an individual whose role is to facilitate the administration of coordination (meetings, communications, recording notes, etc.).

- It is important to clarify roles and responsibilities, and processes, and to identify challenges.
- Entities should have a role in identifying the terms of reference of the coordination and how it will be undertaken. This is important for buy-in and partnership.
- Information sharing is important for coordination. What information will be shared, how often and how (by email, at meetings, by other means) should be decided by the group. The group should develop a clear understanding of what can and cannot be shared and why (e.g. medical files, which cannot be shared due to doctor–patient confidentiality).
- Face-to-face meetings are important for coordination. Entities should help identify how often and where meetings will be held. Meetings should be held in a location that is accessible to all.
- Draft agendas for meetings should be shared in advance, to give participants an opportunity to provide feedback.
- Written summaries of meetings, which include action points and who is responsible for them, are important for recording decisions taken and ensuring appropriate follow-up.
- An important component of coordination is the clarification of roles and responsibilities and the establishment of referral pathways between the different sectors and providers.

Additional resources

- UN General Assembly Resolution 65/228. Strengthening crime prevention and criminal justice responses to violence against women. Also the Annex: Updated model strategies and practical measures on the elimination of violence against women in the field of crime prevention and criminal justice. 31 March 2011. New York: United Nations; 2011 (http://www.unodc.org/documents/justice-and-prison-reform/crimeprevention/Model_Strategies_and_Practical_Measures_on_the_Elimination_of_Violence_against_Women_in_the_Field_of_Crime_Prevention_and_Criminal_Justice.pdf, accessed 8 May 2014).
- GBV Area of responsibility Establishing Gender-based Standard Operating Procedures (SOPs) for Multi-sectoral and Inter-organisational Prevention and Response to Gender-based Violence in Humanitarian Settings, 2008 (<http://gbvaor.net/resources/establishing-gender-based-standard-operating-procedures-sops-for-multi-sectoral-and-inter-organisational-prevention-and-response-to-gender-based-violence-in-humanitarian-settings-english/>)
- Global Protection Cluster. Gender-based Violence Area of Responsibility Working Group. Handbook for coordinating gender-based violence interventions in humanitarian settings. 2010 (<http://gbvaor.net/wp-content/uploads/sites/3/2012/10/Handbook-for-Coordinating-Gender-based-Violence-in-Humanitarian-Settings-GBV-AoR-2010-ENGLISH.pdf>, accessed 8 May 2014).



Key stakeholders

Background/rationale

The provision of coordinated and appropriate medico-legal services to victims of sexual violence requires the involvement of a range of systems and professions, as well as of victims themselves. These key stakeholders should be included in the development and coordination of systems, in order to ensure that they are responsive and effective. Government entities are key stakeholders and have the primary responsibility to participate and bring others on board. While this may be challenging in conflict-affected settings, the development/reconstruction of government systems should be a priority. It is important to integrate medico-legal services in the existing health-care services.

In settings affected by conflict, it is also important for national systems to engage with international actors such as the United Nations and international nongovernmental organizations and, where relevant, international criminal tribunals.

Key stakeholders

- Service providers (may include international and national nongovernmental organizations)
 - Health providers
 - » Accident and emergency room staff
 - » Specialist health providers (obstetrics and gynaecology, paediatrics, mental health)
 - » Midwives
 - » Nurses
 - » Physicians

- Providers of psychosocial support and social services
 - » Case managers
 - » Social workers
 - » Psychosocial assistants
 - » Psychosocial counsellors/psychologists
- Specialized services for children
- Forensic medicine
 - Forensic physicians (may also be the health care providers)
 - Forensic nurses
- Forensic laboratory services
- Police
- Legal system (may include international criminal tribunals)
 - Judges
 - Prosecutors
 - Investigators
 - Legal aid providers
 - Human rights organizations
- Victim/survivor groups
- Social support groups/nongovernmental organizations
 - Women's groups
 - Ethnic minorities
 - People with disabilities
 - Religious organizations
 - Indigenous people
 - Organizations working with children
 - Lesbian, gay, bisexual, transgender and intersex groups

Also relevant to:

See also: Facts about sexual violence, Competencies, Support and protection, Special considerations for children



Ethics

Background/rationale

Individuals, agencies and organizations that are part of the medico-legal process must act in accordance with the following core ethical principles.

Key principles

- The physical safety and emotional well-being of the victim should be the primary consideration.
- The confidentiality of the victim and her/his information must be guaranteed. Where there are legal limitations to confidentiality, this information must be shared with the victim as early as possible, to allow her/him to make an informed decision about disclosure.
- The victim's wishes and rights must be respected. The victim must be informed of her/his options and be able to exercise her/his autonomy to make informed choices (informed consent).
- Individuals, agencies and organizations must not discriminate against victims on any basis, including religion, race, sex, gender identity, age, ethnic group, profession, socioeconomic level, political affiliation or sexual orientation.
- Those interacting with victims must be careful not to make promises and misrepresentations (particularly regarding security) that cannot be guaranteed.
- There must be policies in place to protect those who may not be in a position to legally consent to medical and medico-legal processes.

