Clinical management of rape and intimate partner violence survivors

Developing protocols for use in humanitarian settings

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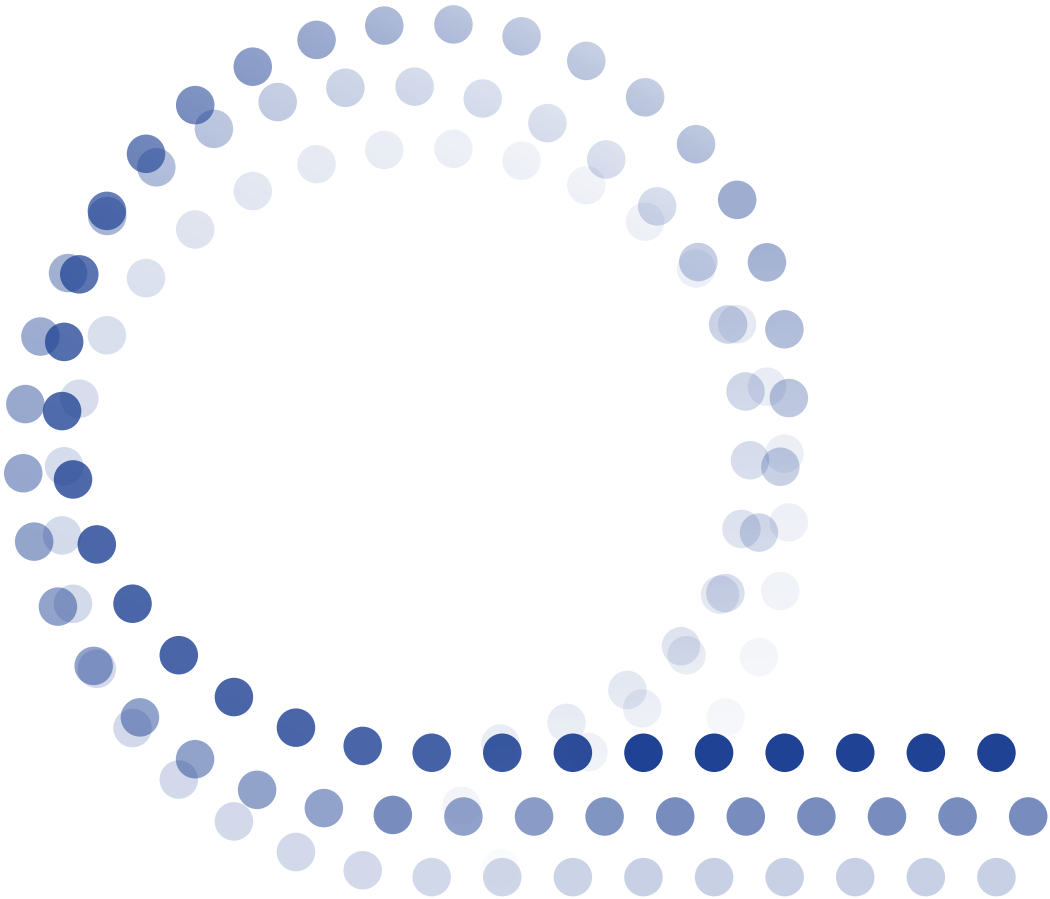

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Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings

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Acknowledgements

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Abbreviations and acronyms

EC	emergency contraception
GBV	gender-based violence
IDP	internally displaced person
IM	intramuscular
IPV	intimate partner violence
IUD	intrauterine device
PEP	post-exposure prophylaxis
PTSD	post-traumatic stress disorder
STI	sexually transmitted infection
TT	tetanus toxoid
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
WHO	World Health Organization

1 World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape survivors: developing protocols for use with refugees and internally displaced persons, revised edition. Geneva: WHO/UNHCR; 2004 (https://apps.who.int/iris/handle/10665/43117, accessed 3 September 2019).

Introduction

Sexual violence and intimate partner violence (IPV) – which may be physical, sexual and/or emotional/psychological – are global problems, occurring in every society, country and region. In humanitarian settings, as a result of mass displacement and the breakdown of social protections, women and children who are refugees, internally displaced persons (IDPs), or otherwise affected by conflict-related or natural humanitarian crises, are at increased risk. The high rates of sexual violence and IPV are well documented and constitute a serious violation of international humanitarian law and human rights law.

This guide is intended for use by qualified health-care providers (medical doctors, clinical officers, midwives and nurses) who are working in humanitarian emergencies or other similar settings, and who wish to develop specific protocols for the medical care of survivors of sexual violence and IPV. This guidance will need to be adapted to each setting, taking into account available resources, materials, medications, and national policies and procedures. It can also be used to update existing protocols, to help plan and provide services and train health-care providers.

How to use this guide

This guide offers clear steps and suggestions (i) to help you provide quality care to survivors of sexual violence and IPV, and (ii) to guide the development of a protocol for care. It is divided into six parts:

- Part 1: Preparations
- Part 2: Providing first-line support
- Part 3: Clinical management of rape (step by step)
- Part 4: Identification and care for survivors of intimate partner violence
- Part 5: Additional care for mental health and psychosocial support
- Part 6: Caring for child survivors

The job aids throughout this guide will help you care for and support a woman who has experienced violence. At the end of this publication, you will find annexes to be used as needed to accompany the information in the parts of this guide, including sample forms. Annex 1 gives a list of key resources and publications.

The health sector and violence against women

Sexual violence and IPV damage women's health in many ways – immediate and long-term, obvious and hidden. Women who have experienced violence can suffer injuries (including genital injuries), unintended pregnancy and pregnancy complications, sexually transmitted infections (STIs) including HIV, pelvic pain, urinary tract infections, fistula and chronic conditions. The mental health impacts of sexual violence and IPV may include acute stress reactions, post-traumatic stress disorder (PTSD), depression, anxiety, sleep disturbances, substance misuse, self-harm and suicidal behaviour. In addition, survivors may face stigma and rejection from their families and communities.

Presented in this guide are simple but important ways that every heath-care provider – including those who are not specialists – can assist a woman who has experienced violence to meet a range of critical needs, including:

- immediate and ongoing emotional/psychological health needs;
- immediate and ongoing physical health needs; and
- safety needs.

Globally, around one in three women will experience physical and/or sexual violence by a partner or sexual violence by a non-partner.[2] Men may also be victims of sexual violence, particularly in conflict settings, and can experience violence from an intimate partner, although the rates are much lower and the impacts are different. Sexual violence against men in emergencies tends to be committed by other men as a means of disempowering them, their families and communities. Boys may be at risk of child sexual abuse, which is usually perpetrated by family members or other men who are known to the child. Sexual and gender

2 World Health Organization (WHO) Department of Reproductive Health and Research, London School of Hygiene and Tropical Medicine, South African Medical Research Council. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO; 2013 (https://www.who.int/reproductivehealth/publications/violence/9789241564625, accessed 8 March 2019).

minorities, people with disabilities, children and adolescents are also often at increased risk of violence.

Men and boys face many of the same barriers to services that women and girls do, such as shame and stigma, but may experience them differently.[3] Since norms and systems in most societies give men more power than women, women generally experience more frequent sexual violence and IPV, more severe physical violence in the context of interpersonal relationships, and more control from their male partners.

Given that most survivors of sexual violence and IPV are women, the starting point for this guide is care for women, and female pronouns are used throughout when referring to a survivor. However, much of the advice is also relevant to sexual violence against men, and where special considerations are needed for male survivors, or other vulnerable groups, they are noted.

3 Gender-based Violence Information Management System (GBVIMS) Steering Committee. Interagency gender-based violence case management guidelines. GBVIMS; 2017 (http://www.gbvims.com/wp/wp-content/uploads/Interagency-GBV-Case-Management-Guidelines_Final_2017.pdf, accessed 8 March 2019).

Key terms

This guide focuses on the clinical management of survivors of rape and intimate partner violence (IPV) in humanitarian settings. Violence in this guide refers to the use of power and/or physical force with the intent to cause physical or psychological harm.[4]

Sexual violence

This refers to "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting".[5] Sexual violence includes rape, defined as non-consensual penetration – even if slight – of the vulva, mouth or anus, using a penis, other body part or an object. The attempt to do so is known as "attempted rape".[6] The term "sexual assault" is often used interchangeably with rape.

Intimate partner violence (IPV)

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner – a husband, boyfriend or similar. Women may suffer several types of violence by a male partner, including physical violence, emotional/psychological abuse, controlling behaviours and sexual violence (see Table 1).

Table 1: Examples of different types of intimate partner violence (IPV)

Physical violence	Emotional/ psychological abuse	Controlling behaviours	Sexual violence
• Hitting, kicking, beating, pushing, burning, choking, and hurting with or without a weapon, which can cause injury or harm to the body	• Criticizing her repeatedly • Insulting her or making her feel bad about herself • Threatening to hurt her or people she cares about, such as her children • Threatening to destroy things she cares about • Belittling or humiliating her in front of other people	• Not allowing a woman to go out of the home, or to see family or friends • Insisting on knowing where she is at all times • Becoming angry if she speaks with another man • Not allowing her to seek health care without permission • Blocking her access to services • Withholding money needed to run the home	• Forcing her to have sex or perform sexual acts when she does not want to; this may involve the use of physical force or coercion and intimidation • Reproductive coercion – forcing her to have sex without protection from pregnancy or infection, or controlling her use of contraception

4 Rape and intimate partner violence are types of gender-based violence (GBV). GBV is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed differences between males and females (i.e. gender) or on the unequal power relations between women and men. In humanitarian settings, the term GBV is often used to describe multiple forms of violence including rape, intimate partner violence, forced marriage and other forms of gendered violence.

5 Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health. Geneva: World Health Organization; 2002 (https://apps.who.int/iris/bitstream/handle/10665/42495/9241545615_eng.pdf, accessed 27 August 2019).

6 Ibid. The legal definitions of rape may vary across different countries and can differ from medical and social definitions.

Guiding principles

This guide offers an approach to service provision that is **survivor-centred,** which prioritizes the rights, needs and wishes of the survivor. Survivor-centred care promotes the following survivors' rights.

- **Dignity and respect** – the right to be treated with dignity and respect, and not be blamed for the violence perpetrated against her.
- **Life** – the right to a life free from fear and violence.
- **Self-determination** – the right to make one's own decisions, including sexual and reproductive decisions; to refuse medical procedures and/or take legal action; and to choose the course of action.
- **The highest attainable standard of health** – the right to health-care services of good quality, that are available, accessible and acceptable.
- **Non-discrimination** – the right to be offered health-care services without discrimination, i.e. treatment is not refused based on race, ethnicity, caste, sexual orientation, gender identity, religion, disability, marital status, occupation, political beliefs or any other factor.
- **Privacy and confidentiality** – the right to be provided with care, treatment and counselling that is private and confidential, and to decide which information is included in one's records and for information not to be disclosed without consent.
- **Information** – the right to know what information has been collected about one's health and to have access to this information, including medical records.

In addition, promoting gender equality is crucial (see Box 1).

Box 1: Promoting gender equality

Important facts:

- Violence against women is rooted in unequal power between women and men.
- Women may have less access than men to resources, such as money or information.
- Women may not have the freedom to make decisions for themselves, including about their health care.
- Women may face the risk of violence based on their health outcomes (e.g. if they acquire an STI or become pregnant); they may not be able to share information safely with others.
- Women may be blamed and stigmatized for violence they experience and may feel shame and low self-esteem as a result.

Health-care providers must promote women's autonomy and dignity and, at a minimum, avoid reinforcing these inequalities by:

- being aware of the power dynamics and norms that perpetuate violence against women and how these may affect a woman's ability to safely access and continue to receive health care;
- being careful not to put her at further risk through your actions or recommendations;
- listening to her story, believing her, and taking what she says seriously;
- not blaming or judging her;
- providing information and counselling that helps her to make her own decisions; and
- supporting her autonomy – her right to choose what medical care and which additional services she accepts.

Part 1: Preparations

A protocol to provide care for survivors of sexual violence and intimate partner violence (IPV), whether it is a newly developed or updated protocol, must support a thorough and compassionate response to the survivor. Such a protocol requires careful preparation. In setting up a service and developing a treatment protocol, the following questions and issues need to be addressed, and standard procedures developed for implementation within the local context.

1.1 Understanding the laws and policies

- What forms of sexual violence and IPV are considered crimes under the applicable law?
- Are same-sex relationships criminalized?
- What are the national laws relevant to the management of the possible consequences of rape (e.g. emergency contraception, abortion, testing and prevention of HIV infection)?
- What are the legal requirements for health-care providers with regard to reporting cases of sexual violence or IPV to authorities?
- Does the law have requirements about who may provide clinical care to survivors? For example, if the person wishes to report the rape officially to the authorities, the country's laws may require that a certified, accredited or licensed medical doctor provide the care and complete the official documentation.
- What are the legal requirements with regard to forensic evidence? Who may collect it?

1.2 Awareness of available resources and services

- Do national or sub-national protocols for managing care for survivors of sexual violence already exist? Do they exist for IPV? Are there clinics that are already providing this type of care?
- Is there a national STI treatment protocol, a post-exposure prophylaxis (PEP) protocol and/or a vaccination schedule? Which vaccines are available? Is emergency contraception available? Is comprehensive abortion care available, and for which indications?
- What psychological or psychosocial support services are available?
- What possibilities are there for referral to a secondary health-care facility or a specialized service provider (e.g. gynaecology/obstetrics, counselling, surgery, paediatrics, case management)?
- What facilities exist for screening/testing for sexually transmitted infections (STIs, including HIV)?
- Is there equipment for documenting and for collecting and storing forensic evidence? What laboratory facilities are available for forensic testing (e.g. DNA analysis, acid phosphatase)?

1.3 Identifying where appropriate care can be provided, if not already available

Generally, a clinic or outpatient service that already offers reproductive health services, such as antenatal care, basic delivery care or the management of STIs, can also offer care for survivors of sexual violence and IPV. In cases of severe injury or other complications, survivors may need to be referred to a hospital.

1.4 Preparing the facility

- All health care for survivors should be provided in one place within the health-care facility so that the person does not have to move from place to place.
- If this is not possible, a clear patient flowchart should be developed and "warm referral" provided.[7]
- A health-care facility that can provide services 24 hours a day, seven days a week should be identified.
- All supplies and medications from the checklist in Job aid 1 should be prepared and kept in a special box/container or place, so that they are readily available.

1.5 Training staff

- Ensure that health-care providers (doctors, medical assistants, nurses, midwives, etc.) are trained to provide appropriate care and referral options and that they have the necessary medical supplies.
- Female health-care providers should be trained as a priority, but a lack of trained female health workers should not prevent the health service from providing care for survivors; if a male health-care provider conducts the examination, a female chaperone should be present.

7 "Warm referral" can include ensuring she knows the location of the service and the name of who will assist her, offering to make an appointment for her, providing written information about the service or arranging for someone to accompany her.

- All other health-care facility staff, such as cleaners and administrators, should also receive awareness training, including on how to respect confidentiality and communicate compassionately, without discrimination.

1.6 Developing a protocol

- This guide can be used as a reference document to develop a national or situation-specific health-care protocol for managing sexual violence and IPV. If one exists already, then review it and make sure that all is up to date and in line with the latest evidence-informed standards that are included in this guide.

1.7 Coordinating with other service providers and developing referral systems

- Interagency and intersectoral coordination should be established to ensure comprehensive care for survivors of sexual violence and IPV, including mental health care and psychosocial support, health services, safety/security and access to legal services/justice.
- As a multisectoral team, establish and document clear referral networks and pathways, communication systems, coordination mechanisms and follow-up strategies.
- The referral network should indicate clear focal points and contacts for each service provider, locations, procedures and pathways for making a referral and for sharing and protecting information, and who will be in charge of following up. This process should also identify referral pathways for male, child and other survivors (e.g. people with disabilities, and sexual and gender minorities) that not all service providers will have the capacity to assist.
- In humanitarian settings, governmental agencies, the gender-based violence (GBV) sub-cluster/subsector/working group or other relevant coordination bodies can help in identifying existing networks, maintaining an active referral pathway and identifying training opportunities for clinical staff (see Box 1.1).

Box 1.1: Gender-based violence (GBV) coordination in humanitarian settings

In humanitarian contexts, GBV coordination mechanisms may be established that focus on developing referral pathways, supporting multisectoral programming to address GBV and ensuring that GBV prevention and mitigation are integrated across sectors, in accordance with the Inter-Agency Standing Committee (IASC) *Guidelines for integrating gender-based violence interventions in humanitarian action*.[8] GBV coordination structures may be chaired by government actors, nongovernmental organizations (NGOs), international NGOs (INGOs), and/or United Nations agencies, depending on the context.

At the global level, GBV coordination is facilitated by the GBV Area of Responsibility (AoR), led by the United Nations Population Fund (UNFPA), as one of the "functional components" of the Protection Cluster. At the field level, the GBV AoR may alternatively be known as the GBV sub-cluster, subsector or working group.

GBV coordination mechanisms work closely with the IASC Health Cluster, led by the World Health Organization (WHO), which oversees the coordination of health interventions related to GBV, including those for reproductive health and mental health. In many humanitarian settings, a Reproductive Health Working Group (RHWG) will be established as a subgroup within the Health Cluster; RHWGs are often led by UNFPA. The RHWG has responsibility for ensuring the implementation of the Minimum Initial Service Package for Reproductive Health (MISP), including services and qualified personnel to administer protocols for the clinical management of rape.

8 Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery. Inter-Agency Standing Committee (IASC); 2015 (https://gbvguidelines.org, accessed 27 August 2019).

1.8 Conducting community outreach

It is important to reach out to community members, once services are established, so that they understand what kinds of services are available for survivors and how they can access them or help others to do so. Members of the community should know:

- what services are available for someone who has experienced sexual violence and/or IPV, including where to access services 24 hours a day, seven days a week;
- why survivors would benefit from seeking medical care and other services, and the importance of survivors of rape coming within 72 hours to prevent HIV and pregnancy,[9] and for forensic evidence collection (if available);[10] and
- that rape survivors can trust the service to treat them with dignity, to maintain their security, and to respect their privacy and confidentiality.

