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# Child Sexual Abuse in Malawi

A retrospective audit of documented cases at Queen Elizabeth Central  
Hospital, Blantyre, in 2009

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## 1. Executive Summary

Child abuse in different forms, ranging from domestic violence against children to sexual abuse, is a worldwide phenomenon with a dramatic influence on the future of the abused child. In African countries, the number of reported cases is rising which may be a result of increased awareness amongst medical staff and parents. In sub-Saharan Africa, outside South Africa, there has been limited research on child abuse, in particular on child sexual abuse, and little is known about the extent of health services offered to the victims.

The Ministry of Health in Malawi introduced national guidelines for the management of sexual assault and rape in November 2005. These include sections on child sexual abuse, dealing with the definition and clinical examination, medical treatment for sexually transmitted diseases, post HIV exposure prophylaxis and emergency contraception.

At Queen Elizabeth Central Hospital (QECH), the largest teaching hospital in Malawi, a service for victims is offered, responding to the rising incidence of Child Sexual Abuse (CSA) in Malawi. A standard protocol form was introduced in 2007 to guide the medical examiner in collecting necessary information of children presenting with alleged abuse. To further improve the service offered to those children, training was provided to the medical personnel regarding the interpretation of clinical signs and symptoms. The Blantyre Child Protection Team, a collaboration between social welfare, police, judicial and medical staff, was established in February 2009.

The aim of this retrospective study was to audit the service offered to families and children presenting to QECH in 2009 following an allegation of CSA. Collected data included demographic details (e. g. age, sex, source of referral), the type, nature and extent of abuse and the person who reported it as well as details surrounding the disclosure of the abuse. Furthermore, details about the clinical findings and the received treatment were collected. The use of the protocol was assessed, shortcomings in the care of the children identified and recommendations were made. Finally, the introduced protocol and clinical care were compared with regard to the prescribed national guidelines.

In 2009, 128 children, with an median age of seven years, ranging from one to fourteen years, presented at QECH with alleged sexual abuse, an increase of almost 30% compared to a previous study done by Chesshyre and Molyneux in 2009 (Chesshyre, Molyneux 2009). The great majority of the children was female, and, in most cases, presented with mild physical signs of abuse. Over 80% (82%, 105/128) of the children were referred to the hospital by the police, and were referred from a distance within 10km around QECH. The majority presented within 72 hours after the assault. The perpetrators were known in 70% (89/128) of cases. A small percentage was family members; 17% (22/128) of the perpetrators were adolescent. Only 15% (19/128) of the children disclosed purposely to a trusted person, most of the disclosure was accidental either due to witnesses or because of physical signs that sparked the suspicion of abuse.

The standard protocol included all the points of medical examination and treatment as recommended by the national guidelines, except that in 2009 psychological counseling was not yet available. The medication for Post Exposure Prophylaxis (PEP) and Sexually Transmitted Infection (STI) chosen at QECH were in keeping with those stated in the guidelines.

The physical examination revealed signs of sexual abuse in 65% (83/128) of the cases, no gross injuries like perineal tears, Grade 2 and 3, or anal tears were found. STIs were suspected in 11% (14/128) of the presenting children. HIV tests were performed in 72% (92/128) of cases, a non reactive test result was reported in 75% (69/92), of which 64% (44/69) of the children received PEP as documented. A baseline hemoglobin test was not performed.

In more than half the cases STI treatment was administered. Emergency contraception was prescribed twice; however, in one case, it was unclear if the girl received it. In 16 girls of 11 years and older, the menarchal status was not documented although penetrative abuse was suspected.

While 44% (56/128) of the files reported a follow-up date, data about the follow-up assessment was not collected.

Generally, about 20% of the files show a lack of documentation concerning HIV testing (19%, 25/128), test results (22%, 20/92) and administration of PEP for those eligible (24%, 14/58). STI treatment was not documented in

30% (39/128) of cases and documentation was missing in 52% (16/31) of cases where emergency contraception should have been considered. In 17% (22/128) the handwriting of the examiner was illegible to the principle investigator and contact details were insufficient in 12.5% (16/128). Although recommended, the children were examined by a female clinician in only 37% (47/128) of cases.

The limitations about the value of the demographic data are discussed as the study population is mainly from the urban area of Blantyre and mainly those who have reported the alleged crime to the police prior to being sent for medical assessment.

The necessity of meticulous documentation for data collection, service evaluation, and possible presentation at court is stressed and recommendations are made for an expansion of the service to other district hospitals including the training of pediatric staff and sensitizing health workers and community towards a further increase in using the health service for the benefit of CSA children.

## 2. Introduction and background information

Over the last few decades steadily rising awareness of child abuse (Wissow 1995), along with the realization of children's rights have contributed towards changing attitudes concerning children's status in society. Well resourced countries have implemented specialized child health and child welfare services for over two decades. However, many African countries do not yet offer these specialized services and are therefore failing to fulfill their children's rights to be protected against abuse and neglect and furthermore failing to appropriately care for abused children (African charter on the rights and welfare of the child, 1990).

In Africa, the prevalence of child sexual abuse is alarmingly high. A meta-analysis of 217 publications about the prevalence of CSA around the world done by Stoltenborgh et al in 2011 found that CSA rates in Africa range among the highest in the world concerning girls (200/1000) and is the highest rate worldwide concerning boys (193/1000) (Stoltenborgh et al. 2011). A very recent representative cluster survey study in Swaziland revealed that more than a third of the respondents were sexually abused before the age of 18 years (Reza et al. 2009). A study performed in Cameroon in 2009 which interviewed 37 719 women revealed that one woman in every 19 was raped, with more than half being raped before the age of 15 and that the number of rapes has been steadily increasing since 1980 (Ndonko et al. 2009). Notably, these figures only indicate reports of sexual abuse and not of any other aspects of child abuse such as physical abuse, emotional abuse and the most common type of child abuse: neglect (Wissow 1995).

While there is a paucity of reports on child sexual abuse in Malawi (Lalor 2004, p.457), media reports on abuse appear to be increasing (Namasasu, van der Hoeven et al. November 2005). A comprehensive survey performed in 2005 focusing on gender-based violence in Malawian schools found that 99% of the interviewed school children reported being victims of bullying and about 25% had been forced to have sex without their consent. Furthermore, the survey showed that girls were more likely to be victims of violence, that repeated victimization was common, that violence was exerted more often in

rural than in urban areas and that sexual abuse occurred predominantly at home (Burton 2005). These findings are in line with those from Swaziland. Although more than 60% of the offenses were reported to someone, in case of sexual abuse, mainly to the parents (Burton 2005), little action was taken, i. e. seeking medical care or reporting to the police. In addition, the majority of the Malawian school children interviewed apparently knew about their rights regarding their bodies and sexuality but failed to translate this knowledge into appropriate action (Burton 2005).

Although the Malawian health service guidelines for care of abused children provide a definition of CSA quoted from WHO 2003: “Child sexual assault is the involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society”, a large obstacle placed on reporting any kind of maltreatment of children to police or welfare services was disagreement regarding the exact definition of child abuse (Levett 1991). As Anne Levett stated in her article “behaviours which are seen as abusive and sexual in one cultural context may not be seen as such in another” (Levett 1991, p.11). This statement can also be translated to different socio-economic contexts and thus to the inter-individual level, where two people can have a very different view on what they consider to be child abuse (Lachman 1996). That dilemma is not solved easily as it requires a broad educational campaign and clear guidelines to all members of the community and public. This is especially urgent as the very newly enacted Child Care, Protection and Justice Bill of Malawi includes the compulsory reporting of alleged cases of child abuse by medical officers, family members, child care providers and members of the community who can be legally penalized for failing to do so (Child Care, Protection and Justice Bill, 2010, Section 33 – 36, enacted 29/7/2010).

Overall the numbers of reported cases of child abuse and in particular child sexual abuse are generally increasing in Malawi (Chesshyre, Molyneux 2009), probably accountable to the parents’ fear of a subsequent HIV infection of the abused child due to a high prevalence of HIV infection in the community

(personal communication with Dr. Neil Kennedy, Head of Department of Pediatrics & Child Health, Queen Elizabeth Central Hospital).

The consequences of abuse are manifold including physical, psychological and social problems (Ndonko et al. 2009). While the long-term consequences are largely psychological and social with an increased prevalence of depression, anxiety and substance abuse (Wissow 1995, Reza et al. 2009), the short term consequences include acute physical as well as emotional trauma, STIs, including HIV and unwanted pregnancies. Thus a physical examination after the disclosure and reporting of the incident is mandatory in order to provide any necessary prophylaxis or treatment and to collect any evidence of the abuse. In addition psychosocial intervention is indicated and beneficial (Cohen 1985).

At present the Malawian health service guidelines for care of abused children emphasize the reduction of short-term consequences with treatment of STIs, the prescription of HIV post exposure prophylaxis and the provision of emergency contraception. The National guidelines also recommend provision of counseling on post-traumatic stress, if available (Namasasu, van der Hoeven et al. November 2005).

As medical personnel are crucial in the detection and identification of possible abuse and the provision of health care to alleged cases, it is most important that they are well trained in examining a victim and recognizing all possible signs and symptoms. The already victimized child requires the utmost consideration and compassion and a professional handling of the assessment to prevent unnecessary negative experiences for the child.

The medical service for victims of CSA offered by the pediatric department at Queen Elizabeth Central Hospital aims to provide high quality care and it is important to know if this service is functioning according to national and international guidelines. Thus, the aim of this retrospective study was to audit the service offered to families and children presenting to QECH in 2009 following an allegation of CSA.

### 3. Methods

#### *Study design and study period*

The study is a retrospective analysis of documented CSA cases reporting to Queen Elizabeth Central Hospital in Blantyre between 1<sup>st</sup> of January and 31<sup>st</sup> of December 2009.

#### *Study setting*

Queen Elizabeth Central Hospital is the largest hospital in Malawi and the teaching hospital for the University of Malawi/ College of Medicine. It is a tertiary level referral hospital but also functions as a district hospital for Blantyre Health District. In addition, there are close academic links to several universities abroad like University of Liverpool, University of Edinburg, University of Dundee and University of Michigan.

The data were originally collected from the Accident and Emergency Department of Pediatric Medicine. A separate examination room is assigned for the assessment of alleged CSA victims equipped with the necessary instruments (including a rapid HIV test kit) and medication (with the exception of emergency contraception) to allow a smooth and practical “one-stop” service.

