Non-accidental injury

47.1 Introduction

Much trauma to children & adults is not accidental; some is indiscriminate but much is deliberate. Violence is ever more present, organized and institutionalized. In certain areas, it is heavily influenced by drug-related crime. Although it is commoner in lower socio-economic circumstances, the rich are not exempt.

Where injury is deliberate, it may be hidden both by the perpetrator and the victim, who thus may present late. Help may also not be immediately available, resulting in severe complications.

In cases of assault, look for deliberate signs of torture. Sexual violence is a type of torture.

Don't forget 'suicide attempts' may actually be cases of assault. The classical gunshot injury on the left by a right-handed person is a case in point!

Self-inflicted harm is a specific form of psychological disturbance, often represented by multiple relatively superficial cuts on arms & legs.

Specific types of injuries are described:
Rectal enema: 26.11
Circumcision: 27.29
Oil aspiration: 42.1
Strangling: 42.5
Uvulectomy: 42.6
Caustic ingestion: 43.6
Drowning: 42.7
Hypothermia: 45.2
Hyperthermia: 45.3
Gunshot wounds: 46.14
Explosions: 46.15
Volcano eruptions: 46.16
Burns (fire, hot liquids & chemical): 50.9

(a) Patterns of torture
Torture is either inflicted deliberately on political prisoners, or to extract information or confession. Maltreatment in custody is similar, with less defined aims. As such, much injury is deliberately calculated to cause maximal pain with minimal signs.

Thus you need to look carefully to assess such injuries, and document everything precisely, especially with photographs.

You should try to distinguish between maltreatment which is not life-threatening, that which is, and that which intended to kill.

Typically these are:
(1) multiple bruises, or patterned skin injuries,
(2) internal trauma to thorax & abdomen,
(3) electrical & thermal injuries,
(4) suspension by the limbs for long periods, causing rhabdomyolysis (49.9), as can multiple beatings, which may result in renal failure; or suspension by the thumb or fingers, causing their gradual necrosis,
(5) isolated ulnar fracture (63.6) (from warding off blows to the face)
(6) periosteal tibial swellings (from repeated beating of the legs),
(7) gunshot destruction ('capping') of the patella (68-10),
(8) suffocation producing either lung aspiration or cerebral hypoxia,
(9) being kept in forced positions for long, resulting in joint contractures (32.1),
(10) electrocution causing muscle contracture, fractures (especially high T1-T5 vertebral), broken teeth & jaw,
(11) burn wounds, lacerations, and remnants of foreign bodies used to inflict harm,
(12) multiple rib fractures sustained at different times,
(13) avulsion of fingernails & toenails,
(14) compression of digits by screws, stamping on them, or squeezing them together,
(15) amputation of fingers, toes & hands.

Rope marks on the limbs are tell-tale signs of forcible restraint, as CT signs of brain injury.

Falanga, the repeated beatings of bare soles of the feet or palms of the hand, is one of the most commonly used methods of torture. On the feet, it can produce: (1) plantar fasciitis, (2) rupture of the plantar aponeurosis, (3) a crushed heel, or (4) a compartment syndrome (49.6). Radiographs of hands & feet may be helpful, showing old fractures & calcifications.

Psychological torture is more frequently used, as evidence of its use is harder to prove. Mock executions, near drowning ('water boarding'). Unfortunately many governments hide their culpability by describing torture as 'allegations', implying victims invent or exaggerate their maltreatment. This does occur, though rarely: a prisoner might fear to be denied an early release that has been promised.

(b) Surgical trauma

N.B. Don't forget that operative complications are a special sort of non-accidental injury!

So, remember always to explain and discuss any surgical intervention with your patient & relaives, and obtain unforced consent.

Be very careful to persuade a patient against their better judgement, unless it is a matter of survival!

(c) Sexualized violence

INTRODUCTION

Several projects have been started in LMICs which address the challenging topic of *sexualized violence*. This term is primarily used to emphasize violence and more specifically where sexual means or targeting sexuality is used.

N.B. We should like to use the term of 'survivor' as opposed to 'victim' to emphasize resilience on the part of the patient, but the sense of many a sentence is obscured thereby.

One famous example is the famous Panzi hospital in Congo; its founder Dr. Mukwege was awarded the Nobel Peace prize for his efforts to establish a hospital dedicated to the survivors of sexualized violence in conflict.

This hospital exhibits a most vital aspect of care for survivors of sexualized violence: to provide care in a 'one-stop shop approach'. This requires that all services are available in one place, so that the patient is not discouraged having to run from one place to the other, re-tell the situation, and be re-examined all over again. Similar efforts have been made in Rwanda at the Isange one-stop shop centres where medical care is given, forensic evidence is gathered, social workers and legal advice is available and access to a safe house is granted. Such multi-disciplinary centres are difficult to establish even in rich countries, but if you are willing to tackle this challenge and if you are in charge of rolling out a strategy, this is the gold standard of care which has successfully been implemented.

Keep in mind several pitfalls when faced with this complex topic!

Sexualized violence has long been used to motivate society to wage war, either by using rape as a trophy, or, on the other hand, to use the threat of rape by the enemy as an efficient way to recruit combatants and mobilize battle strength.

These factors have an impact on numbers reported, and not only increases the complexity of the problem but may exert adverse political influence on your work.