1.9 Taking care of your own needs as a health-care provider

Your needs are as important as those of the women you are caring for. You may have strong reactions or emotions when listening to or talking about violence with women. This is especially true if you have experienced violence yourself. Health-care providers can develop stress-related conditions, such as burnout, compassion fatigue or vicarious trauma. If you are working with survivors, be aware of these risks and take action to maintain your well-being in the face of work-related stress. The psychosocial support exercises in Part 5 of this guide ("Additional care for mental health and psychosocial support") can be helpful to you as a health-care provider to reduce stress and reinforce positive coping mechanisms.

9 Note that emergency contraception can be provided up to 120 hours after the incident, though the sooner it is given the more likely it is to be effective.

10 Note that survivors should be encouraged to come in for medical care as soon as possible, without bathing or changing clothes, if they wish to have forensic evidence collected.

	Job aid 1
Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence (IPV)	
1. Protocol	Available?
Written medical protocol in the language of the provider*	
2. Personnel	Available?
Trained (local) health-care professionals (where possible, it is ideal to have an on-call system 24 hours a day, seven days a week)*	
A female health-care provider who speaks the same language as the survivor is optimal; if this is not possible, a companion of choice or another female health/social worker should be in the room during the examination*	
3. Furniture/setting	Available?
A clean, quiet, child-friendly, accessible consultation room, with access to a toilet or latrine, and with a door, curtain or screen for visual privacy*	
An examination table*	
Light, preferably fixed (a torch may be threatening for children)*	
A magnifying glass (or colposcope)	
Access to an autoclave to sterilize equipment*	
Access to laboratory facilities/microscope with a trained technician	
Weighing scales and a height chart for children	
4. Supplies	Available
Speculums* (only adult sizes)	
Tape measure for measuring the size of bruises, lacerations, etc.*	
Syringes/needles* (butterfly type for children) and tubes for collecting blood	
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	
Resuscitation equipment*	
Sterile medical instruments (kit) for repair of tears, and suture material*	
Tongue depressor (for inspection of oral frenulum and injury)	
Cover (gown, cloth, sheet) to cover the survivor during the examination*	
Spare items of clothing to replace those that are torn or taken for evidence	
Sanitary supplies (disposable or cloth pads)*	
Pregnancy tests	
Pregnancy calculator disk to determine the age of a pregnancy	
Additional supplies that may be needed for forensic evidence collection/documentation	
Comb for collecting foreign matter in pubic hair	
Cotton-tipped swabs/applicators/gauze compresses for collecting samples	
Glass slides for preparing wet and/or dry mounts (for sperm)	
Laboratory containers for transporting swabs	
Paper sheet for collecting debris as the survivor undresses	
Paper bags for collection of evidence	
Paper tape for sealing and labelling containers/bags	

5. Medications (with age-appropriate dosages)	Available
For treatment of STIs as per country protocol*	
For post-exposure prophylaxis (PEP) of HIV transmission*	
Emergency contraceptive (EC) pills* and/or copper-bearing intrauterine device (IUD)	
Tetanus toxoid, tetanus immunoglobulin*	
Hepatitis B vaccine*	
Pain relief* (e.g. paracetamol)	
Anxiolytic (e.g. diazepam)	
Sedative for children (e.g. diazepam)	
Local anaesthetic for use when suturing*	
Antibiotics for wound care*	
6. Administrative supplies	**Available**
Medical history and examination form including chart with pictograms*	
Medical certificate/medico-legal forms	
Referral directory	
Job aids in the language of the provider (e.g. care/treatment algorithm, referral flow chart)	
Consent forms*	
Information pamphlets for post-rape care (for the survivor)	
Safe and locked filing space to keep records confidential, or password-protected computer for electronic files*	

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

In humanitarian settings, essential medicines and supplies for managing the consequences of sexual violence are available through Kit 3 of the Inter-Agency Reproductive Health Kits (IARH Kit 3)[11] and the Interagency Emergency Health Kit (IEHK) additional module for PEP.[12]

11 Available at: https://www.unfpa.org/resources/emergency-reproductive-health-kits

12 Available at: https://www.who.int/emergencies/kits/iehk

Part 2: Providing first-line support

First-line support is an essential part of the care that you can provide to survivors of sexual violence and intimate partner violence (IPV). It involves **responding to a woman who discloses violence in a way that is supportive, helps to meet her needs, and prioritizes her continued safety without intruding on her privacy**. First-line support helps to meet the survivor's emotional and practical needs and may be offered whether or not she chooses to have a physical examination or requires any additional physical or mental health treatment. First-line support is consistent with principles of psychological first aid, which helps people who have been through various adverse or distressing events. This type of support can be lifesaving, particularly in an emergency.

First-line support involves five simple elements, as summarized below. The letters in the word "LIVES"[13] can help you to remember them.

With first-line support, you do NOT need to:

- solve the survivor's problems;
- convince her to leave a violent relationship;
- convince her to go to any other services, such as the police or the courts; or
- ask detailed questions that force her to relive painful events.

These actions could do more harm than good.

Box 2.1 provides general tips for what you can do to provide effective first-line support.

Box 2.1: Tips for providing first-line support

- Choose a private place to talk with the survivor, where no one can see or overhear you (but not a place that indicates to others why you are there).
- Assure her that you will not repeat what she says to anyone else and you will not mention that she was there to anyone who does not need to know. If you are required to report her situation, explain in advance what you must report and to whom.
- Encourage her to talk without pushing her, and show that you are listening.
- Encourage her to continue talking if she wishes, but do not force her to talk. You could ask, for example, "Do you want to say more about that?"
- Allow silences. If she cries, give her time to recover.

Remember: Always respect the survivor's wishes.

L ISTENING	Listen to the woman closely, with empathy, and without judging
I NQUIRING ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns – emotional, physical, social and practical (e.g. childcare)
V ALIDATING	Show her that you understand and believe her. Assure her that she is not to blame
E NHANCING SAFETY	Discuss a plan to protect herself from further harm if violence occurs again
S UPPORTING	Support her by helping her to access information, services and social support

13 Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization; 2014 (http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook, accessed 11 March 2019).

2.1 Listening

Listening is the most important part of good communication and the basis of first-line support. It gives the woman a chance to say what she wants to say in a safe and private place to a caring person who wants to help. This is important to her emotional recovery and to meeting her practical needs and ensuring her safety (see Box 2.2).

Box 2.2: Active listening dos and don'ts

Do	Don't
How you act	
Be patient and calm. In humanitarian settings, there are so many pressing needs and demands, but the few extra minutes you offer her could make all the difference	Don't pressure her to tell her story
Your attitude	
Acknowledge how she is feeling. Let a woman know that you are hearing what she is telling you, e.g. "I hear how difficult this has been for you"; "It sounds like a very scary situation"	Don't judge what she has or has not done or how she is feeling. Don't put words in her mouth. Avoid phrases such as, "You shouldn't feel that way" or "You should feel lucky you survived" or "Why did you do that?"
What you say	
Give her the opportunity to say what kind of help she wants, if any. To do this, you may ask questions such as, "How can we help you today?" or "What would you like me to do for you today?"	Don't assume that you know what is best for her
Encourage her to keep talking if she wishes. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until she has finished before asking questions

2.2 Inquiring about needs and concerns

Asking a woman about her needs and concerns is a way to learn what is most important for her. It is important to respect her wishes and respond to her needs (see Box 2.3).

Box 2.3: Techniques for inquiring about needs and concerns

Technique	Examples
Phrase your questions as invitations to speak	"What would you like to talk about?"
Ask open-ended questions to encourage her to talk, instead of asking questions that can be answered with just "yes" or "no"	"How do you feel about that?"
Reflect her feelings back to her in your words so she knows that you have listened/observed and understood	"It sounds as if you are feeling angry about that" "You seem upset"
Ask for clarification if you do not understand	"Can you explain that again, please?" "Could you tell me more about that?"
Help her to identify and express her needs and concerns	"Is there anything that you need or are concerned about?" "It sounds like you may need a place to stay" "It sounds like you are worried about your children"
Summarize what she has expressed	"You seem to be saying that..."
Things to avoid	
Do not ask leading questions, such as, "I would imagine that made you feel upset, didn't it?"	
Don't ask "why" questions, such as "Why did you do that?" They may sound accusing	

2.3 Validating

Validating lets a woman know that her feelings are normal, that it is safe to express them, that she has a right to live without violence and fear, and that you believe what she says without judgement or conditions.

Important things that you can say:
- "It's not your fault. You are not to blame."
- "Help is available." (Say this only if it is true.)
- "What happened has no justification or excuse."
- "No one deserves to be hit by their partner or anyone."
- "You are not alone. Unfortunately, many other women face this problem too."
- "You are valuable. Your life and your health are important."
- "I am worried that this may be affecting your health."

See also the following sections in Part 5 of this guide to help the survivor to deal with various emotions and reactions:
- Provide information about normal stress reactions to an experience of violence.
- Explore and strengthen positive coping methods.

2.4 Enhancing safety

Enhancing safety means helping a woman to assess her situation and make a plan that helps her to stay safer in the future. It often involves

small, incremental steps that can reduce the risk or severity of further violence.

Many women who have been subjected to violence have fears about their safety and may continue to be in situations that are insecure, particularly in emergencies. If a woman has experienced sexual violence, she may face the risk of further violence from the perpetrator, or from other community members, including family. Adolescent girls and unmarried women may be at particular risk due to norms related to honour and virginity. Male survivors may face significant shame and stigma that prevents them from accessing family or community support. Discrimination, persecution and, in some contexts, the criminalization of same-sex relationships pose significant challenges to the safety of sexual and gender minorities. In cases of IPV, safety risks are often ongoing and require careful attention. Vital forms of support include acknowledging safety concerns, helping a survivor to assess the immediate risks of violence, and planning for safety.

Assessing immediate risk and enhancing safety

It is not possible to eliminate a woman's risk of violence completely; however, it is possible to enhance her safety, even if only slightly, within her given situation. This involves assessing her immediate risks of violence, exploring options and available resources, and identifying concrete steps within her control to make herself safer.

- If she is worried about her safety, take her seriously.
- If she is unsure, ask specific questions to see if any situations or people continue to place her at risk.
- Explore existing safety and support strategies that she has used. If any places within a camp or community are unsafe, discuss strategies to avoid them or, if this is not possible, explore whether she has a trusted friend or family member to accompany her to provide support or protection.
- Discuss any available and safe referral options (if she wishes to) including: (i) shelter or safe housing, (ii) contacting an NGO that supports survivors, or (iii) reporting to police or other service providers. In humanitarian settings these options are often limited. In these circumstances work with the survivor to identify other safe places (such as a friend's home or church space) (Job aid 2).
- Particularly in cases of IPV, if she is not safe at home but she still chooses to return home, respect her wishes. Refer her for further support from someone who can help her make a safety plan that she can use if the violence starts again (see Part 4, Step 4). Emphasize that you are there for her and encourage her to come back at any time.
- Avoid putting her at risk.
  - Maintain the confidentiality of her health records by keeping paper-based and electronic files out of sight, in a safe place, and by anonymizing them through coding systems.
  - Discuss with the woman how she will explain where she has been. If she must take paperwork with her (for the police or agencies such as UNHCR, for example), discuss what she will do with the papers so that they will not put her safety at further risk.
  - Talk about abuse only when you and she are alone. No one older than 2 years of age should overhear your conversation. Never discuss it if her husband or other family members or anyone else who has accompanied her – even a friend – may be able to overhear, unless it is her wish to be accompanied in this conversation.

2.5 Supporting

Survivors' needs are generally beyond what can be provided in a clinic. Nevertheless, discussing the woman's needs with her, telling her about other sources of help, and assisting her to get the additional help she wants is part of a health-care provider's essential support (see Box 2.4).

Making referrals

Use the established referral networks and pathways in your setting to refer survivors for additional support or services (see Part 1: Preparations, section 1.7). Whenever possible, give the woman the name of a specific person who can support and assist her at each of the other places.

Box 2.4: How to help

- Ask the survivor what issues are most important to her right now. You can ask her, "What would help the most if we could do it right away?"
- Help her to identify and consider her options.
- Discuss her social support system. Does she have a family member, friend or trusted person in the community to whom she could talk? Does she have anyone who could help her with money?

It may not be possible to address all of a woman's concerns the first time you see her. Let her know that you are available to meet again to talk about other issues. Keep in mind that survivors may not come in for follow-up, however, in humanitarian settings. Therefore, ensure she receives essential information before she leaves.

You can fill in the chart in Job aid 2 to keep track of services in the camp or community. These referrals could be to internal or external resources.

Finally, Box 2.5 answers some common questions about first-line support.

Job aid 2

Referral chart			
Type of support or service	Organization	Contact details	Responsibility for follow-up
Case management and/or psychosocial services			
Protection/safety			
Legal services/justice			
Mental health care			
Services for children, men, sexual and gender minorities and other vulnerable groups			

Box 2.5: Common questions about first-line support

Here are answers to some common questions that health-care providers often ask about working with women who have experienced violence.

Why should I not offer her advice?
Women who have experienced violence need someone who will listen to them actively and without judgement. Listening well, responding with empathy, and giving her space to make her own decisions are far more helpful than you may realize; they may be the most important things you can do. This approach shows her that she matters and helps her to regain some control over her life and her decisions. In addition, only the survivor can understand the full scope of her situation and make the most informed decisions about her life. Advice, though well intended, can put women at even greater risk of violence.

What can I do when I have so few resources and so little time?
First-line support ("LIVES", as described in this section of this guide) is the most helpful care you can give. It does not necessarily take a long time, and it does not require additional resources. You can also make referrals to additional services that may offer important support to women who have experienced violence.

What if she decides not to report to the police?
Respect her decision. Let her know if there is someone she can talk to further about her options, who can also help her report to the police if she changes her mind.

What if I suspect violence but she doesn't acknowledge it?
Do not try to force her to disclose. Your suspicions could be wrong and she understands best how disclosing violence might affect her. You can still provide care and offer further help.

Part 3: Clinical management of rape (step by step)

Rape survivors require specific urgent medical care that is directly related to the type of violence that they have experienced. This is true whether they have experienced rape by a partner or someone else. This section offers step-by-step guidance in providing clinical care to rape survivors. For children who have been raped, please also see Part 6: Caring for child survivors.

IMPORTANT! Immediately refer survivors with life-threatening or severe conditions for emergency treatment.

Steps for the clinical management of rape

Step 1	First-line support (LIVES, Part 2): listening, inquiring about needs and concerns, and validating the survivor
Step 2	Obtaining informed consent and preparing the survivor
Step 3	Taking the history
Step 4	Performing the physical and genital examinations
Step 5	Providing treatment
Step 6	Enhancing safety and referring for additional support (LIVES, Part 2)
Step 7	Assessing mental health and providing psychosocial support
Step 8	Providing follow-up care

Step 1: Listening, inquiring about needs and concerns, and validating

A person who has been raped has experienced a traumatic event and may be in an agitated, depressed or dissociated state. She often feels fear, guilt, shame or anger, or any combination of these. Using the LIVES approach described in Part 2, listen to her, inquire about her needs and concerns, and validate her feelings and experiences. This is the first line of support needed to provide survivor-centred care.

Step 2: Obtaining informed consent and preparing the survivor

Obtaining informed consent

Informed consent is required for examination and treatment and for the release of information to third parties, such as the police and the courts, as relevant.

Steps for obtaining informed consent:

- Explain to the survivor that she will be examined and treated only if she wants. Explain that she can refuse any (or all) aspects of the examination and can stop at any time (even after initial consent).
- Adapt the consent procedures when working with child survivors (see Part 6). A parent or caregiver should sign the consent form unless he or she is the suspected offender. Older adolescent minors may be able to give consent themselves, depending on their age and evolving capacities.
- Describe the four parts of the examination, explaining what is going to happen during each part, why it is important, what it will tell you, and how it will influence the care you are going to give:
  1. physical examination
  2. genital examination
  3. forensic evidence collection (if available and relevant)
  4. sharing medical information and evidence with the police if she wants legal redress.
- When describing each part of the examination, ask the survivor if she has any questions, and answer them fully. Make sure that the survivor understands. Then, ask her to decide whether she consents to each part (yes or no) and tick the corresponding boxes on the form (see Annex 2).
- After ensuring that the survivor has understood the examination and the form completely, ask her to sign. If she cannot write, obtain a thumb print.
- Ask another person to sign the form as a witness, if required.

Do not force or pressure the survivor to do or say anything against her will. Explain that she can refuse any step of the examination at any time as it progresses.

Box 3.1 provides further information about mandatory reporting and informed consent, and Box 3.2 briefly covers the issue of talking to a survivor about reporting to the police.

Box 3.1: Mandatory reporting and informed consent

Health-care providers need to be aware of the laws and obligations on mandatory reporting of sexual violence/rape and intimate partner/domestic violence to the police or authorities. While mandatory reporting is often intended to protect survivors (particularly children), in some cases it may conflict with the guiding principles for working with survivors. Furthermore, in the case of adults, it impinges on their autonomy and ability to make their own decisions. It may raise safety concerns as women may experience retaliation, fear losing custody of their children, or face legal consequences (e.g. in countries where extramarital sex is illegal).

In countries where same-sex relationships are criminalized, men and/or sexual and gender minorities may be hesitant to seek health services if mandatory reporting is required. Health-care providers need to understand their legal obligations (if any) and their professional codes of practice to ensure that survivors are informed fully about their choices and limitations of confidentiality where this is the case. By ensuring survivors are aware of mandatory reporting requirements, health-care providers can help survivors make informed decisions about what to disclose during a health visit.

Box 3.2: Talking to a survivor about reporting to the police

- If the law requires you to report to the police, tell the survivor that as early as possible.
- If the survivor wants to go to the police, ensure that you have all the forms health professionals are required to complete. Explain what the forms are and why they are needed.

In some contexts, the police may require forensic evidence. If this is the case and the survivor wishes to report to the police, refer to Step 4 and Annex 3 for guidance on collecting forensic evidence.