The department uses a standard protocol which was introduced in 2007, to guide the medical examiner in collecting necessary information from children presenting with alleged sexual abuse (see appendix). This protocol consists of three pages. The first page allows for documentation of contact details and the history taken from the victim or an accompanying adult, details concerning present symptoms and any medical history that could be of relevance to the present wellbeing of the child. The second page allows for documentation of the physical examination of the child, with a diagram of the genital region to add drawings for further details (different copies for boys and girls are available). The examiner is asked to write down a conclusion at the end of the page. In a box at the bottom the opportunity is given to document HIV testing, PEP, antibiotic treatment, emergency contraception and whether a follow-up appointment was made. The last page consists of a report which is meant to be handed over to the police by the victim, with a copy remaining in the department. Included is a consent - concerning the clinical examination and

the data transfer to the police - which needs to be signed by the accompanying adult, a witness' signature, details of the examining clinicians and an additional agreement for a second clinician. A short summary of the history and the physical examination should be included and a final conclusion signed by the clinician who wrote the report.

To ensure quality standard of care service to sexually abused children, training was provided to the medical personnel in how to interpret clinical signs and symptoms. The Blantyre Child Protection Team, a collaboration between social welfare, police, judicial and medical staff, was established in February 2009.

#### *Study population*

All children presenting with alleged Child Sexual Abuse during the study period at QECH were selected regardless of the nature or extent of sexual abuse, in total 128 files. Files reporting physical abuse were excluded. Definition of a child is age 0 up to 18 years.

#### *Data management and analysis*

The files were recorded and analyzed using Microsoft Excel in regard of demographic data, physical findings and the medical care received by the alleged victims of CSA.

The results were compared to the Guidelines for the Management of Sexual Assault & Rape in Malawi, which was published by the Ministry of Health in November 2005 (Namasasu, van der Hoeven et al. November 2005).

#### *Audit criteria*

The audit criteria were extracted from the standard protocol and national guidelines which provide clear guidance how to manage children after an incident of sexual abuse. According to the accepted standards the study looked at the following criteria:

- Proportion of cases where consent to conduct physical examination was obtained.
- Proportion of files where documented history was conclusive, giving a clear description of when and how the abuse took place. Details given

about the nature of the abuse, the perpetrator, the mode of disclosure and the time of the incident were used to present qualitative data.

The mode of disclosure was defined as purposeful disclosure, where the children disclosed to a trusted person without any external stimuli such as witnesses or questioning, whereas accidental disclosure suggests disclosure due to external stimuli. The second group was further divided into 3 categories where: (1) Either witnesses led to the questioning of the victim; (2) Signs or symptoms led to a suspicion of abuse or (3) An oblique reference of the victim started the suspicion which led to further questioning. This classification partly follows the classification chosen in a study done by Paula Schaeffer et al in 2010 (Schaeffer, Leventhal & Asnes 2011).

- Proportion of cases where the physical findings suggest sexual abuse, are not determinate for abuse or could be also caused by other medical conditions. The chosen categorization is following those outlined in the guidelines of Adams et al. (Adams et al. 2007). A summary is shown below:

<b>Category of physical findings</b>	<b>Examples of findings</b>
I. Normal variants	<ul style="list-style-type: none"> <li>- Intravaginal ridges or columns</li> <li>- Hymenal bumps or mounds</li> <li>- Hymenal notch in the superior half of the hymenal rim</li> </ul>
II. Findings commonly caused by other medical conditions	<ul style="list-style-type: none"> <li>- Erythema of the vestibule, penis, scrotum or perianal tissues (often due to irritants, infection or trauma)</li> <li>- Vaginal discharge (often due to infectious and non-</li> </ul>

	<p>infectious causes)</p> <ul style="list-style-type: none"> <li>- Anal fissures (usually due to constipation, perianal irritation)</li> </ul>
<p>III. Indeterminate findings (may support a child's disclosure of sexual abuse but are not diagnostic evidence in case of no disclosure)</p>	<ul style="list-style-type: none"> <li>- Wart-like lesions in the genital or anal region</li> <li>- Deep notches or clefts in the posterior rim of the hymen in pre-pubertal girls, located between 4 and 8 o'clock, in contrast to transections</li> <li>- Deep notches or clefts in the hymen at 3 or 9 o'clock in adolescent girls</li> </ul>
<p>IV. Findings diagnostic of trauma and/or sexual contact (support a disclosure of sexual abuse and are highly suggestive of abuse in the absence of disclosure)</p>	<ul style="list-style-type: none"> <li>- Acute trauma (i.e. Lacerations, bruising) to external genital/ anal tissue</li> <li>- Injuries indicative of blunt force penetration trauma</li> <li>- Positive confirmed culture for gonorrhea, syphilis, Trichomonas vaginalis (in a child older than 1 year of age) and Chlamydia (in a child older than 3 years)</li> <li>- Positive serology for HIV (if vertical transmission, transmission from blood products and needle contamination has been</li> </ul>

	<p>ruled out)</p> <ul style="list-style-type: none"> <li>- Pregnancy</li> <li>- Sperm identified from a child's body</li> </ul>
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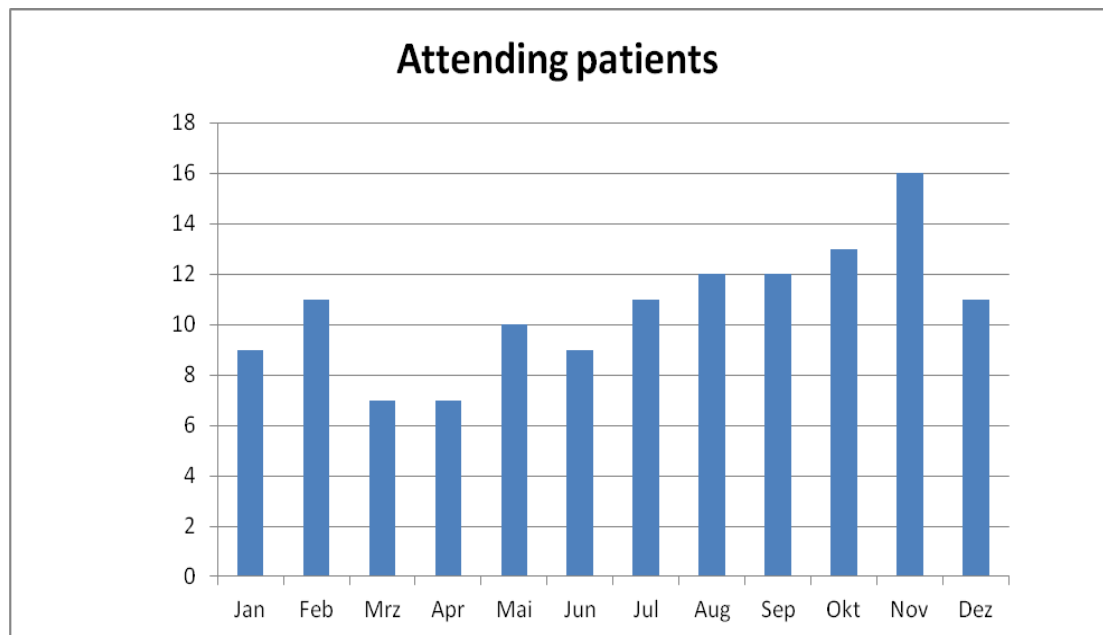
Table 1: Categories of physical findings supporting the allegation of sexual abuse according to the guidelines of Adams et al., 2007

- Proportion of cases where a comprehensive documentation about the physical findings led to the examiners impression that sexual abuse could be confirmed.
- Proportion of children who received HIV testing and PEP, presumptive STI treatment and/or emergency contraception (if indicated).
- Proportion of PEP eligible children where a baseline hemoglobin reading was done.
- Proportion of children who received post rape counseling.
- Proportion of children who were asked to come to a follow-up appointment.
- Proportion of children who were examined by a female health worker with a second medical professional present.

#### 4. Results

##### *Demographic data*

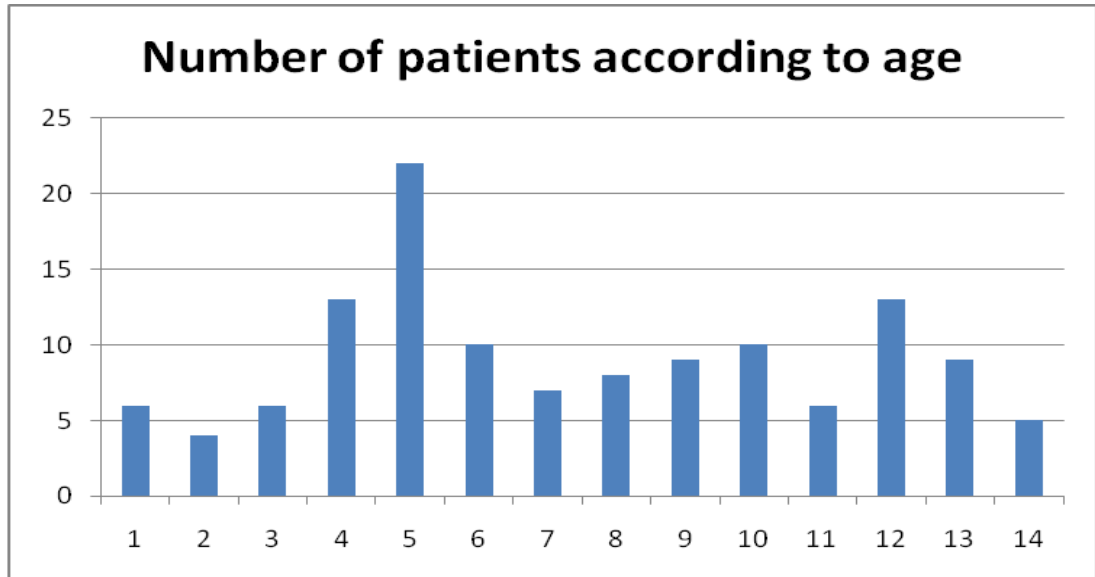
In 2009, the department of pediatrics provided medical services to 128 children presenting after alleged sexual abuse. This is an average of 10.7 (SD 2.84) children per month. The number of children attending per month increased during the year from a mean of 8.8 children/ months (SD 1.97) in the first six months to a mean of 12.5 (SD 1.87) children/months in the second half of the year. (graph 1)



Graph 1: Number of children presenting with alleged child sexual abuse to Queen Elizabeth Central Hospital per month in 2009

The great majority of the children presenting were female (124/128, 97%), four of the children were male (4/128, 3%).

