Health Care for Survivors of Gender based Violence in Pakistan

A clinical handbook

World Health Organization

UN WOMEN

Planet 50-50 by 2030
Step It Up for Gender Equality

UNFPA

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The publication is the adaptation of the global WHO clinical handbook for Pakistan to provide health care services to survivors of Gender based Violence (GBV)[1] . This adapted clinical handbook is the complementary guideline for adminstering clinical care at health facility level to implement National Protocol on Health Sector Response to GBV. We benefited from the inputs of participants of expert review workshop and National consultation in Lahore and Islamabad, Feburary 2017 for adaptation. The participants represented Ministry of National Health Services, Regulation and Coordination; Departments of Health, other social sector line departments, legislative bodies, parliamentariians, law enforcement agencies from all provinces of Pakistan, Rahnuma Famil Planning Association of Pakistan representatives, other civil society groups, and UN agencies. The adaptated version benefited from initial review of expert review recomendations from external consultant Ms. Kanwal Qayyum. The key technical contrbutions were made by Masooma Butt , Megin Reijnders and Avni Amin from WHO to incorporate expert review recommendations for this adapted version . Azam Chaudhry Law Associates, Islamabad provided legal consultations and inputs to this adapted clinical handbook.

The global version of clinical handbook draws on the work of the many people around the world dedicated to preventing violence against women and to the care and support of survivors subjected to violence. Claudia García-Moreno in the WHO Department of Reproductive Health and Research (RHR) led the preparation of this handbook and oversaw the development of the final text. Avni Amin, Christina Pallitto and Thais de Rezende

[1] WHO Global Clinical Handbook for Health care for women subjected to intimate partner violence or sexual violence (www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/)

of RHR provided inputs and Thais de Rezende developed the field testing guide. Sarah Johnson and Ward Rinehart of Jura Editorial Services were responsible for writing and editing.

Preface

This handbook is based on the World Health Organization (WHO) guideline *Responding to Intimate Partner violence and sexual violence against women: WHO clinical and policy guidelines,* 2013. It also draws on other WHO guidance documents, in particular:

- *Clinical management of rape survivors* (WHO, UNFPA and UNHCR, 2004)
- *Guidelines for medico-legal care for survivors of sexual violence* (WHO, 2003)
- *Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children Recommendations for a public health approach - December 2014 supplement to the 2013 consolidated ARV guidelines*
- *Psychological first aid: guide for field workers* (WHO, War Trauma Foundation & World Vision International, 2011)
- *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings* (WHO, 2010); *Clinical management of mental, neurological and substance use conditions during humanitarian emergencies* (WHO & UNHCR, forthcoming)

The handbook is the implementation guide for the health component of the Joint UN Global Programme on Essential Services for Women and Girls subject to Violence.

What is this handbook?

This handbook is for health-care providers like you. It can help you care for survivors who have been subjected to violence. This can be physical, sexual or emotional violence.

In Pakistan violence against women (VAW) is the most common form of gender-based violence (GBV). Therefore the terms GBV and VAW are used interchangeably in this document. GBV is used to describe different forms of VAW. It includes domestic violence, sexual assault and rape. Domestic violence includes physical, sexual or emotional violence in a domestic setting whether it is by a spouse or any other family member or relative. Domestic violence is mostly prevalent in the context of Pakistan.[2] The globally used term 'intimate partner violence (IPV)' is replaced with spousal violence in this handbook. The terms sexual assault and rape are also used to describe sexual violence by any perpetrator.

While this handbook focuses on women, girls and children subjected to violence, some aspects of care for sexual assault such as provision of first line support, HIV PEP, STI treatment, psychosocial support and mental health care are also relevant for men and boys who are subjected to such violence.

Violence damages women's health in many ways, both immediate and long-term, both obvious and hidden. Women who have been abused or assaulted need care and support. As her health-care provider, you may be the first person that she

[2] Pakistan Demographic and Health Survey 2012-13

talks to about the violence. This handbook is meant especially to help you respond appropriately.

What this handbook does

When providing first-line support to a woman who has been subjected to violence, **4 kinds of needs** deserve attention:

- Immediate emotional/psychological health needs
- Immediate physical health needs
- Immediate and ongoing safety needs
- Ongoing support and mental health needs.

There are simple ways that every health-care provider – including those who are not specialists – can assist a woman subjected to violence. This can be very important to her health.

This handbook offers easy steps and suggestions to help you provide that care. This handbook has 4 parts:

1. Awareness about violence against women
2. First-line support for domestic/spousal violence and sexual assault
3. Additional clinical care after sexual assault
4. Additional support for mental health.

There are job aids throughout this handbook to help you while caring for and supporting a woman who has experienced or is experiencing violence.

Men and sexual violence

Men also may be survivors of violence and sexual assault. However, in general, because of the gender and power dynamics, women experience more sexual violence, more severe physical violence, and more control from spouses and male family members.

While the focus here is on violence by men against women, much of the advice is also relevant to sexual violence against men and boys. It also applies to violence against women by other family members (e.g. in-laws and immediate family members)

Why is violence against women different and requires a specific approach?

A woman who has been subjected to violence may have some different needs from most other health-care patients. In particular:

- She may have various emotional needs that require attention.
- She may be frightened and need reassurance.
- Support, not diagnosis, is your most important role.
- She may or may not need physical care.
- Her safety may be an immediate or ongoing concern.
- She may need referrals or other resources for needs that the health system cannot meet.
- She needs help to make her feel more in control and able to make her own decisions.

Guiding principles for providing survivor-centred care

Survivor-centred care. The survivor's wishes determine the care that you give.

Act in response to her wishes, provide the best care possible, and avoid causing her further harm.

Survivor-centred care is guided by two fundamental principles: respect for women's human rights and promotion of gender equality. What does this mean in practical terms?

1. A rights-based approach. Women's human rights are set forth in international human rights agreements. Pakistan has signed many of these agreements. These rights include the right to:

- **Life** – a life free from fear and violence;
- **Self-determination** – being entitled to make their own decisions including sexual and reproductive decisions; entitled to refuse medical procedures and/or take legal action;
- **The highest attainable standard of health** – health services of good quality, available, accessible and acceptable to women;
- **Non-discrimination** – health care services offered without discrimination, and treatment is not refused based on race, ethnicity, caste, sexual orientation, religion, disability, marital status, occupation, or political beliefs;
- **Privacy and confidentiality** – provision of care, treatment, and counselling that is private and confidential; information disclosed only with the consent of the woman;

- **Information** –the right to know what information has been collected about their health and have access to this information, including their medical records.

In your practice: Treat all women in a fair and respectful way and do not discriminate. Also, recognize that a woman may face multiple forms of discrimination – not only because she is a woman, but also because of her race, ethnicity, caste, sexual orientation, religion, disability, or other characteristics – or because she has been subjected to violence.

2. Gender sensitivity and equality. Gender sensitivity means being aware of how differences in power between women and men determine the way that men and women treat each other, their access to resources to protect their health and often how the health system treats them. Assuring gender equality in health means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy.

It is important to understand that: violence against women is rooted in unequal power between women and men; that women may have less access than men to resources, such as money or information, and they may not have the freedom to make decisions for themselves; women may be blamed and stigmatized for violence and may feel shame and low self-esteem.