Additional resources

- WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva: World Health Organization; 2007 (http://www.who.int/gender/documents/OMS_Ethics&Safety10Aug07.pdf, accessed 8 May 2014).

Also relevant to:

See also: Facts about sexual violence, Ethics, Support and protection, Special considerations for children



Competencies

Background/rationale

Professionals involved in the provision of medico-legal services should have specific skills and knowledge related to their functions within the system. In addition to these professional competencies, there are some core competencies that all those working with victims of sexual violence should possess.

*Core competencies**

All those working in the medico-legal system should:

- know the relevant laws and policies about sexual violence in the country's jurisdiction, including what is considered a crime and who is competent to collect evidence and/or testify as a professional or expert witness in cases of sexual assault;
- know about any informal or traditional justice systems that may be in place;
- know the relevant information on gender and sexual violence;
- know and abide by the relevant professional ethical standards;
- have an appropriate level of professional training and qualification in their field;
- understand that a victim has the right to decide who has access to her/his information; to choose the sex of the forensic examiner and other professionals providing services; and to choose what care he/she receives;
- understand and respect the choices that a victim makes;
- understand the importance of prioritizing the well-being and safety of the victim over anything else, including collection of medico-legal evidence;
- know the relevant principles, policies and laws that regulate confidentiality of consultations and records, including any mandatory reporting requirements;
- know how to interact with victims in ways that minimize further traumatization and harm;

- communicate with victims in a non-judgmental and empathetic way;
- know the components of the medico-legal system and how they relate to each other;
- understand the importance of working in a multidisciplinary way to deliver services that minimize harm in the short term and longer term;
- be aware of basic facts regarding sexual violence.

Additional resources

*Drawn from Zadnik L, Grove J. Resources for sexual violence preventionists. Enola, PA: National Sexual Violence Resource Center; 2005 (http://nsvrc.org/sites/default/files/Publications_NSVRC_Core-competencies-sexual-violence-prevention-practitioners.pdf, accessed 9 May 2014).

Also relevant to:

See also: Ethics, Competencies, Special considerations for children



Support and protection for victims

Background/rationale

All aspects of the response to sexual violence should ensure support and protection for victims. In conflict-affected settings, victims may face retribution by perpetrators if they report the sexual violence, and stigmatization or rejection by their community or family if the fact that they were raped becomes known. A 'survivor-centred approach', which prioritizes the rights, choices and needs of the victim, is an essential component of ensuring protection and promoting recovery and is enhanced by well-coordinated responses.

Key points

- A 'survivor-centred approach' means that:
 - the victim's autonomy is respected and she/he is provided with the information needed and the right to make decisions about her/his case, including whether to report the case to the police. If there are mandatory reporting laws, these are explained clearly to the victim so she/he can make an informed choice as to whether to proceed or not;
 - the victim's safety is considered the highest priority;
 - the victim is not discriminated against, regardless of religion, race, sex, gender identity, age, ethnic group, profession, socioeconomic level, political affiliation or sexual orientation or other factor;
 - the victim's right to confidentiality is respected.
- Victims must be provided with accurate information about where they can receive services to address their immediate and longer-term needs (e.g. health, psychosocial, legal, economic, safety and security). This information about where services are available should also be made available to the community.

- Victims must be enabled to access all aspects of the medico-legal system. This includes ensuring that they receive support to overcome barriers, including
 - support for transport;
 - support for family care obligations (children, elderly);
 - support through all steps of the investigation and any subsequent police case.
- There should be specific provisions for care for those with specific needs, including children, men, and elderly or disabled people who are victims of sexual violence.

Additional resources

- Caring for survivors of sexual violence in emergencies: training guide. New York: United Nations Office for the Coordination of Humanitarian Affairs, Inter-Agency Standing Committee; 2010 http://www.globalprotectioncluster.org/_assets/files/tools_and_guidance/gender_based_violence/GPC_GBV_Caring_Survivors_Training_Pack_2010_EN.pdf

Also relevant to: Social services, Coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Special considerations for children, Documenting the story and responses



Preparing to gather the story

Background/rationale

Telling others about the experience of sexual assault is often stressful, embarrassing and difficult. It can also be challenging for the person listening to the account. The aim of this job aid is to provide some suggestions to prepare individuals to whom the story of sexual violence is told. If someone is willing to talk about what happened and is comfortable with you hearing their account, it suggests that they trust you with this information. It is essential to respect and maintain this trust. Anyone obtaining the story must be trained to interview victims of sexual violence.