Preparing the survivor

- Reassure the survivor that she is in control of the pace, timing and components of the examination.
- Reassure her that the examination findings will be kept confidential unless she decides to bring charges or if there are mandatory reporting laws.
- Seek consent for and ensure that another person is present during the examination. Ask her if she wants to have a specific person present for support. Try to ask her this when she is alone. If the survivor does not have someone specific she requests, this should preferably be a trained support person or female health worker. It is essential to have a woman present if the provider conducting the examination is male. Introduce this person, explain that she is there to give the survivor help and support.
- Keep the number of people in the examination room to the minimum necessary.

Step 3: Taking the history

The survivor's history includes four parts: (a) general medical information; (b) talking about the rape incident(s); (c) gynaecological history; and (d) assessment of mental state. A sample history and physical examination form are included in Annex 4, outlining specific information and questions you might ask for the history. Job aid 3 also details the topics to cover when taking the history.

General tips for taking the history

- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Before taking the history, review any papers that the survivor has brought with her. Avoid asking questions that have already been asked and documented.
- Let the survivor tell the story the way she wants to, at her own pace. Do not interrupt or pressure her.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Do not make stigmatizing or blaming remarks, such as "What were you doing there?" Take time to collect all information needed, without rushing.

IMPORTANT! Do not force a survivor to talk about sexual violence she has experienced if she does not want to. Limit questions to what is required for medical care. However, if a survivor clearly wants to talk about what happened, it is very important to listen actively, with empathy and without judgement.

Job aid 3

Topics to cover when taking the history with a rape survivor		
Topics to cover	**Purpose**	**What to cover**
General information	• Recording and monitoring	• Identifier/name, address, sex, date of birth or age • Date and time of examination and staff or support person present
Prior medical history	• To understand examination findings • To inform most appropriate treatment to provide, counselling needed and follow-up health care	• Current or past health problems • Allergies • Use of medications • Vaccination • HIV status
Rape incident	• To guide the examination so that all injuries can be found and treated • To assess the risk of pregnancy, sexually transmitted infections (STIs), HIV, tetanus and hepatitis B • To guide specimen collection and documentation • To determine most appropriate treatment, counselling and follow-up health care	• Timing of the incident (how recent) • General description of incident • Has she bathed, urinated, vomited, used a vaginal douche or changed her clothes after the incident (relevant if collecting forensic evidence)?
Gynaecological history	• To identify whether there is a risk of pregnancy and/or STIs • To check whether any examination findings could result from previous traumatic events, pregnancy or delivery	• Evaluation for possible pregnancy • Details of contraceptive use • Date of last menstrual period
Mental health	• To assess mental health status and need for referral • To help her identify positive coping strategies • To assess her sources of support	• How she is feeling, what are her emotions; see Part 4, Step 5 (Assess mental health and provide psychosocial support) and further information in Part 5

Step 4: Performing the physical and genital examinations

The main reason for the physical and genital examinations is to determine what medical care is needed for the survivor. These examinations are also used to complete any legal documentation.

Make sure you obtain voluntary informed consent for the examination and for obtaining any samples if collecting forensic evidence (see Step 2 above and the sample consent form in Annex 2), and make sure all equipment and supplies are prepared before proceeding. In most instances, forensic evidence must be collected within 72 hours of the incident, though this will vary depending on the type of evidence being collected and national protocols. Even if forensic evidence collection is not feasible or the survivor does not want it, a thorough physical examination is recommended for documenting and treating injuries.

General guidelines

- Assure the survivor that she is in control. She can ask questions, stop the examination at any time and refuse any part of the examination.

- Never ask her to undress or uncover completely. Examine the upper half of her body first, then the lower half; and give her a gown, sheet or blanket to cover herself.
- At each step of the examination, tell her what you are going to do, and ask her permission before you do it.
- Always look at the survivor before you touch her and pay attention to her appearance and emotional state.
- Ask often if she has any questions and if you can proceed. If she says "no", then stop the examination at that point.
- Take the survivor's vital signs (pulse, blood pressure, respiratory rate and temperature).
- Record all your findings and observations as clearly and completely as possible on a standard examination form (see Annex 4).

The initial assessment of a survivor may reveal severe medical complications that need to be treated urgently, and for which the patient may have to be admitted to hospital. The treatment of these complications is not covered here. Such complications might include:

- extensive trauma (to genital region, head, chest or abdomen);
- asymmetric swelling of joints;
- neurological deficits; and/or
- respiratory distress.

Physical examination

- Systematically examine the survivor, using Job aid 4 and Annex 4.
- Remember to look in the eyes, nose and mouth (inner aspects of lips, gums and palate, in and behind the ears, and on the neck).
- Look for signs that are consistent with the survivor's story, such as bruises, bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or perforated eardrums, which may be a result of being slapped (see Job aid 4).
- If the survivor reports being throttled or choked, look in the eyes for petechial haemorrhages and on the neck for bruises or finger marks.
- Examine the body area that was in contact with the surface on which the sexual violence occurred to see if there are injuries.
- Record all your findings and observations clearly and fully on the examination form and the pictograms (Annexes 4 and 5), taking care to document and record the type, size, colour, location and form of any bruises, lacerations, injuries, ecchymoses and petechiae, as this can be important evidence.
- Take note of the survivor's mental and emotional state (withdrawn, crying, calm, etc.)
- If collecting forensic evidence, take samples of any foreign material on the survivor's body or clothes (blood, saliva and semen), fingernail cuttings or scrapings, swabs of bite marks, etc., according to the local evidence collection protocol.

Special considerations for male rape survivors are described in Box 3.3. Note that postmenopausal women have decreased hormonal levels, resulting in reduced vaginal lubrication and a thinner and more friable vaginal wall. If sexually assaulted, they are at a higher risk of vaginal and/or anal tears and injury, and transmission of STIs, including HIV. Use a narrow speculum for the genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

Box 3.3: Special considerations for male rape survivors

- Men and boys are also at risk of rape (see also Part 6: Caring for child survivors for further guidance on care for boys). The role of the health-care provider is the same for male survivors, and first-line support remains important care that you can give (see LIVES, in Part 2).
- Male survivors of rape can be as likely as women to underreport the incident, because of shame and stigma. While the physical effects differ, the psychological trauma and emotional after-effects for men are similar to those experienced by women.
- When a man is raped anally, pressure on the prostate can cause an erection and even orgasm, which can contribute to feelings of shame and self-blame; reassure the survivor that, if this has occurred during the rape, it was a physiological reaction and was beyond his control.
- The physical examination can be sensitive for male survivors, and it is important to follow the general guidelines above.

Genital examination

- A genital examination is a sensitive examination, particularly the speculum examination. Therefore, use the general guidance above to help the survivor to feel as comfortable as possible. Remember to let the survivor know when and where you will touch them and ask for permission when conducting each part of the examination.

Remember: Being sexually assaulted/raped is a traumatic event. Survivors may be very sensitive to being examined or touched, particularly by a male health-care provider. Proceed slowly. Ask often if she is okay and if you can proceed. Be very careful not to increase her distress.

Virginity (or "two-finger") testing has no medical or scientific validity. It should never be conducted.

Examination of the external genital and anal areas for women

Examine the survivor systematically, using Job aid 4 to guide you. Make sure that you have a good light source to view injuries. Specifically, be sure to conduct the following steps.

- Help the woman to lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her body and expose only the parts of her body you are examining.
- Inspect, in the following order, the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra and introitus.
  - Note any previous scars from female genital mutilation or childbirth.
  - Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette). Note the location of any tears, abrasions and bruises on the pictogram and the examination form.
  - Look for any sign of infection, such as ulcers, vaginal discharge or warts.
  - Check for injuries to the vulva, introitus and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.
  - If collecting forensic evidence, take samples according to your local evidence collection protocol. If collecting samples for DNA analysis, make sure you take swabs from around the anus and perineum before the vulva, in order to avoid contamination.
- For the anal examination, the patient may have to be in a different position than for the genital examination. Write down the position used for each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination).
- Note the shape and dilatation of the anus; any fissures around the anus; the presence of faecal matter on the perianal skin; and any bleeding from rectal tears.
- If collecting forensic evidence, and if agreed by the survivor and indicated by the history, collect samples from the rectum according to the local evidence-collection protocol.

Examination of the internal genital and anal areas for women

An internal, speculum examination is very sensitive and should be done only if there has been vaginal penetration and if there are any of the following indications: bleeding, pain, foul-smelling discharge, or to reassure the survivor that there are no serious injuries. The appropriate procedures are listed below.

- Gently insert a speculum, preferably warm, lubricated with water or normal saline. Lubricants are not recommended as they may interfere when collecting samples. Never use a speculum when examining prepubescent girls (see Part 6: Caring for child survivors).
  - Under good lighting, inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
  - If collecting forensic evidence, take swabs and collect vaginal secretions according to the local evidence collection protocol. This can be sensitive for the survivor, so remember to inform her in advance and ensure she is comfortable proceeding.
- If indicated by the history and the examination findings thus far, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.
- If indicated, do a rectovaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge. Note the sphincter tone. If there is bleeding, pain or the suspected presence of a foreign object, refer the patient to a hospital.
- Record all your findings and observations clearly on the history and examination forms (Annex 4) and on the pictograms (Annex 5).

Be aware of social norms that, in some cultures, may prohibit internal vaginal examinations, including with a speculum, finger or swab. Respect the survivor's choice as to whether or not to have an internal examination. You may have to limit your examination to inspection of external genitalia unless there are symptoms of internal damage or other indications.

Examination of the external and internal genital and anal areas for men

When examining male survivors:

- Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus and anus.
- Note if the survivor has been circumcised.
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.

- Torsion of the testis is a medical emergency and requires immediate surgical referral.
- If the urine contains large amounts of blood, check for penile and urethral trauma.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- If relevant, collect material from the anus for direct examination for sperm under a microscope.

Recording the examination findings and the treatment provided

In contexts where mandatory reporting is in place or the survivor chooses to report the rape to the authorities, health-care providers often must answer questions from police, lawyers or the courts about injuries and other consequences to women they have treated. Careful documentation of the findings and the treatment provided (see Step 5: Provide treatment), using the history and examination form (Annex 4), will make it easier for you to answer accurately. Survivors who do not consent to a physical examination, or who are not able to complete the examination, should still be offered treatment based on a thorough history.

Tips for documentation

- Record the interview and your findings at the examination in a clear, complete, objective, non-judgemental way. Do not reformulate the verbal account of the patient.

Box 3.4: If a rape survivor presents *after* 72 hours

If the survivor presents more than 72 hours after the incident, the ability to collect forensic evidence will be limited. A thorough physical examination remains important for documenting and treating injuries.

Assess them for:

- size and colour of any bruises and scars;
- evidence of possible complications of the rape/assault (deafness, fractures, abscesses, etc.);
- signs of pregnancy; and
- mental state (withdrawn, depressed, suicidal).

Even when one might not expect to find injuries, the survivor might feel that she has been injured. A careful inspection with subsequent reassurance that no physical harm has been done may be a great relief and of benefit to the survivor, and it might be the main reason for seeking care. It is also important to explain to the survivor that genital injuries heal quickly and that the absence of injuries does not necessarily mean they were not raped or previously injured.

For the genital examination, if the assault occurred more than 72 hours prior to it, note any healing injuries and/or recent scars to the genitalia. If the assault occurred more than a week ago and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal discharge or ulcers), there is no indication to do an internal/speculum examination.

Job aid 4

Post-rape examination checklists	
Look at all the following	**Look for and record the following**
Physical examination checklist	
• General appearance • Hands and wrists, forearms, inner surfaces of upper arms, armpits • Face, including inside of mouth • Ears, including inside and behind ears • Head • Neck • Chest, including breasts • Abdomen • Buttocks, thighs (including inner thighs), legs, feet	• Active bleeding or fresh wounds • Bruising • Redness or swelling • Cuts or abrasions • Evidence that hair has been recently pulled out, and evidence of recent loss of teeth • Injuries such as bite marks, scratchings, or stabbing or gunshot wounds • Evidence of internal, traumatic injuries to the abdomen • Ruptured ear drum
Genital examination checklist	
• Genitals (external) • Genitals (internal examination, using a speculum) • Anal region (external)	• Active bleeding or fresh wounds • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

- It is not the health care provider's responsibility to determine whether or not someone has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- Completely assess and document the physical and emotional state of the survivor.
- Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds (see Table 3.1). Record your findings on pictograms (see Annex 5). Health-care providers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible (see Table 3.1), without speculating about the cause, as this can have profound consequences for the survivor and accused attacker.
- Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.
- Make a note of any sample collected as evidence.

The medical certificate

- Medical care of a survivor of sexual violence/rape includes preparing a medical certificate (see Annex 6). This is a legal requirement in most countries. It is the responsibility of the health-care provider who examines the survivor to make sure such a certificate is completed.
- The medical certificate is a confidential medical document that the health-care provider must hand over to the survivor. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story.
- Depending on the setting, the survivor may use the certificate up to 20 years after the event to seek justice or compensation. The health-care provider should keep one copy locked away with the survivor's file, in order to be able to certify the authenticity of the document supplied by the survivor before a court, if requested. The survivor has the sole right to decide whether and when to use this document.
- The medical certificate may be handed over to legal services or to organizations with a protection mandate only with the explicit agreement of the survivor.
- The medical certificate should be available for free; survivors should not be charged for it.
- The medical certificate should not include a requirement or tick-box to indicate whether or not rape has occurred.

While the health-care provider may document the examination and care they provide, it is NOT their job to determine whether a rape has occurred. Rape is a legal definition and it is not

Table 3.1: Describing features of physical injuries

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

Box 3.5: Forensic evidence collection for rape survivors

The main purpose of the examination of a rape survivor is to determine what medical care is needed. Forensic evidence may also be collected to help the survivor to pursue legal redress where this is possible and if they wish to do so. However, in many settings, the ability to process forensic evidence or for it to be used for legal action is extremely limited or non-existent. This is particularly true in humanitarian contexts.

- Do not collect evidence that cannot be processed or that will not be used for legal action.
- Do not collect evidence if the violence reported is not considered a crime under the relevant laws.
- *Do not collect evidence if the survivor chooses not to have evidence collected. Respect her choice.*

If forensic evidence is going to be collected (i.e. if there is capacity to process and use forensic evidence in your setting, and the survivor consents), then – whenever possible – it should be collected during the medical examination so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic. Documenting injuries and collecting samples, such as blood, hair, saliva and semen, within 72 hours of the rape may help to support the survivor's story and might help to identify the perpetrator(s). If the survivor presents more than 72 hours after the rape, the amount and type of evidence that can be collected will depend on the situation.

Before beginning the examination or collection of evidence:

- Explain to the survivor what evidence collection would involve.
- If she wants evidence collected, call in or refer her to a specifically trained provider who can do this.
- Even if forensic evidence is not collected, conduct the full physical and genital examination (if the survivor gives consent to do so) and make sure it is well documented (see Step 4, Job aid 4, and Annexes 4 and 5). The examination documentation itself can be useful if a survivor decides to pursue a legal case.

necessary to make this determination in order to provide appropriate care.

For further details on forensic examinations, see Annex 3 as well as *Strengthening the medico-legal response to sexual violence*.[14]

Step 5: Providing treatment

Remember: Immediately refer survivors with life-threatening or severe conditions for emergency treatment.

Treatment will depend on how soon after the incident the survivor presents to the health service. Follow the steps in section A if she presents within 72 hours of the incident, and section B if she presents more than 72 hours after the incident. Male survivors need the same vaccinations and STI treatment as female survivors. Section C outlines self-care information.

Job aid 5 at the end of Step 5 presents treatment timelines for different appropriate interventions.

A. Treatment for a rape survivor who presents within 72 hours of the incident

Treat physical injuries or refer

Provide wound care

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

Complications that may need urgent hospitalization, include:

- extensive injury (to genital and/or anal region, head, chest or abdomen);
- neurological deficits (e.g. cannot speak, problems walking);
- respiratory distress;
- swelling of joints on one side of the body; and/or
- fever and sepsis.

14 World Health Organization (WHO), United Nations Office on Drugs and Crime (UNODC). Strengthening the medico-legal response to sexual violence. Geneva: WHO; 2015 (https://www.who.int/reproductivehealth/publications/violence/medico-legal-response/en/, accessed 27 August 2019).

Prevent tetanus

Good to know before you develop your protocol

- Tetanus toxoid is available in several different preparations. Check local vaccination guidelines for recommendations.
- Tetanus immunoglobulin (antitoxin) is expensive and needs to be refrigerated. It is usually not available in low-resource settings.

- If there are any breaks in the skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.
- Use Table 3.2 to decide whether to administer tetanus toxoid vaccination (which gives active protection) and tetanus immunoglobulin, if available (which gives passive protection).
- If the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes, and different sites of administration.
- Advise survivors to complete the vaccination schedule for full protection (i.e. second dose at 4 weeks, third dose at 6 months to 1 year).

Prevent pregnancy

A woman who has been raped should be offered emergency contraception (EC). If EC is used within 120 hours (5 days) after the rape, it can help a woman to avoid pregnancy, although it is most effective immediately and within the first 72 hours (3 days) after the incident. If available, do a pregnancy test to assess for pre-existing pregnancy. A pregnancy test is *not* necessary before providing EC but can be helpful to determine whether she was pregnant prior to the rape. There are three regimens for EC pills:

- ulipristal acetate (30 mg single dose);
- progestogen only (levonorgestrel 1.5 mg single dose or two 0.75 mg tablets); and
- combined estrogen-progestogen (100 µg ethinyl estradiol + 0.5 mg levonorgestrel, repeated 12 hours later).

The combined EC pills are less effective and have more side-effects than the other options. See Annex 7 for protocols for EC.

Facts about emergency contraception pills

- Any woman can take EC pills; there is no need to screen for health conditions or to test for pregnancy.
- EC does not cause termination of an already existing pregnancy. It simply prevents a potential pregnancy from happening.
- A woman can also receive a supply of EC pills in advance for future need.
- There are no restrictions on age.

Explaining emergency contraception

You may ask the woman if she has been using an effective contraceptive method, such as oral contraceptive pills, injectables, implants, an intrauterine device (IUD) or female sterilization. If so, it is not likely that she will get pregnant. If her last menstrual period began within 7 days before the rape, she is also not likely to get pregnant.