In your practice: As a provider, you must at a minimum avoid reinforcing these inequalities and promote women's autonomy and dignity by:

- being aware of the power dynamics and norms that perpetuate violence against women

- reinforcing her value as a person
- respecting her dignity
- 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.

Part 1
Awareness about violence against women

What is violence against women

This handbook focuses on violence against women (VAW) by men, in particular sexual assault and spousal/domestic violence . VAW is defined by the United Nations as "any act of gender-ased violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".

Sexual assault

This refers to forced sex or rape; it can be by someone a woman knows (reletive, other family member, friend or acquaintance) or by a stranger.

Domestic/spousal violence

This refers to ongoing or past violence and abuse by a husband or ex-spouse.

Women may suffer several types of violence by a spouse: physical violence, emotional/psychological abuse, controlling behaviours, denial of resources, and sexual violence.

Physical violence

This includes causing injury or harm to the body by, for example, hitting, kicking or beating, pushing, hurting with a weapon.

Emotional/psychological abuse

This can include many types of behaviours such as:

- criticizing her repeatedly
- calling her names or telling her she is ugly or stupid
- threatening to hurt her or her children
- threatening to destroy things she cares about
- belittling or humiliating her in public.

Controlling behaviours

This includes, for example:

- 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
- often being suspicious that she is unfaithful
- not allowing her to decide and seek health care without permission and escort
- leaving her without money to run the home.

Sexual violence

This includes:

- forcing her to have sex or perform sexual acts when she doesn't want to
- harming her during sex
- forcing her to have sex without protection from pregnancy or infection.

Identifying a woman who may be subjected to violence

It is important for health-care providers to be aware that a woman's health problems may be caused or made worse by violence. She may be facing ongoing abuse at home or has in the past. Or she may have suffered a sexual assault recently or in the past.

Women subjected to violence in relationships often seek health care for related emotional or physical conditions, including injuries. However, often they do not tell about the violence due to shame or fear of being judged or fear of their husband and family.

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

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

You may also suspect a problem of violence if a woman's husband or family is intrusive during consultations, if she often

misses her own or her children's health-care appointments, or if her children have emotional and behavioural problems.

The World Health Organization does not recommend universal screening for violence of women attending health care. WHO does encourage health-care providers to raise the topic with women who have injuries or conditions that they suspect may be related to violence.

"What do I do if I suspect violence?"

Never raise the issue of violence 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 general statement on VAW and open questions, before asking direct questions. 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.

The job aid on the next page provides examples of the type of statements and questions you can use to ask about domestic/spousal violence.

Asking about violence

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

- "Many women experience problems with their husband or someone else they live with."
- "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. Depending on her answers, continue to ask questions and listen to her story. If she answers "yes" to any of these questions, offer her first-line support (see page14).

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

Documenting domestic/spousal violence

Documenting is important to providing ongoing sensitive care, to remind yourself or to alert another provider at later visits. Documentation of injuries could be important if the woman decides to go to the police.

- Tell her what you would like to write down and why. Ask her for her consent and 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 woman, 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 it can be seen by those who do not need to know, 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 where and where you leave the records. Better if you have locked cabinets.
- For greater confidentiality, some facilities use a code or special mark to indicate cases of abuse or suspected abuse. Coding ensures anonymity.

What to do if you suspect violence, but she doesn't disclose it

- Do not pressure her, and give her time to decide what she wants to tell you.
- Tell her about services that are available if she chooses to use them.
- Offer information on the effects of violence on survivors's health and their children's health.

- Offer her a follow-up visit.

Part2
First-line support

What is first-line support

First-line support provides practical care and responds to a survivor's emotional, physical, safety and support needs, without intruding on her privacy.

Often, first-line support is the most important care that you can provide. Even if this is all you can do, you will have greatly helped your client. First-line support has helped people who have been through various upsetting or stressful events, including survivors subjected to violence.

> Remember: This may be your only opportunity to help a woman subjected to violence.

As a health care provider, you should be equipped to offer First line support. The trust established at this level may ensure the utilization of other referral services by the survivor.

First-line support involves 5 simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word "LIVES" can remind you of these 5 tasks that protect survivors's lives:

LISTEN	Listen to the woman closely, with empathy, and without judging.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns—emotional, physical, social and practical (e.g. childcare)
VALIDATE	Show her that you understand and believe her. Assure her that she is not to blame.
ENHANCE SAFETY	Discuss a plan to protect herself from further harm if violence occurs again.
SUPPORT	Support her by helping her connect to information, services and social support.

Please go to pages 18-38 for more about each of the 5 tasks of first-line support. A reminder card for the steps of LIVES appears on the last page of this handbook.

First-line support cares for emotional needs

First-line support may be the most important care that you can provide, and it may be all that she needs.

First-line support is care for emotional and practical needs. Its goals include:

- identifying her needs and concerns
- listening and validating her concerns and experiences
- helping her to feel supported, connected to others, calm and hopeful
- empowering her to feel able to help herself and to ask for help
- exploring what her options are
- respecting her wishes
- helping her to find social, physical and emotional support
- enhancing safety.

Remember: When you help her deal with her practical needs, it helps with her emotional needs.

When you help with her emotional needs, you strengthen her ability to deal with practical needs.

You do not need to:

- solve her problems
- convince her to leave a violent relationship
- convince her to go to any other services, such as police or the courts
- ask detailed questions that force her to relive painful events
- ask her to analyse what happened or why
- pressure her to tell you her feelings and reactions to an event

These actions could do more harm than good, and are not in line with the survivor-centered approach.

Tips for managing the conversation

- Choose a safe place to talk, where no one can overhear (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 doesn't need to know. If you are required to report her situation, explain what you must report and to whom.
- First, encourage her to talk and show that you are listening.
- Encourage her to continue talking if she wishes, but do not force her to talk. ("Do you want to say more about that?")
- Allow silences. If she cries, give her time to recover.

Remember: Always respect her wishes.

LISTEN

Purpose

To give 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.

Listening is the most important part of good communication and the basis of first-line support. It involves more than just hearing the woman's words. It means:

- being aware of the feelings behind her words
- hearing both what she says and what she does not say
- paying attention to body language – both hers and yours – including facial expressions, eye contact, gestures
- sitting or standing at the same level and close enough to the woman to show concern and attention but not so close as to intrude
- through empathy, showing understanding of how the woman feels.

Active listening dos and don'ts	
Dos	**Don'ts**
How you act	
Be patient and calm.	Don't pressure her to tell her story.
Let her know you are listening; for example, nod your head or say "hmm…."	Don't look at your watch or speak too rapidly. Don't answer the telephone, look at a computer or write.
Your attitude	
Acknowledge how she is feeling.	Don't judge what she has or has not done, or how she is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived", or "Poor you".
Let her tell her story at her own pace.	Don't rush her.
What you say	
Give her the opportunity to say what she wants. Ask, "How can we help you?"	Don't assume that you know what is best for her.

Active listening dos and don'ts	
Dos	**Don'ts**
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.
Allow for silence. Give her time to think.	Don't try to finish her thoughts for her.
Stay focused on her experience and on offering her support.	Don't tell her someone else's story or talk about your own troubles.
Acknowledge what she wants and respect her wishes.	Don't think and act as if you must solve her problems for her.