Key points

- Make sure that the immediate environment is secure and private.
- Ensure that any medical, psychological and safety issues have been addressed.
- Provide a trained interpreter if needed and with the consent of the victim/survivor.
- Ensure that victims have access to and choice of a same-sex interviewer.
- Acknowledge the difficulty in telling the account, which will include embarrassment, fear and patchy recollections; and respect cultural, religious and ethnic sensitivities.
- Ensure that the victim is comfortable speaking and is not doing so under coercion.
- Seek the victim's informed consent to document (in writing, photographs/videos, recording devices) the details she/he tells you and to hold this information securely until a later date, and ensure she/he knows to whom you may pass it on. Explain how information may be used and any limits to confidentiality.
- Stress the importance of being truthful and of the value of her/his account.
- Allow the victim to have another person present (obligatory for children) if they wish.
- Offer emotional and social support during the process.
- Allow the victim to tell her/his account when and how she/he wishes. Respect her/his choice if she/he wishes to stop at any time.

- Be sensitive to cultural, ethnic and religious needs of victims and/or their caregivers. Be aware that female and male victims may have different needs and concerns, and respond to these (i.e. be gender sensitive).

Above all else – listen with empathy and allow a free narrative.

Some questions that could be asked of the person telling her/his story

- **Personal information** (ideally supported by official identification papers) – name, address, telephone number, email address. How does the victim wish to be contacted?
- **Is she/he a victim or witness?** Is she/he recounting details of what happened to her/him or to another person (if the latter, then details of that other person should also be recorded)?
- **Setting of the assault** – when, where, what time and date, how many times, were there any other witnesses (and if so, who), were any photographs or other recordings made?
- **Details of the assault** – health providers should focus on details relevant to the provision of medical care. Specific information about perpetrators for the purpose of legal processes should be gathered by trained investigators. The victim can be asked to provide as many details as possible about what happened before, during and after the assault – in particular, details of any penetration, any acts of humiliation, other assaultive events, restraint or detention, threats or blackmail, assaults or threats to friends, family or other members of the community.

Additional resources

- Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings. Geneva: World Health Organization; 2012 (WHO/RHR/HRP/12.16; http://apps.who.int/iris/bitstream/10665/75175/1/WHO_RHR_HRP_12.16_eng.pdf; accessed 9 May 2014).
- Guidelines for medico-legal care of victims of sexual violence. Geneva: World Health Organization; 2003 (http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/; accessed 9 May 2014).

United Nations Office on Drugs and Crime (UNODC) and United Nations Children's Fund (UNICEF) tools for child victims and witnesses

- UNODC, UNICEF. Handbook for professionals and policymakers on justice in matters involving child victims and witnesses of crime. New York: United Nations; 2009 (<http://www.unrol.org/files/Handbook%20for%20Professionals%20and%20Policymakers%20on%20Justice%20in%20Matters%20involving%20Child%20Victims%20and%20Witnesses%20of%20Crime.pdf>; accessed 9 May 2014).
- UN Economic and Social Council Resolution 2005/20 of 22 July 2005. Guidelines on justice in matters involving child victims and witnesses of crime. New York: United Nations; 2005 (<http://www.refworld.org/docid/468922c92.html>; accessed 9 May 2014).
- UNODC, UNICEF. United Nations guidelines on justice in matters involving child victims and witnesses of crime. Online training (<http://www.unodc.org/justice-child-victims/>; accessed 9 May 2014).
- UNODC, UNICEF. Justice in matters involving child victims and witnesses of crime: model law and related commentary. New York: United Nations; 2009 (http://www.unicef.org/albania/Justice_in_matters.pdf; accessed 9 May 2014).

Primary target audience(s): **Health** **Forensics** **Law** **Investigation** **Social services**

Coordination

Also relevant to:

See also: Ethics ; Competencies



Special Considerations for medico-legal services for child victims

Rationale

In many settings affected by conflict, a significant proportion of victims of sexual violence are children (under the age of 18). Medico-legal care of children demands even stricter and more rigorous consideration of ethical and safety issues, as children are among the most vulnerable population subgroups.

Key points

1. Only those who have had specialized training and experience in working with children (e.g. child friendly communication, specialized exam techniques, evidence collection) should provide medico-legal services to children.
2. Medico-legal evaluations (history taking, examination, specimen collection and medico-legal report) should only be conducted on children if child-specific health and other services are accessible for referral.
3. All medico-legal practitioners working with children should be aware of the relevant laws and policies in place in the setting, including those related to consent, mandatory reporting, definitions of sexual violence against children, and who can collect and provide medico-legal evidence in court.
4. Where possible children should be offered a choice of male or female examiner.
5. A child should never be examined against his or her will unless the examination is essential for the provision of health care. Occasionally, examinations may need to be done under general anesthesia but this should only occur for health and not legal indications.