Another aspect is that sexualized violence against men has been widely under-estimated; in fact, c.25% of men living in war-afflicted households in Congo were affected. So, if you are caring for survivors of sexual violence, don't think of this as a female problem only, and be careful of your wording, and creating implied barriers to accessing care.

Using the term, 'victim' may not always be helpful; be mindful of creating stereotypes! In Sierra Leone, for example, the UN Disarmament Demobilization and Reintegration programme offered opportunities for education, apprenticeship and public job placements for former combatants who put down their weapons. Here, as many as 75% of girl soldiers or abducted women had been raped, but they identified themselves as soldiers with rank and military roles and many, if not all, carried a weapon. However, when it came to accessing re-integration benefits, only a limited set of choices were offered to women to allow them to be financially independent. In some cases, NGOs focused on re-instating social and marital 'normality' which obliged women to 'blend in' and marry their sexual assailant.

Don't forget so-called 'troop behaviour' by regular army personnel, which has been recorded from former Yugoslavia to West Africa and Vietnam. Such behaviour may be casually passed off as 'boys will be boys', even by high ranking UN officials, although these attitudes are slowly changing, on account of more stringent consequences, and close media scrutiny.

Remember that it is difficult, often impossible, to *prove* rape in war time, although forensic evidence and DNA sampling make this much easier now. Remember though that where society perceives pre-marital sexual contact as taboo, it may be difficult to discern whether an alleged rape might be an exit strategy to mask consensual sexual activity. However, it is all too easy to accept alleged consent on the part of the woman, if claimed by the man. There is all too often a 'culture of silence' on the part of both the victims & the aggressors.

Note that sometimes rape is facilitated by adding hypnotics to drinks ; then the victim often has absolutely no recollection of the event, except for bizarre neurological or hallucinatory effects of the drugs.

A maybe unexpected knock-on effect, is that patients seeking treatment at a specialized hospital like the Panzi may claim rape in order to receive treatment for an obstetric VVF.

Remember that prevention is always better than cure! For example, lighting on paths leading to the toilets are essential, the architecture of facilities must ensure proper privacy.
Remember also that survivors are not all young!

Despite the complexity of this subject, *don't hesitate to get involved and offer as adequate care as possible* to survivors of sexualized violence no matter which gender or age group.

47.2 Traditional rituals

Surprisingly, many harmful rituals still persist, despite educational efforts. We describe a few, but would be interested to learn of others not mentioned.

(1) Umbilical sepsis & bacteraemia:
Applying cow dung or other substances to a child's umbilicus.
(2) Burns to feet (50.14f):
Fire as treatment for epilepsy.
(3) Rectal injury (57.3):
Enemas as treatment of intestinal ailments.
(4) Penile & urethral injury (57.2):
Circumcision for religious reasons.
(5) Uvula injury (42.6):
Uvulectomy for stammer or epilepsy.
(6) Head injury (51.3):
Trepanation, or thrusting a nail into the cranium for supposed witchcraft.
(7) Amputations : (as forms of punishment).

The introduction of ornaments to stretch facial skin is well-known (and has been adapted in plastic surgery flaps, 34.16) but rarely harmful.

Tattooing may, however, be not so benign, as some inks are truly permanent and may be oncogenic. Piercing various parts of the body has become widespread: obvious possible complications are bleeding & infection.

In a significant number of countries, **albinism, mental illness or congenital deformity** are associated with possession by evil spirits. Such children are often ostracized, but also distressingly penalized in various extreme ways, even including human sacrifice. The burning or use of human body parts is also widespread in some parts. Little of such practice reaches the hospitals or doctors, alas.

47.3 Child abuse

This exists unfortunately throughout the world and is much commoner than anyone really wants to believe. Out of 1 million cases reported in the USA per year, 5,000 die.

Child abuse is more common in lower socio-economic groups, but also exists in rich homes. The most vulnerable age is that of the infant between 6 & 12 months of age. Most children abused are <4yrs old, and over 50% <2yrs.

A specific sibling may be singled out for abuse; this may be physical (battered child syndrome), emotional, sexual or through wilful neglect. This may be because the care giver is underaged or minimally interactive.

A deliberately deprived child may be malnourished, dehydrated, anaemic and have growth retardation. There is often other violence or alcohol abuse at home, and a family history of abuse.
N.B. Overfeeding a child is also a form of abuse!

Child labour and child soldiers are other more extreme forms of abuse which still exist in several parts of the world, particularly, Afghanistan, Chad, Congo, Myanmar, Somalia, Sudan & Yemen. The misuse of children is not limited as fighters; they are also used as human shields, spies, sex slaves & suicide bombers.

RED FLAGS
Beware of:
(1) Inconsistent injury history, discord between history & findings, delay before presentaion, inappropriate agitation by carers, visits to different health centres,
(2) Buttock, trunk, scalp & neck bruising,
(3) Burns, especially by cigarette ends, & scalds from hot water.
(4) Solitary head, chest or abdominal injury (especially in children <3yrs: 50% fatal),
(5) Repeated fractures,
(6) Multiple fractures sustained at different times,
(7) Marks (cuts, abrasions, ecchymoses) in unusual sites, especially bites, half-hidden.
(8) Poisoning (deliberate, or by overdose, or leaving noxious substances within reach),
(9) Electrocution marks.
(10) An apathetic child.