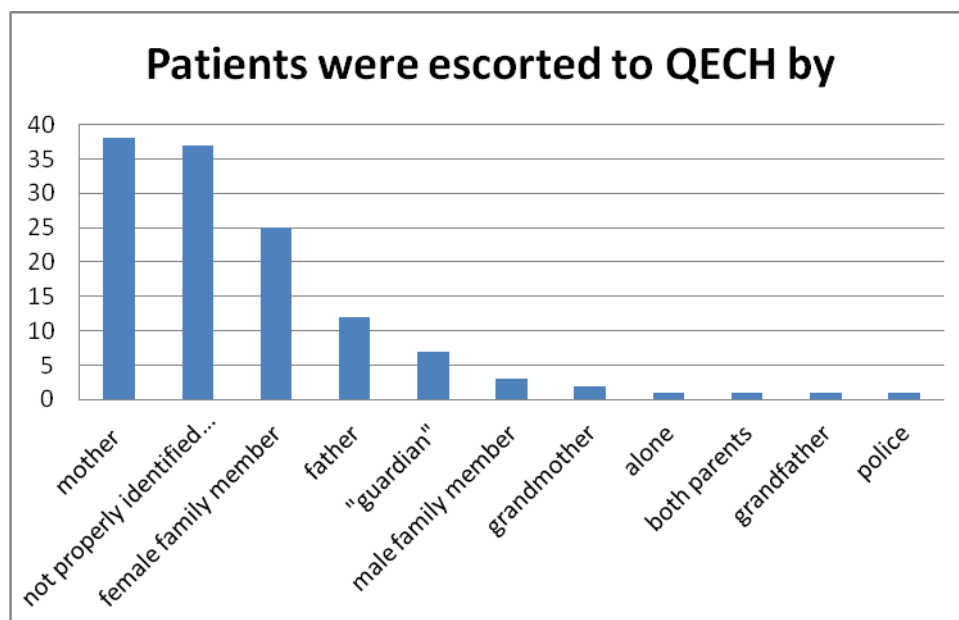
The median age of all presenting children was seven years, ranging from 17 months to 14 years, the mode is 5 years. (graph 2) The percentage of children under five years of age was 23% (29/128), 52% (66/128) of the children were between 5 and 10 years of age and 26% (33/128) were between 11 and 14 years.



Graph 2: Number of patients according to years of age presenting with CSA at Queen Elizabeth Central Hospital in 2009

In 82% of the cases (105/128), the patients were referred to Queen Elizabeth Central Hospital by the police, only 16% (21/128) came straight for medical attention. Of those referred, 36% (38/105) reported the assault to the police the same day, 26% (27/105) reported the following day. Twenty percent presented between 2 and 3 days after the assault and 18% (19/105) after more than three days. Comparing the dates on the police referral letters and on the medical reports, 52% (55/105) of the victims sought medical attention on the day they reported the incident to the police, while the remaining 48% (50/105) presented the following day.

Most of the victims came to the hospital with a female family member. In 30% (38/128) of all cases, the accompanying adult was documented to be the mother while in 20% (25/128), the exact relationship was not documented. Fathers accompanied 9% (12/128) of the children, whereas others were accompanied by different family members such as grandparents and others, details shown in the graph below. One child arrived entirely unaccompanied and one came in the company of the police. In 29% (37/128), the escorting adult was not identified and recorded on the file. (graph 3)



Graph 3: Identification of adults escorting the children to seek health service at QECH after alleged CSA.

The majority of children (106/128, 83%) seeking health service after an assault lived within 10km of the Queen Elizabeth Central Hospital. From those reported, the areas with the highest incidence of CSA are within the urban area of Blantyre, particularly suburbs with low income and known for poverty, such as Mbayani, Chirimba and Ndirande (see Appendix). (table 2)  
In 9 cases (7%) the home address was not indicated.

Area with most victims of CSA presenting at QECH	Number of children	Percentage(out of 128)
Manase (Blantyre urban)	5	4
Machinjiri (rural)	6	5
Soche (Blantyre urban)	7	5
Mbayani (Blantyre urban)	8	6
Chirimba (Blantyre urban)	9	7
Blantyre City	12	9

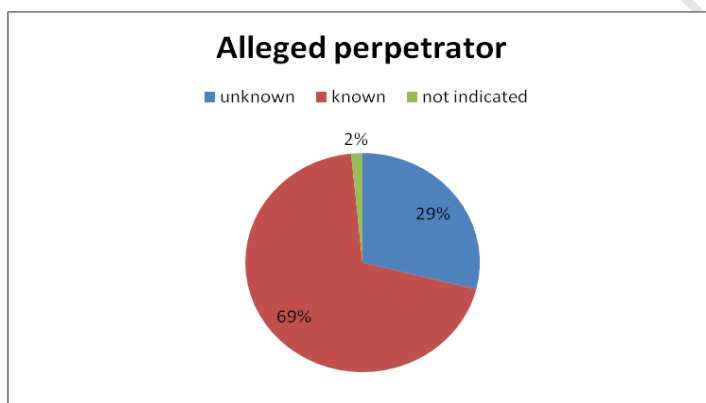
Ndirande (Blantyre urban)	19	15
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Table 2: Distribution of CSA cases according to area of living

*Details from the history*

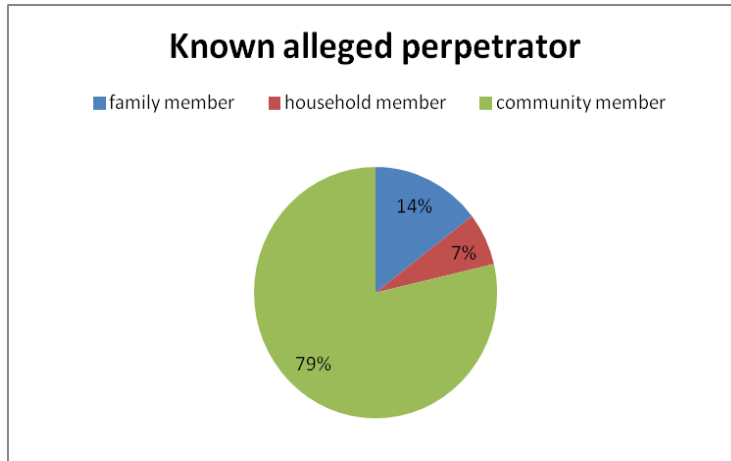
In 63% (80/128) of the cases, the alleged sexual abuse was reported to have happened for the first time. Twenty two children, 17%, however, reported repeated occurrences of abuse. In 12% (15/128) of the cases, the frequency of the abuse was not known and in 9% (11/128) nothing was indicated on the medical record.

The alleged sexual abuse was committed by an unknown perpetrator in 29% (37/128) and by a known person in 70% (89/128) of the cases. (graph4) All known perpetrators were male.



Graph 4: Alleged perpetrator

The known alleged perpetrator was a member of the community in 78% (70/89), a family member in 15% (13/89) and a member of the household (either working in the house or living with the family) in 7% (6/89) of cases. (graph5)



Graph 5: Categorization of known alleged perpetrators

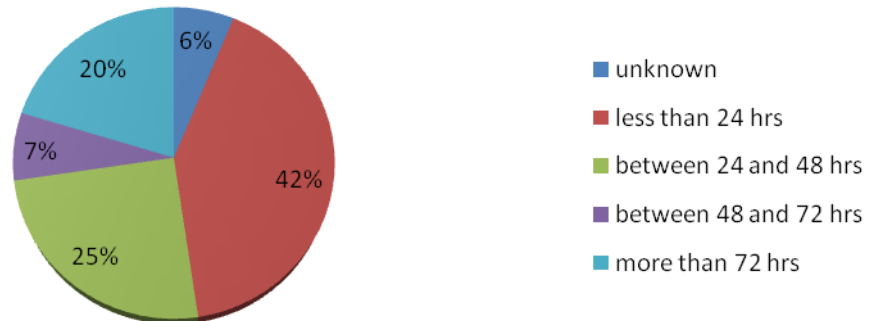
From the perpetrators among family members, 7 out of 13 (54%) were uncles, 2 out of 13 (15%) fathers and in one case, a stepfather (8%). In three cases (23%) the perpetrator was documented being a “relative”.

In 17% (22/128) of cases the age of the perpetrators was reported to be under the age of 18 years. One perpetrator was known HIV positive.

In summary, the history was regarded conclusive in 77% (99/128) (this is regardless whether the mode of disclosure was stated), and inconclusive in 21% and not documented in two cases (2%).

The time between the reported incidents and receiving medical care was less than 24 hours in 42% (53/128) of cases, between 24 and 48 hours in 25% (32/128) and between 48 and 72 hours in 7% (9/128) of the cases. In 20% (26/128) of all cases, the time lapsed was more than 72 hours. The time between the reported incidents and receiving medical care was unknown or not indicated in 6% (8/128) of cases. The percentages are again presented in graph 6:

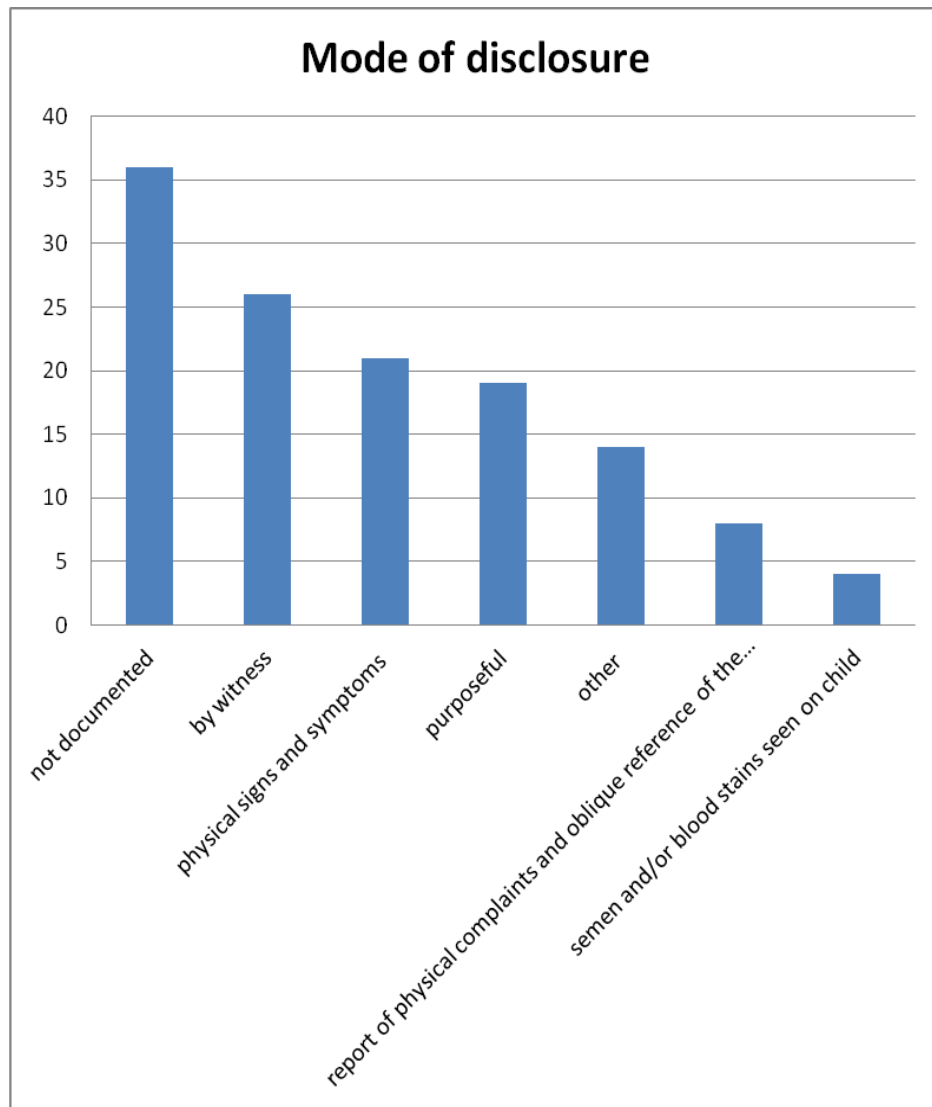
### Time between incident and received health service (n= 128)



Graph 6: Time difference between the alleged abuse and the received health service at Queen Elizabeth Central Hospital

#### *Mode of disclosure*

Purposeful disclosure to another person like their mother, father, a friend or the police (one child went directly to the police station after the assault) occurred in 15% of cases (19/128). In 20% (26/128), the incident was witnessed by other children, neighbours or the mother. In 20% (25/128), physical signs and symptoms of the children or the discovery of blood or semen stains led to questioning and consequently to disclosure by the child. Reporting physical complaints and oblique referencing led to questioning and disclosure in 6% (8/128) of cases. Details about the disclosure of the incident by the children were not documented in 28% (36/128) of cases. In the other 11% (14/128) of cases, other reasons led to the suspicion of alleged abuse, such as the victim going missing or being found after the assault. Graph 7 is again showing the distribution in columns of absolute numbers:

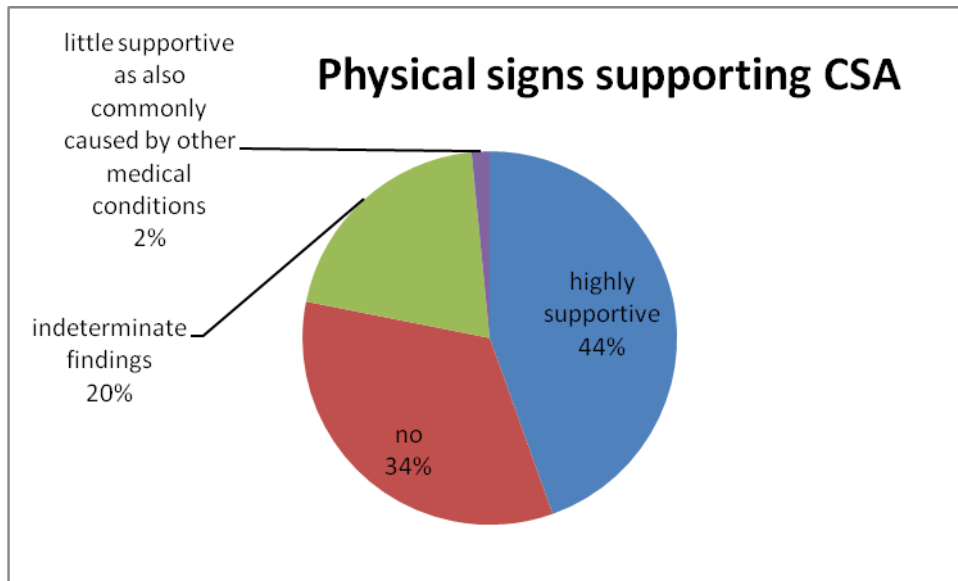


Graph 7: Mode of disclosure resulting in seeking health service at QECH in 2009

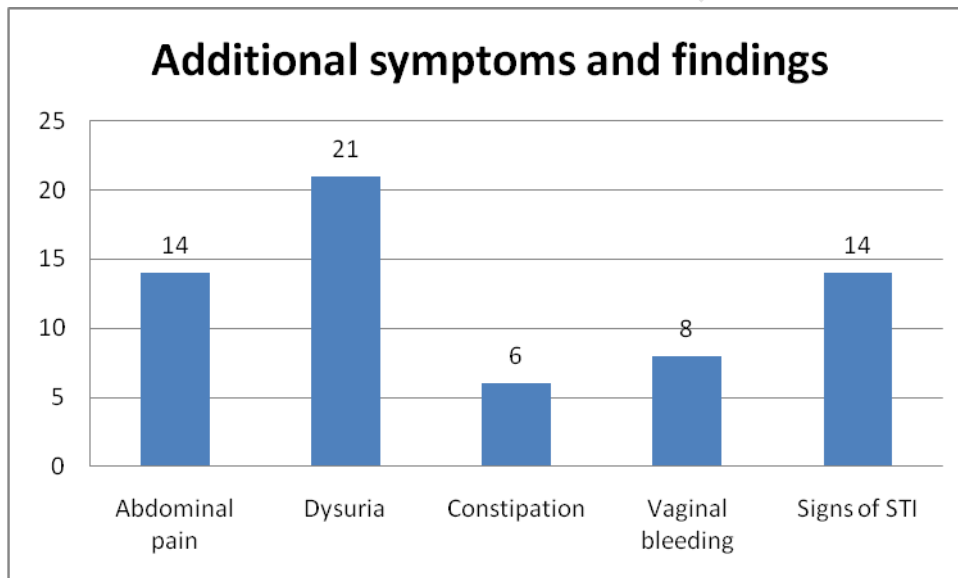
### *Results of medical assessment*

In 44% (57/128) of cases, physical findings in the medical examination of the genital region supported the allegation of Child Sexual Abuse as the examiner found signs of acute trauma (e.g. fresh looking bruising or lacerations of the genital or perianal region, an acute tear or bruising of the hymen, semen-like vaginal discharge – category IV, see Methods). However, in 34% of cases (43/128), the examiner did not find any pathology or abnormality. In 20% (26/128), the only finding was a “notch” or “cleft” in the posterior rim of the hymen (category III) and in 2 cases (2%) offensive vaginal discharge (category II). (graph 8) In addition, a STI (sexually transmitted infection) was suspected but not confirmed in 11% (14/128). Patients complained about abdominal pain in 11% (14/128), presented with dysuria in 16% (21/128) and constipation in 5% (6/128) and suffered vaginal bleeding in 6% (8/128) of

cases. (Graph 9) None of the victims had any gross injuries that needed surgical intervention, nor was any scarring reported that suggested a healed perineal tear of second or third degree.

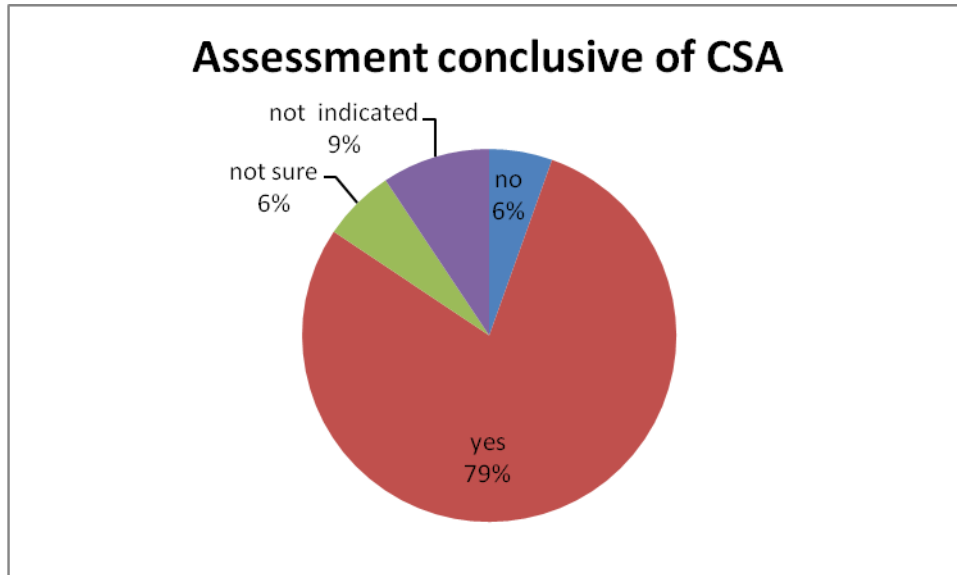


Graph 8: Percentage of physical signs detected in the examination that support the allegation of CSA



Graph 9: Symptoms reported by the victims not present prior to the assault and additional findings of physical examination

At the end of the medical examination, clinicians were asked to summarize the history and the clinical findings. Examiners concluded that the assessment was conclusive of CSA in 79% (101/128) of the cases. However, 5% (7/128) thought that the allegation of sexual abuse could not be supported by the findings; 9% (12/128) of the examiners chose not to write any comment and 6% (8/128) stated that they could not reach a conclusion based on the assessment of the patient. (graph 10)