6. Informed consent procedures must be child friendly, informed by legal age of consent, age, and level of understanding of the child.
 - a. Informed consent must be provided by a parent or guardian unless local laws state otherwise. In addition, children who are of an age to be able to understand the nature of the medico-legal process (i.e. are developmentally capable) should also be provided with information and given the opportunity to provide their informed assent.
 - b. Determining acceptable and appropriate ages when adolescents may be able to give consent without parental involvement requires understanding of the applicable laws, culture, and context as well as careful evaluation of security in the setting.
7. If there are mandatory reporting requirements in the setting, this information must be disclosed to parent/guardian and child during the informed consent process
8. A small child can be examined on her or his mother's lap. Older children should be offered a choice (sitting on a chair, on mother's lap, on bed).
9. Health practitioners (and others) should not conduct virginity examinations or hymenal reconstruction; these activities can not be supported scientifically or ethically.
10. Do not use a speculum to examine pre-pubertal girls. It is painful and may cause injury.
11. Do not carry out a digital examination on a child to assess anal sphincter tone – such assessments have no validity..
12. Do not collect forensic evidence unless it can be stored securely and there are systems accessible for their analysis.

Additional resources

Convention on the Rights of the Child. (1989) New York: United Nations General Assembly <http://www.unhchr.ch/html/menu3/b/k2crc.htm>

International Rescue Committee & UNICEF (2012) Caring for Child Survivors <http://gbvresponders.org/node/1542>

WHO (2007) WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva: World Health Organization <http://www.who.int/reproductivehealth/publications/violence/9789241595681/en/>

WHO/UNHCR/UNFPA (2009) Clinical management of rape survivors e-learning programme (also in French) <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/>

Primary target audience(s): **Health** **Forensics** **Law** **Investigation** **Social services**

Coordination

Also relevant to: Social services, Coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Special considerations for children, Preparing to gather the story



Documenting the story and responses

Background/rationale

Documenting an individual's account of sexual violence is an important component of the medico-legal process. Such documentation captures the allegation and examination findings and creates a permanent record of details of any subsequent interventions. These records are important for the medical management of the individual and for any subsequent investigation and prosecution. Documentation may also have an important role in the therapeutic process for those who have been assaulted. It is important to identify whose role it is to document the story, and to recognize that it is not the role of health providers to make legal determinations.

Key points

- Allegations of sexual violence made by individuals (victims, family members or witnesses) should be documented.
- Such documentation should occur at the time the allegation is made, or as soon as possible afterwards.
- Ensure victims understand how and why you are documenting the story, and how this information will be stored and used.
- The documentation should be hand written, typed or recorded (e.g. computer, phone) and signed and dated by the person doing it and by the victim.
- Try to capture the words/language used by the individual. Document the story in her/his words as comprehensively as possible.
- Clearly indicate the language used for the interview and whether an interpreter was used.
- Identify who provided the account, where and when it was obtained, and any other parties present.
- Document all examination findings and any treatment initiated.

- If possible, photograph any injuries while ensuring confidentiality. Generally, photographs of the breast(s) and genitalia should not be undertaken.
- Ensure that the photographs do not allow direct identification of the individual. Use a confidential code system to allow authorized staff to identify the individual and note when photographs were taken.
- Record details of any specimens obtained (including date and time) and their subsequent handling.
- Make certain that notes, photographs and other records are held securely and only accessed by authorized individuals.

Additional resources

- Guidelines for medico-legal care of victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf?ua=1>, accessed 9 May 2013).
- Sexual violence. In: Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R. World report on violence and health. Geneva: World Health Organization; 2002: 147–81 (http://www.who.int/violence_injury_prevention/violence/global_campaign/en/chap6.pdf, accessed 9 May 2014).

Primary target audience(s): **Forensics** **Investigation**

Also relevant to: Health, Law, Social services, Coordination

See also: Facts about sexual violence, Coordination and cooperation, Ethics, Competencies, Support and protection for victims, Special considerations for children



Elements of the initial investigation

Background/rationale

Multiple personnel and services are required to investigate an allegation of sexual assault. Police may be the first to respond to a report. Their role is important in securing the safety of the victim, ensuring any immediate medical needs are met and controlling the scene until the arrival of the investigators.

The crime scene(s) is a location where physical evidence should be sought and retrieved. Scene investigators are responsible for the management of the scene and the collection and submission of specimens to the laboratory.

The laboratory has an important role in providing scientific services for the investigation of sexual offences. If such services cannot be provided locally, there may be the capacity to store at, and transit specimens to, another laboratory.

Key points

- Victims should have any medical needs addressed immediately. Their ongoing care and support should be a priority.
- It is important to ensure that a prompt policing response can be provided whenever an allegation of sexual violence is received. The priorities will include identification of a crime, ensuring the safety of all individuals involved, and preservation of the crime scene.
- Suspects should be identified, searched, secured and removed from the scene as soon as possible. Investigators should inform suspects of their rights and ensure their safety.
- Effective crime scene management requires that the documentation, preservation, collection, labelling, packaging, security, chain of custody and storage of evidence is undertaken in a professional manner that can withstand subsequent scrutiny.

- Interviewing victims (and witnesses) requires care, patience and sensitivity. Interviews should be conducted by individuals who have received specific training in this field and in a location and manner that respect the choices, privacy, safety and confidentiality of the victim. Victims should have access to, and choice of, a same-sex interviewer if at all possible. Special measures must be taken when interviewing child victims.
- Forensic laboratories require specialist staff, secure storage facilities and reliable equipment. If such a service is not accessible, then arrangements should be made to securely store specimens and send them to an appropriate service.
- The need for effective communication between the services involved (police, health, social, laboratory and legal) is a fundamental element of a coordinated response.