- Use of EC is a personal choice that only she, the woman herself, can make.
- EC can help her to avoid pregnancy, but it is not 100% effective.
- EC pills work mainly by stopping the release of the egg.
- EC pills will not cause abortion.
- EC pills will not prevent pregnancy the next time she has sex.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant.
- She does not need to have a pregnancy test before taking EC pills. However, a pregnancy test may identify if she is pregnant already. If she is already pregnant, EC pills will not work, but they will not harm the pregnancy.

Table 3.2: Decision table for administration of tetanus toxoid (TT) and tetanus immunoglobin (TIG)

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

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

Instructions for taking emergency contraception pills

- The girl/woman should **take the EC pills as soon as possible**, as they become less effective with each day that passes.
- EC pills, antibiotics for STIs and post-exposure prophylaxis (PEP) for HIV prevention can be taken at the same time without harm. EC and antibiotics can be taken at different times and along with food to reduce nausea, and an antiemetic can be given to prevent nausea and vomiting (see below).
- If she vomits within 2 hours after taking EC pills, she should return for another dose as soon as possible. If she is taking combined pills for EC, she can take antiemetic medicine (meclizine hydrochloride) 30 minutes to 1 hour before the EC pills to reduce nausea.
- She may have spotting or bleeding a few days after taking EC pills.
- She should return if her next menstrual period is more than one week late.
- Note that certain enzyme-inducing medications (e.g. rifampicin or efavirenz) reduce the effectiveness of oral hormonal contraceptives. If the patient had been taking one of these medications before the rape, she will need to take a double dose of EC pills.

Emergency copper-bearing intrauterine device

- This IUD can be used for EC up to 5 days after unprotected intercourse.
- This should not be considered as an option if she is pregnant.
- This option is more effective for EC than EC pills.
- This IUD offers long-term pregnancy protection and can be maintained for up to 12 years after insertion. Fertility returns with no delay after this IUD is removed.
- If an IUD is inserted, make sure you give full STI treatment, as recommended in Annex 8.

Prevent HIV

Post-exposure prophylaxis for HIV infection (PEP) should be started **as soon as possible and up to 72 hours after possible exposure to HIV** (see also Annex 9).

There are situations when PEP is not recommended, even within 72 hours:

- The rape survivor is living with HIV (note that if the survivor is living with HIV and not taking antiretroviral therapy, she should be referred for HIV treatment immediately).
- The perpetrator is known not to have HIV infection (if there is doubt, PEP should be offered).

Health-care providers should provide information on risk factors for HIV transmission so that survivors are able to make an informed decision about whether to take PEP. The risk of a potential HIV transmission is high if any of the following apply:

- there was vaginal, anal or oral penetration;
- the survivor has been exposed to bodily fluids that may pose a risk of HIV infection (e.g. blood, blood-stained saliva, genital secretions, rectal fluids) through wounds or tears in other mucous membranes;
- the survivor was unconscious or does not remember what happened;
- the assailant is known to be an injecting drug user; or
- the survivor was raped by multiple perpetrators.

Taking PEP to prevent HIV is the survivor's decision. Discuss the following points to help her decide.

- Certain factors increase the risk of HIV transmission (see above).
- PEP can lower her chances of acquiring HIV, but it is not 100% effective.
- The medication needs to be taken for 28 days, either once or twice daily depending on the regimen used.
- About half of people who take PEP experience side-effects, such as nausea, tiredness and headaches. For most people, the side-effects decrease in a few days.
- It is important to complete the full course of PEP to ensure protective efficacy.

Instructions for taking post-exposure prophylaxis

- Start the regimen as soon as possible and no later than 72 hours after the incident.
- The choice of PEP medications should be based on national guidelines.
- Nevirapine (NVP) should not be used for PEP due to the high risk of toxicity that can lead to a higher likelihood of PEP discontinuation.
- Offer follow-up at regular intervals.
- Offer HIV counselling and testing at the initial consultation. Do an HIV test only if the survivor consents and if PEP and treatment for HIV are available in the setting.
- Retest for HIV three or six months (or both) after giving PEP, with survivor consent.
- In the case of a positive test result for HIV, refer for HIV treatment and care. Referral services and pathways should have been identified in the preparatory phase (see Part 1).

Post-exposure prophylaxis adherence counselling

Adherence is an important element of providing PEP since it must be taken once or twice daily for 28 days. Discuss the following points with the survivor.

- It is important to remember to take each dose. It can help to take the treatment at the same time every day, such as at breakfast and/or dinner (depending on frequency of dosing) or to receive scheduled reminders or messages through a mobile phone, family member or friend. Taking the pills at regular intervals ensures that the level of the medication in the blood stays about the same.
- Some PEP medications may need to be taken with food.
- In the case of a missed dose:
  - With once-daily regimens, if she forgets to take her medicine on time, she should still take it, if it is less than 12 hours late. If it is more than 12 hours late, she should wait and take the next dose at the regular time.
  - With twice-daily regimens, if a dose is missed, she should not take two doses at the same time.
- The survivor should return to the clinic if she experiences side-effects that do not go away in a few days, if she is unable to take the medications as prescribed, or if she has any other problems.

Prevent sexually transmitted infections

- Survivors of rape should be given antibiotics to presumptively treat chlamydia, gonorrhoea and syphilis.
- Provide STI presumptive treatment on the survivor's first visit.
- Give presumptive treatment for STIs based on national protocols. As much as possible, provide single oral doses, as these are easiest to take.
- On return visit, provide additional treatment based on STI testing if available, or if STI testing is not done, treat STIs syndromically. This will also be a good time to do a syphilis test if possible.

Sample medication regimens for STI treatment, including for children, are included in Annex 8.

Prevent hepatitis B

Good to know before you develop your protocol

- Find out the prevalence of hepatitis B in your setting, as well as the vaccination schedules in the survivor's country of origin and in the host country.
- Several hepatitis B vaccines are available, each with different recommended dosages and schedules. Check the dosage and vaccination schedule for the product that is available in your setting.

The hepatitis B virus can be sexually transmitted. Rape survivors should therefore be offered immunization for hepatitis B, particularly in high-prevalence settings.

- Ask the survivor about any prior vaccinations against hepatitis B. See Table 3.3 for treatment guidance.
- If her immunization status is uncertain, test first if possible. If she is already immune (i.e. test results show the presence of the hepatitis B surface antibody in serum), no further vaccination is needed. If testing is not possible, vaccinate.
- Use the type of vaccine, dosage and immunization schedule that is used in the country where you are working.
- A vaccine without hepatitis B immunoglobulin (HBIG) can be used.
- Give the vaccine intramuscularly in the deltoid region of the arm.

Table 3.3: Prior hepatitis B vaccination and treatment guidance

Immunization status	Treatment guidelines
No, never vaccinated for hepatitis B	1st dose of vaccine: at first visit 2nd dose: 1–2 months after the first dose (or at the 3-month follow-up visit* if not done earlier) 3rd dose: 4–6 months after the first dose
Started but has not yet completed a series of hepatitis B vaccinations	Complete the series as scheduled
Yes, completed series of hepatitis B vaccinations	No need to re-vaccinate

* See Step 8: Provide follow-up care.

Laboratory testing

If indicated by the history or the findings on the examination, further samples may be collected for medical purposes.

- If the survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and for possible culture.
- Do a pregnancy test, if indicated and available.
- Other diagnostic tests, such as X-ray and ultrasound examinations, may be useful in diagnosing fractures and abdominal trauma.

B. Treatment for a rape survivor who presents 72 hours or more after the incident

Treat physical injuries or refer

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

Tetanus

Tetanus usually has an incubation period of 3–21 days, but it can be many months. Refer the survivor to the appropriate level of care if you see signs of a tetanus infection. If she has not been fully vaccinated, vaccinate immediately, no matter how long it has been since the incident. If there remain major, dirty, unhealed wounds, consider giving tetanus immunoglobulin if this is available (see "Prevent tetanus" and Table 3.2 in section A of Step 5, above).

Pregnancy

If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, emergency contraceptive (EC) pills will reduce the chance of a pregnancy. The regimen is most effective if taken within 72 hours, but it is still moderately effective within 120 hours after unprotected intercourse. The insertion of a copper-bearing IUD is an effective method of preventing pregnancy if inserted within 5 days of the rape.

If a woman presents 5 or more days after the incident, EC will not be effective, and she should be tested for pregnancy if her next menstrual period is more than a week late.

Female survivors of rape are likely to be very concerned about the possibility of becoming pregnant as a result of rape. If the survivor does become pregnant, emotional support and clear information are needed to ensure that she understands the choices available.

In many countries, the law allows the termination of a pregnancy resulting from rape. Furthermore, the local interpretation of abortion laws in relation to the mental and physical health of the woman may allow termination of the pregnancy if it is the result of rape. Find out whether this is the case in your setting. If you are unable to provide safe abortion, determine where it is available so that you can refer survivors, if legal and if they choose this option. More guidance can be found in WHO's *Clinical practice handbook for safe abortion care*.[15]

There may be adoption or foster care services in your area. Find out what services are available and give this information to the survivor.

HIV transmission

PEP for HIV should not be offered if the survivor comes after 72 hours. However, health-care providers should consider the range of other HIV interventions and referrals that should be offered to survivors presenting 72 hours or more after the incident. In some settings, testing for HIV can be done as early as six weeks after a rape. Generally, however, it is recommended that the survivor is referred for testing and counselling 3–6 months after the incident, to avoid the need for repeated testing. Check the HIV services available in your setting and their protocols.

STIs

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

Hepatitis B

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

Laboratory testing

- If the survivor has complaints that indicate a urinary tract infection, collect a urine sample to test for erythrocytes and leukocytes, and for possible culture.

15 Clinical practice handbook for safe abortion care. Geneva: World Health Organization; 2014 (https://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion, accessed 14 March 2019).

- Do a pregnancy test, if indicated and available.
- Screen for STIs, if testing is available.
- If you suspect fractures or abdominal trauma, consider other diagnostic tests, such as X-ray and ultrasound examinations.

C. Plan for rape survivor's self-care (regardless of whether the survivor presented within 72 hours of the incident or later)

Explain your examination findings and treatment plan

Discuss the examination findings, what they may mean for the survivor's health, and any treatments provided. Invite her to voice questions and concerns. Respond in detail and check her understanding.

Self-care for injuries

- Teach the survivor how to care for any injuries.
- Describe the signs and symptoms of wound infection (i.e. if the wound is warm, red, painful or swollen, if there is blood or pus, a bad smell, or fever). Ask her to return or to see another health-care provider if these signs develop.
- Explain the importance of completing the course of any medications given, particularly antibiotics. Discuss any likely side-effects and what to do about them.

Self-care for preventing STIs

- Discuss the signs and symptoms of STIs, including HIV. Advise the survivor to return for treatment if any signs or symptoms occur.
- Advise her to avoid sexual intercourse until all treatments or prophylaxis for STIs have finished.
- Encourage her to negotiate for the use of condoms during sexual intercourse at least until her STI/HIV status has been determined at the three- or six-month follow-up visit (see Step 8). Discuss strategies for refraining from sexual intercourse or negotiating the use of condoms, recognizing that she may be at risk of violence as a result.

Step 6: Enhancing safety and referring for additional support

Address safety concerns and ensure the rape survivor is referred to further support services

It is important to try to understand the immediate risks to a survivor and help her to make a plan to enhance her safety. A survivor of rape often knows the person who has assaulted her. Even when the perpetrator is unknown, the survivor may face risks from her family or community. Ask the survivor if she has a safe place to go, and if she does not, efforts should be made to find one

Job aid 5

Post-rape treatment timelines

	Treatment	Timeline and specifics
Priority within 72 hours	**Treatment of physical injuries**	**Immediately** refer the survivor to emergency care for life-threatening conditions. Clean and treat less severe injuries on-site.
	Post-exposure prophylaxis for HIV infection (PEP)	Provide PEP **as soon as possible and within 72 hours of the rape**. People may not be able to access services within this time. Health-care providers should refer survivors accessing services more than 72 hours after the incident to other HIV services.
	Emergency contraception (EC)	Provide EC **as soon as possible** and up to 120 hours after the rape.
	Presumptive treatment of sexually transmitted infections (STIs)	**As soon as possible**, provide presumptive treatment for chlamydia, gonorrhoea and syphilis. If the survivor presents more than a few weeks after the incident, treat according to syndromic model or through laboratory testing, if available.
	Tetanus prophylaxis	Treat according to risk and pre-exposure vaccination status.
	Hepatitis B prophylaxis	Vaccinate according to protocol, unless already vaccinated.
	Management of unwanted pregnancy	Provide counselling and discuss options with the survivor.

for her. For further guidance, refer to "Enhance safety" in Part 2: Providing first-line support.

Once safety issues are addressed, ensure that the survivor is referred to other appropriate services, such as GBV case management, the police, legal support or support groups, according to established referral pathways and based on her needs and wishes (see Part 1: Preparations). Survivors may face numerous problems, such as stigma, isolation and family rejection, which require attention from multiple service providers. To help you to support survivors to access further services, use the guidance in the section on "Support" in Part 2: Providing first-line support.

Step 7: Assessing mental health and providing psychosocial support

The health-care provider's role does not end with the physical examination. Medical care for survivors of rape includes assessing for psychological and emotional problems, and providing basic psychological and other support and, if necessary, referring the survivor to other service providers to address common mental disorders, substance abuse, risk-taking behaviour and other mental health or social problems. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to psychosocial support services if they exist.

Survivors are at an increased risk of a range of symptoms, including feelings of guilt and shame, anger, anxiety, fear, nightmares, suicidal thoughts or attempts, numbness, substance abuse, sexual dysfunction, medically unexplained somatic complaints and social withdrawal.

Provide basic, non-intrusive practical care. Listen, but do not force her to talk about the event, and ensure that her basic needs are met. Because it may cause greater psychological problems, do not push survivors to share their personal experiences beyond what they would naturally share. Acknowledge that the survivor has experienced a serious physical and emotional event. Explain that it is common to experience strong negative emotions or numbness after rape.

In most cultures, there is a tendency to blame the survivor in cases of rape. If the survivor expresses guilt or shame, explain gently that rape is always the fault of the perpetrator and never the fault of the survivor. Assure her that she did not deserve to be raped, that the incident was not her fault, and that it was not caused by her behaviour or manner of dressing. Do not make moral judgements of the survivor.

More detailed guidance for addressing the mental health concerns of survivors is included in Part 5: Additional care for mental health and psychosocial support.

Step 8: Providing follow-up care

Follow-up visits should take place two weeks, one month, three months and six months after the initial visit. In some humanitarian settings, longer-term follow up may not be feasible, particularly if displacement is ongoing. Health-care providers should aim to have at least one follow-up visit within the first three months and should ensure that essential care and medication is provided during the first visit. A checklist for each of the follow-up visits is provided in Table 3.4.

Table 3.4: Checklist for follow-up visits with a rape survivor

Two-week follow-up visit	
Injury	• Check that any injuries are healing properly.
STIs	• Check that the survivor has taken the full course of any medication given for sexually. transmitted infections (STIs). • Check adherence to post-exposure prophylaxis (PEP), if she is taking it. • Discuss any test results.
Pregnancy	• Test the woman for pregnancy if she was at risk. If she is pregnant, explain and discuss the available options. If abortion is legally available, and she chooses this option, refer her for safe abortion.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status (see Step 7).
Planning	• Remind her to return for further hepatitis B vaccinations in 1 month and 6 months, and for HIV testing at 3 months and 6 months, or else to follow up with her usual health-care provider. • Ask her to return for follow-up care if emotional or physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by 1 month after the incident. • Make the next routine follow-up appointment for 1 month after the initial visit.
One-month follow-up visit	
STIs	• Give the second hepatitis B vaccination, if needed. Remind her of the 6-month dose. • Test for syphilis, gonorrhoea, chlamydia and trichomoniasis (if available), even if presumptive treatment (and testing) was provided near the time of exposure. • Ask the survivor about symptoms of STIs and examine for genital and/or anal lesions or other signs of STIs.[16]
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status (see Step 7). For depression, post-traumatic stress disorder (PTSD), self-harm, suicide or unexplained somatic complaints, see Annex 10.
Planning	• Make next routine follow-up appointment for 3 months after the initial visit.
Three-month follow-up visit	
STIs	• Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care. • If laboratory testing is available, retest for syphilis. • If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status (see Step 7). For depression, PTSD, self-harm, suicide or unexplained somatic complaints, see Annex 10.
Planning	• Make next follow-up appointment for 6 months after the sexual violence incident. Also, remind her of the 6-month dose of hepatitis B vaccine, if needed.
Six-month follow-up visit	
STIs	• Offer HIV counselling and testing if not done before. Make sure that pre- and post-test counselling are available and refer for HIV prevention, treatment and care, as needed. • Give the third dose of hepatitis B vaccine, if needed. • If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status (see Step 7). For depression, PTSD, self-harm, suicide, or unexplained somatic complaints, see Annex 10.

16 When genital ulcers suspicious for syphilis are present on physical exam and a syphilis test is negative, repeat testing may be required to exclude syphilis due to delayed antibody response. A negative treponemal or non-treponemal test at three months after sexual exposure excludes the diagnosis of syphilis. Presumptive treatment with benzathine penicillin or doxycycline (non-pregnant women only) should be provided if suspicious lesions are present. Similarly, testing for chlamydia and gonorrhoea may be negative if provided less than one week after exposure. Repeat testing is needed.

Part 4: Identification and care for survivors of intimate partner violence

Step 1: Identifying whether a woman may be experiencing intimate partner violence

IMPORTANT! WHO does not recommend universal screening for intimate partner/domestic violence of women attending health-care services. WHO does encourage health-care providers to have a high level of awareness of the issue and raise it with women who have injuries or conditions that they suspect may be related to violence.

How do you know if it is intimate partner violence?