Have a high index of suspicion, if something doesn't feel or look right. *Don't be beguiled by a sweet-talking parent or health carer.* Get advice & share findings with a colleague!

CLASSICAL INJURIES are:
(1) Fractures of the sternum, acromion, posterior rib, long bone metaphysis (47-2), both limbs simultaneously, scapula, & unsuspected fractures on radiographs.
(2) Epiphyseal separation & subperiosteal bone formation (47-3): (late coxa vara of femurs)
(3) Carpal dislocation (64.5),
(4) Anoxic head injury (from strangling),
(5) Spinal injury without radiographic changes
(6) Subdural & subarachnoid haemorrhage (from shaking) : *N.B. this may cause hypovolaemic shock in young children!*
(7) Lip & oral lacerations, torn frenulum (53.8),
(8) Dental injuries (53.2), maxillary (53.3) & mandibular fractures (53.6)
(9) Retinal haemorrhage, & hyphaema (52.9),
(10) Perineal injuries (57.1).
(11) Hot water burns, especially soles of feet, sparing popliteal fossae & medial surfaces.
(12) Multiple fractures of varying age (47-1)

DIFFERENTIAL DIAGNOSES to exclude are:
(1) Osteogenesis imperfecta
(2) Scurvy (rare <5 months)
(3) Rickets
(4) Congenital syphilis
(5) Cortical hyperostosis (Caffey's disease)
(6) Birth delivery injury (47.4)

MULTIPLE OLD OR NEW RIB FRACTURES

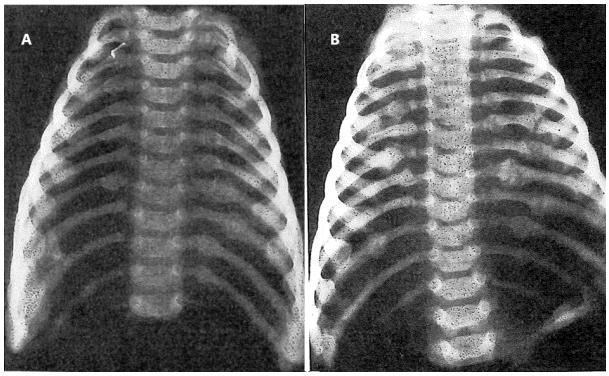

Fig. 47-1 Multiple rib fractures of varying age is a classical sign of child abuse. A, multiple fractures at posterior costochondral junctions 2-4 wks old. B, mostly 3wks old. *After Cameron JM, Rae LJ Atlas of the Battered Child Syndrome. Churchill Livingstone Edinburgh 1975.*

MULTIPLE METAPHYSEAL FRACTURES

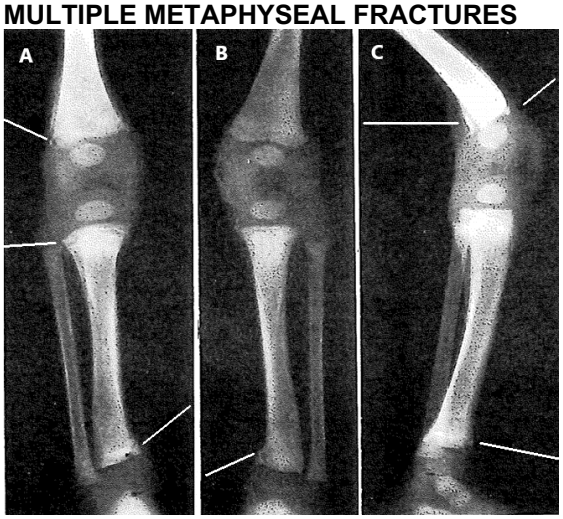

Fig. 47-2 Metaphyseal fractures of different ages in an infant of 4months. A, fragment fractures of the right distal femur, proximal & distal tibia 7-10days old. B, similar fractures on the left >10days old. C, lateral view showing more extensive damage. *After Cameron JM, Rae LJ Atlas of the Battered Child Syndrome. Churchill Livingstone Edinburgh 1975.*

SUBPERIOSTEAL HAEMATOMA

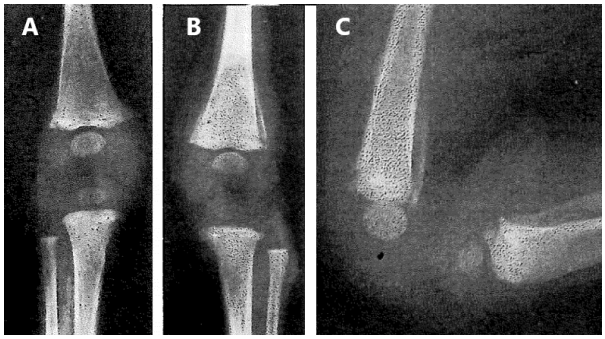

Fig. 47-3 A, Metaphyseal injuries of the distal right femur. B, periosteal calcification of the distal left knee. C, Lateral view showing this clearly. *After Cameron JM, Rae LJ Atlas of the Battered Child Syndrome. Churchill Livingstone Edinburgh 1975.*

You need to get institutional help where available, and often need to involve the police; these are difficult cases. Careful documentation is mandatory: get photographs. Pictures taken under UV light may show up bite marks well.