Additional resources

- United Nations Office on Drugs and Crime. Policing. Forensic services and infrastructure. Criminal justice assessment toolkit. New York: United Nations; 2010 (http://www.unodc.org/documents/justice-and-prison-reform/cjat_eng/Forensic_services_and_infrastructure.pdf, accessed 9 May 2014).
- United Nations Office on Drugs and Crime. Handbook on effective police responses to violence against women. New York: United Nations; 2010 (http://www.unodc.org/documents/justice-and-prison-reform/Handbook_on_Effective_police_responses_to_violence_against_women_English.pdf, accessed 9 May 2014).
- United Nations Office on Drugs and Crime. Crime scene and physical evidence awareness for non-forensic personnel. New York: United Nations; 2009 (http://www.unodc.org/documents/scientific/Crime_scene_awareness__Ebook.pdf, accessed 9 May 2014).
- United Nations Office on Drugs and Crime. Guidelines for the forensic analysis of drugs facilitating sexual assault and other criminal acts. New York: United Nations; 2011 (<http://www.unodc.org/unodc/en/scientists/guidelines-for-the-forensic-analysis-of-drugs-facilitating-sexual-assault-and-other-criminal-acts.html>, accessed 9 May 2014).

Primary target audience(s): Health**Also relevant to:** Forensics, Law, Social services, Investigation, Coordination**See also:** Facts about sexual violence, Coordination and cooperation, Ethics, Competencies, Support and protection for victims

Minimum requirements for the health facility

Clinical management of rape is possible even in very low-resource settings, including those affected by conflict. The basic infrastructure, personnel, supplies and medications needed are detailed below. The clinical management of rape must take precedence over other aspects of the medico-legal process.

The basics for clinical management of rape

General

- A victim should have the choice to have a support person or companion with them at any or all stages of the process.
- The wishes of the victim should always be respected.
- The safety of the victim is of primary importance.

Protocol

- Written medical protocol in the language of the health provider

Personnel

- Trained (local) health-care professionals (on call 24 hours a day)
- A "same-language" same-sex health worker or a translator, with the offer of a companion or support person in the room during examination

Furniture/setting

- Room (private, quiet, accessible, clean, with access to a toilet or latrine)
- Examination table
- Light, preferably fixed

Supplies

- Access to equipment that is sterilized or disposable and unused (e.g. speculum/proctoscope)
- Supplies for collection of forensic evidence (2); these items are sometimes available as prepackaged "rape kits":

- Swabs and containers for transporting swabs
 - Microscope slides
 - Blood tubes
 - Urine specimen containers
 - Sheets of paper (drop sheet)
 - Paper bags
 - Plastic specimen bags
 - Tweezers, scissors, comb
- Supplies for universal precautions (gloves, masks, cleaning materials, soap)
 - Medical supplies for wound care
 - Gown, cloth or sheet to cover the victim during the examination
 - Sanitary supplies (pads or local cloths)
 - Set of replacement clothes for the victim, including footwear: these should not be clothes that may identify the victim as someone who has been raped or that can link them to the clinic

Medications

- For prophylaxis or treatment of sexually transmitted infections as per country protocol
- Antiretroviral drugs for post-exposure prophylaxis for HIV
- Emergency contraception
- Analgesics (e.g. paracetamol)
- Antibiotics for wound care
- Tetanus prophylaxis

Administrative supplies

- Medical chart with pictograms/body charts
- Consent forms
- Information pamphlets for post-rape care (for survivor – in the language of choice)
- Safe/secure, locked filing space to keep confidential records
- Information on support and other services to which the survivor can be referred

References

1. Minimum care for rape survivors in low-resource settings. Checklist of supplies. In: World Health Organization, Office of the United Nations High Commissioner for Refugees. Clinical management of survivors of rape. Geneva: World Health Organization; 2001 (<http://helid.digicollection.org/en/d/Js2664e/20.html>, accessed 9 May 2014).
2. Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).

Additional resources

- WHO/UNHCR. Clinical management of rape survivors. Developing protocols for use with refugees and internally displaced persons. Revised edition. Geneva: World Health organization; 2004 (<http://whqlibdoc.who.int/publications/2004/924159263X.pdf>, accessed 9 May 2014).

Primary target audience(s): **Health** **Forensics** **Law** **Investigation**

Also relevant to: Social services; coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Preparing to gather the story, Minimum requirements for the health facility



Managing the health issues

Background/rationale

Sexual violence may result in a range of negative outcomes for the victim: physical, psychological/mental and social. A victim's presentation to a health service provides an opportunity to identify and address a range of health issues, which may be pre-existing or the result of the assault(s). The first priority is ensuring a victim's access to health services that deliver a timely, comprehensive and professional service, both at the time of presentation and subsequently. National laws need to be considered and respected, with particular regard to pregnancy prevention and management.