Learn to listen with your

Eyes – giving her your undivided attention

Ears – truly hearing her concerns

Heart – with caring and respect

INQUIRE ABOUT NEEDS AND CONCERNS

Purpose

To learn what is most important for the woman. Respect her wishes and respond to her needs.

As you listen to the woman's story, pay particular attention to what she says about her needs and concerns – and what she doesn't say but implies with words or body language. She may let you know about **physical needs**, **emotional needs**, or **economic needs,** her **safety** concerns or **social support** she needs. You can use the techniques below to help her express what she needs and to be sure that you understand.

Techniques for interacting	
Principles	**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 saying yes or no.	"How do you feel about that?"

Repeat or restate what the person says to check your understanding.	"You mentioned that you feel very frustrated."
Reflect her feelings.	"It sounds as if you are feeling angry about that…" "You seem upset."
Explore as needed.	"Could you tell me more about that?"
Ask for clarification if you don't understand.	"Can you explain that again, please?"
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."
Sum up what she has expressed.	"You seem to be saying that…."
Some things to avoid	
Don't 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.	

VALIDATE

Purpose

To let her know that her feelings are normal, that it is safe to express them and that she has a right to live without violence and fear.

Validating another's experience means letting the person know that you are listening attentively, that you understand what she is saying, and that you believe what she says without judgment or conditions.

Important things that you can say

- "It's not your fault. You are not to blame."
- "It's okay to talk."
- "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 husband and family member ."
- "You are not alone. Unfortunately, many other women have faced this problem too."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

The following job aid suggests some ways that you can help survivors of violence deal with various emotions and reactions.

Job aid

Helping women cope with negative feelings

The feeling	Some ways to respond
Hopelessness	"Many women do manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on her strengths and how she has been able to handle a past dangerous or difficult situation.
Powerlessness, loss of control	"You have some choices and options today in how to proceed."
Flashbacks	Explain that these are common and often become less common or disappear over time.
Denial	"I'm taking what you have told me seriously. I will be here if you need help in the future."
Guilt and self-blame	"You are not to blame for what happened to you. You are not responsible for this behaviour."
Shame	"There is no loss of honour in what happened. You are of value."
Unrealistic fear	Emphasize, "You are in a safe place now. We can talk about how to keep you safe."
Numbness	"This is a common reaction to difficult events. You will feel again—all in good time."
Mood swings	Explain that these can be common and should ease with the healing process.
Anger with perpetrator	Acknowledge that this is a valid feeling.
Anxiety	"This is common, but we can discuss ways to help you feel less anxious."
Helplessness	"We are here to help you."

ENHANCE SAFETY

Purpose

To help a woman assess her situation and make a plan for her future safety.

Many women who have been subjected to violence have fears about their safety. Other women may not think they need a safety plan because they do not expect that the violence will happen again. Explain that spousal violence is not likely to stop on its own: It tends to continue and may over time become worse and happen more often.

Assessing and planning for safety is an ongoing process – it is not just a one-time conversation. You can help her by discussing her particular needs and situation and exploring her options and resources each time you see her, as her situation changes.

Assessing safety after sexual assault

A woman who is assaulted often knows the person who assaulted her, and it often happens at home or in familiar settings. If it was someone she knows, discuss whether it is safe for her to return home.

Assessing immediate risk of spousal violence

Some women will know when they are in immediate danger and are afraid to go home. If she is worried about her safety, take her seriously.

Other women may need help thinking about their immediate risk. There are specific questions you can ask to see if it is safe for her to return to her home. It is important to find out if there is an immediate and likely risk of serious injury.

If there seems to be immediate high risk, then you can say "I'm concerned about your safety. Let's discuss what to do so you won't be harmed." You can consider options such as contacting the police and arranging for her to stay that night away from home in shelter home or crisis centre.

Job aid

Questions to assess immediate risk of violence

Women who answer "yes" to at least 3 of the following questions may be at especially high immediate risk of violence.

- Has the physical violence happened more often or gotten worse over the past 6 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?

Adapted from Snider, 2009.

If it is **not safe for the woman to return home**, 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).

Making a safety plan

Even women who are not facing immediate serious risk could benefit from having a safety plan. If she has a plan, she will be better able to deal with the situation if violence suddenly occurs.

The following are elements of a safety plan and questions you can ask her to help her make a plan.

Job aid

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 will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items 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[3], or come with assistance for you if they hear sounds of violence coming from your home?

[3] Rescue 1122 Service in Punjab and KP Province as well as many helplines in other provinces

Discuss how to stay safer at home

If she cannot avoid discussions that may escalate with her husband or perpetrator, advise her to try to have the discussions in a room or an area that she can leave easily.

Advise her to stay away from any room where there might be weapons.

If she has decided that leaving is the best option, advise her to make her plans and leave for a safe place BEFORE letting her husband or perpetrator know. Otherwise, she may put herself and her children at more risk of violence.

Avoid putting her at risk

Talk about abuse only when you and she are alone. No one older than age 2 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. You may need to think of an excuse to be able to see the woman alone, such as sending the person to do an errand or fill out a form. If her children are with her, ask a colleague to look after them while you talk.

Remember to maintain the confidentiality of her health records. Keep such documents in a safe place, not out on a desk or anywhere else that anyone can see them. Use codes, instead of names for keeping the identity of the survivor confidential.

Discuss with the woman how she will explain where she has been. If she must take paperwork with her (for the police, for example), discuss what she will do with the paper.

Remember that as a health care provider, you need to follow up on the safety plan every time you see the survivor as her circumstances and needs may change.

SUPPORT

Purpose

To connect a woman with other resources for her health, safety, and social support.

The needs of survivors of violence generally are beyond what you can provide in the clinic. You can help by discussing the woman's needs with her, telling her about other sources of help, and assisting her to get help if she wants it.

How to help

- Ask her 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. Does she have a family member, friend, or trusted person in the community whom she could talk to? Does she have anyone who could help her with money?

Possible resources

Find out what support and resources are available to the woman in the community. It can help if you have a personal contact to send her to at each place.

- helpline
- support groups

- crisis centre
- legal support
- mental health counsellor
- social worker
- psychologist.

It will usually not be possible to deal with all her concerns at the first meeting. Let her know that you are available to meet again to talk about other issues.

Do not expect her to make decisions immediately.

It may seem frustrating if she does not seem to be taking steps to change her situation. However, she will need to take her time and do what she thinks is right for her. Always respect her wishes and decisions.

Referrals

Often survivors of violence do not follow up on referrals from health-care providers. You can help make it more likely that she gets the help that you have recommended.

Tips on giving referrals

- Be sure that the referral addresses her most important needs or concerns.
- If she expresses problems with going to a referral for any reason, think creatively with her about solutions.
- Problems you might discuss:
    - No one to leave the children with.
    - Her husband might find out and try to prevent it.
    - She doesn't have transport.

- If she accepts a referral, here are some things you can do to make it easier for her:
    - Tell her about the service (location, how to get there, who she will see).
    - Offer to telephone to make an appointment for her if this would be of help (for example, she does not have a phone or a safe place to make a call).
    - If she wants it, provide the written information that she needs – time, location, how to get there, name of person she will see. Ask her to think how she will make sure that no one else sees the paper.
    - If possible, arrange for a trusted person to accompany her on the first appointment.