Women subjected to intimate partner violence (IPV) often seek health care for related emotional or physical conditions, including injuries and symptoms of stress. Their health problems may be caused by the violence or made worse by it. They may be facing ongoing abuse at home, or they may still be affected by abuse that occurred in the past. Often, a woman will not tell you about the violence due to shame or fear of being judged, or fear of her partner.

You may suspect that a woman has been subjected to IPV if she has any of the following:

- injuries that are repeated or not well explained;
- repeated sexually transmitted infections (STIs);
- multiple unintended pregnancies, miscarriages or unsafe abortions;
- unexplained chronic pain or conditions (e.g. pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches);
- repeated health consultations with no clear diagnosis;
- ongoing emotional issues, such as stress, anxiety or depression;
- harmful behaviours, such as misuse of alcohol or drugs;
- thoughts, plans or acts of self-harm or (attempted) suicide.

What to do if you suspect violence

If you are treating a woman at your health-care facility and suspect that she may have experienced IPV (or that it may be ongoing), there are safe and supportive ways that you can start a conversation with her. Job aid 6 provides examples of the types of statements and questions you can use when asking about IPV.

Before speaking to a woman about IPV, consider the following.

- Never raise the issue of IPV unless a woman is alone. Even if she is with another woman, that woman could be the mother or sister of an abuser.
- If you do ask her about violence, do it in an empathic, non-judgemental manner.
- Use language that is appropriate and relevant to the culture and community you are working in. Some women may not like the words “violence” and “abuse”. Cultures and communities have ways of referring to the problem with other words. It is important to use the words that women themselves use.

Asking about IPV

Here are some statements you can make to raise the subject of violence before you ask direct questions:

- Is anything at home troubling you?
- Many women experience problems with their husband or partner, or someone else they live with. Do you feel safe at home?
- I have seen women with problems like yours who have been experiencing trouble at home.

Here are some simple and direct questions that you can start with that show you want to hear about her problems:

- Are you afraid of your husband (or partner)?
- Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm you in some way? If so, when?
- Does your husband (or partner) or someone at home bully you or insult you?
- Does your husband (or partner) try to control you, for example by not letting you have money or go out of the home?
- Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?
- Has your husband (or partner) threatened to kill you?

Depending on her answers, continue to ask questions, and listen to her story. If she answers "yes" to any of these questions, continue offering empathic support as you assess her needs.

What if you suspect violence but she does not disclose it?

- Do not pressure her; give her time to decide what she wants to tell you. Let her know that if it ever happens to her, or someone else, she is welcome to come back and talk about it.
- Tell her about services that are available if she chooses to use them. Use the referral protocol that is in place to refer her to other services, according to her wishes.
- Offer information on the effects of violence on women's health and their children's health.
- Offer her a follow-up visit.

Step 2: Listening, inquiring about needs and concerns, and validating

Using the LIVES approach described in Part 2, listen to the survivor, inquire about her needs and concerns, and validate her feelings and experiences. This is the first step in providing supportive, survivor-centred care.

Step 3: Providing physical care

A woman who has experienced IPV may have physical injuries or other health conditions that require medical treatment. She may present to your clinic seeking services for a particular condition, whether or not she discloses that it is related to violence. It is important to provide the highest level of health care, in accordance with relevant protocols, while also providing first-line support and ensuring adherence to the guiding principles presented in this guide. Health-care providers should not discriminate against survivors, judge or blame them for the violence they experience, nor deny them the care that they need. If a survivor does not present with any physical or mental health problems, then continue by providing first-line support (see Part 2) and making any referrals to additional services, as needed.

Step 4: Enhancing safety and referring for support

Women who experience IPV often face the threat of continued violence if they return home, and many have limited options but to remain at home and in the relationship. In the case of IPV, women are likely to be at continued risk, even if they do not express concern for their safety. Help the survivor to assess the immediate risk of violence (see Job aid 6), identify and take steps to make herself safe, and access additional support.

Women who continue to live in violent relationships need more comprehensive safety planning and specialized support. Job aid 7 presents elements of a safety plan and

> **IMPORTANT!** If it is not safe for the woman to return to her home or dwelling, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place she can go to (such as a friend's home or a church). These situations should be anticipated and discussed during the process of establishing referral networks and pathways (see Part 1: Preparations), and appropriate resources identified.

Job aid 6

Questions to assess the immediate risk of violence

Women who answer "yes" to at least three of the following questions may be at an especially high immediate risk of violence.

- Has the physical violence happened more often or become worse over the past six months?
- Has he ever used a weapon or threatened you with a weapon?
- Has he ever tried to strangle you?
- Do you believe he could kill you?
- Has he ever beaten you when you were pregnant?
- Is he violently and constantly jealous of you?

Job aid 7

Safety planning	
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How would you get there?
Items to take with you	Would you need to take any documents, keys, money, clothes or other things with you when you leave? What is essential? Can you put these items together in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police and/or assist you if they hear sounds of violence coming from your home?

questions that you can ask her to help her make a plan.

Safety planning and case management are specialized skills that are typically held by trained social workers, psychologists, NGO staff or others working in programmes to respond to violence against women. If these programmes exist in your area, refer IPV survivors to them for more comprehensive, longer-term support.

Once safety issues are addressed, ensure that the survivor is referred to other desired services, such as GBV case management, the police, legal support or support groups, according to established referral pathways and based on her needs and wishes (see Part 1: Preparations). Survivors may face numerous problems such as stigma, isolation and family rejection that require attention from multiple service providers. Use the guidance in the section on "Support", in Part 2: Providing first-line support, to help you support survivors to access further services.

Step 5: Assessing mental health and providing psychosocial support

IPV often involves high levels of emotional abuse and can severely impact a survivor's mental health. Assess the woman's mental health status, provide basic psychosocial support and, if necessary, provide a referral for further services to address psychological problems, such as common mental disorders, substance abuse and risk-taking behaviour. Even though psychological symptoms may not occur, or may disappear over time, all survivors should be offered a referral to a source of psychosocial support for GBV, if one exists.

More detailed guidance for addressing the mental health concerns of survivors is included in Part 5: Additional care for mental health and psychosocial support.

Step 6: Documenting her visit

Documentation is an important part of providing sensitive, ongoing care, as it enables you to remind yourself of what was discussed and addressed and/or to alert another provider at later visits. Documentation of injuries could also be important if the survivor decides to report to the police. To document injuries appropriately, take the following steps.

- Tell the survivor what you would like to write down and why. Ask her if this is okay with her. Follow her wishes. If there is anything she does not want written down, do not record it.
- Enter in the medical record any health complaints, symptoms and signs, as you would for any other patient, including a description of her injuries. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her.
- Do not write anything where those who do not need to know can see it; for example, on an X-ray slip or a bed chart.
- Be aware of situations where confidentiality may be broken. Be cautious about what you write on what document, where you are doing the writing, and where you leave the records. For greater confidentiality, some health-care facilities use a code or special mark to indicate cases of abuse or suspected abuse.
- Remember, the woman trusted you with private and sensitive info rmation. Your actions could easily put her at further risk. Keep her informed and respect her wishes.

Part 5: Additional care for mental health and psychosocial support

Sexual violence and intimate partner violence (IPV) are among the most severe stressors that individuals may experience in their lifetime. They can have important mental health consequences.

Psychological distress reactions are common following violence and may include fear, sadness, anger, feeling dazed or numb, self-blame, feelings of guilt and shame, nightmares, problems sleeping, as well as social isolation and withdrawal. These reactions, however overwhelming, are often temporary and are normal reactions to traumatic events. These problems will likely get better over time, if the violent situation passes. Most survivors recover, especially if they feel safe and receive emotional support and understanding from people they trust.

With IPV, the impact on mental health can be more insidious since IPV may occur repeatedly and over a long period, at times escalating and potentially involving high levels of emotional abuse.

Some women may develop more severe mental health problems such as depression, suicidal ideation, self-harm, post-traumatic stress disorder (PTSD) or have medically unexplained somatic complaints, sleep disorders or anxiety.

General health-care staff should do the following.

- Offer first-line support (see Part 2) and basic psychosocial support (see section 5.1) to all survivors of IPV and sexual violence. This support may be sufficient for those experiencing transient signs of psychological stress. In an emergency setting where a health-care provider may see a survivor only once, this type of support may be the most important help you can give.
- Assess the survivor for mental health problems if symptoms are severe enough to affect day-to-day functioning and do not diminish over time (see section 5.2). If possible, link her to a social worker, counsellor or psychologist who may have more training and/or more time to provide appropriate care.
- Make regular follow-up appointments for monitoring and further support over the next 1–3 months after the incident, if possible.

Cautions

1. Do not routinely prescribe benzodiazepines for insomnia.
2. Do not prescribe benzodiazepines or antidepressants for acute distress.

5.1 Providing basic psychosocial support

Provide information about normal stress reactions to an experience of violence

This can bring relief to survivors and help them to cope better. Health-care providers should let survivors know the following.

- Most women who have been exposed to violence experience symptoms of emotional distress.
- These reactions are normal and common in people who are have gone through a stressful and frightening experience.
- In most cases, these reactions to an experience of violence will improve over time and she is likely to feel better, especially if she has received practical and emotional support from others.

Address current psychosocial stressors

Identify and discuss issues that are causing stress and having an impact on the survivor's life.

Ask:

- What is your biggest worry these days? What are your most serious problems right now?
- How are these problems or worries affecting you?

Assist her to manage stressors:

- Explore and strengthen the survivor's social supports and coping methods.
- Teach stress-management techniques, such as relaxation exercises.
- Work with her to identify potential solutions and coping strategies. In general, do not give direct advice. Encourage the woman to find her own solutions.
- Discuss possible referrals to relevant agencies and community resources.

Explore and strengthen positive coping methods

In humanitarian settings, routines and daily activities are often disrupted due to displacement, fragmentation of social networks, limited resources and upheaval. In addition, a survivor's experience of violence can make it more difficult to engage in day-to-day tasks. Talk to her about her life and activities and about how she is coping.

Ask:

- How has (the violence) been affecting you?
- How do you deal/cope with these problems day by day?

Explore positive coping strategies that are feasible for her, in a supportive and non-judgemental manner.

Encourage her to:

- build on her strengths and abilities (e.g. ask what is going well currently and how she has coped with difficult situations in the past);
- continue activities, especially ones that she used to find interesting or pleasurable;
- engage in relaxing activities to reduce anxiety and tension (e.g. walk, sing, pray, play with children);
- spend time with friends and family who are supportive and avoid isolating herself;
- try to engage in regular physical activity;
- try to keep a regular sleep schedule and avoid sleeping too much; and
- avoid using self-prescribed medications, alcohol or illegal drugs to try to feel better.

Stress reduction and relaxation exercises

Stress-reduction techniques can be used to manage stress and anxiety. Make sure you demonstrate the techniques and practise together with her during the session. Encourage her to practise at home when she feels stressed. Box 5.1 provides instructions for a slow breathing technique.

Box 5.1: Slow breathing technique

First, explain the goal. You can say: "I am going to teach you how to breathe in a way that will help relax your body and mind. It will take some practice before you feel the full benefits of this breathing technique. The reason this strategy focuses on breathing is because when we feel stressed, our breathing becomes fast and shallow, making us feel more tense. You can do these exercises whenever you are stressed or anxious or cannot sleep."

Provide the following instructions and demonstrate the steps and/or practise them together:

- Sit with your feet flat on the floor. Put your hands in your lap. You may close your eyes or keep them open.
- Relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Now place one hand on your belly and the other hand on your upper chest. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon. → *Demonstrate this breathing – try and exaggerate the pushing out and in of your stomach.*
- Continue to breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out. → *Demonstrate by counting slowly for breathing in and out.*
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

5.2 Assessment of mental health conditions

While most survivors of sexual violence or IPV will recover with basic support, some will experience persistent symptoms and problems in daily functioning that require you to assess their mental status and refer them to a mental health specialist.

General principles

- **Be cautious when involving family members and caregivers in mental health assessment and care**. Family members and caregivers are often involved in the care and support of people with mental health problems and can be an important source of support. However, some caregivers or family members may be unsupportive, may not keep information confidential, or may be perpetrators of IPV or sexual violence. It can be helpful to involve supportive and "non-offending" family members if the survivor consents.
- **Involve the woman as much as possible**. Even if the woman's functioning is impaired and supportive family members are present, always involve her in the discussion as much as possible.
- **Explain the limits of confidentiality**. Let the woman know that you will maintain confidentiality, except when you perceive a risk to her (e.g. suicide or self-harm) or to others, or if there are legal requirements.
- **Ensure that the information provided is clear**. Repeat information, allow time for

questions and consider providing written information on specific mental health conditions.

Details on the assessment and management of the mental health conditions covered here, and other priority mental health conditions, such as harmful use of alcohol and drugs in humanitarian settings, can be found in the ***mhGAP humanitarian intervention guide*** (mhGAP-HIG; available at: http://www.who.int/mental_health/publications/mhgap_hig/en/).

Mental health assessment

Box 5.2: Suicide and self-harm

Some health-care providers fear that asking about suicide may provoke the person to commit it. This is not correct. On the contrary, talking about suicide often reduces an individual's anxiety around suicidal thoughts and helps them to feel understood and may encourage them to seek help.

You can start with general questions such as:

- "What are your hopes for the future?"

If the survivor expresses hopelessness, ask if she has current – or a history of – thoughts or plans to commit suicide or to harm herself. If so, there is an immediate risk of harm or suicide; refer her immediately to a mental health specialist. She should not be left alone until you can ensure that she is in appropriate care.

Pay attention to her mental health status, including:

- overall appearance (e.g. taking care of her appearance);
- behaviour (e.g. agitation);
- facial expression, mood (e.g. crying, anxious, without expression);
- body language (e.g. posture, eye contact); and
- speech (e.g. fast, slow, silent) and thoughts (e.g. recurrent memories).

Ask general questions about how she is feeling and what her emotions are while taking her history; for example:

- How do you feel?
- Are you having any difficulties coping with daily life?
- To what extent are your difficulties affecting your life, such as relationships with family and friends, or your work or other activities?

Box 5.3 summarizes considerations relating to pre-existing mental health conditions.

Conduct a more detailed mental health assessment if needed

If your assessment identifies problems with mood, thoughts or behaviour and if the woman is unable to function in her daily life (e.g. problems getting out of bed, taking care of children, going to work or doing housework), she may have more severe mental health problems. To help you understand when to refer to a specialist, see Annex 10 for brief guidance on the assessment of depressive disorder, post-traumatic stress disorder (PTSD), self-harm and suicide, and unexplained somatic complaints.

Box 5.3: Consider pre-existing mental health conditions

Pre-existing mental health conditions should be considered when making assessments and planning care for survivors of sexual violence and intimate partner violence (IPV).

Important notes:

- Every community will have people with pre-existing mental health problems, which may be exacerbated or reoccur if they experience IPV or sexual violence.
- Women with mental health and substance abuse problems may be at a greater risk of IPV and sexual violence, so there may be a disproportionate burden of pre-existing mental health and substance abuse problems among survivors.
- If a woman has suffered from mental health problems (e.g. depressive disorder or substance use disorder) before experiencing violence, she will be much more vulnerable to suffering from them again.
- Similarly, having a history of exposure to violence (e.g. childhood sexual abuse, IPV, war-related trauma, etc.) should be considered in the mental health assessment and treatment planning process.

Part 6: Caring for child survivors

The United Nations Convention on the Rights of the Child[17] defines a child as any person under the age of 18 years. The fundamental role of a health-care provider is the same for child survivors of sexual abuse as it is for adults – to provide quality first-line support and additional care. However, the needs and capacities of children and the ways of responding to those needs differ. For comprehensive guidance on working with child survivors, refer to the WHO clinical guidelines, *Responding to children and adolescents who have been sexually abused*.[18] Important points about caring for child survivors are listed in Box 6.1, and guideline principles are provided in Box 6.2.

Box 6.1: Important things to know before caring for child survivors

- If it is obligatory to report cases of child abuse in your setting, obtain a copy of the national child abuse management protocol (and reporting form) and information on customary police and court procedures. Evaluate each case individually – in some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.
- Find out about specific laws in your setting that determine who can give consent on behalf of minors for medical care and who can go to court as an expert witness.
- Health-care providers should be knowledgeable about child development and growth as well as normal child anatomy. It is recommended that health-care staff receive special training in examining children who may have been abused.

Box 6.2: Guiding principles to be observed when providing care to children and adolescents

1. Attention to the best interests of children or adolescents by promoting and protecting safety, providing sensitive care, and protecting and promoting privacy and confidentiality.
2. Addressing the evolving capacities of children or adolescents by providing information that is appropriate to age, seeking informed consent as appropriate, respecting their autonomy and wishes, and offering choices in the course of their medical care, as appropriate.
3. Observing non-discrimination in the provision of care, irrespective of their sex, race, ethnicity, religion, sexual orientation, gender identity, disability or socioeconomic status.
4. Ensuring the participation of children or adolescents in decisions that have implications for their lives, by soliciting their opinions and taking those into account, and involving them in the design and delivery of care.

Source: Responding to children and adolescents who have been sexually abused: WHO clinical guidelines (2017) – based on the United Nations Convention on the Rights of the Child and other human rights standards

6.1 Providing first-line support to child survivors

Children who have been sexually abused are most likely to come to your attention through a caregiver or another adult; abused children rarely seek help on their own. Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers. Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children to feel better, while a negative response (such as not believing the child or getting angry with the child) could cause them further harm. Health-care providers should give first-line support that takes into account the different needs of boys and girls (i.e, gender-sensitive) and is child- or adolescent-centred. This includes the actions shown in Box 6.3.

6.2 Creating a safe environment

Take special care in determining who is present during the interview and the examination of a child survivor. Health-care providers should seek to minimize additional trauma and distress. **Remember that it is possible that an accompanying family member is the perpetrator of the abuse.** Children should be interviewed on their own (i.e. separately from

17 Convention on the Rights of the Child. New York (NY): United Nations; 1989 (https://www.ohchr.org/en/professionalinterest/pages/crc.aspx, accessed 18 March 2019).

18 Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/, accessed 18 March 2019).