Key points

- Ensure victims are informed of every step of the medical process, so they can consent to each part, are prepared and can make informed decisions.
- Ensure that all injuries are documented (notes/photographs) and treated.
- Respond to any concerns regarding the risks of pregnancy; this might include baseline testing, offering of post-coital contraception, follow-up reviews and management of any resultant pregnancy, in conformity with national/local policies and laws.
- Explain and address HIV and other sexually transmitted infections. This might include a risk assessment, baseline testing, recommendation of post-exposure prophylaxis and subsequent reviews.
- Ensure that the victim (or their guardian-support person) comprehends the potential health consequences of the assault, the significance and possible side-effects of any interventions, and the decision-making required.
- Make sure that the victim (or their guardian-support person) understands the key issues and her/his options and rights and is able to consent to any treatment decisions.
- Refer the victim to other centres/services when more specialized interventions are required.

- Offer the victim access to counselling and support services. Ideally, this should occur at the time of first recitation, at any subsequent reviews, and when requested by the victim or their family.
- Make certain that the victim's personal safety is dealt with. Issues of confidentiality/security of information, housing and personal protection for the victim and their family may need to be addressed.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).
- World Health Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees. Clinical management of rape survivors. E-learning programme. Geneva: World Health Organization; 2009 (<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/index.html>, accessed 9 May 2014).
- World Health Organization. Mental health and psychosocial support for conflict-related sexual violence: principles and interventions Summary. Geneva: World Health Organization; 2012 (http://www.who.int/reproductivehealth/publications/violence/rhr12_18/en/).
- World Health Organization, War Trauma Foundation and World Vision International. Psychological first aid: Guide for field workers. Geneva: World Health Organization; 2011 (http://www.who.int/mental_health/publications/guide_field_workers/en/).

Primary target audience(s): **Health** **Forensics**

Also relevant to: Law, Investigation, Social services, Coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Special considerations for children, Preparing to gather the story, Minimum requirements for the health facility, Medico-legal evidence in sexual violence, Forensic specimens, Female genitalia: definitions and comments, Male genitalia: definitions and comments



The forensic medical examination

Background/rationale

The clinical assessment is an important component of the health service for victims of sexual violence. It provides an opportunity for clinical management, the documentation of findings and the collection of material required to assist a criminal investigation. By its very nature, the examination is time consuming, intrusive, possibly traumatizing to the victim, and often challenging. Careful explanation and consent to the procedure, and a compassionate and sensitive health-care worker are the cornerstones of a good service. Ideally, the forensic medical examination should be done at the same time as the provision of medical care. Health workers must be specifically trained and have supervised experience in order to conduct forensic medical examinations. While it may be the role of health workers to document injuries and to collect other forms of medico-legal evidence, it is not their role to determine whether sexual assault has occurred.

Key points

- Only providers who have been explicitly trained and supervised should undertake full forensic examinations. All health providers should be able to, as a minimum, provide care to the victim, as well as document the victim's story, conduct a medical examination and record any injuries.
- Only medico-legal evidence that can be collected, stored, analysed and used should be gathered, and only with the full informed consent of the victim.
- A careful explanation should be provided to the victim. This should include the reasons for, and the extent of, the proposed examination, any procedures that might be conducted, the collection of specimens and photography. A sensitive and specific explanation of any genital or anal examination is required.
- Prior to commencing the examination, it is important to ensure that the facility is clean and secure, a chaperone (agreed to by the subject) is present and all relevant equipment is accessible.

- Specific measures should be taken if the victim is a minor (see factsheet 8).
- Consent to undertake the examination should be obtained from the individual or their guardian. The consent should be specific to each procedure (and particularly the genital examination), to the release of findings and specimens, and to any photography. The victim may consent to some aspects and not others and may withdraw consent. The consent should be documented by signature or fingerprint.
- The hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girls.
- There is no place for virginity testing; it has no scientific validity and is humiliating for the individual.
- Digital examinations of the vagina and anus are rarely warranted. They should not be used to assess the tone or elasticity of the vagina or anus, or to comment on likelihood or frequency of penetration.
- The general appearance and functioning of the individual (demeanour, mental status, drug effects, cooperation) should be documented, as well as the identity of the examiner and the date/time/location of the examination.
- Any limitations to the examination (lighting, cooperation etc.) should also be documented.
- A comprehensive examination should be performed, directed by the history provided. The sites examined/not examined should be documented.
- All recent and old injuries should be recorded and described in detail, recording any pertinent negative findings.
- The victim should be informed that some injuries might become more visible after some days and that, if this happens, she/he should return for examination and documentation
- A note should be made of any specimens collected, photography undertaken, diagnostic tests ordered or treatment initiated.
- The individual should be given a detailed explanation of the findings and their treatment and follow-up.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).
- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/index.html>, accessed 9 May 2014).
- World Health Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees. Clinical management of rape survivors. E-learning programme. Geneva: World Health Organization; 2009 (<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/index.html>, accessed 9 May 2014).