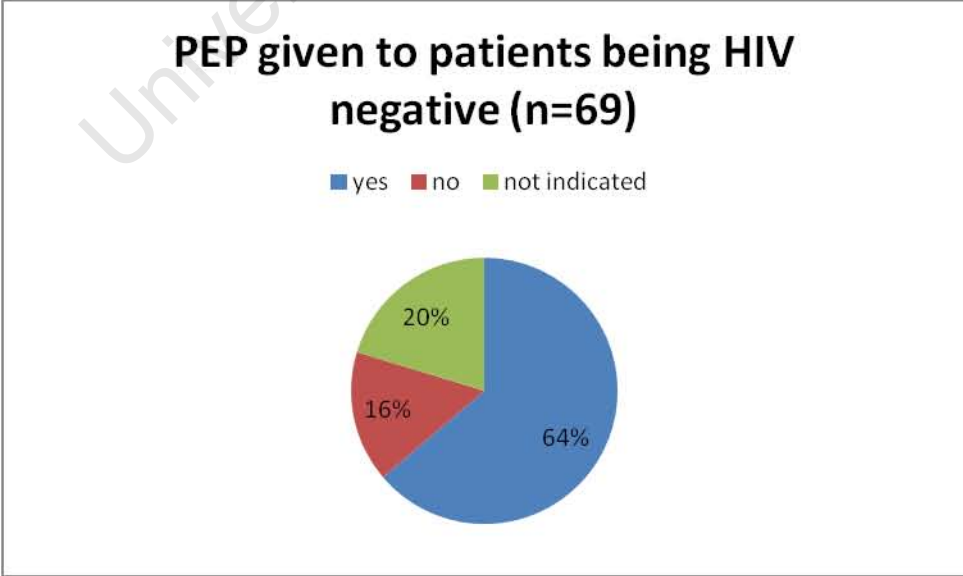
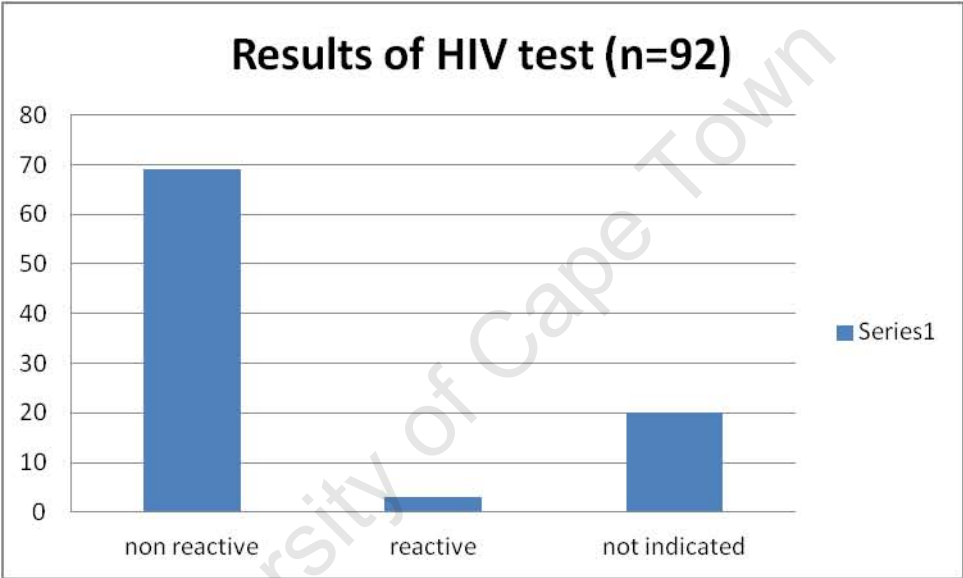
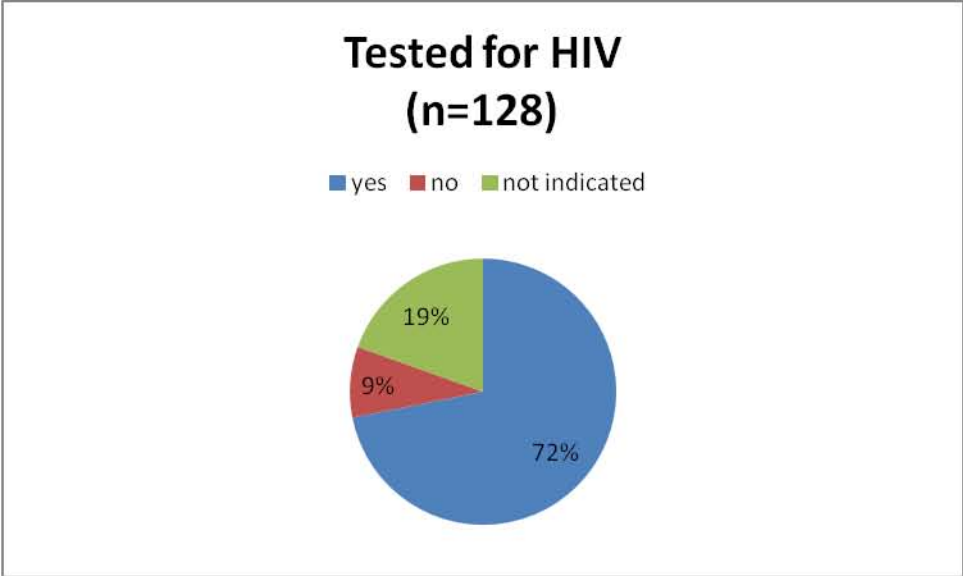


Graph 10: Examiners' conclusion on the assessment of the child with alleged CSA

### *Clinical management*

#### - HIV testing and PEP:

HIV testing was administered to 72% (92/128) of all cases, 9% (11/128) were not tested and in 19% (25/128), no documentation concerning the HIV test was found in the files. (graph 11) The results of the test done were non-reactive in 75% (69/92), reactive in 3% (3/92) and not documented in 22% (20/92). (graph 12) Of those patients tested negative for HIV 64% (44/69) received PEP. In 16% (11/69) of the cases PEP was not given, as the clinicians reasoned in 9 of 11 cases that it was not indicated since the examination was normal, the history suggested non-penetrative abuse or the patients presented more than 72 hours after the incident. (graph 13) In two cases the reason for not giving PEP was not documented. In both cases the abuse was of repeated occurrence. From cases eligible for PEP (presented within 72 hours and HIV negative), 76% (44/58) received PEP whereas in 24% (14/58) the documentation about PEP administration was missing. Overall 38% children (49/128) received PEP. Baseline hemoglobin reading were not performed for any patient receiving PEP. In the case of the known HIV positive perpetrator all the documentation about HIV test and possible PEP were missing.



Graph 11 – 13: Percentages of patients with HIV test, HIV test results and PEP given

A follow-up appointment was made as recommended for repeat HIV testing in 44% of cases (56/128), it was not given as deemed not indicated in 8.6% (11/128) and not documented in the file in 47.6% (61/128) of cases. Findings of the repeated HIV test are not documented in any of the files.

- Treatment of sexually transmitted infections:

Antibiotics to prevent or treat STIs were prescribed in 55.5% (71/128), notably not prescribed in 14% (18/128) and not reported in any way in 30.5% (39/128). Reasons for not administering antibiotic treatment were not reported. Of the 18 cases where no antibiotics were prescribed, 33% (6/18) of the children had physical signs of penetrative or attempted penetrative abuse, two complained about dysuria, although there were no sign of vaginal penetration, in one case “genital manipulation” was suspected and nine cases (9/18, 50%) revealed a normal physical examination of which one victim had disclosed repeated episodes of sexual abuse. Vaginal swabs were performed in three patients (3/128, 2%), of which one was rendered positive.

- Emergency contraception:

Regarding emergency contraception, all girls from the age of 11 and older were assessed. Emergency contraception was documented to be given once and ordered in writing once, in 18% (6/33) it was stated not to be given and in most cases (25/33, 76%) it was not mentioned or documented at all. Of the 31 girls that did not receive emergency contraception (also including those whose files contained no documentation), 19% (6/31) were documented premenarchal, 10% (3/31) had a history of non-penetrative sexual abuse and 19% (6/31) presented more than 72 hours after the incident. In 52% (16/31) of the cases however, penetrative sexual abuse was suspected within 72 hours prior to the health service and neither menarchal status nor administration of emergency contraception was stated. Pregnancy testing was not performed at all.

*General aspects of the health service*

According to the Malawi guidelines, victims of CSA should preferably be examined by female health professionals, ideally with a second clinician. In

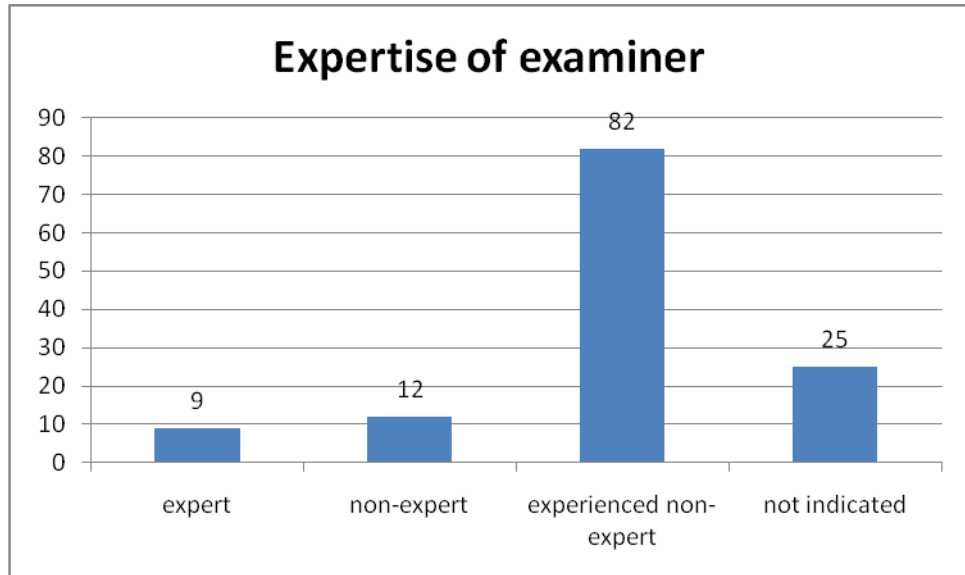
2009, 38% (48/128) of the children were assessed by only one examiner and 63% (81/128) of assessments were done by male examiners only.

Three children were initially referred from the police station to a primary health centre first where they were partly examined and assessed to be referred further to Queen Elizabeth Hospital. Two children who came to Queen Elizabeth Central Hospital during after hours only received medical care the next morning.