Box 6.3: The LIVES (Listening, inquiring about needs and concerns, validating, enhancing safety and supporting) approach adapted for children

- Listen actively and empathically to the child, and believe them when they speak (refer to Part 2 of this guide on providing first-line support).
- Be nurturing, comforting and supportive.
- Reassure the child (validate) that they are not at fault for what has happened to them and that you believe them.
- Empower non-offending caregivers with information about the care of the child or adolescent.
- Provide age-appropriate information in an age-appropriate manner and environment.
- Do no harm: be careful not to traumatize the child further. Do not become angry with the child, force the child to answer a question they are not ready to answer, force the child to speak about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people.
- Speak in a way that the child understands.
- Help the child to feel safe.
- Tell the child why you are talking with them.
- Choose appropriate people to help. In principle, only female service providers and interpreters should speak with girls about sexual abuse. Boy survivors of abuse should be offered the choice (if possible) to talk with a female or male provider, as some boys are likely to feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to speak with male or female trained staff.
- Pay attention to non-verbal communication. A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture. Be aware of the cues your body language is giving as well, to gain the child's trust.
- Respect the child's opinions, beliefs and thoughts.[19]

caregivers), while offering to have another adult or trusted person (such as a trained health worker) – present for support. Always ask the child whom they would like to be present, and respect their wishes.

- Introduce yourself to the child.
- Sit at eye level and maintain eye contact.
- Assure the child that he or she is not in any trouble.
- Ask a few questions about neutral topics, such as school, friends, whom the child lives with, favourite activities.
- Have toys available if possible, especially for younger children.

6.3 Obtaining informed consent

The main considerations involved in obtaining consent from a child are as follows.

- A child should never be examined against their will, whatever their age, unless the examination is necessary for medical care.
- Parents or legal guardians are typically responsible for giving informed consent on behalf of the child for relevant clinical care, until the child or adolescent is legally able to do so for themselves. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from the child or adolescent themselves.

6.4 Taking the history

- For younger children, make sure that there are dolls, crayons or other toys to keep them busy during the conversation.
- Begin the interview by asking open-ended questions, such as "What brings you here today?" or "What were you told about coming here?"
- Reassure the child that you are there to help.
- Avoid asking leading or suggestive questions.
- Assure the child that it is okay to respond to any questions with "I don't know".
- Be patient; go at the child's pace and do not interrupt his or her train of thought. Observe whether the child becomes upset or distressed, and allow time for breaks.
- Ask open-ended questions to get information about the incident. Ask yes/no questions only for the clarification of details.
- For girls, depending on age, ask about menstrual and obstetric history (sexual history is not relevant).
- Sexual abuse of children is often repeated abuse. To get a clearer picture of what happened, try to obtain information on:
  - the home situation and whether the child has a secure place to go to;
  - how the rape/abuse was discovered;
  - who did it, and whether that person is still a threat;

19 Caring for child survivors of sexual abuse: guidelines for health and psychosocial service providers in humanitarian settings. New York (NY): International Rescue Committee (IRC); 2012 (https://www.unicef.org/pacificislands/IRC_CCSGuide_FullGuide_lowres.pdf, accessed 18 March 2019).

- if this has happened before, how many times and the date of the previous incident;
- whether there have been any physical symptoms (e.g. bleeding, dysuria, discharge, difficulty walking, etc.); and
- whether any siblings are at risk.

6.5 Preparing the child for the physical examination

With adequate preparation, most children will be able to relax and participate in the examination. If the child cannot relax, this may be because he or she is in pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.

- As for adult examinations, in addition to the survivor and the health-care provider, there should be a support person or trained health worker whom the child trusts in the examination room with them.
- Encourage the child to ask questions about anything he or she is concerned about or does not understand at any time during the examination.
- Explain what will happen during the examination, using terms the child can understand.
- Never restrain or force a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety, and may worsen the psychological impact of the abuse.
- It is useful to have a doll on hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.

6.6 Examining the child

Conduct the examination in the same order as the examination for adults (see Part 3, Step 4). The form in Annex 4 and the adult pictograms in Annex 5 may be used, too.

Special considerations for children are as follows.

- Note the child's weight, height and pubertal stage. Ask girls whether they have started menstruating. If so, they may be at risk of pregnancy.
- Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed. Undress them as little as possible.
- **Genital examination in girls**:
  - Note the location of any fresh or healed tears in the vulva, introitus and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Do not carry out a digital examination (i.e. inserting fingers into the vaginal orifice to assess its size).

> Virginity testing is a harmful practice and not recommended.

  - Look for vaginal discharge. In prepubertal girls, vaginal specimens can be collected with a dry sterile cotton swab.
  - Do not use a speculum to examine prepubertal girls; it is extremely painful and may cause serious injury.
  - A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a prepubertal girl is usually done under general anaesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- **Genital examination in boys**:
  - Check for injuries to the frenulum of the prepuce, and for anal or urethral discharge; take swabs if indicated.
- **Anal examination in boys and girls**:
  - Examine the anus with the child in the supine or lateral position; avoid the knee-chest position, as assailants often use it.
  - Record the position of any anal fissures or tears on the pictogram (Annex 5).
  - Reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
  - Do not carry out a digital examination to assess anal sphincter tone.

What to do if the child is highly agitated

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

- diazepam, by mouth, 0.15 mg/kg of body weight; maximum 10 mg; or
- promethazine hydrochloride, syrup, by mouth:
  - 2–5 years: 15–20 mg
  - 5–10 years: 20–25 mg.

These medicines do not provide pain relief. If you think the child is in pain, **give simple pain relief first**, such as paracetamol (1–5 years: 120–250 mg; 6–12 years: 250–500 mg). Wait for this to take effect.

Oral sedation will take 1–2 hours to fully take effect. In the meantime, allow the child to rest in a quiet environment.

6.7 Providing treatment

Emergency contraception (EC) can be offered to girls who have attained menarche (i.e. post-menarche), as well as those who are in the beginning stages of puberty (i.e. have reached Tanner stage 2 or 3) without any restrictions, as long as they reported within 120 hours (5 days) of the rape (see Part 3, Step 5).

With regard to STIs, HIV, hepatitis B and tetanus, children have the same prevention and treatment needs as adults but may require different doses. Special protocols for children should be followed for all vaccinations and medication regimens; these are included in Annex 8 (see Part 3, Step 5).

Presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis is suggested for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex, particularly in settings where laboratory testing is not feasible. For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic case management is suggested for vaginal/urethral discharge (gonorrhoea, chlamydia, trichomoniasis) and for genital ulcers (genital herpes, syphilis and chancroid), particularly in settings where laboratory testing is not feasible.

As much as possible, screen for gonorrhoea and chlamydia using a nucleic acid amplification test (NAAT) and screen for syphilis and HIV using a rapid dual HIV–syphilis test. The presence of a laboratory diagnosis of an STI in a child is diagnostic of sexual abuse.

For post-exposure prophylaxis to prevent HIV transmission (PEP), a triple-therapy regimen of antiretroviral medications – that is, with three medications – is preferred, but a two-medication regimen is also effective. Recommended PEP doses for children are given in Annex 9.

6.8 Follow-up care

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

Annexes

1. Key resources
2. Sample consent form
3. Forensic evidence collection
4. Sample history and examination form
5. Pictograms
6. Sample medical certificates
7. Protocols for emergency contraception
8. Protocols for prevention and treatment of sexually transmitted infections
9. Protocols for post-exposure prophylaxis of HIV infection
10. Assessment and management of mental health conditions
11. Information needed to develop a local protocol

Annex 1: Key resources

Gender-Based Violence Area of Responsibility (2019). Handbook for coordinating gender-based violence interventions in emergencies (https://gbvaor.net/).

Inter-Agency Standing Committee (IASC) (2015). Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery (https://gbvguidelines.org/en/).

Inter-Agency Working Group on Reproductive Health in Crises (IAWG) (2018). Inter-agency field manual on reproductive health in humanitarian settings (http://iawg.net/iafm/).

International Consortium for Emergency Contraception (ICEC) (2018). Emergency contraceptive pills: medical and service delivery guidelines, fourth edition. Washington (DC) (https://www.cecinfo.org/publications-and-resources/icec-publications/).

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World Health Organization (WHO) (2013). Psychological first aid: facilitator's manual for orienting field workers. Geneva (https://www.who.int/mental_health/emergencies/facilitator_manual_2014/en/).

World Health Organization (WHO) (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva (http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/).

World Health Organization (WHO) (2014). Clinical practice handbook for safe abortion. Geneva (https://www.who.int/reproductivehealth/publications/unsafe_abortion/clinical-practice-safe-abortion/en/).

World Health Organization (WHO) (2014). Consolidated guidelines on HIV prevention, diagnosis, treatment and care for key populations. Geneva (https://www.who.int/hiv/pub/guidelines/keypopulations/en/).

World Health Organization (WHO) (2014). Counselling for maternal and newborn health care: a handbook for building skills. Geneva (http://www.who.int/maternal_child_adolescent/documents/9789241547628/en/index.html).

World Health Organization (WHO) (2014). Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children. Geneva (http://www.who.int/hiv/pub/guidelines/arv2013/arvs2013upplement_dec2014/en).

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World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR) (2009). Clinical management of rape survivors: e-learning programme. Geneva (http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/). Being updated to reflect the updated guidance. It will be available early 2020.

Annex 2: Sample consent form

Notes on completing the consent form

Consent for an examination is a central issue in medico-legal practice. Consent is often called "informed consent" because it is expected that the survivor (or their parent(s) or guardian) will receive information on all the relevant issues, to help the survivor to make a decision about what is best for them at the time. It is important to make sure that the survivor understands that their consent or lack of consent to any aspect of the examination will not affect their access to treatment and care. The health-care provider must provide information in a language that is readily understood by the survivor or their parent/guardian to ensure that they understand:

- what the history-taking process will involve;
- the type of questions that will be asked and the reason they will be asked;
- what the physical examination will involve;
- what the examination of genital and anal areas will involve;
- that the physical examination and the examination of genital and anal areas will be conducted in privacy and in a dignified manner;
- that during part of the physical examination, the survivor will lie on an examination couch;
- that the health-care provider will need to touch him/her for the physical examination and the examination of genital and anal areas;
- that an examination of genital and anal areas will require the patient to lie in a position where their genitals can be adequately seen with the correct lighting;
- that specimen collection (where needed) involves touching the body with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva; that clothing may be collected; and that not all of the results of the forensic analysis may be made available to the patient and why;
- that they can refuse any aspect of the examination they do not wish to undergo; and
- that they will be asked to sign a form that indicates that they have been provided with the information and that documents what procedures they have agreed to.

Inform the survivor that if, and only if, they decide to pursue legal action, and only with their consent, the information told to the health-care provider during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice.

Sample consent form

Name of facility: .....

Note to the health worker:

After providing the relevant information to the patient as explained above, read the entire form to the patient (or their parent/guardian), explaining that they can choose to refuse any (or none) of the items listed. Obtain the signature of the survivor, or the thumb print of the survivor and the signature of a witness.

I, ...(print name of survivor)

authorize the above-named health-care facility to perform the following (tick the appropriate boxes):

	Yes	No
Conduct a physical examination	☐	☐
Conduct a genital examination	☐	☐
Collect evidence, such as body fluid samples, clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of these examinations and any relevant follow-up care provided.	☐	☐

I understand that I can refuse any aspect of the examinations I do not wish to undergo.

Signature: .....

Date: .....

Witness: .....

Annex 3: Forensic evidence collection

The capacity of laboratories to analyse forensic evidence varies considerably, and in humanitarian contexts is extremely limited. This annex describes the different types of forensic evidence that can be collected, and outlines procedures for doing so. Health-care providers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence. Do not collect evidence that cannot be processed.

Important considerations

- Health-care providers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence.
- The survivor should be informed that some injuries might become more visible after some days and that, if this happens, they should return for examination and documentation.
- Only those who have had specialized training and experience in working with children (e.g. child-friendly communication, specialized examination techniques, evidence collection) should provide medico-legal services to children.
- Medico-legal evaluations (history taking, examination, specimen collection and medico-legal report) should be conducted on children only if child-specific health and other services are accessible for referral.
- All medico-legal practitioners working with children should be aware of the relevant laws and policies in place in the setting, including those related to consent, mandatory reporting, definitions of sexual violence against children, and who can collect and provide medico-legal evidence in court.

Before beginning

- A careful explanation should be provided to the survivor. This should include the reasons for, and the extent of, the proposed examination, any procedures that might be conducted, the collection of specimens and photography.
- A sensitive and specific explanation of any genital or anal examination is needed.
- Consent to undertake the examination should be obtained from the individual or their guardian. The consent should be specific to each procedure (particularly the genital examination), to the release of findings and specimens, and to any photography. The victim may consent to some aspects and not others and may withdraw consent. The consent should be documented by signature or fingerprint.
- Photographs are a useful adjunct to injury documentation. Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital photographs are taken) need to be addressed and agreed with the victim.
- Consent for the collection and release of the specimens (to investigators) should be obtained from the victim. The impact on the victim (both physically and psychologically) of the collection of specimens should be carefully considered.

Inspection of the body

- Examine the survivor's clothing under good light before they undress. Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, foreign hairs). Ask the person to undress while standing on a sheet of paper to collect any debris that falls. Do not ask them to uncover fully. Examine the upper half of their body first, then the lower half, or provide a gown for them to cover themselves. Collect torn and stained items of clothing only if you can give replacement clothes. Clothes will need to be air dried before storage.
- Document all injuries in as much detail as possible (see Part 3, Step 4).
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit the survivor) or semen on the skin, with the aid of a sterile cotton-tipped swab, lightly moistened with sterile water if the skin is dry.
- The survivor's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity for direct examination for sperm and for DNA and acid phosphatase analysis. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.
- Take blood and/or urine for toxicology testing if indicated (e.g. if the survivor was drugged).

Inspection of the anus, perineum and vulva

Inspect and collect samples for DNA analysis from the skin around the anus, perineum and vulva/penis using separate cotton-tipped swabs moistened with sterile water. For children, always examine both the anus and the vulva/penis.

Examination of the vagina and rectum

Depending on the site of penetration or attempted penetration, examine the vagina and/or the rectum.

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis). Do not use a speculum to examine prepubertal girls. It is painful and may cause injury.
- Using a cotton-tipped swab, collect fluid from the posterior fornix for examination for sperm. Put a drop of the fluid collected on a slide, if necessary with a drop of normal saline (wet-mount), and examine it for sperm under a microscope. Note the motility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.
- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina for acid phosphatase analysis.
- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

Maintaining the chain of evidence

It is important to maintain the chain of evidence at all times, to ensure that the evidence will be admissible in court. This means that the evidence must be collected, labelled, stored and transported properly.

Documentation must include the signature of everyone who has had possession of the evidence at any time, from the individual who collects it to the one who takes it to the courtroom, to keep track of the location of the evidence since collection.

Take precautions against contamination: restrict access to examination facilities, ensure facilities are cleaned between cases and change gloves frequently.

If it is not possible to take the samples immediately to a laboratory, precautions must be taken.

- All clothing, cloths, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper (not plastic) bags. Samples can be tested for DNA many years after the incident, provided the material is well dried.
- Blood and urine samples can be stored in the refrigerator for five days. To keep the samples longer they need to be stored in a freezer.

Follow the instructions of the local laboratory.

- All samples should be clearly labelled with a confidential identifying code (not the name or initials of the survivor), date, time and type of sample (what it is, from where it was taken), and put in a container.
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your initials across the tape. In the adapted protocol, clearly write down the local laboratory's instructions for collection, storage and transportation of samples.
- Evidence should be released to the authorities only if the survivor decides to proceed with a legal case.

The survivor may consent to have evidence collected but not to have it released to the authorities at the time of the examination. In this case, advise her of the laws and procedures around maintaining evidence and whether there is a time frame for the storage of evidence before it is destroyed. If she changes her mind during this period, she can advise the authorities where to collect the evidence.

Reporting medical findings in a court of law

If the survivor wishes to pursue legal redress and the case comes to trial, the health-care provider who examined them after the incident may be asked to report on the findings in a court of law. Only a small percentage of cases actually go to trial. Many health workers may be anxious about appearing in court or feel that they do not have enough time to do this. Nevertheless, providing such evidence is an extension of the health worker's role in caring for the survivor.

In most settings, the health-care provider is expected to give evidence as a factual witness (that means reiterating the findings as they

recorded them), not as an expert witness. The health-care provider should meet with the prosecutor prior to the court session to prepare their testimony and obtain information about the significant issues involved in the case.

When giving evidence as a factual witness, the health-care provider should conduct themselves professionally and confidently in the courtroom.

- Dress appropriately.
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whomever you are speaking to.
- Use precise medical terminology.
- Answer questions as thoroughly and professionally as possible.
- If you do not know the answer to a question, say so. Do not make an answer up and do not testify about matters that are outside your area of expertise.
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions.

The notes written during the initial interview and examination of the survivor are the mainstay of the findings to be reported. It is difficult to remember things that are not written down. This underscores the need to record all statements, procedures and actions in sufficient detail, accurately, completely and legibly. This is the best preparation for an appearance in court.