Primary target audience(s): **Health** **Forensics** **Law** **Investigation**

Also relevant to: Social services, Coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Elements of the initial investigation, The forensic medical examination, Forensic specimens, Female genitalia: definitions and comments, Male genitalia: definitions and comments



Medico-legal evidence in sexual violence

Background/rationale

All parties involved in managing cases of sexual assault should be aware of the evidence that might be collected or require interpretation. The objectives of evidence collection can include: to prove a sexually violent act and some of its circumstances, to establish a link between the aggressor and the victim, to link facts and persons to the crime scenes, and to identify the perpetrator. Only medico-legal evidence that can be collected, properly stored, analysed and used should be gathered, and only with the full informed consent of the victim.

Key points

- The physical examination is primarily conducted to address health issues. If it is performed within 5 days of the assault, there may be value in collecting forensic specimens. All examinations should be documented.
- Penetrative sexual activity of the vagina, anus or mouth rarely produces any objective signs of injury. The **hymen** may not appear injured even after penetration has occurred. Hence, the absence of injury does not exclude penetration. The health practitioner cannot make any comment on whether the activity was consensual or otherwise.
- There are different purposes and processes for the collection of specimens for health (pathology) and legal (forensic) investigations. **Pathology specimens** are analysed to establish a diagnosis and/or monitor a condition. **Forensic specimens** are used to assess whether an offence has been committed and whether there is a linkage between individuals and/or locations. Pathology specimens may have a significant forensic importance, especially if a sexually transmitted infection is found.
- The **forensic laboratory** requires information about the specimen (time, date, patient name/ID number, nature and site of collection) and what is being looked for.

- **Forensic specimens:** the account of the assault will dictate whether and what specimens are collected. If in doubt, collect. Persistence of biological material is variable. It will be affected by time, activities (washing) and contamination from other sources. The maximum agreed time interval (time of assault to time of collection) for routine collection is:
 - skin including bite marks – 72 hours;
 - mouth – 12 hours;
 - vagina – up to 5 days;
 - anus – 48 hours;
 - foreign material on objects (condom/clothing) – no time limit;
 - urine (toxicology) 50 mL – up to 5 days;
 - blood (toxicology) 2 × 5 mL samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate.
- **Hair** – cut scalp hair may be useful if there is concern of covert drug administration.
- Careful labelling, storage and chain-of-custody recording is required in all cases.
- Samples should not be placed in culture media and should be dry before being packaged.
- **Clothing** (especially underwear) and toxicological samples should be collected if required.
- **Photographs** provide a useful adjunct to injury documentation. Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital photographs are taken) need to be addressed and agreed with the victim.
- Sexual violence should be considered during an **autopsy** examination. Documentation and specimen collection should occur in such cases.
- If sexual assault results in a **pregnancy**, then consideration should be given to collection of specimens for paternity testing.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).
- World Health Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees. Clinical management of rape survivors. E-learning programme. Geneva: World Health Organization; 2009 (<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/index.html>, accessed 9 May 2014).
- United Nations Office on Drugs and Crime. Guidelines for the forensic analysis of drugs facilitating sexual assault and other criminal acts. New York: United Nations; 2011 (<http://www.unodc.org/unodc/en/scientists/guidelines-for-the-forensic-analysis-of-drugs-facilitating-sexual-assault-and-other-criminal-acts.html>, accessed 9 May 2014).

Primary target audience(s): **Health** **Forensics** **Investigation**

Also relevant to: Law, Social services, Coordination

See also: Facts about sexual violence, Ethics, Competencies, Support and protection for victims, Elements of the initial investigation, The forensic medical examination, Medico-legal evidence in sexual violence, Female genitalia: definitions and comments, Male genitalia: definitions and comments



Forensic specimens

Background/rationale

Collection of specimens from individuals alleging sexual violence may provide investigators (and a court) with information to support or negate allegations. Consent for collection should be obtained from all individuals. Specimens may corroborate contact between individuals or between an individual and location; evidence of contact occurs at the time of the offence but disappears quickly. Only evidence that has been correctly collected, stored and analysed should be used in the investigation/court proceedings. Results of analysis must be interpreted carefully, objectively and in the context of the investigation; it is exceedingly rare for a case to proceed on a single piece of evidence, e.g. DNA, fingerprint.