#### *Documentation and report writing*

Miscellaneous findings concerning documentation and report writing are listed below:

- In 17% (22/128) the examiners' handwriting was not legible for the author.
  - Several times abbreviations were used recording the physical examination
  - Inconsistency of dates were found in 3 of the 128 files (2%)
  - In 12.5% (16/128) of the cases the files were incomplete regarding the three pages of the standard forms. In five cases only one page of the three was filled, in eleven cases two out of three were used.
  - Twice the police letter was attached to the wrong file.
  - In 3% (4/128) the copy done with carbon paper had faded so badly that it was nearly impossible to read the file.
  - In 12.5% (16/128) of cases important contact details were missing which would make it impossible to contact the family of the victim.
  - The examiners rated themselves being experts in 7% (9/128) of cases, being non-experts in 9% (12/128) and being experienced non-experts in 64% (82/128) of cases. No details were given in 20% (25/128) of the files.
- (graph 14)



Graph 14: Degree of expertise of the examiners by self-evaluation

- Consent given by the family, guardians or the patients themselves were indicated in 95% (122/128) of cases, consent was not documented in 5% (6/128) of the files.
- A witness to the consent giving was signing the files in 77% (98/128) of cases and no signature was found in 23% (30/128). The witness was often one of the two examiners, but also nurses or attending interns.
- The Malawi guidelines as well as the standard protocol points out that all findings, tests and given medication are supposed to be documented in the child's health passport for future reference. Whether that was done correctly could obviously not be checked, as the patients were not contacted for this audit.

## 5. Discussion

### *Demographic aspects*

The number of children presenting at Queen Elizabeth Central Hospital to seek medical care after an alleged sexual abuse has risen steadily over the last five years as there was an average of 5.3 children per months in 2004 (Ellis, Ahmad & Molyneux 2005) and an average of 8.3 children/month between January 2005 and February 2007 (Chesshyre, Molyneux 2009). There could be many reasons for an increase in the reporting of CSA and increased reporting does not necessarily imply an increase in the incidence of Child Sexual Abuse. A likely reason may be the increased collaboration between the Malawian police and the Department of Pediatrics at QECH. Most of the victims presenting to QECH were referred by a police unit. Another reason may be the growing awareness of the risk of HIV acquisition. The rise in the numbers suggests that more victims of alleged CSA are now reporting the incident to the police as compared with the findings of a study from 1997 performed by Lema, where many parents were still reluctant to report a sexual assault of their child to the police (Lema 1997).

PEP was firstly introduced in Malawi in January 2004 (Chesshyre, Molyneux 2009, p.54) and is given to eligible child victims free of charge. It is assumed that parents who are aware of the fact that a possible HIV infection of their child could be prevented are more likely to present their child to a hospital and to do so earlier than parents who are unaware of potential risk of treatment.

Nevertheless, the rising number of children seen at QECH for medical service after an alleged sexual abuse represents only a fraction of the overall prevalence of CSA. It is estimated that 1 in 4 girls and 1 in 10 boys are victims of some form of sexual abuse before the age of 18 (van As et al. 2001, Hinds, Baskin 1999). The Blantyre district alone has around 460000 inhabitants below the age of 15 years (Welfare Monitoring Survey 2007), therefore statistically there could be as many as 5.367 sexual abuse cases ( $[(0.25 \times 230.000) + (0.1 \times 230.000)] \times 1/15$ ) each year including a large proportion of male victims. At Queen Elizabeth Central Hospital only 1 percent of the patients were male victims. A possible explanation could be that Malawi's society is still highly patriarchal, not only resulting in male dominance over

females, but perhaps also preventing male victims from disclosing events perceived as shameful.

The median age of the sexually abused child presenting at QECH is 7 years but there were three times more children presenting at the age of 5 than at the age of seven. More than half of the children were between 5 and 10 years old. This might imply on the one hand that they are more vulnerable to sexual abuse, on the other hand it might also be the age group where most of the disclosure happens. Either they deliberately disclose as they are old enough to tell or the incident is disclosed by chance as they present with symptoms which are detected by the parents or the guardians, less well hidden as can be done when they are older. The range was from one to fourteen years, assuming that adolescent girls present at the department of obstetrics and gynecology for medical management post rape. It, however, raises the question of where adolescent boys seek medical care after having been abused. It is likely that they rarely seek medical service (hindered by shame) except in those cases where they have sustained serious injuries. This underrepresentation of male victims in clinical samples is a known phenomenon in the literature (Hinds, Baskin 1999).

As most children were brought to the hospital by either the mother or another female family member, it is again obvious that the responsibility for the care of the children lies mainly with the women. Maybe they are also the driving force behind the fact that the abuse was reported to the police initially.

All the perpetrators were males, known to the child in 70% of cases (89/128). Among those, the majority of perpetrators were members of the community (78%, 70/89), i.e. neighbours. In 7%, the perpetrator was a member of the household but unrelated to the child and a relative in 13 cases (15%). Most likely victims of incestuous sexual abuse are underrepresented in our study population as the abuse is often more secretive and the disclosure less frequent than in cases of non incestuous abuse. In the literature it is stated that the perpetrator was found to be parent or a parent surrogate in 30 to 50% of cases (Cohen 1985). The fact that almost one fifth (17%) of the perpetrators was

less than 18 years of age is in keeping with reported studies (Hinds, Baskin 1999).

Time is an important aspect in the adequate provision of medical care to the children who are sexually assaulted. Most of the children received medical treatment within 72 hours after the alleged abuse (73%, 94/128), but only less than half within the first 24 hours (42%). Thus most of them received medical care within the time window needed to receive PEP and emergency contraception but it must be pointed out that the majority of the victims were living within a radius of ten kilometres around Queen Elizabeth Hospital therefore accessibility of the service was good. Considering that 82% of the victims reported the incident to the police before, the police service acts as an important gateway between victims and the health service. However, this can also cause delays as some victims may believe that medical attention can only be provided with a referral from the police. Referral through other health facilities also delayed treatment in three reported cases and it is known that two children were delayed at QECH itself as they received medical attention the morning after they arrived at the hospital as they were not considered to be emergency cases (Adams et al. 2007). No data were available to measure the time interval alleged victims spent between arrival at the hospital and the start of the medical care delivery. That would have been an important aspect to assess as long waiting hours at the hospital itself could add to the delay as well.

The history taken from victims revealed that more than half of the children had experienced sexual abuse for the first time, but in 17% it was reported to have occurred repeatedly. In 12% of cases, frequency was unknown, as the child might have been too young to report or was not willing to reveal due to shame and fear. In 9% it was not noted in the medical report.

In case of the abuse being recent, the follow up examination is of great importance as a new HIV infection can occur even months after the sexual assault. Although the risk of HIV acquisition after a single episode of penetrative sexual abuse and the incidence of HIV among children due to CSA is unknown (Schaaf 2004, p. 782), studies conducted in Africa have

found an HIV prevalence among sexually abused children ranging from 1% in Cape Town to 33.8% in Cameroon (van As et al. 2001, Menick, Ngoh 2003). Malawi has a high HIV prevalence of 12% among adults (National Statistical Office and ORC Marco 2005), thus HIV transmission through CSA appears plausible and a realistic threat. In addition, a follow-up can provide the opportunity to assess the safety of the child, to control the effectiveness of provided medical treatment (e.g. STI treatment) and to check on psychological problems.

As mentioned before, only a small part of all cases of child sexual abuse are receiving medical attention either after having reported to the police or presenting directly to the hospital. Many of the victims of CSA never disclose to anyone or when they do are still not taken to medical institutions for treatment. In Cameroon, a survey among female rape survivors has revealed that only 56% of the victims disclosed to someone, but even less (33%) consulted a health facility for medical assessment (Ndonko et al. 2009). Data from South Africa suggests that only 11% of all rape cases are reported and thus the great majority do not receive appropriate medical care (Jina et al. 2010). Concerning the children presenting at QECH, only 15% of the children disclosed to a trusted person and only one child directly to the police. In the majority of the cases, the disclosure was either accidental due to physical symptoms and signs leading to questions from parents and guardians or someone who had witnessed the event. Notably, none of the cases were reported due to the suspicion by a health worker, a teacher or any other child care provider, one possible reason could be the lack of sensitization

The reasons why so many victims of CSA do not disclose are manifold, ranging from self-blame to fear of stigmatization (Smith et al. 2010). In 28% of the cases details about the disclosure were missing in the reports. The “Guidelines for the Management of Sexual Assault & Rape in Malawi” do not ask for stating the mode of disclosure when taking the history from the child victim.

In summary, much of the data that was collected in the files of the 128 children presenting with alleged abuse at Queen Elizabeth Central Hospital is in line with international studies done in other societies. However, it must be

emphasized that this study population cannot be representative for the whole of Malawi, as the majority of victims live in close proximity to the service, mostly in urban parts of Blantyre. In Malawi, the rural population represents 82% of the overall population (World Health Organisation 2009). Little is known about the incidence of CSA in the rural parts of Malawi and even less about the medical care victims receive after having been abused. Poverty is widespread in the rural areas, and transport to the respective authorities, agencies or healthcare centres expensive. Additionally, parents may have a lack of confidence in them (Smith et al. 2010, p.265), and believe that it is their own community's responsibility to look after their children's welfare (Lachman 1997). Furthermore, the patients that seek medical care at the government hospital QECH are mostly those with no health insurance. Upper middle class families and those with a health insurance might rather go to private health institutions. Again, these arguments suggest that the study population might not be representative and thus the collected data distorted.

#### *Medical Assessment and Clinical Management*

Even though the medical examination revealed findings supporting alleged penetrative sexual abuse in 44% (57/128) of cases, none of the children presented with severe injuries like perineal tears, Grade 2 and 3 or anal tears that would have required surgical intervention. However, in the cases of abuse that took place more than a week ago or repeatedly over a period of time more subtle injuries could have healed by the time of examination. In 34% (43/128) of cases, the children did not show any pathology. In the literature, it is stated that most of the child victims do not have any obvious signs or symptoms due to miscellaneous reasons (Berenson et al. 2000, Paradise 1990). It is plausible that children with physical findings are overrepresented in our study population as disclosure might have resulted from physical signs and symptoms and that victims with very subtle or no injuries were less likely to present for medical care.

The health care workers at QECH appeared to be aware of the above mentioned facts and reasoned nevertheless in 79% of cases that CSA could be suspected due to the history and/or the physical examination. In seven cases (5%), however, the collected evidence did not support the allegation of sexual

abuse and in eight cases (6%) the examiner was unable to make a definite diagnosis due to lack of evidence. Additional laboratory testing (i.e. vaginal swabs) could be helpful to reach to a conclusion when the history and physical examination are not convincingly indicative for sexual abuse. In 12 cases (9%) the conclusion in the report was missing altogether. Since the medical report may be used later as evidence in court it is most important that the clinicians reach a conclusion reflecting their findings and professional opinion.