Always check to see if she has questions or concerns and to be sure that she has understood.

You can fill in the following chart to keep track of resources in your community. These referrals could be internal or external resources.

It is best to have formal referral agreements with organizations that you refer survivors of GBV to. If possible, these agreements should specify how you will find out if the woman reaches the referral resource – will you contact them or will they contact you?

Job aid

Referral chart

What to refer for	Where / who to refer to	Contact info	Responsibility for follow-up
Shelter/housing			
Crisis centre			
Financial aid			
Legal aid			
Support groups			
Counselling			
Mental health care			
Primary care			
Child care			
Other			

Taking care of your own needs

Your needs are as important as those of the survivors you are caring for. You may have strong reactions or emotions when listening to or talking about violence with survivors. This is especially true if you have experienced abuse or violence yourself – or are experiencing it now.

Be aware of your emotions and take the opportunity to understand yourself better. Be sure to get the help and support you need for yourself.

Questions and answers

Here are answers to some questions that health-care providers often ask about working with survivors subjected to violence.

"Why not offer advice?"

What is important to survivors of violence is to be listened to and to have an opportunity to tell their story to an empathetic person. Most survivors do not want to be told what to do. In fact, listening well and responding with empathy are far more helpful than you may realize. It may be the most important thing you can do. Survivors need to find their own path and come to their own decisions, and talking about it can help them do this.

"Why doesn't she just leave him?"

There are many reasons that survivors, particularly women stay in violent relationships. It is important not to judge her and not to urge her to leave. She has to make that decision herself in her own time. Reasons for not leaving include:

- She depends on her husband's income. In Pakistan it is often difficult for a woman to earn her own living due to cultural reasons as well as lack of education.
- She believes that children should be raised with a father and thinks that her own welfare is less important than this ideal.

- She thinks that violence is normal in relationships and that all men will be violent and controlling.
- She fears an extreme and violent reaction to her leaving.
- Her self-esteem is low and she believes that she cannot manage on her own.
- She feels she has no place to go or no one to turn to for support.
- She still loves him and thinks he will change.
- She thinks that he needs her.
- She does not want to be alone.
- She is afraid of being abandoned by the community for having left her husband and family.

"How did she get herself into this situation?"

It is important to avoid blaming the woman for what happened. Blaming the woman will get in the way of your giving her good care. Violence is never appropriate in any situation. There is no excuse or justification for violence or abuse. Just because a woman did something that made her husband angry does not mean that she deserved to be hurt.

"What can I do when I have so few resources and so little time?"

First-line support ("LIVES") is the most helpful care you can give. It does not necessarily take long, and it does not require additional resources. Also, you can learn about resources in the health-care system and in the

community that can help her (see page 29-30). You might even consider whether you could help a confidential community support group get started.

“That wasn’t the way we were taught.”

Health-care providers are generally taught that their main role is to diagnose the problem and treat it. However, in this situation limiting the focus to medical concerns is not helpful. Instead, you need to add a human focus by listening, identifying her needs and concerns, strengthening her social support and enhancing her safety. Also, you can help her see and consider her options and help her feel she has the strength to make and carry out important decisions.

“What if she decides not to report to the police?”

Respect her decision. Let her know that she can change her mind. However, evidence of sexual assault must be collected within 5 days. Let her know if there is someone she can talk to further about her options and help her make the report if she chooses to.

“How can I promise confidentiality if the law says I have to report to the police?”

If the law requires you to report violence to the police, you must tell her this. You can say, for example,

"What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is….."

As a health-care provider, learn about the specifics of the law and conditions in which you are required to report (for example, the law may require reporting rape or child abuse). Assure her that, outside of this required reporting, you will not tell anyone else without her permission.

"What if she starts to cry?"

Give her time to do so. You can say "I know this is difficult to talk about. You can take your time."

"What if you suspect violence but she doesn't acknowledge it?"

Do not try to force her to disclose. (Your suspicions could be wrong.) You can still provide care and offer further help. See page 3 for more details.

"What if she wants me to talk to her husband."

It is not a good idea for you to take on this responsibility. However, if the woman feels it is safe to do so and it will not make the violence worse, it may be helpful for someone he respects to talk to him – perhaps a family member, friend, or religious leader.

Warn her that if this is not done carefully, it could lead to more violence.

"What if the husband is one of my clients, too?"

It is very hard to keep seeing both spouses when violence and abuse is happening in the relationship. Best practice is to try to get a colleague to see one of them, while ensuring that confidentiality of the woman's disclosure is protected. Do not offer couple counselling.

"What if I think her husband is likely to kill her?"

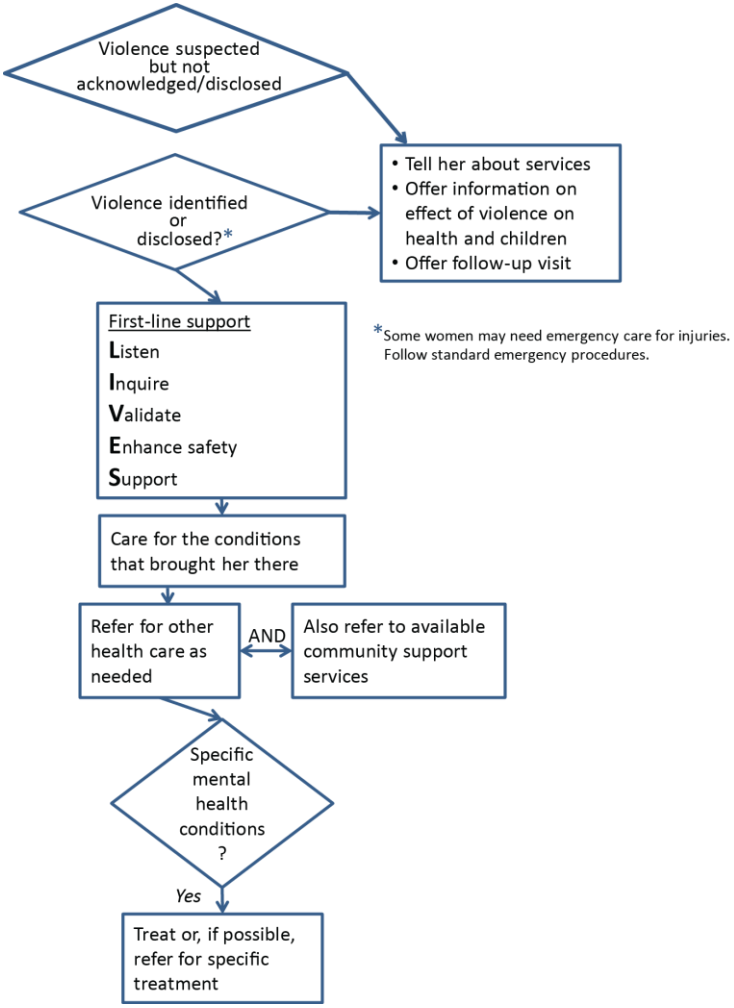
- Share your concerns honestly with the woman, explaining why you think she might be at grave risk and explain that you want to discuss with her the possible options for making her safe. In this situation identifying and offering secure alternatives where she can go is particularly important.
- Depending on the law you may be obliged to report the risk to the police.
- Ask if there is a trusted person you can include in the discussion and whom you can alert to the risk.