Key points

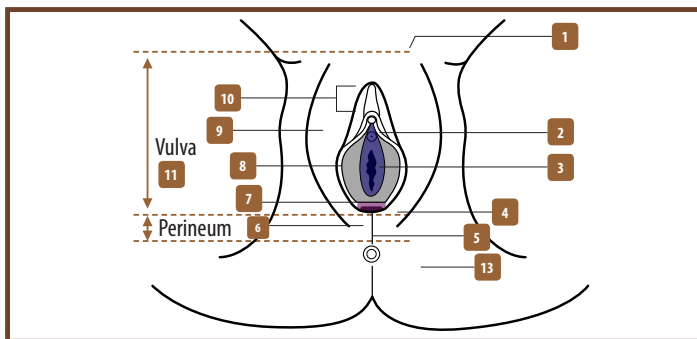
- Consent for the collection and release of the specimens (to investigators) should be obtained from the victim. The impact of the collection of specimens on the victim (both physically and psychologically) should be carefully considered.
- The account provided by the victim (or witnesses), and the time between the alleged assault and examination, will dictate whether collection should occur and what type of specimens are collected.
- Collect specimens from locations where biological material might have been deposited: skin, hair and oral, vaginal and anal orifices.
- Pay careful attention to detail in the labelling and recording of specimens collected.
- Allow any wet specimens to dry. Do not use culture media for forensic specimens.
- Collect blood and urine samples for toxicological analysis if there are allegations of covert or non-consenting drug administration.

- Document transfer of specimens (chain of custody): what, to whom and when transfer occurred. Alternatively, ensure specimens are stored appropriately.
- Take precautions against contamination: restrict access to examination facilities, ensure facilities are cleaned between cases and change gloves frequently.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014)
- Victorian Institute of Forensic Medicine. Sexual Assault: Collection of Forensic Specimens. A guide to the collection of forensic exhibits; 2015(<http://www.vifm.org/wp-content/uploads/2015/07/Specimen-Collection.pdf>, accessed 30 September 2015)

Female genitalia: definitions and comments



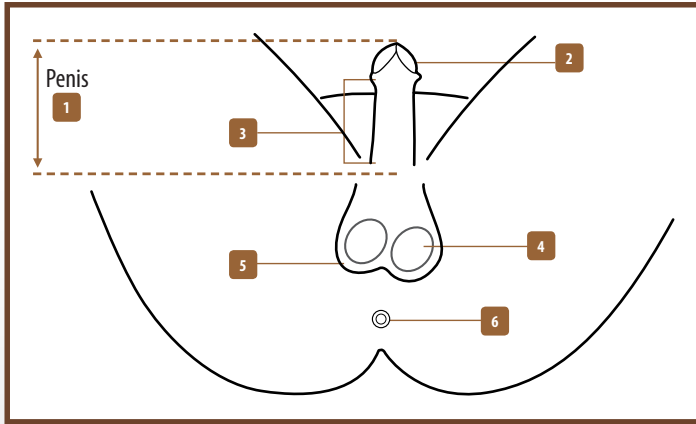
Definitions

1. **Mons pubis:** where the labia majora meet in front and covered with hair after puberty
2. **Urethral opening:** opening of the urethra to external environment to allow urine to be expelled
3. **Hymen (shaded):** membrane at the vaginal opening, almost always with a visible opening
4. **Posterior fourchette:** where the labia minora meet at the back in the midline
5. **Perineal raphe:** the visible line running from the genitalia to the anus
6. **Perineum:** region between the thighs that is bounded by the vulva in the front and the anus at the back
7. **Fossa navicularis:** the concave area between the back of the vaginal wall and the posterior fourchette
8. **Labia minora:** skin folds that cover or partially cover the hymen and vagina
9. **Labia majora:** broad skin fold that surrounds the labia minora (covered with hair after puberty)
10. **Clitoris:** erectile tissue that expands when stimulated
11. **Vulva:** all of the components of the external genitalia, including the mons pubis, labia majora, labia minora, clitoris and vaginal orifice
12. **Vagina** (not displayed): a tubular canal between the cervix and the hymen
13. **Anus:** outlet for faeces

Comments

- In most cases, penetration of the adult vagina or anus does **not** result in injury.
- The hymen may not appear injured, even after penetration has occurred. The hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girls.
- Digital examinations of the vagina and anus are rarely warranted. They should not be used to assess the tone of the orifice or to comment on the likelihood or frequency of penetration.
- Penetration of the prepubertal genitalia (and some other forms of sexually abusive actions) do not necessarily result in physical injury.

Male genitalia: definitions and comments



Definitions

1. **Penis:** male organ of copulation and of urinary excretion
2. **Glans (head):** the expanded head of the penis
3. **Shaft:** the cylinder of tissue between the body and the head of the penis
4. **Testicle:** the egg-shaped glands housed within the scrotum
5. **Scrotum:** the pouch of skin containing the male reproductive glands (testes)
6. **Anus:** outlet for faeces

Comments

- The uncircumcised male has a retractable piece of skin that may cover the glans – **the foreskin**.
- In most cases, **penetration** (or repeated penetration) of the anus does **not** result in injury or other changes.
- **Digital examination** of the anus is rarely indicated. This procedure should not be used to assess the tone of the orifice or to comment on the likelihood or frequency of penetration.
- **Sexual activity** (touching, sucking, masturbation or intercourse) rarely causes any objective changes to the male genitalia.
- **The passage of hard stools**, some medical conditions (e.g. Crohn disease), and sometimes chronic diarrhoea, may cause anal fissures and other changes.

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