In case of death, an autopsy is essential (37.6), together with an examination of clothing & its state of disrepair, cleanliness & nutrition.
Check for a disparity between stasis & the position of the body, is temperature & details of whether the history & physical findings match.

47.4 Neonatal injury

Neonates are usually well protected. In utero, fetal injury may occur when a pregnant woman is hurt. The fetus is also at risk in amniocentesis, and with amniotic infection, whose adhesions may produce limb amputations or constriction bands.

The fetus is particularly at risk in delivery, from dysproportion or malpresentation, and delay in the 2nd stage of labour.

Typical injuries seen are:
(1) Petechiae, bruising & purpura on the head, or buttocks & perineum in breech delivery.
(2) Cephalhaematoma (a subpericranial haemorrhage, which is limited at suture lines): this may ossify to produce a 'volcano cone'.
(3) Intra-orbital haemorrhage leading to ptosis.
(4) Cerebral haemorrhage, especially with long labour, use of forceps or vacuum.
(5) Lacerations at Caesarean section.
(6) Scalp degloving (with use of vacuum).
(7) Clavicular fracture & brachial plexus injury (in manipulative delivery).
(8) Hepatic rupture & adrenal haemorrhage (rarely in manipulative delivery).

Minor injuries from poor nursing care include:
(1) Burns from towels too warm,
(2) Tissue necrosis from IM injections,
(3) Bruising from venepuncture,
(4) Transfixion from a nappy safety pin.

A baby may injure itself by lacerating its skin with long fingernails, bruising the head or limbs when restless, or burning is skin from acid vomitus.

Accidental injury may occur by a fall, or being dropped, or from other children; *but beware of the possibility of abuse* (47.3).

Over-enthusiastic massaging of limbs by oil may produce a femoral fracture (73.11)

47.5 Sexual violence

DEFINITIONS
The WHO defines sexual violence as: 'Any sexual act, attempt to engage in a sexual act, unwanted sexual comments or advances, act of trafficking for sexual purpose, act directed against a person's sexuality using coercion, by any person in any setting, regardless of their relationship to the victim, in any place'.

In armed conflicts, the breakdown of social infrastructures, the disintegration of families and communities and the disruption of responses leave women and girls vulnerable to sexual and other forms of gender-based violence, including rape by combatants and intimate partners or acquaintances and, at times, sexual exploitation by humanitarian carers.

Reports of the dimension of the problem are being documented more and more.

BACKGROUND
Sexual violence is no new problem in both peacetime & war. Women and girls bear the burden of insecurity and loss of access to health care in ways that have both immediate and potentially long-lasting implications. Men & children have been victims as well. Although it is difficult to obtain reliable representative figures, many societies still tolerate violence against women.

Sexual violence against women in war has existed since humans started fighting, although almost unbelievable atrocities are still being perpetrated. Many think of sexual violence in general, and rape in particular, as unfortunate but inevitable collateral damage in an armed conflicts. This can take on enormous dimensions, as armies increasingly employ traumatization of the civil population as military strategy.

"Rape is not a aggressive form of sexuality but a sexualized form of aggression."

Rape in the presence of the husband, children, or neighbours, is used to demoralize a whole community and terrorize people into leaving their land, or humiliate men by showing they cannot protect their families. Rape is also used as a tool of ethnic cleansing.

Forced pregnancies to 'dilute' the ethnic identity of the enemy or gang rapes by HIV infected men to infect their victims are part of explicit extermination strategies.

In 2001, the International Criminal Tribunal in The Hague has recognized rape as a crime against humanity. Sexual violence affects millions of people across the world. It destroys people, families, and communities. The statistics on violence against women are daunting. Rape is the world's most underreported crime.

WHO statistics suggest 20% of women globally are victims of sexual violence in their lifetime (this includes 'honour' crime, domestic

violence, rape, forced prostitution). In some countries, this figure is as high as 80%. In peacetime situations, perpetrators are often known to the victims. Most episodes of rape remain unreported because victims are unable, too scared or too ashamed, to seek assistance and be counted.

A state of shock, and shame, as well as fear of reprisal and stigmatization, are just some of the factors that contribute to victims' reluctance to speak out. Approximately, only 3% officially report sexual aggression to the police and >50% are unable to access healthcare either due to lack of means or unwillingness on the part of health providers to assist.

PREVENTION OF SEXUAL VIOLENCE; REDUCING THE RISK FACTORS

Analyzing where, how and by whom sexual violence is committed in a community is the first step at prevention. The perpetrator in peacetime is often a family member, or a tenant. Recognition of unsafe places (usually related to the location of water and sanitation) is important. Children must also learn the signs of potential sexual abuse. Many women are abused when they are in a state of inebriation or under the influence of drugs. Other women are abused in the context of marriage, where protracted violence is usually hidden.

CONSEQUENCES OF SEXUAL VIOLENCE:

Sexual violence, particularly rape, has serious negative somatic, psychological and socio-economic effects on the survivors. These include gynaecological as well as other physical injuries, sexually-transmitted infections and unwanted pregnancy.

Mental health impairment can result in long-term anxiety, post-traumatic stress disorders, depression and even suicide.

Social effects may mean expulsion from the community.