The medical treatment is primarily concerned with the preventive or presumptive treatment of STIs, the prevention of HIV acquisition and the provision of emergency contraception in postmenarchal girls to prevent unwanted pregnancies. While more than one tenth of the patients showed signs of sexually transmitted infection, only one was confirmed by a vaginal swab. Due to the high prevalence of STIs in Malawi, the national guidelines recommend treatment for all children presenting after sexual abuse. However, a different guideline for the care of victims of CSA, presented by Adams et al, discourages presumptive treatment of STI and recommends a confirmation of the infection before treatment instead (Adams et al. 2007). On the other hand, it appears difficult to get laboratory results in Malawi even at a tertiary hospital like QECH, requiring the patients to come back for the results (maybe even several times) and therefore bearing the risk of not receiving any treatment at all. Considering these obstacles and looking at the suspected prevalence of STI among the children presenting, treatment seems indicated for all the victims. According to the records it was prescribed in 55.5% (71/128) of cases. Among those who did reportedly not receive antibiotics, one third (6/18, 33.3%) showed physical evidence of either penetrative or attempted penetrative abuse. Reasons for not administering antibiotics were not reported. Overall, in almost one-third of cases it was not recorded if antibiotic therapy was given. This is a breach in the obligation to provide thorough medical documentation and should be improved upon.

The administration of HIV post exposure prophylaxis, where documented, followed the protocol to a great extent. However, a necessary prerequisite for the administration of post exposure prophylaxis with Anti-retrovirals is the

HIV test. Unfortunately, there was a lack of documentation in about 20% regardless of looking at HIV testing, stating the HIV result or the decision to administer PEP. In summary, the missing documentation adds up to about 59 cases in which the quality of the received medical service cannot be evaluated. Considering that 102 out of 128 children arrived at QECH within the 72 hours period, more than half of the cases of eligible children were not appropriately treated.

In two cases, PEP was reportedly not given, even though sexual abuse was assumed and the HIV test result was non reactive; most likely because the child reported repeated occurrences of abuse over a period of time. According to the article by Chesshyre and Molyneux, it was agreed at QECH not to prescribe PEP to children with multiple episodes of abuse over the last six months as they were likely to already have been infected but still in the window period for seroconversion (Chesshyre, Molyneux 2009, p.57). However, this practice contravenes the Malawi guidelines. In the only case where the HIV status of the perpetrator was HIV positive, documentation concerning HIV test and PEP administration was missing.

Queen Elizabeth Central Hospital is a tertiary referral hospital but none of the children had a baseline haemoglobin test performed before they received the antiviral medication. The national guidelines recommend a change in PEP drugs (esp. Zidovudine) when the haemoglobin level is below 8 g/dl. At QECH, it is not easy to get such test performed rapidly at the laboratory, especially after hours. Results are often only available the following day unless the clinician keeps on pressing for the results personally. As a result the clinicians may delay the blood test and start on the standard PEP medication immediately. However, it should be considered that anaemia is not uncommon in Malawian children, since Malaria is endemic and hookworm infection as well as malnutrition is widespread. Therefore Zidovudine (AZT) which potentially causes anaemia may be a real risk.

A study done in Kenya found that while the mean menarchal age was 12.5 years, more than 10% of the girls had their first menstrual period before the age of 11 years (Ogeng'o, Obimbo & Ogeng'o 2011). Even though menarchal

age can vary between countries due to environmental and genetic factors (Thomas et al. 2001, p.271), it is necessary to consider pregnancy in sexually abused girls aged 11 years and older in order to decide if emergency contraception is indicated. Emergency contraception (EC) was largely neglected in the cases during 2009, but received more attention after it was added as a “tick box” on the standard form. Since administration of hormonal contraception is not a common practice among paediatric clinicians, this should be stressed as an important part of post sexual abuse treatment with severe implications for the abused girl if omitted in indicated cases. In 16 cases of girls between, 11 and 14 years of age the menarchal status should have been inquired and EC given accordingly.

Following examination a follow-up appointment should be made. The clinicians failed to document a follow up appointment in almost half of all cases. This study did not assess if it was documented somewhere else such as in the health passports of the victims. At the follow-up appointment, a repeat HIV test is indicated and the additional opportunity is provided to investigate again for STIs and/or if appropriate any pregnancy. In case where a follow-up appointment was made, there was no documentation to indicate if the child attended the appointment. In these cases useful data may be lost and in case of presentation at court, valuable information will be missing.

#### *General aspects of the health service*

As most CSA victims are female and most perpetrators male, the suggestion that the clinical examiner should be female is understandable. In the author’s experience the department of Paediatrics and Child Health at QECH is well staffed with female clinicians. Thus, the result that most victims were examined by a male doctor seems to hint towards a lacking understanding of the extent of traumatisation the victim has undergone. The requirement of the standard form that two clinicians should perform the medical assessment has two advantages: first the training of the less experienced clinician by assisting the more experienced colleague, and second the provision of an alternative expert when it comes to court presentation and one of the two is not available.

### *Documentation and report writing*

One of the challenges of the study was the lack of documentation and the legibility of the examiners' handwriting. In general, the lack of documentation ranged between 5% to almost 50%. The average was that in 20% of cases some documentation was missing. The standard protocol consisting of three pages was not always completed, resulting in missing details and documentation. In 17% of the files, the handwriting was partially illegible which can cause difficulties when the need arises to review the file at a later stage, especially when the examiner might have left the department of paediatrics. Similar problems can occur when carbon paper or ink pens are used that fade over time. Finally, the obstacles mentioned might have caused a fragmentary picture of the provided medical service.

Meticulous documentation cannot only provide data in case of evaluation or auditing, it is also an important back-up for the clinician to justify future management of the patient as well as to give testimony at court. Additionally, it also may prevent the need for the child to be re-examined (Adams et al. 2007). To facilitate further medical care the "Guidelines for the Management of Sexual Assault & Rape in Malawi" recommend that an abstract of the management plan should be documented in the patient's health passport for future reference at any health facility (Namasasu, van der Hoeven & et al. November 2005). This study was unable to assess if this was performed routinely since the children attending the health service for CSA were not contacted. It should further be noted that in one eighth of the cases contact details were insufficient to such degree that contacting the family of the victim again would have been impossible.

## 6. Conclusion and Recommendation

Assessing the data collected by reviewing the medical reports it becomes clear that, due to a lack of documentation, the real proportion of children having received full medical care according to the present standards could not be appropriately assessed. Generally, there was a significant deficit in documentation in approximately 20% of cases, regardless of the type of missing information. These included patient details, history taking, test results and/or administration of medication. Overall medical service may have been better, but this could not be assessed with any certainty in this study. According to the data given the proportions of children having received STI treatment, PEP or emergency contraception compared to the number of children who were presumptively eligible range between 11% and 55%.

In the author's opinion, the standard of care for CSA victims should be very high; at least 90% of children should have received all necessary medication and medical treatment according to the standard protocol and guidelines. A reputation of high quality care may attract more victims to seek medical care and may assist in overcoming obstacles that prevent the victim and its family from utilising the service offered at Queen Elizabeth Central Hospital.

The study showed that the service clearly failed a standard of 90% or more.

### *Recommendation: Expansion on the One-stop service*

It is generally recommended that the history about the CSA incident should be taken only once as repeated disclosure by the victim can be very traumatic. It might be helpful to intensify the cooperation within the Blantyre Child Protection Team by sharing documentation to ensure that the victim does not need to provide the information more than once.

### *Recommendation: Training*

As there is a high turnover in the staff of the paediatric department, regular training sessions are necessary to introduce the service to those who are new and to re-iterate and update those providing the service for a long time. Training should be holistic in its character and the police should be informed and strongly encouraged to advise victims to seek medical care as a matter of

urgency. Victims (or their caretakers) should be informed how crucial the time of presentation is at the hospital especially with regards to the effectiveness of PEP and emergency contraception, as well as the collection of forensic evidence.

*Recommendation: Expanding the service*

Health services for sexually abused children are only available at Queen Elizabeth Central Hospital and at Zomba Central Hospital. Ideally the service should be offered at every district hospital in Malawi to ensure timely medical care. It is stated in the Medical Council Act and Nurses & Midwives Act from 1995 that every medical health care worker registered with either of the two should be competent in providing a medical assessment and report in case of sexual abuse (Namasasu, van der Hoeven & et al. November 2005). However experience is crucial as signs and symptoms are often subtle or even nonexistent in abused children (Adams et al. 2007, Adams 2008). Training sessions could be offered at QECH inviting paediatric staff from district hospitals to encourage them to establish a health service for abused children. The standard protocol could be offered for use to facilitate the medical examination. Health workers at health centres also require training to be able to suspect sexual abuse even without prior disclosure and to refer to the hospitals for further specialised management avoiding repeated examinations. Health workers in outreach clinics should be familiar with the available health service to inform the communities and enhance the confidence in the health services provided.

*Recommendation: psychological service and counselling*

All guidelines concerning the care of victims of abuse stress the importance of psychological service as it can reduce short and long term psychological disorders after the traumatizing event (Namasasu, van der Hoeven & et al. November 2005). Not yet institutionalised during 2009, there is a social health worker offering counselling sessions to victims of CSA at Queen Elizabeth since 2010 and plans are in progress to extend counselling services further (personal communication with Dr. Neil Kennedy, Head of Pediatric Department, QECH).

*Recommendation: Follow up*

At present, no data are available on how many patients are lost during follow-up. This study indicates that a standardized follow-up form be completed by the clinician who will see the child on the recommended follow-up date. This form could be attached to the medical report at a later stage to complete the data about the health service received by the children presenting after sexual abuse. Furthermore, a review of the medical reports could then reveal the adherence rate, the efficacy of the service, new HIV infections that might be related to the abuse, any side effects of the medication provided, data that could help to measure the benefit of the service in the long run and to improve the service where necessary.

*List of recommendations:*

Although this study clearly indicates a number of gaps in the medical management of sexually abused children treated at the QECH, a number of issues, warranted to be mentioned specifically, are stated here:

- Emphasis on a female examiner whenever possible.
- Emphasis on the presence of two examiners whenever possible.
- Availability of emergency contraception within the “one-stop-shop” service including pregnancy testing
- A simple method for baseline haemoglobin to be performed by the health worker who also performs the HIV test and weighing. (E.g. hemocue®)
- Provide the possibility of taking specimens for forensic purposes and certify that the laboratory results are reported in the file
- Provide a standard form with more “tick-boxes”, to improve legibility and improve efficiency.
- Add “child’s safety” tick-box for assessment by the clinician. Child Protection Services should be informed immediately if the clinician feels that the child’s safety cannot be guaranteed.
- A check list as an additional page for the standard examination form to guide the examiner through the assessment as a backup.
- Discourage the use of ink pens and carbon paper, as the reports may fade over time - rather use ball point pens instead.