Annex 4: Sample history and physical examination form

CONFIDENTIAL CODE:

Medical History and Examination Form - Sexual Violence

1. GENERAL INFORMATION

First name:		Last name:
Address:		
Sex:	Date of birth (dd/mm/yy):	Age:
Date / time of examination: /		In the presence of:

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

2. THE INCIDENT

Date of incident:	**Time of incident:**
Description of incident (survivor's description)	

Physical violence	**Yes**	**No**	**Describe type and location on body**
Type (beating, biting, pulling hair, etc.)			
Use of restraints			
Use of weapon(s)			
Drugs/alcohol involved			

Penetration	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal, type of object)**
Penis				
Finger				
Other (describe)				
	Yes	**No**	**Not sure**	**Location (oral, vaginal, anal, other)**
Ejaculation				
Condom used				

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

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defaecate?			Wash or bath?		
Brush teeth?			Use tampon or pad?		
Contraception use					
Pill			Condom		
Injectable			Sterilization		
Intrauterine device			Other		
Menstrual/obstetric history					
Last menstrual period (dd/mm/yy)			Menstruation at time of event		
	Yes	**No**			
Evidence of pregnancy			Number of weeks pregnant	.....weeks	
Obstetric history					

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date (dd/mm/yy)	Name of individual:
Other health-related conditions		
History of female genital mutilation, type		
Allergies		
Current medication		

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Known		Unknown	

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)			
Mental state (calm, crying, anxious, cooperative, depressed, detached, other)			
Weight:	Height:	Pubertal stage: Prepubertal ☐ Pubertal ☐ Mature ☐	
Pulse rate:	Blood pressure:	Respiratory rate:	Temperature:
Physical findings Describe systematically, and draw on the body pictograms (Annex 5), the exact location of all wounds, bruises, petechiae, marks, and so on. Document type, size, colour, form and other particulars. Be descriptive but do not interpret the findings.			
Head and face		Mouth and nose	
Eyes and ears		Neck	
Chest		Back	
Abdomen		Buttocks	
Arms and hands		Legs and feet	

5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	Introitus	Anus
Vagina/penis	Cervix	Bimanual/rectovaginal examination
Position of patient (supine, prone, knee-chest, lateral, mother's lap)		
For genital examination:	For anal examination:	

6. INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result

7. EVIDENCE TAKEN

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

8. TREATMENTS PRESCRIBED

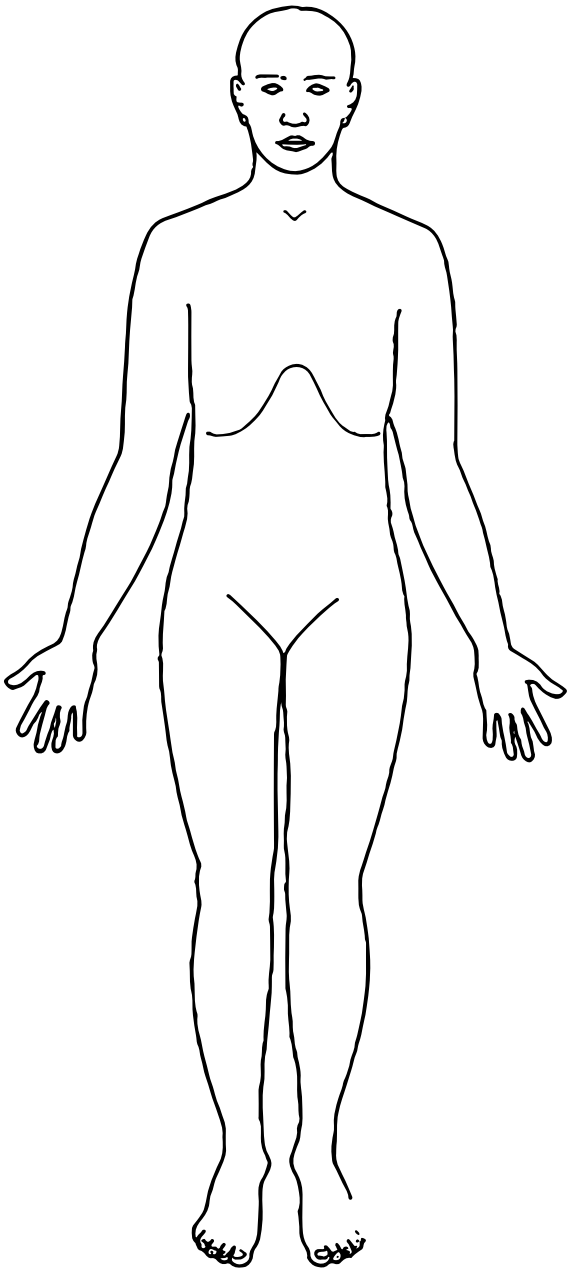
Treatment	Yes	No	Type and comments
Wound treatment			
Emergency contraception			
Sexually transmitted infection prevention/treatment			
Post-exposure prophylaxis for HIV			
Tetanus prophylaxis			
Hepatitis B vaccination			
Other			

9. COUNSELLING, REFERRALS, FOLLOW-UP

General psychological status

	Yes	No
Survivor plans to report to police OR has already made report		
Survivor has a safe place to go to		
Survivor has someone to accompany them		
Counselling or psychological intervention provided:		
Referrals: Case management/psychosocial services ☐ Police ☐ Legal services ☐ Mental health services ☐ Other ☐		
Follow-up required:		
Date of next visit:		
Name of health worker conducting examination/interview:		
Title:	**Signature:**	**Date:**

Annex 5: Pictograms



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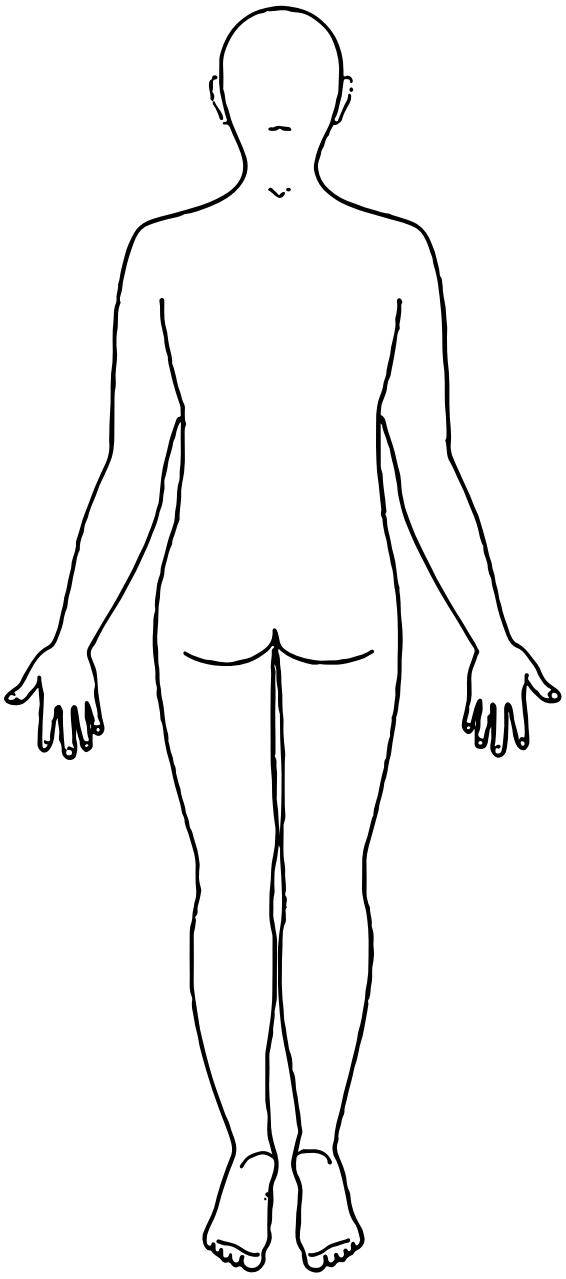

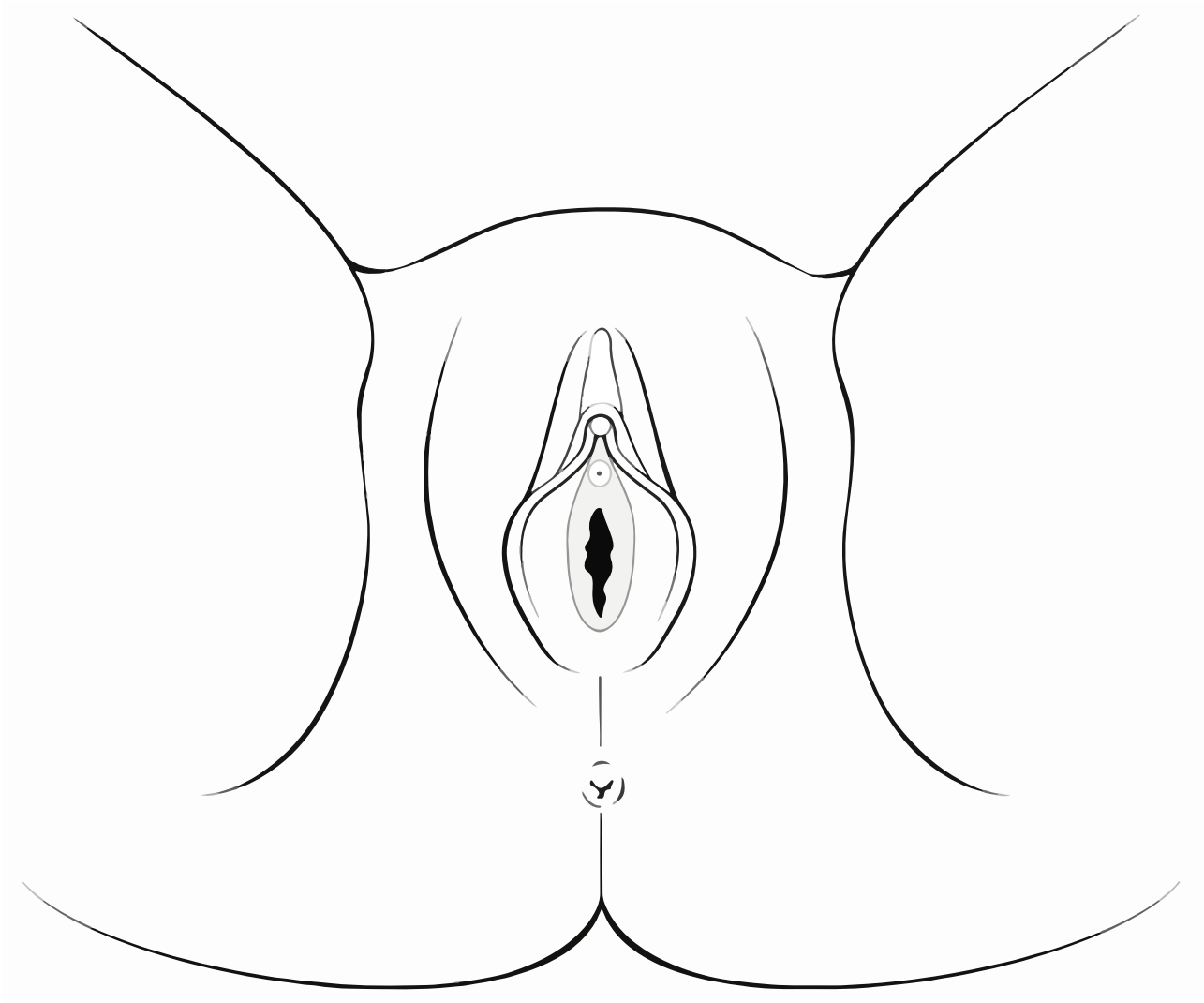

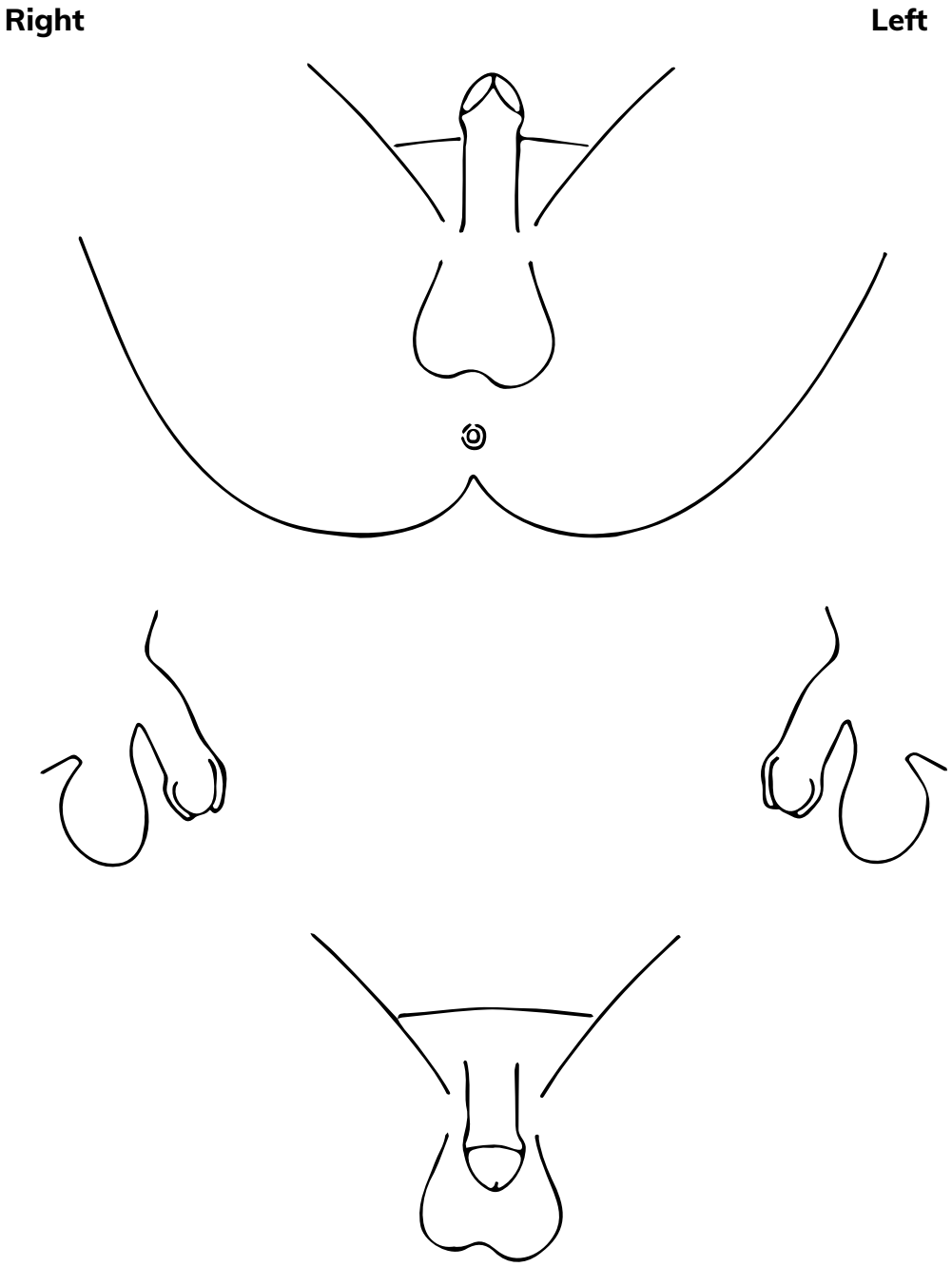
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Annex 6: Sample medical certificates

MEDICAL CERTIFICATE for an adult

I, the undersigned: (last name, first name) .....

title (indicate the function): .....

on this date and time (day / month/ year; hh:mm) .....

certify having examined at her/his request

Mrs, Miss, Ms, Mr: (last name, first name) .....

date of birth: (day / month / year) .....

address: (exact address of the woman or man)

.....

.....

She/He declared that she/he was the victim of a sexual attack

on (day / month / year) .....

at (hh:mm) .....

at (place) .....

by: ☐ known person: (name) .....

☐ unknown person.

Mrs, Miss, Ms, Mr..... presents the following signs:

General examination (behaviour: prostrate, excited, calm, afraid, mute, crying, etc.)

.....

.....

.....

.....

.....

.....

.....

Physical examination (detailed description of lesions, the site, extent, pre-existing or recent, severity)

.....

.....

.....

.....

.....

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.....

Genital examination (bruises, abrasions, tears, etc.)

.....

.....

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.....

.....

Anal examination (bruises, abrasions, tears, etc.)

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.....

.....

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Other examinations carried out and samples taken

.....

.....

.....

.....

.....

Evaluation of the risk of pregnancy

.....

.....

.....

.....

.....

The absence of lesions should not lead to the conclusion that no sexual attack took place.

Certificate prepared on this day and handed over to .....
(name of parent, caregiver, guardian) as proof of evidence.

Signature of the clinician

.....

The medical certificate should be filled in duplicate with one copy for patient or caregiver and one to be kept in clinic, stored safely in a locked cabinet or cupboard.

MEDICAL CERTIFICATE for a child

I, the undersigned: (last name, first name) .....

title (indicate the function):.....

on this date and time (day / month / year; hh:mm) .....

certify having examined at the request of: Mrs, Miss, Ms, Mr (name of parent, caregiver, guardian)

.....

child: Miss, Mr (last name, first name) .....

date of birth: (day / month / year) .....

address: (exact address of the parents or place of residence of the child)

.....

.....

During the meeting, the child told me (repeat the child's own words as closely as possible)

.....

.....

.....

.....

.....

.....

.....

.....

During the meeting, Mrs, Miss, Ms, Mr (name of the person accompanying the child)

..... **stated** (repeat the words of the accompanying person as closely as possible)**:**

.....

.....

.....

.....

.....

.....

.....

The child presents the following signs:

General examination (behaviour: prostrate, excited, calm, fearful, mute, crying, etc.)

.....

.....

.....

.....

.....

.....

.....

Physical examination (detailed description of lesions, the site, extent, pre-existing or recent, severity)

.....

.....

.....

.....

.....

.....

.....

Genital examination (bruises, abrasions, tears, etc.)

.....

.....

.....

.....

.....

.....

.....

Anal examination (bruises, abrasions, tears, etc.)

.....

.....

.....

.....

.....

.....

.....

Other examinations carried out and samples taken and results:

.....

.....

.....

.....

.....

.....

.....

The absence of lesions should not lead to the conclusion that no sexual attack took place.

Certificate prepared on this day and handed over to .....
(name of parent, caregiver, guardian) as proof of evidence.

Signature of the clinician

.....

Annex 7: Protocols for emergency contraception

Emergency contraception (EC) regimens

	EC pills			Intrauterine device (IUD) for EC
Type of EC	**Levonorgestrel (LNG) only**	**Combined regimen**	**Ulipristal acetate (UPA)**	**Copper-bearing IUD**
Dose	Single-dose 1.5 mg LNG (or 2 x 0.75 mg LNG tablets)	100 µg ethinyl estradiol + 0.5 mg LNG. Repeat 12 hours later	30 mg UPA	
Timing/ effectiveness	• As early as possible, within 120 hours after the incident • The longer the delay in taking EC pills, the lower the effectiveness • Combined EC pills are less effective and have more side-effects than LNG or UPA			• Up to 120 hours (5 days)

Source: Contraceptive delivery tool for humanitarian settings. Geneva: World Health Organization; 2018 (https://apps.who.int/iris/handle/10665/276553).