ACCESSIBILITY OF CARE FACILITIES; POPULAR ACCEPTANCE

As rape is an acute medical emergency, it requires an immediate response. Any health care provider should ensure facilities are in place so that victims are guaranteed confidentiality, privacy, and sympathy (from cleaners to doctors).

Most times, a female victim prefers to be seen (and especially examined) by a female healthcare worker.

Consultation should be easily accessible, whatever the hour of day or night, and cost-free.

Often professional counselling is limited, but everyone can be sympathetic. Many victims fear not being believed about the incident, and lack trust in unprepared professional help.

It is therefore crucial to set up a comprehensive system for provision of care and, if necessary, referral. You should write out guidelines for staff to follow and train your staff accordingly.

N.B. If you have safe housing available, or legal help, this may be of great comfort for the victim.

N.B. There is a decisive difference if a victim presents <72h after the incident or later (57-5).

Train your health care providers how to recognize victims of rape.

N.B. Although the vast majority of sexual violence is meted out to women, it may also occur to men! The victim in the text is assumed to be female.

SIGNS

Signs may vary depending on the context of the assault and the pre-exising condition & activity of the survivor.

Physical injuries may be visible but may often be internal, and so invisible. There may sometimes be no physical injuries at all, even after an incident of violence or abuse.

Signs may range in severity: bruising, bleeding vaginal or anal lacerations, fractures and dislocations. There may also be signs of incidental thoracic or abdominal injury. Walking may be impaired,

There are often hidden, psychological, mental or behavioural effects such as depression, anxiety, apathy and withdrawal, with later manifestations such as self-harming behaviour or suicidal attempts, or inappropriate use of drug and alcohol.

Many victims may not initially report what happened. Look out for vulnerable people: unaccompanied women, adolescents, children, disabled or mentally handicapped people.

Explain everything that will happen during the examination and reassure the victim that she can refuse anything she does not feel

comfortable with or stop the examination at any time. It is crucial to emphasize that the guilty party is not the victim of violence but the aggressor, and such assault is a very serious crime.

PROVIDING CARE TO RAPE SURVIVORS

If there are many victims presenting simultaneously, beware of burnout amongst staff working with survivors, because the emotional stress is enormous.

You must show empathy from the very start. Don't ever make light of the event!

N.B. You may need one or more 'safe houses' for the survivors.

MEDICAL INTERVIEW & DOCUMENTATION

Make sure the victim is not feeling unprotected. Help her to realize everything said remains confidential; this applies equally to any interpreter present. Explain that a detailed medical history and a careful but thorough examination is needed. Involve the patient throughout the process.

1ST CONTACT WITH THE RAPE SURVIVOR

Where a victim is bleeding, hypotensive or has obvious serious injuries, you need to apply ABC criteria to the treatment (41.1), but *don't omit the psychological support!* Particularly in armed conflicts, rape is very often accompanied by physical torture and intended mutilation; serious injuries in addition, outside of the genital area, are not at all unusual.

Get written consent *(without coercion)* for your examination, and obtaining laboratory samples
A victim's emotional reaction may vary depending on individual factors such as personality, age, previous experiences, and external circumstances, *e.g.* culture, level of support, and the extent & chronicity of suffered violence.

HISTORY

Take your time, and show empathy. *Don't rush your patient to get facts.* Be prepared that the survivor will have difficulty describing what happened, and may not relate a logical sequence of events.
You should concentrate on listening rather than just wanting to document the incident report form (47-3). Be very mindful that certain questions may be extraordinarily embarrassing, even hurtful. Allow the survivor space also to cry and grieve. *Don't ignore physical injuries when concentrating on the sexual assault !* Remember that there may be repeated episodes of abuse & trauma.

Explain that many questions may be difficult to answer, and that you can go back to these if the survivor is too distressed to answer. Make it your mission to show that you are on the victim's side!

Get a detailed history:
(1) date, time,
(2) number of assailants (if known),
(3) where and on what surface the attack took place,
(4) clothing removed (if any, by whom),
(5) position of both parties in the attack,
(6) resistance put up,
(7) injuries to the assailant,
(8) verbal & physical threats (*e.g.* weapons),
(9) type of sexual assault, ejaculation,
(10) use of instruments,
(11) use of a condom,
(12) loss of consciousness of the survivor.

Find out if, afterwards, the survivor has passed urine, stools, bathed or washed. Find out if there is discharge, bleeding or deep pain, and if the survivor has changed clothing.

A gynaecological history is important: parity, last menstruation, menstrual cycle irregularity, contraceptive use, and previous interventions.

EXAMINATION & DOCUMENTATION

Start with a general physical examination (heart rate, blood pressure, temperature, inspection of the skin etc). Have a previously prepared standardized specific 'rape kit' box available.

As the examination may have forensic importance, *meticulous documentation with diagrams & photographs is vital*. Adequate analgesia is of great benefit; sedation is only required in special cases.

N.B. Violence to a pregnant woman is just as much an assault to the unborn child as to the mother. Its consequences may include abortion, sepsis, haemorrhage or all three (20.2)

MEDICAL CERTIFICATE

Sample Incident Report Form

NOTE: Staff filling this form must be properly trained in interviewing survivors and in how to complete this form correctly. This form is NOT an interview or examination guide. Separate guides and forms are available that should be used for counselling and health exam/ treatment.