Job aid

Identify Barriers and Challenges	
Barriers and Challenges	**Potential solutions**
• Socio-cultural challenges: • Society's perceptions that: wife beating is justified[1] • Women are not allowed to see male care providers and self decision making to seek their own health care • Health care providers are under the influence of masculine norms so its difficult to disclose about violence for seeking care • Cultural bias that blames survivors for the violence occuring to them	
• Lack of clinical supplies to respond GBV and confidential space at health facility for consultation	
• Poor referral mechanisms	
• Safety plan for care provider is not implementable at primary health care level	
• Lack of awareness, communication skills and training on survivor centred approach among care providers	

[1] PDHS 2012-13

Pathway of care for spousal violence



Part 3
Additional care for physical health after sexual assault

Immediately refer patients with life-threatening or severe conditions for **emergency treatment**.

If the woman comes **within 5 days** after sexual assault, care involves 6 steps in addition to the LIVES steps in first-line response (see Part 2):

First, ***L**isten, **I**nquire, **V**alidate* (first-line support). Then:

1. Take a history and conduct the examination (page 42).
2. Treat any physical injuries (page 50).
3. Provide emergency contraception (page 51).
4. Prevent sexually transmitted infections (STIs) (page 54-57).
5. Prevent HIV (page 58).
6. Plan for self-care (page 61).

Then, **E**nhance safety, arrange **S**upport (first-line response).

The **examination** and **care of physical and emotional health** should take place together. They are divided in this handbook to help you understand key actions. See Part 4 for mental health.

The following pages explain the six steps. Also, the care pathway on page 40 shows the order of steps.

For follow-up actions after the first 5 days, see pages 59–63.

"What can I do if she delays coming in after the assault?"

PEP for HIV must be started as soon as possible and no later than 72 hours after exposure. EC pills should also be started as soon as possible and can be taken up to 5 days after unprotected intercourse

If a woman comes too late for some of these steps, you can still always:

- Provide first-line support (page14)
- Offer STI prevention and treatment (page54)
- Offer hepatitis B immunization(page57-58)
- Test for pregnancy and HIV
- Assess mental health and provide care as needed (see Part 4, page70).

1. Take a history and examine

This step involves the following actions:

- Take a history—overall medical history, information about the assault, and gynaecological and mental health assessments.
- Prepare for the examination and obtain informed consent (page 45).
- Do a head-to-toe physical examination (page 47).

A. Take a history

The history-taking includes: (1) general medical information, (2) questions about the assault (only ask about what is needed for medical care (e.g. penetration, oral, vaginal, anal?), (3) a gynaecological history, (4) an assessment of mental state (see Part 4). The history should be taken preferably in the language the survivor understands and speaks with probing skills.

The history and exam form on pages127-36 suggests questions.

General tips

- First, review any papers that the woman has. Avoid asking questions she has already answered.
- Keep a respectful attitude and a calm voice.
- Maintain eye contact as culturally appropriate.
- Avoid distraction and interruption.
- Take time to collect all needed information.

(1) Ask about general medical information

General medical information should cover any current or past health problems, allergies, and any medications that the woman is taking. See the history and exam form on pages127-36 for questions to ask.

This information may help with understanding examination findings.

(2) Talk about the assault

The reason to obtain an account of the violence is to:

- guide the exam so that all injuries can be found and treated;
- assess her risk of pregnancy, STIs and HIV;
- guide specimen collection and documentation.

Communicate

- Politely ask the woman to briefly describe the events.

Do not force a woman to talk about the assault if she does not want to. In all cases limit questions to just what is required for medical care. However, if a woman clearly wants to talk about what happened, it is very important to listen empathetically and allow her to talk.

- Explain that learning what happened will help you give her the best care. Assure her that you will keep what she says private unless she wants the police to take up her case or the law requires you to report.
- Explain that she does not have to tell you anything that she does not want to talk about.
- Let her tell her story in the way that she wants and at her own pace. Do not interrupt. If it is essential to clarify any details, ask after she has finished.
- Question gently. Use open-ended questions that cannot be answered yes or no. Avoid questions that might suggest blame, such as "What were you doing there alone?" or “Why did you…?”.
- The woman may omit or avoid describing painful, frightening or horrific details. Do not force her to describe them. If you really need specific information in order to treat her properly, explain why you need to know.

(3) Take a gynaecological history

The examination form on pages127-36 suggests the questions to ask.

The purpose of taking a gynaecological history is to:

- check the risk of pregnancy and STIs
- check whether any exam findings could result from previous traumatic events, pregnancy or delivery.

(4) Assess mental health

Ask general questions about how she is feeling and what her emotions are while taking her history.

If you see signs of severe emotional distress, ask specific questions. See Part 4.

B. Prepare for the exam and obtain informed consent

Communicate

- Ask the woman's permission to do a physical exam and obtain informed consent for each step.
- Ask if she wants a specific person to be present for support, such as a family member or friend.
- Find a female provider to do the exam for a woman survivor as per her consent and choice

Have an observer there

- See that another person is present during the exam – preferably a specifically trained support person or female, health worker. It is especially important to have a woman present if the provider is male.
- Introduce this person, and explain that she is there to give the woman help and support.

- Otherwise, keep the number of people in the exam room to a minimum.

Obtain 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.

- Explain to the woman that she will be examined and treated only if she wants. Explain that she can refuse any aspect of the examination (or all).
- Describe the four aspects of the exam:
    - medical exam
    - pelvic exam
    - evidence collection
    - turn-over of medical information and evidence to the police if she wants legal redress.
- For each aspect of the exam, invite her questions, and answer fully. Make sure that she understands. Then, ask her to decide yes or no. Tick the box on the form.
- Once you are sure that she has understood the exam and the form completely, ask her to sign.
- Ask another person to sign the form as a witness, if required.

Talking to a woman about reporting to the police

- If the law requires you to report to the police, tell her that.
- If she wants to go to the police, tell her that she will need to have forensic evidence collected. Tell her whether a health-care provider trained to do this is available.
- Tell her what evidence collection would involve.
- If she hasn't decided whether or not to go to the police, the evidence can be collected and held. If more than 7 days

have passed since the assault, it is too late to collect evidence.

- If she wants evidence collected, call in or refer to a specifically trained provider and authorised medico legal professional who can do this.
- Even if the forensic evidence is not collected, the full physical exam should be done and well documented (see form page127). The exam can be useful if a woman decides to pursue a legal case.

For further details on forensic examinations, see the following guidelines: *Clinical management of rape survivors*, 2004 at http://www.who.int/reproductivehealth/publications/emergencies/9241 59263X/en/ and *Guidelines for medico-legal care for survivors of sexual violence,* 2003 at http://www.who.int/violence_injury_prevention/ publications/violence/ med_leg_guidelines/en/.

C. Do a head-to-toe examination, including genito-anal exam

The main reason for the physical examination is to determine what medical care is needed. It is also used to complete any legal documentation.

Communicate

- Assure her that she is in control. She can ask questions, can stop the exam at any time and can refuse any part of the exam.
- Look at the woman before you touch her and pay attention to her appearance and emotional state.
- At each step of the exam, tell her what you are going to do, and ask her permission first.
- Ask often if she has any questions and if you can proceed.