Giving EC pills[20]

1. Give EC pill (or pills).

- The woman can take the pill or pills immediately.
- If she is using a two-dose regimen, tell her to take the next dose in 12 hours.

2. Describe the most common side-effects.

- Nausea, abdominal pain, possibly others.
- Slight bleeding or change in timing of monthly bleeding.
- Side-effects are not signs of illness and they do not last long. Most women have no side-effects.

3. Explain what to do about side-effects.

- Nausea:
  - Routine use of anti-nausea medications is not recommended. Women who have had nausea with previous EC pill use or with the first dose of a two-dose regimen can take anti-nausea medication such as 25–50 mg meclizine hydrochloride (e.g. Agyrax, Antivert, Bonine, Postafene) 30 minutes to 1 hour before taking EC pills.
- Vomiting:
  - If the woman vomits within 2 hours after taking a progestin-only or combined EC pill, she should take another dose. If she vomits within 3 hours of taking a UPA EC pill, she should take another dose. (She can use anti-nausea medication with this repeat dose, as above.) If vomiting continues, she can take a repeat dose of progestin-only or combined EC by placing the pills high in her vagina. If vomiting occurs more than 2 hours after taking a progestin-only or combined EC pill, or 3 hours after taking a UPA-EC pill, then she does not need to take any extra pills.

4. Give more EC pills and talk to the woman about an ongoing method of contraceptive.

- If possible, and if she may need EC in the future, give her more EC pills to take home.
- Discuss possibilities for starting an ongoing method of contraception, if she is interested.

20 World Health Organization Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs Knowledge for Health Project. Family planning: a global handbook for providers: 2018 edition. Geneva and Baltimore: World Health Organization and Johns Hopkins Bloomberg School of Public Health; 2018 (https://apps.who.int/iris/bitstream/handle/10665/260156/9780999203705-eng.pdf).

5. Follow-up.

- Encourage her to return for an early pregnancy test if her monthly bleeding is more than 7 days late.

Use of a copper-bearing intrauterine device (IUD) as EC

- If the survivor presents within 5 days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle), insertion of a copper-bearing IUD is an effective method of EC. It will prevent more than 99% of expected subsequent pregnancies.
- Women should be offered counselling on this method so as to reach an informed decision.
- A skilled provider should counsel the patient and insert the IUD. If an IUD is inserted, make sure to give full treatment for sexually transmitted infections (see Annex 8).
- The IUD may be removed at the time of the woman's next menstrual period or left in place for future contraception.

Girls:

- The protocol for EC provided in this annex can be applied to girls who have attained menarche (i.e. post-menarche), as well as those who are in the beginning stages of puberty (i.e. have reached Tanner stage 2 or 3) without any restrictions.

Annex 8: Protocols for prevention and treatment of sexually transmitted infections

Based on WHO-recommended treatments[21] for sexually transmitted infections (STIs) for adults (may also be used for prophylaxis)

Note: These are examples of treatments for STIs. There may be other treatment options. Always follow **local** treatment protocols for STIs.

For adults

STI	Treatment	
Gonorrhoea[22] Dual therapy preferred – also in pregnant women	**Ceftriaxone**	250 mg intramuscularly (IM), single dose
	PLUS	
	Azithromycin	1 g orally, single dose
	OR	
	Cefixime	400 mg orally, single dose
	PLUS	
	Azithromycin	1 g orally, single dose
If single therapy (treatment based on local resistance data)	**Ceftriaxone**	250 mg IM, single dose
	OR	
	Cefixime	400 mg orally, single dose
	OR	
	Spectinomycin	2 g IM, single dose
Chlamydial infection	**Azithromycin**	1 g orally, single dose
	OR	
	Doxycycline (contraindicated in pregnancy)	100 mg orally 2 times a day for 7 days – recommended in case of anal rape
	OR	
	Tetracycline (contraindicated in pregnancy)	500 mg 4 times a day for 7 days
	OR	
	Erythromycin	500 mg orally 4 times a day for 7 days
	OR	
	Ofloxacin (contraindicated in pregnancy)	200–400 mg orally 2 times a day for 7 days
Chlamydial infection in pregnant women	**Azithromycin**	1 g orally, single dose
	OR	
	Amoxicillin	500 mg orally 3 times a day for 7 days
	OR	
	Erythromycin	500 mg orally 4 times a day for 7 days
Early syphilis (also in pregnant women)	**Benzathine penicillin**	2.4 million IU IM once

21 WHO (2016). Guidelines for the treatment of Chlamydia trachomatis; WHO (2016). Guidelines for the treatment of Neisseria gonorrhoeae; WHO (2016). Guidelines for the treatment of Treponema pallidum (syphilis). Geneva.

22 WHO recommends that local resistance data should determine the choice of therapy (both for dual and single therapy).

STI	Treatment	
Early syphilis, patient allergic to penicillin	**Doxycycline** (contraindicated in pregnancy)	100 mg orally 2 times a day for 14 days
Early syphilis in pregnant women allergic to penicillin	**Erythromycin**[23]	500 mg orally 4 times a day for 14 days
	OR	
	Ceftriaxone	1 g IM 1 time a day for 10–14 days
Late syphilis (also in pregnant women)	**Benzathine penicillin**	2.4 million IU IM for 3 doses at 1-week intervals
Late syphilis, patient allergic to penicillin	**Doxycycline** (contraindicated in pregnancy)	100 mg orally 2 times a day for 28 days
Late syphilis in pregnant women allergic to penicillin	**Erythromycin**[23]	500 mg orally 4 times a day for 28 days

Give one easy-to-take, short treatment for each of the infections that are prevalent in your setting.

Example of presumptive treatment for gonorrhoea, syphilis and chlamydial infection:

- Ceftriaxone 250 mg intramuscular single dose (for gonorrhoea) plus azithromycin 1 g orally single dose (for chlamydial infection and incubating syphilis)

OR

- Cefixime 400 mg single dose for (gonorrhoea) plus azithromycin 1 g orally single dose (for chlamydial infection or incubating syphilis).

Remarks:

Doxycycline 100 mg orally twice a day for 14 days can replace azithromycin for presumptive treatment of chlamydial infection and incubating syphilis, unless the survivor is pregnant or unlikely to comply with a 14-day course. Doxycycline should not be used in pregnant women because of adverse effects.

If trichomoniasis is prevalent, add a single dose of 2 g metronidazole orally.

23 Although erythromycin treats the pregnant woman, it does not cross the placental barrier completely and as a result the fetus is not treated. It is therefore necessary to treat the newborn infant soon after delivery.

For children (by weight)

STI	Treatment	
Gonorrhoea	**Ceftriaxone**	< 45 kg: 25–50 mg/kg intramuscularly (IM) or intravenously (IV) single dose > 45 kg: 250 mg IM once
Chlamydial infection	**Erythromycin**	< 45 kg: 50 mg/kg orally divided into 4 doses daily for 14 days
	Azithromycin	> 45 kg: 1 g orally once
	OR	
	Doxycycline	> 45 kg and > 8 years of age: 100 mg orally 2 times a day for 7 days
Early syphilis	**Benzathine penicillin**	50 000 IU/kg IM up to adult dose of 2.4 million IU/kg IM once
Late syphilis	**Benzathine penicillin**	50 000 IU/kg IM up to adult dose of 2.4 million IU/kg IM for 3 doses at 1-week intervals

Annex 9: Protocols for post-exposure prophylaxis of HIV infection

The following are examples of post-exposure prophylaxis (PEP) protocols used for preventing HIV infection after rape. These examples do not outline all the care that may be needed. If it is not possible in your programme to provide PEP, refer the survivor as soon as possible (within 72 hours) to a clinic where this service can be provided.

- HIV PEP should be offered and initiated as early as possible for all individuals with an exposure that has the potential for HIV transmission, preferably within 72 hours.
- An HIV PEP regimen with two antiretroviral medications is effective, but three medications are preferred.
- Pregnancy is not a contraindication to PEP. A three-medication regimen is recommended for pregnant women. While dolutegravir appears to be safe in pregnancy, there are concerns that exposure to dolutegravir in the peri-conception period may be associated with neural tube defects. This concern should be balanced against the better efficacy and tolerability of the medications overall. Efavirenz is a safe and effective alternative for women during pregnancy, though side-effects may affect completion rates.

Choice of HIV PEP regimen should consider the antiretroviral medications already being procured within national HIV programmes. Below is the WHO-recommended preferred regimen for HIV PEP for adults and adolescents. Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options.

PEP for adults and adolescents over 10 years (over 30 kg)			
Three-medication regimen recommended	Dose/ tablet	Dosage	Duration
Lamivudine[24] + tenofovir	300 mg/300 mg	1 tablet once daily	28 days
Plus			
Dolutegravir[25]	50 mg	1 tablet once daily	28 days

24 Or emtricitabine.

25 Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options for PEP.

Below are the WHO-recommended regimens for children by weight.

PEP for children under 10 years (under 30 kg)															
	Zidovudine and lamivudine[26]				**AND**	**Lopinavir and ritonavir**								**OR**	**Dolutegravir**[27]
Weight	Tablet of 60 mg zidovudine and 30 mg lamivudine		Tablet of 300 mg zidovudine and 150 mg lamivudine			Tablet of 100 mg lopinavir and 25 mg ritonavir			Oral liquid containing 80 mg/ml of lopinavir and 20 mg/ml of ritonavir			Pellets or granules (40 mg lopinavir and 10 mg ritonavir)[28]		50 mg tablet	
kgs	am	pm	am	pm		am	pm		am	pm	or	am	pm	Once/day	
3.0–5.9	1	1			*and*	NR*	NR*	or	1 ml	1 ml	or	2	2		
6.0–9.9	1.5	1.5			*and*	NR*	NR*	or	1.5 ml	1.5 ml	or	3	3		
10.0–13.9	2	2			*and*	2	1	or	2 ml	2 ml	or	4	4		
14.0–19.9	2.5	2.5			*and*	2	2	or			or	5	5		
20.0–24.9	3	3			*and*	2	2	or			or			or	1
25.0–29.9			1	1	*and*	3	3	or			or			or	1

* not recommended

Duration for PEP for children: 28 days

26 Abacavir plus lamivudine or tenofovir plus lamivudine are alternatives.

27 Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options for PEP. Dolutegravir 50 mg can be used once daily from 20 kg.

28 Lopinavir plus ritonavir liquid can also be used, although it needs a cold-chain during transport and storage. The lopinavir plus ritonavir heat-stable tablet formulation must be swallowed whole and should not be split, chewed, dissolved or crushed. The adult 200 mg or 50 mg tablets could be used for patients 14.0–24.9 kg (1 tablet every morning and 1 tablet every evening) and for patients 25.0–34.9 kg (2 tablets every morning and 1 tablet every evening). Lopinavir plus ritonavir pellet formulation should not be used in infants younger than 3 months. More details on the administration of lopinavir plus ritonavir pellets can be found at http://apps.who.int/iris/bitstream/handle/10665/193543/FactsheetIATT_WHO_UNICEF_lopinavir_eng.pdf. While limited experience exists with using lopinavir plus ritonavir granules, this formulation is approved for use from 2 weeks of age.

Annex 10: Assessment and management of mental health conditions

If a survivor is experiencing any of the conditions listed in this annex, provide basic psychosocial support as described in Part 5 of the guide and refer to a specialist for further care. More information on the assessment and management of mental health conditions is available in *mhGAP-HIG*.[29]

Moderate-severe depressive disorder

Moderate-severe depressive disorder is likely if A, B *and* C are present *for at least two weeks*	
A.	The woman has had at least one of the following core symptoms: • persistent depressed mood (for children and adolescents: either irritability or depressed mood) • markedly diminished interest in or pleasure from activities, including those that were previously enjoyable
B.	The woman has had several of the following additional symptoms to a marked degree, or many of the listed symptoms to a lesser degree: • disturbed sleep or sleeping too much • significant change in appetite or weight (decrease or increase) • beliefs of worthlessness or excessive guilt • fatigue or loss of energy • reduced ability to concentrate and sustain attention on tasks • indecisiveness • observable agitation or physical restlessness • talking or moving more slowly than normal • hopelessness about the future • suicidal thoughts or acts
C.	The woman has **considerable difficulty with daily functioning** in any of the following aspects of daily life: • personal, family, social, educational/school, occupational/work, household/domestic, or other (ask about each of these different aspects/activities)
If moderate-severe depressive disorder is likely:	
√	**Rule out and manage any physical conditions** that can resemble depressive disorder, such as anaemia, malnutrition, hypothyroidism, stroke and medication side-effects (e.g. mood changes from steroids)
√	Rule out and manage other mental health conditions (e.g. alcohol and drug use)
√	**Rule out a history of manic episode(s)** that may have included symptoms such as: • elevated (intensely happy) or irritable mood • decreased need for sleep • racing thoughts, increased activity, rapid speech • impulsive or reckless behaviour (e.g. making important decisions without planning, excessive spending) • inflated self-esteem If she experienced these symptoms and they interfered with daily functioning for at least one week, or if there is a history of hospitalization or of confinement because of these symptoms, consult a specialist.
√	**Rule out normal reactions to the violence or to major loss** (e.g. bereavement, displacement). The reaction is more likely a normal reaction if: • there is marked improvement over time without clinical intervention • there is no previous history of moderate-severe depressive disorder or manic episode • symptoms do not impair daily functioning significantly

Note: The decision to treat for moderate-severe depressive disorder should be made only if the survivor has persistent symptoms over at least 2 weeks and cannot carry out her normal activities.

29 World Health Organization (WHO), United Nations High Commissioner for Refugees (UNHCR). mhGAP humanitarian intervention guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO; 2015 (http://www.who.int/mental_health/publications/mhgap_hig/en/, accessed 28 August 2019).

Post-traumatic stress disorder (PTSD)

PTSD is likely if A, B, C *and* D are present *about one month after the violence*	
A	**Re-experiencing symptoms**: Repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (e.g. through frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror)
B	**Avoidance symptoms**: Deliberate avoidance of thoughts, memories, activities or situations that remind the woman of the violence (e.g. avoiding talking about issues that are reminders of the violence, or avoiding going back to places where the violence happened)
C	**A heightened sense of current threat**: Excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements (e.g. being "jumpy" or "on edge")
D	The woman has **considerable difficulty with daily functioning** in personal, family, social, educational/ school, occupational/work, household/domestic, or other important areas of daily life (ask about each of these different aspects/activities)
IF PTSD is likely:	
√	**Rule out and manage any physical conditions** that can explain symptoms of PTSD (e.g. physical symptoms associated with distress such as heart palpitations, headaches, gastric upset, insomnia)
√	Rule out and manage **other mental, neurological and substance use conditions** (e.g. moderate-severe depressive disorder, suicidal thinking or alcohol and drug use problems)
√	**Rule out normal reactions to the violence**. The reaction is more likely a normal reaction if: there is marked improvement over time without clinical intervention symptoms do not impair daily functioning significantly

Note: Immediately after a potentially traumatic experience such as sexual violence, most women experience psychological distress. For many women these are passing reactions that do not require clinical management. However, when a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after the event, she may have developed PTSD.

Suicide and self-harm

Notes on asking about suicide
• Ensure that you ask questions in a culturally sensitive and non-judgemental way • If the woman expresses suicidal ideas, maintain a calm and supportive attitude and do not make false promises

The woman is considered at imminent risk of suicide or self-harm if either A or B is present	
A	**Current** thoughts, plans or recent attempt(s) of suicide
B	A **history** of thoughts or plans for self-harm in the past month or acts of self-harm in the past year and current signs of being extremely **agitated, violent, distressed** or **uncommunicative**

Medically unexplained somatic complaints

Unexplained somatic complaints are likely if all of these criteria are met	
A	**Physical causes are excluded** based on a general physical examination followed by appropriate medical investigations
B	**Other mental, neurological and substance use conditions** are excluded
C	The woman is **seeking help** to relieve symptoms or has considerable difficulty with daily functioning because of these symptoms

Annex 11. Information needed to develop a local protocol

Certain information is needed before a local protocol can be developed. This table shows the information that will be needed to develop a protocol and offers suggestions for where such information can be found.

Information needed	Where information may be found
Medical laws and legal procedures	
Abortion laws	Ministry of Health
Emergency contraception regulations	Ministry of Health
Foster placement and adoption laws and procedures	Ministry in charge of women and/or children (e.g. Ministry of women's affairs or gender, social welfare, children, community development, etc.)
Crime reporting requirements and obligations, for adult or child survivors	Ministry of Justice
Police and other forms required	Ministry of Home Affairs
Forensic evidence	
Which medical practitioner can give medical evidence in court (e.g. doctor, nurse, forensic doctor, forensic nurse, other)	Ministry of Justice
Training for general medical staff in forensic examination (of adult or child survivors)	Ministry of Health
Evidence allowed/used in court for adult and child rape cases that can be collected by medical staff	Ministry of Justice
Forensic evidence tests possible in country (e.g. DNA, acid phosphatase)	Forensic laboratory in capital
How to collect, store and send evidence samples	Forensic laboratory in capital; laboratory at regional level
Existing "rape kits" or protocols for evidence collection	Referral hospital at regional level or in capital
Medical protocols	
National protocol for sexually transmitted infections	Ministry of Health
Vaccine availability and vaccination schedules	Ministry of Health
Location of HIV testing and treatment services	National AIDS Control Programme, Ministry of Health
Confirmatory HIV testing strategy and laboratory services	National AIDS Control Programme, Ministry of Health, Regional Medical Officer
Possibilities/protocols/referral for post-exposure prophylaxis of HIV infection	National AIDS Control Programme, Ministry of Health
Clinical referral possibilities (e.g. psychiatry, surgery, paediatrics, gynaecology/obstetrics)	Referral hospital at regional level

For further information, please contact:

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World Health Organization
20 Avenue Appia
1211 Geneva 27, Switzerland

Email: rhrpublications@who.int
Website: https://www.who.int/reproductivehealth