INCIDENT TYPE		Secondary incident type	
Case Number	Camp Name/Area of Town	Date and Time of Interview	
Previous Incident Numbers for This Client (if any)			
VICTIM/SURVIVOR INFORMATION			
Name: (optional)	Age:	Yr of Birth:	Sex
Address:	Tribe/Ethnic back-ground:	Marital Status:	Occup:
No. of Children:	Ages:	Head of family (self OR name, relationship to survivor)	
If victim/survivor is a child>>Name of Caregiver:			Relation:
THE INCIDENT			
Location:	Date:	Time of Day:	
Description of Incident (summarize circumstances, what exactly occurred, what happened afterward):			

Sample Incident Report Form - page 2 (can be copied 2-sided for easy use in the field)

PERPETRATOR INFORMATION		
Name:	No. of Perpetrators:	Sex:
Address:	Nationality: Age:	Tribe/Ethnic background:
Relationship to Victim/Survivor:	Marital Status:	Occup.:
If perpetrator unknown, describe him/her, including any identifying marks:		
Current location of perpetrator, if known: Is perpetrator a continuing threat?		
If perpetrator is a child: Name of Caregiver:		Relation:
WITNESSES		
Describe presence of any witnesses (including children):		
Names and Addresses:		
ACTION TAKEN – Any action already taken as of the date this form is completed		
Reported to	Date Reported	Action Taken
POLICE Name		
SECURITY Name		
UNHCR Name		
LOCAL LEADERS Name		
HEALTH CARE Name/nfo.		
OTHER Name		
MORE ACTION NEEDED AND PLANNED ACTION – as of the date this form is completed		
Physical Security Needs Assessment and Immediate Safety Plan:		
Has the victim/survivor received any kind of counselling – if yes, which kind?		
Is victim/survivor going to report the incident to the police? □ Yes □ No Is she/he seeking action by traditional court? □ Yes □ No		
What follow-up will be done by community development/SGBV workers?		
What further action is needed ?		
Form completed by (Print Name):		**Signature:**

Fig. 47-4 SAMPLE INCIDENT REPORT FORM. *(example from IASC Guidelines for Gender-based violence Interventions in Humanitarian Settings, Geneva, September 2005 [58]).*

Collect samples carefully and package them *without contaminating them!* (Change your gloves frequently!) Take care to label them properly!

N.B. A 'rape kit' should have Dacron swabs, sterile water, catch paper, self-adhesive seals & blood collection equipment.

You need to persuade the victim that it is important to send as much material as possible for medical analysis. *Stress that these items don't go to the police.*

Obtain:
(1) Oral swabs (in case of oro-genital contact) under the tongue, along the gums, from cheeks & palate.
(2) Sanitary towels, tampon & underwear,
(3) Finger swabs from under the nails & Dacron swabs elsewhere where saliva or semen has been deposited.
(4) Hair samples from combing the head & pubis, pulling (x5 hairs with consent!), & cutting away any matted hair.
(5) Foreign débris such as soil, leaves, sand, fibres,
(6) Wet anal swabs (collect these before genital swabs) by gently puling the buttocks apart,
(7) Wet swabs of external & internal *labia majora* & *minora*, clitoris, peri-urethral area & *fossa naviculais*, with a little gentle pressure,
(8) Vaginal swabs (before you perform an internal examination) of anterior & posterior fornix & cervical os.
(9) Blood samples depending on your facilities for DNA, HIV, Hepatitis, Syphilis etc.
(10) Urine sample for a pregnancy test.

Look for and describe carefully as abrasion, laceration, contusion, incision, or penetrating injury, noting size, shape,& age, especially:
(1) Petechial haemorrhage in the eyes (signs of strangulation), on lips & mouth,
(2) Finger nail damage and finger imprint contusions,
(3) Abrasions, especially on the neck, breasts & inner thighs (so-called 'love bites')
(4) Defence wounds in the hands,
(5) The surface the body was forced against,
(6) Peri-anal and perineal lacerations & bruising: *N.B. the abscence or presence of tears of the hymen can be misleading!*
(7) Vaginal contusions (darker red than the normal mucosa), especially anteriorly on the lower $^1/_3$ & posteriorly on the upper $^1/_3$, and lacerations which may extend deeply or into the perineum.

N.B. You may need to re-examine wounds 24-48h later, as bruising may only become visible later!

N.B. Keep copies of your documentation; make sure everything is legible!

PREGNANCY MANAGEMENT

Determine whether the victim is already pregnant. History and the pregnancy test will help: if the test is +ve within 2wks of the rape assault, the pregnancy is *not the result of the rape*.

If you cannot perform a pregnancy test, consider offering emergency contraception, as this will not harm a pre-existing pregnancy: use 1.5mg Levonorgestrel once, or x2 0.1mg Ethinyloestradiol with 0.5mg of Levonorgestrel 12h apart.

Therapeutic abortion may be indicated but you must abide by the wishes of the victim and her family, and the relevant laws of the country in place.