Examine

- Make sure equipment and supplies are prepared.
- Take the patient's vital signs—pulse, blood pressure, respiratory rate and temperature.
- Work systematically. Use the chart on page49.
- Be unhurried. Give time to the examination.
- Record all your findings and observations clearly and fully on a standard exam form (see page127).
- Document carefully and fully any injury or other mark as this can be important for medical treatment as well as evidence.

Do genito-anal examination

In cases of sexual assault, a genito-anal examination is necessary. This is a sensitive examination, particularly the speculum exam.

- Help the woman feel as comfortable as possible.
- Let her know when and where you will touch her.
- Help the woman to lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her body. It should be drawn up at the time of the examination.
- Work systematically. Have a good light source to view injuries. Follow the chart on page 49.
- Record all your findings and observations clearly and fully on a standard exam form (see page127).

Remember: Being sexually assaulted is a traumatic event. Survivors may be very sensitive to being examined or touched. Proceed slowly. Ask often if she is okay and if you can proceed.

There is no place for virginity (or 'two-finger') testing; it has no scientific validity.
Be very careful not to increase her distress.

Job Aid

Physical exam checklist

Look at all the following	Look for and record
• 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 and feet	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Evidence that hair has been pulled out, and recent evidence of missing teeth • Injuries such as bite marks or gunshot wounds • Evidence of internal traumatic injuries in the abdomen • Ruptured ear drum
Genito-anal examination	
• Genitals (external) • Genitals (internal examination, using a speculum) • Anal region (external)	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

Record findings and treatment

Health-care providers often must answer questions from police, lawyers or the courts about injuries to survivors they have treated. Careful documentation of findings and treatment on the history and exam form (pages127-36) will make it easier for you to answer accurately.

Issues that the authorities want to know about:

- type of injury (cut, bruise, abrasion, fracture, other)
- description of the injury (length, depth, other characteristics)
- where on the body the injury is
- possible cause of the injury (e.g. gunshot, bite marks, other)
- the immediate and potential long-term consequences of the injury
- treatment provided.

2. Provide treatment

2.1 Treat physical injuries or refer

Immediately refer patients with life-threatening or severe conditions for emergency treatment.

Complications that may require urgent hospitalization:

- extensive injury (to genital region, head, chest or abdomen)
- neurological deficits (for example, cannot speak, problems walking)
- respiratory distress
- swelling of joints on one side of the body (septic arthritis).

Patients with less severe injuries – for example, superficial wounds – can usually be treated on site. Clean and treat any wounds as necessary.

The following medications may be indicated:

- antibiotics to prevent wound infection
- a tetanus booster or vaccination (according to local protocols)
- medications for relief of pain
- medication for insomnia (for use in exceptional cases).

Cautions

1. Do not routinely prescribe benzodiazepines for insomnia (see Annex 1).
2. Do not prescribe benzodiazepines or antidepressants for acute distress.

2.2 Provide emergency contraception

If emergency contraception (EC) is used soon after sexual assault, it can help a woman avoid pregnancy.

Offer EC to any woman who has been sexually assaulted along with counselling so that she can make an informed decision (see counselling, next page).

Facts about emergency contraception pills

- 2 kinds of pills are commonly used for EC:
    - **Levonorgestrel-only**

      Works better and causes less nausea and vomiting than combined.

      Preferred dosage: 1.5 mg levonorgestrel in a single dose.

- **Combined estrogen-progestogen**
  Use if levonorgestrel-only pills not available.
  Dosage: 2 doses of 100 µg ethinyl estradiol plus 0.5 mg levonorgestrel, 12 hours apart.

- Any woman can take EC pills. There is no need to screen for health conditions or test for pregnancy.
- A woman can take EC pills, antibiotics for STIs and PEP for HIV prevention at the same time without harm. EC and antibiotics can be taken at different times and along with food to reduce nausea.

Emergency contraception counselling points

A woman who has been sexually assaulted is likely to worry if she will get pregnant.

To reassure her, explain emergency contraception. Also, you can ask her if she has been using an effective contraceptive method such as pills, injectables, implants, IUD, or female sterilization. If so, it is not likely she will get pregnant. Also, if her last menstrual period began within 7 days before the attack, she is not likely to get pregnant.

In any case, she can take EC if she wishes.

- Use of emergency contraception is a personal choice that only she, the woman herself, can make.
- Emergency contraception can help her to avoid pregnancy, but it is not 100% effective.
- EC pills work mainly by stopping release of the egg.
- EC pills will not cause abortion.
- EC pills will not prevent pregnancy the next time she has sex.
- EC pills are not meant for regular use in place of a more effective, continuing contraceptive method.

- She does not need to have a pregnancy test before taking EC pills. If she is already pregnant, EC pills will not harm the pregnancy. However, a pregnancy test may identify if she is pregnant already, and she can have one if she wishes.

Instructions

- She should ***take the EC pills as soon as possible*.** She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes.
- EC pills may cause nausea and vomiting. 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 medicine (meclazine 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.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. EC pills will not work, but they will not harm the pregnancy.
- She should return if her next menstrual period is more than 1 week late. Safe abortion should be offered where survivor life is in danger that is in line with the law.

Emergency copper IUD

- Also can be used for EC up to 5 days after unprotected intercourse.
- More effective than EC pills.
- The higher risk of STIs following rape should be considered if using a copper IUD.
- Good choice for very effective long-acting contraception if a woman is interested in the IUD and could be referred for it immediately.

2.3 Prevent sexually transmitted infections

- Survivors who have been sexually assaulted should be given antibiotics to prevent and treat the following sexually transmitted infections (STIs)—chlamydia, gonorrhoea, trichomonas and, if common in the area, syphilis.
- Offer STI treatment on your first meeting with the woman.
- There is no need to test for STIs before treating.
- Give preventive treatment for STIs common in the area (for example, chancroid).
- Give the shortest courses available in the local or national protocol, as these are easiest to take.

See chart on next page with dosage information based on the national protocol[1] for your further reference.

Presumptive Treatment

Ciprofloxacin orally 500mg single dose

+

Doxycycline 100mg,twice a day for 7 days

+

Metronidazole orally 400mg twice daily for 7 days

+

Fluconazole 150mg orally as a single dose

In pregnant women:

Erythromycin[2] 500mg orally 4 times daily for 7 days

+

Vaginal cream for Trichomoniasis and Candidiasis

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[1] National STD Case Management Guidelines Pakistan, 2010

[2] Erythromycin should not be given on empty stomach

Job aid

Syndromic/symptomatic treatment		
STI symptom	**Medication**	**Dosage and schedule**
Vesicular ulcer Herpes Simplex 2	For first episode: acyclovir For recurrent episode: Acyclovir	200mg 5 times daily for 7 days 200mg 3 times daily for 6 weeks
Chancroid	Ciprofloxacin OR Erythromycin	orally 500mg,as a single dose orally 500mg 3 times daily fo 3 days
Syphillis In case of penicillin allergy	Inj.benzathine benzyl penicillin Doxycycline	2.4 million IU I/M - 2 injections at different sites 100mg 2 times daily for 14 days
Enlarged lymph nodes in the inguinal region	Doxycycline OR Erythromycin	100mg orally twice daily for 14 days 500mg orally 4 times daily for 14 days
Vesicles over the lips	Cream Acyclovir for local application	