*Limitations of the study:*

The missing documentation might lead to misrepresented data concerning the received health care. It is plausible that more children have received medication concerning PEP and STI treatment without being documented. Nevertheless documentation was also an audit criterion and thus discussed in the study.

It also needs to be indicated that most of the pit falls and the general recommendations were already stated in a study done by Chesshyre and Molyneux, who reviewed data from January 2005 up to February 2007 (Chesshyre, Molyneux 2009). Since then, some improvements have been effected but ongoing rigorous evaluation is essential to assess the quality of the health care service and effectuate a continuous progress in service delivery to sexually abused children in Malawi.

This study acknowledges the sometimes overwhelming workload of the clinicians at QECH and the difficulties of keeping the work performance at a superior level. However, prioritisation of the service to sexually abused children will benefit the children treated, and may attract more patients (who otherwise may not receive any treatment at all) and ultimately will benefit Malawi. As Lachman stated in 2004: "...in a society where the daily struggles are paramount, it is difficult to address (...) the needs of children" (Lachman 2004, p.814). It is in the hand of the professionals who are concerned with child care, that the needs of the children are realized.

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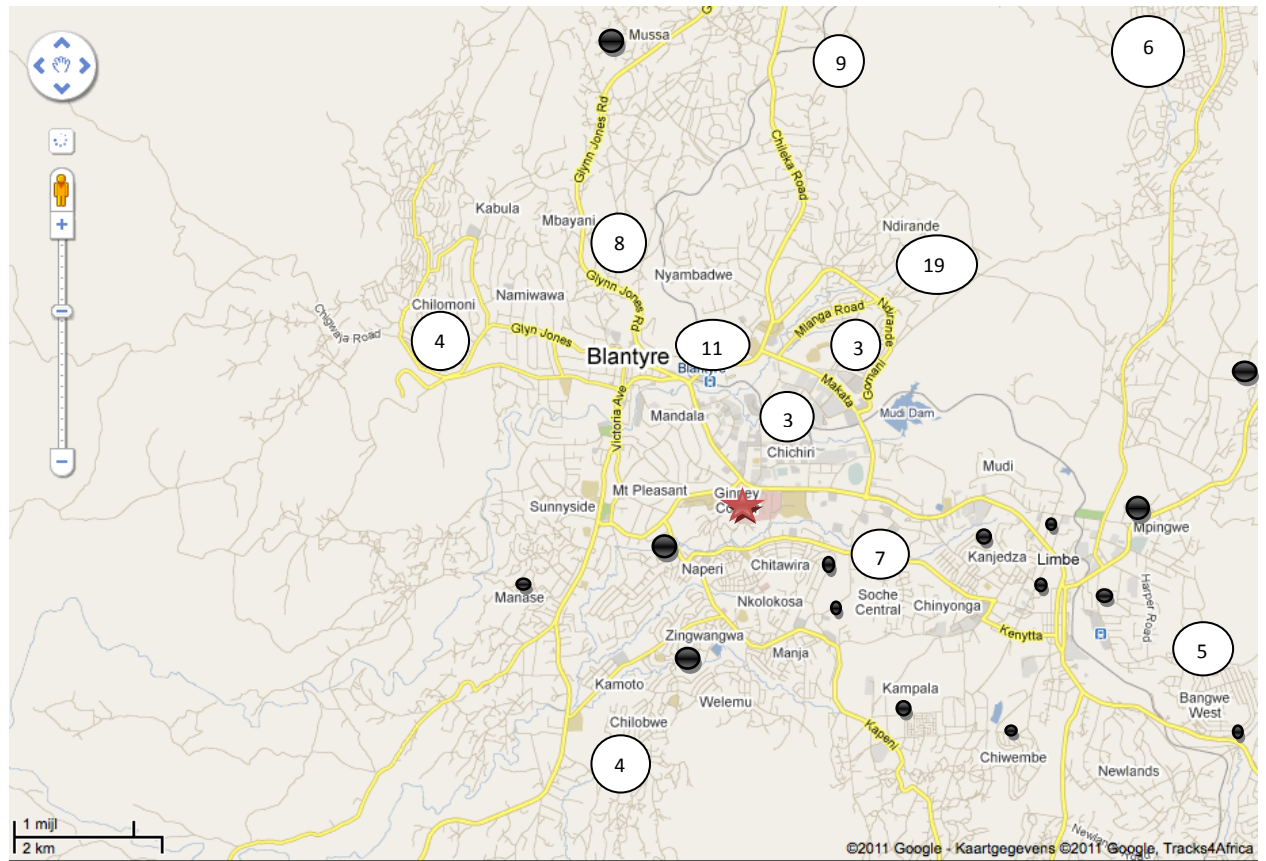
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## 8. Appendix





1. Map of Blantyre
2. Page 1 of Examination Standard Form (History Page)
3. Page 2 of Examination Standard Form
4. Page 3 with Report for Police

Appendix 1:

**Map of City of Blantyre and the neighbouring villages**



Legend:

	Queen Elizabeth Central Hospital
	Small dot: 1 case reported
	Bigger dot: 2 cases reported
	Numbers of cases reported from this area

**MEDICAL ASSESSMENT FOR SUSPECTED DEFILEMENT - HISTORY**

<b>Patient Details</b>	NAME: _____ AGE _____ DOB _____ ADDRESS: _____ Phone Number _____
<b>Consent</b>	I _____ being the mother/father/guardian of the above named child hereby give consent for him/her to be examined and for a written report of the findings to be given to the police and/or social welfare. Signature _____
<b>Clinician Details</b>	Witness Name: _____ Witness Signature _____ Name of examining clinician _____ Position _____ Qualifications _____ <small>Please circle</small> LEVEL OF EXPERTISE: NON-EXPERT EXPERIENCED NON-EXPERT EXPERT
<b>Assessment Details</b>	DATE _____ TIME _____ PLACE _____

Date & time of most recent alleged incident: .....

Was this alleged defilement episode (please tick ✓ below):

1 <sup>st</sup> occasion <input type="checkbox"/>	single occurrence <input type="checkbox"/>	Repeated occurrence <input type="checkbox"/>	Not known <input type="checkbox"/>
---	--	--	------------------------------------

Date(s) & Time(s) of other alleged incidents: .....

DETAILS OF ALLEGED INCIDENT (include details of when, where, what the child has said happened, and any witnesses. Also if child old enough ask if condom used and/or if ejaculation occurred – if too young ask the guardian if there was suspected semen on genitals or in underwear.)

Details of any symptoms since time of incident(s):

Any symptoms?	PRIOR to incident	FOLLOWING incident
Abdo pains	Yes / No	Yes / No
Dysuria	Yes / No	Yes / No
Vaginal discharge	Yes / No	Yes / No
Vaginal bleeding	Yes / No	Yes / No
Constipation	Yes / No	Yes / No
Blood PR	Yes / No	Yes / No

Other past history of note:

DATE OF EXAMINATION \_\_\_\_\_ TIME \_\_\_\_\_

**EXAMINATION**

**General:**

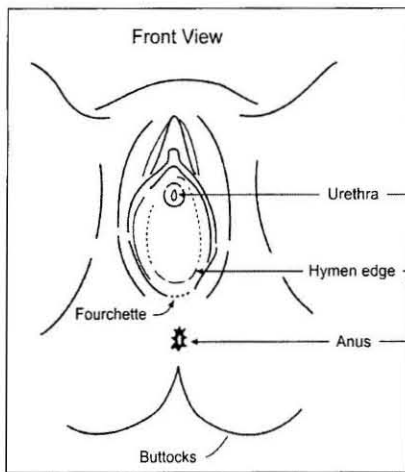
WEIGHT \_\_\_\_\_ KG

**Genital:**

EXAMINATION POSITION: SUPINE FROG-LEG  KNEE-CHEST PRONE

Level of child relaxation & co-operation with examination: (Please circle)

Fully relaxed / cooperative    Partially relaxed/cooperative    Not relaxed/uncooperative



**CONCLUSION:**

**Examining Clinician(s)**

Name \_\_\_\_\_ Position \_\_\_\_\_ Sign \_\_\_\_\_  
 Name \_\_\_\_\_ Position \_\_\_\_\_ Sign \_\_\_\_\_

HIV Test done? Yes / No / VCT*	Result: R / NR	*VCT only if does not need PEP
DUOVIR given? † Yes / No	Dose _____ tablet bd for 30days	
ANTIBIOTICS? Yes / No	B-Pen / Gent / erythromycin / other _____	
Follow up in 3months for rpt HIV test**	Yes/ No	**1 <sup>st</sup> wed of month at 2pm in A&E
Emergency contraception? Yes / No		
† DUOVIR Dose (<14kgs: ¼ Tablet, 15-24kgs:½ Tablet, 25 – 34kgs:¾ Tablet, +35kgs: 1 Tablet)		

Appendix 4

**REPORT OF MEDICAL ASSESSMENT FOR SUSPECTED DEFILEMENT**

**\*\*COPY must be filed with paediatric dept. secretary. ORIGINAL – must be stamped and given to guardian\*\***

NAME: _____ AGE _____ DOB _____  ADDRESS: _____
CONSENT: I _____ being the mother/father/guardian of the above named child hereby give consent for him/her to be examined and for a written report of the findings to be given to the police and/or social welfare. Signature _____  Witness Name: _____ Witness Signature _____

DETAILS OF EXAMINING CLINICIANS CLINICIAN 1: _____ CLINICIAN 2: _____	
Name _____ Position _____ Qualifications _____	Name _____ Position _____ Qualifications _____
DATE OF EXAMINATION _____ TIME _____ PLACE _____	
<b>HISTORY (Use child's words if possible)</b>   	
<b>EXAMINATION FINDINGS:</b>   	
<b>CONCLUSION:</b>   	
<b>REPORT WRITTEN BY:</b> _____ <b>Signature</b> _____	
Complete this section if the patient was seen and examined by a second clinician: Please circle I AGREE / I DISAGREE WITH THE ABOVE DOCUMENTED FINDINGS AND CONCLUSION	
Name of 2 <sup>nd</sup> Clinician _____ Signature _____ Any additional comments/findings (please use additional sheet if needed):	