STI PREVENTION & TREATMENT

Prophylaxis against chlamydia, gonorrhoea, syphilis & chancroid as well as trichomoniasis depending on its prevalence is recommended. Administer 400 mg cefixime plus 1g azithromycin & 2g metronidazole as single doses. Adjust these doses for children, and divide doses in pregnant or lactating women. You may need to add an anti-emetic, and proton-pump inhibitor, because these large doses of antibiotics often cause nausea. Repeat the dose of antibiotic if vomiting occurs within 2h of taking the treatment.

Post-exposure prophylaxis to HIV is advised in most situations where the culprit is unknown (and even if he is), and it is <72h after the incident. Check the HIV status of the victim as well, in case treatment is needed. Repeat this test after 3-6months. Preferred regimes are: Zidovudine 300 mg + Lamivudine 150 mg bd, for 4wks. An alternative regime is: Tenofovir + Lamivudine or Stavudine + Lamivudin.
This will be the most common treatment; triple PEP is indicated only in situations when drug resistance of the source person is known or expected (when the background prevalence of resistance to ART in the community exceeds 15%).

If drug resistance is suspected and a 3rd drug is considered necessary, it should be a boosted-protease inhibitor, *not* a non-nucleoside reverse-transcriptase inhibitor.

Recommended 3-drug combination therapy including a boosted protease inhibitor for HIV post-exposure prophylaxis is: Zidovudine 300mg + Lamivudine 150mg (combined) bd plus Lopinavir/Ritonavir 200mg/50mg bd for 4wks.
Modification of the regimen or adapting the dosage may be necessary for children, pregnant and breastfeeding women or in settings where some of the mentioned drugs are not accessible.

Administer hepatitis B vaccine series into the *deltoid* or anterolateral thigh (in children) if the victim has not been previously immunised; if the immunisation is incomplete or long ago, administer a booster dose. The vaccine is safe for pregnant and breastfeeding women. Symptomatic or asymptomatic HIV infection is *not* a contra-indication. You can administer it at the same time as tetanus vaccine.

N.B. Administer anti-tetanus toxoid according, if there are dirty or contaminated wounds, to unprotected victims.

Medical certification

This document (47-4) contains details of the physical (and psychological) examination. Objective findings, illustrative drawings and, if possible, photographs should describe the victim's condition. Although you cannot verify rape, you can provide evidence of injuries sustained. The document is highly confidential, but you should offer one original dated and signed copy to every victim of sexual violence. In case of child victims, you might offer the document to the parents (provided of course they are not the perpetrators). It may be used in court as legal evidence to achieve justice or for other purposes (i.e. seeking political asylum or accessing other support programmes). Keep one copy of the document in a secure place.

47.6 Female genital mutilation

INTRODUCTION

The impact on the lives of women & girls from female genital mutilation (FGM) is enormous. This traditional practice, sometimes known as female circumcision, or female genital cutting, has its aim centred around female chastity and purity. However, it is usually carried out in non-sterile conditions with primitive instruments, frequently without anaesthesia. There are often terrible, serious lifelong consequences. You must challenge its *raison d'être*: *it is not helpful, not necessary, not a religious requirement, and does not fulfil its supposed purpose*. Furthermore, the girls on whom it is inflicted receive neither a full explanation how it is done nor what complications might ensue, and they are rarely given an informed choice in the matter.

Many believe that FGM is a Muslim requirement, but it is not. It was carried out 5000yrs ago, and is still practiced in several countries in West, Central & East Africa & Arabia. Some 24 countries where FGM is most performed have legislation concerning its practice.

CLASSIFICATION OF FGM

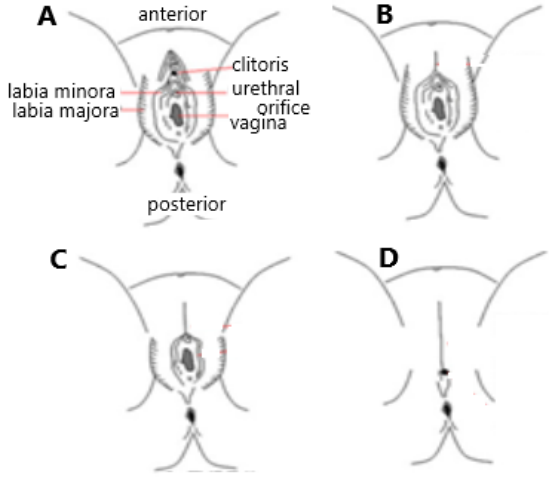

Fig. 47-5 TYPES OF FGM. A, normal. B, Type I a, removal of prepuce only, b, with part or whole of clitoris. C, Type II Clitoridectomy + excision of *labia minora* in part or whole. D, Type III Infibulation (removal of all vulval structures, leaving only a small opening for urine & menstrual flow)
.https://www.flickr.com/photos/blatantworld/5052042821

Many reasons for FGM are given: tradition, social acceptance, religious cleanliness, prevention of promiscuity & adultery, preservation of virginity. Tradition far outweighs other reasons, and FGM is often seen as necessary to improve a woman's chances in marriage.
The role of religion in FGM is, however, important, and it is practiced by Russian Coptic Christians, Israeli Bedouins, Ethiopian Jewish Fallasha, as well as by several Islamic groups. The Bible nor the Qu'ran condone its practice, however.