Genital Warts	Solution Podophyllotoxin OR Cream Imiquimod	0.5% - 2 times for 3 days followed by 4 days no treatment, the cycle repeated upto 4 times 5% 3 times a week for 16 weeks
Diagnostic treatment		
STI	**Medication**	**Dosage and schedule**
Chlamydia In pregnant women	Doxycycline Erythromycin	100mg 2 tabs start and then 1 daily for 7 days 500mg twice daily for 7 days
Gonorrhoea	Ciprofloxacin	500mg twice daily for 7 days
Syphilis In case of penicillin allergy For pregnant women in case of allergy	Inj benzathine benzyl penicillin Doxycycline Erythromycin	2.4 million units IU I/M - 2 injections at different sites 100mg 2 tabs stat and then 1 daily for 14 days 500mg 4 times daily for 15 days

Herpes simplex V2	For first clinical episode: Acyclovir	200mg orally 5 times daily for 7 day OR 400mg orally 3 times daily for 7 days
	For recurrent infection: Acyclovir	200mg orally 5 times daily for 5 days OR 400mg orally 3 times daily for 5 days

Hepatitis B

The hepatitis B virus can be sexually transmitted. Therefore, survivors subjected to sexual violence should be offered immunization for hepatitis B

- Ask if she has received a vaccine against hepatitis B. Respond according to chart below.
- If she is uncertain, test first if possible. If already immune (presence of hepatitis B surface antibody in serum), no further vaccination is needed. If testing is not possible, vaccinate.

Has she been vaccinated for hepatitis B?

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 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.

- Use the type of vaccine, dosage and immunization schedule that is used in your area.
- A vaccine without hepatitis B immune globulin (HBIG) can be used.
- Give the vaccine intramuscularly in the deltoid region of the arm.

2.4 Prevent HIV

Post-exposure prophylaxis (PEP) to prevent HIV should be started as soon as possible up to 72 hours after possible exposure to HIV. Talk to the woman about whether HIV PEP is appropriate in her situation.

When should PEP be considered[1]?

In case of a suspected exposure, a detailed history must be taken to assess if this was a significant exposure on not. The source person (from whom the exposure occurred) should be identified (if possible) and an HIV test obtained of both the source and the exposed person. In cases where the source is unknown or their HIV status cannot be ascertained, PEP must be individualized, based on the situations identified below.

Situation/Risk factor	Suggested procedure
Perpetrator is HIV-infected or of unknown HIV status.	Give PEP
Survivor's HIV status is unknown.	Offer HIV testing and counselling
Survivor's HIV status is unknown and she is NOT willing to test.	Give PEP and make follow-up appointment
Survivor is HIV-positive.	Do NOT give PEP
Survivor has been exposed to blood or semen (through vaginal, anal or oral intercourse or through wounds or other mucous membranes.	Give PEP
Survivor was unconscious and cannot remember what happened.	Give PEP

[1] Based on *Consolidated Guidelines for the Prevention and Treatment of HIV and AIDS in Pakistan 2017*

She was gang-raped.	Give PEP

Communicate

Taking PEP is the woman's decision. Discuss the following points to help her decide.

- How common is HIV in your area or setting?
- Does she know if the perpetrator is HIV-positive?
- Assault characteristics, including the number of perpetrators, if there were lacerations in the genital area or other injuries.
- PEP can lower her chances of getting HIV, but it is not 100% effective.
- She will need to take the medicine for 28 days, either once or twice daily depending on the regimen used.
- About half of people who take PEP have side-effects, such as nausea, tiredness, headaches. (For most people side-effects decrease in a few days.)

If she takes HIV PEP

- Start the regimen as soon as possible and in any case no later than 72 hours after the assault.
- Ensure follow-up at regular intervals.
- The choice of drug for PEP to be offered isTDF+3TC with LPV/r and with adherence support.The recommended dosage is two tabs twice a day.
- Once started, PEP should be continued for 28 days
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals.
- Offer HIV testing at the initial consultation.
- Retest at 6 weeks and at 3 or 6 months.

- In the case of a positive test result, refer for HIV treatment and care.

PEP adherence counselling

Adherence is an important element of delivering PEP. Discuss the following points with the woman:

- It is important to remember to take each dose, and so it is helpful to take it at the same time every day, such as at breakfast and dinner. Taking the pills at regular intervals ensures that the level in the blood stays about the same.
- An alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can help remember.
- 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.
- She should not take 2 doses at the same time.
- She should return to the health facility if side-effects do not go away in a few days, if she is unable to take the drugs as prescribed, or if she has any other problems.

2.5 Plan for self-care

Explain your examination findings and treatment

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

Care of injuries

- Teach the woman how to care for any injuries.
- Describe the signs and symptoms of wound infection—warm, red, painful, or swollen wound; blood or pus; bad smell; 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.

Prevention of STIs

- Discuss the signs and symptoms of STIs, including HIV. Advise her to return for treatment if any signs or symptoms occur.
- Ask her to refrain from sexual intercourse until all treatments or prophylaxis for STIs have finished. Encourage her to use condoms during sexual intercourse at least until her STI/HIV status has been determined at the 3- or 6-month visit.

Follow-up

- Plan follow-up visits at 2 weeks, 6 weeks, 3 months and 6 months after the assault.

3. Follow-up after sexual assault

Follow-up visits should take place at 2 weeks, 1 month, 3 months and 6 months after the assault.

Job aid

2-week follow-up visit		
Injury	• Check that any injuries are healing properly.	☐
STIs	• Check that the woman has completed the course of any medications given for STIs. • Check adherence to PEP, if she is taking it. • Discuss any test results.	☐ ☐ ☐
Pregnancy	• Test for pregnancy if she was at risk. If she is pregnant, tell her about the available options. If abortion is permitted, refer her for safe abortion to save her life.	☐

Job aid

2-week follow-up visit		
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If any problems, plan for psycho-social support and stress management, such as progressive relaxation or slow breathing. *For more details, see Part 4, pages 70–84.*	☐ ☐
Planning	• Remind her to return for further hepatitis B vaccinations in 1 month and 6 months and 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 if emotional and physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by 1 month after the event.	☐
	• Make next routine follow-up appointment for 1 month after the assault.	☐

Job aid

6 week follow-up visit		
STIs	• Give second hepatitis B vaccination, if needed. Remind her of the 6-month dose. • Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care.	☐ ☐
Mental health	• Continue first-line support and care. • Assess her emotional state and mental status. Ask if she is feeling better. If new or continuing problems, plan for psycho-social support and stress management. • For depression, or substance use, or post-traumatic stress disorder, *please see Part 4 (pages 70 to 84) for primary care.* Or, if possible refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐ ☐ ☐
Planning	• Make next routine follow-up appointment for 3 months after the assault.	☐

Job aid

3-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.	☐
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If new or continuing problems, plan for psycho-social support and stress management. • For depression, or substance use, or post-traumatic stress disorder, *please see Part 4 (pages 70 to 84) for primary care.* Or, if possible, refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐ ☐ ☐
Planning	• Make next follow-up appointment for 6 months after the assault. Also, remind her of the 6-month dose of hepatitis B vaccine, if needed.	☐