CLASSIFICATION
The WHO has defined 4 categories:
(1) Preputial removal with or without part or the entire clitoris.
(2) Clitoridectomy + partial or total excision of the *labia minora.*
(3) Infibulation with removal of part or all of the external genitalia with closure of the the vaginal opening, leaving a small passage for urine & menstrual blood.
(4) Other procedures including piercing, tattooing and cosmetic labiaplasty.

RESULTS
The operation may be carried out from birth to adulthood; in some cases the legs are kept apart by paste, and in others bandaged together.

The outcome depends on the age of the child, the type of intervention, the conditions under which it is performed, the general health of the girl, and the skill of the operator. However some 80-90% of victims need medical, surgical, or psychological help. Because of social taboos, they often never get any such assistance.

Although most severe consequences are from infibulation, all other interventions may cause long-lasting problems.

COMPLICATIONS
The most common acute complications are bleeding, infection (often leading to abscess formation or septicaemia), and pain so severe that long-term psychological *sequelae* ensue. Death may result from any of these, including from tetanus, but the mortality is unknown.

The commonest long-term problems are recurrent & persistent urinary tract infection, or chronic PID, both of which impact on menstruation & fertility.

Trauma to adjacent structures, such as the urethra, vagina, perineum & anus, is also common. Results may be: (1) permanent incontinence, (2) chronic urinary retention, (3) swelling & deformity of vagina & vulva.

Where wounds do not heal properly, they may result in fistula formation, keloid, or contracture.

Urethral stenosis will cause incomplete bladder emptying, recurrent urinary infection and stone formation.

Vaginal closure may result in haematocolpos or vaginal stricture (23.17).

The major problem for most young women begins with marriage. In many cases, the vaginal orifice is so small that sexual intercourse is impossible. This may result in attempts by the new husband to 'open up' the wife. This often entails the use of razor blades or other sharp instruments, again without sterile precautions or anaesthesia.

Severe haemorrhage, further uro-genital damage (including VVF, 21.18), & chronic pelvic pain may result.

If anal intercourse takes place as an alternative, this may lead to anal fissure, sphincter incontinence or recto-vaginal fistula.

Dyspareunia is a major issue in up to 65% of cases.

If pregnancy is achieved, prolonged labour, perineal tears, vaginal haemorrhage, and other causes for difficult delivery are commonplace.

Psychological consequences are often severe, diverse and long-standing, leading to post-traumatic stress & depression.

EXAMINATION
In areas where FGM is frequent, women may be extremely reluctant or outright refuse to be examined by a man. They may even not wish to discuss any problem related to FGM, and may present with symptoms that appear unrelated.

Therefore (unless you are female!), you may need to instruct a female assistant how to examine the perineal area and what to look for. A good idea is to produce pre-printed diagrams to draw on.

RECONSTRUCTION
Whilst physiotherapy may restore pelvic floor function and reduces pain, psychotherapy and counselling are essential to treat a woman's suffering, as she rarely can lightly accept FGM even though her society does.
The anatomy may be so distorted that identifying normal structures is difficult. Various restorative measures can be relatively simple to perform; however, *don't perform these under LA* as this will only serve to remind the victim of their first experience.
DE-INFIBULATION (GRADE 2.4)
Divide the skin or scar tissue closing the vaginal orifice, working from the free lower edge to the apex just above the root of the clitoris. Then freshen the edges of the 2 flaps you have made, and suture these to re-create the *labia minora.* Sometimes you may need to suture the skin back onto itself to achieve a good anatomical result. *It is important for the patient to wash, clean & dry the area scrupulously post-operatively if there is any urinary leakage.*

N.B. In severe cases, reconstructive pelvic floor surgery may be necessary.

The aim is to make a functional accessible vagina & to visualize the urethral opening. Most women wish to look normal, feel comfortable, pass urine without obstruction, and have sexual intercourse without fear.

If you perform this procedure at delivery, carry out an anterior episiotomy.
N.B. Don't let inexperienced personnel do this as urethral damage might otherwise easily occur.
N.B. Without an episiotomy, obstructed labour may result in major lacerations, urethral avulsion and fistulae.

DE-INFIBULATION

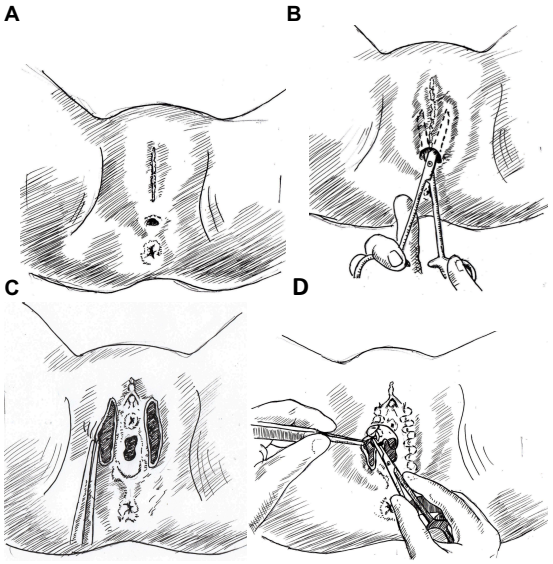

Fig. 47-6 DE-INFIBULATION. A, Insert LA around the perineum, B, divide the scar tissue from below to above the root of the clitoris. C, freshen the edges. D, suture the 2 flaps to re-create the *labia minora* & *majora.*