Job aid

6-month follow-up visit		
STIs	• Offer HIV testing and counselling if not done before. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care. • Give third dose of hepatitis B vaccine, if needed.	☐
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If there are new or continuing problems, plan for psycho-social support and stress management. • For depression, drug use, or post-traumatic stress disorder, refer if possible for specific care to a specifically trained health-care provider with a good understanding of sexual violence. *For details and additional response, see Part 4, pages 70-87 .*	☐ ☐ ☐

Job aid

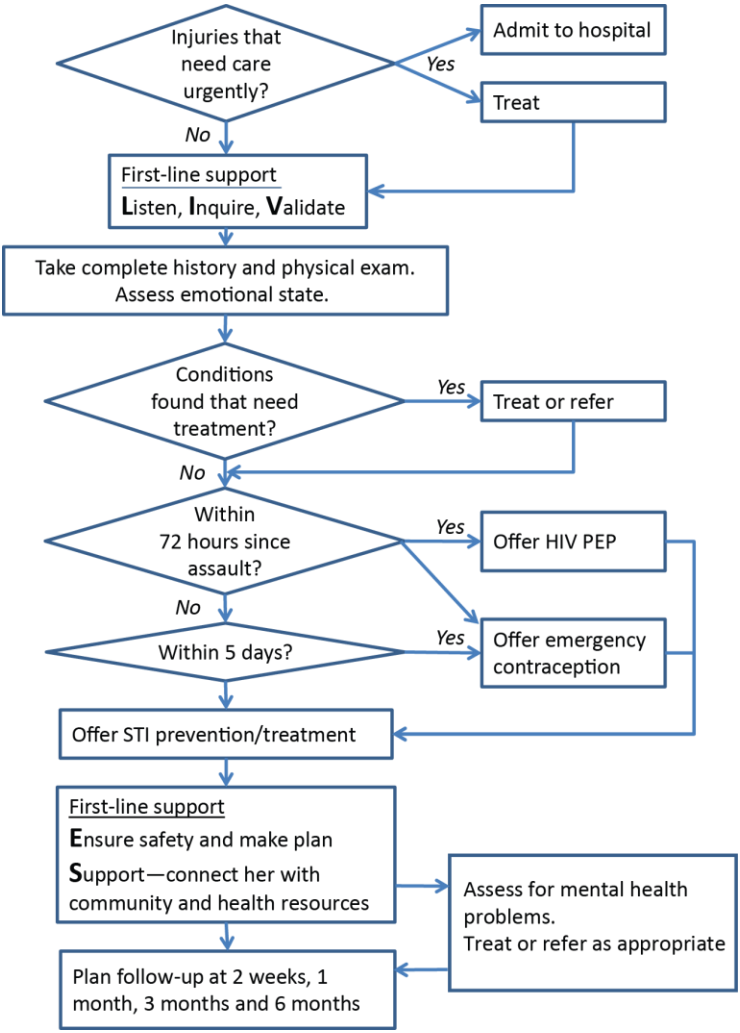
Testing schedule

	Schedule	
Test for:	**Initial test**	**Retest**
Pregnancy	At 2 weeks	None
Chlamydia, gonorrhoea, trichomonas	At 2 weeks	None
Syphilis	At 2 weeks	At 3 months
HIV	On first visit if she is willing*	At 6 weeks and 3 or 6 months
Hepatitis B	At first visit**	None

* If the woman tests positive for HIV at first visit, do not give PEP. If she is unwilling to test and her HIV status is unknown, offer PEP.

** Test if woman is uncertain whether she has received all 3 hepatitis B vaccinations. If testing at first visit shows that she is already immune, no further vaccination is required.

Pathway for intial care after assault



Part 4
Additional care for mental health

Many survivors who are subjected to domestic/spousal violence or sexual violence will have emotional or mental health problems. Once the violent assault or situation passes, these emotional problems will likely get better. Most people recover. There are specific ways you can offer help and techniques you can teach to reduce stress of survivors and help them heal.

Some survivors however, will suffer more severely than others. It is important to be able to recognize these survivors and to help them obtain care. If such help is not available, there are things that front-line health-care providers can do to reduce their suffering.

Basic psychosocial support

After a sexual assault, basic psychosocial support may be sufficient for the first 1–3 months, at the same time monitoring the woman survivor for more severe mental health problems.

Offer first-line support at each meeting (see LIVES, page15).

- Explain that she is likely to feel better with time.
- Help strengthen her positive coping methods (see next page).
- Explore the availability of social support (see next page).
- Teach and demonstrate **stress reduction** exercises. (see pages 73-74. These pages can be copied and given to the woman to take home, if that is safe.)
- Make regular follow-up appointments for further support.

Strengthening her positive coping methods

After a violent event a woman may find it difficult to return to her normal routine. Encourage her to take small and simple steps. Talk to her about her life and activities. Discuss and plan together. Let her know that things will likely get better over time.

Encourage her to:

- Build on her strengths and abilities. Ask what is going well currently and how she has coped with difficult situations in the past.
- Continue normal activities, especially ones that used to be interesting or pleasurable.
- Keep her social life active, to avoid being isolated (i.e. visit her relatives, go for prayers, go to the market etc..)
- Engage in relaxing activities to reduce anxiety and tension.
- Keep a regular sleep schedule and avoid sleeping too much.
- Engage in regular physical activity.
- Avoid using self-prescribed medications, tranqolizers illegal drugs to try to feel better.
- Recognize thoughts of self-harm or suicide and come back as soon as possible for help if they occur.

Encourage her to return if these suggestions are not helping.

Explore the availability of social support

Good social support is one of the most important protections for any woman suffering from stress-related problems. When women experience abuse or violence, they often feel cut off from normal social circles or are unable to connect with them. This may be because they lack energy or feel ashamed.

You can ask:

- “When you are not feeling well, who do you like to be with?”
- “Who do you turn to for advice?”
- “Who do you feel most comfortable sharing your problems with?”

Note: Explain to survivors that, even if there is no one with whom they wish to share what has happened to them, she still can connect with family and friends. Spending time with people they trust and enjoy can distract her from her distress.

Help them to identify past social activities or resources that may provide direct or indirect psychosocial support (for example, family gatherings, visits with neighbours, sports, community and religious activities). Encourage them to participate.

Collaborate with social workers, case managers or other trusted people in the community to connect them with resources for social support such as:

- community centres
- self-help and support groups
- income-generating activities and other vocational activities
- formal/informal education.

Job aid

Exercises to help reduce stress

1. Slow breathing technique

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
- First, 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.
- Put your hands on your belly. 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.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

2. Progressive muscle relaxation technique

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to 3 while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.

- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to 3, and then relax and breathe out slowly.
    - Hold your leg and thigh muscles tight…
    - Hold your belly tight…
    - Make fists with your hands…
    - Bend your arms at the elbows and hold your arms tight…
    - Squeeze your shoulder blades together…
    - Shrug your shoulders as high as you can…
    - Tighten all the muscles in your face….
- Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times. Now, go the other way…inhale to the left and back, exhale to the right and down. Do this 3 times.
- Now bring your head up to the centre. Notice how calm you feel.

Helping with more severe mental health problems

It is important to recognize that not all survivors of intimate partner violence or sexual violence will experience severe mental health problems or need treatment for these problems. While first-line support should be offered to everyone who experiences violence, treatment and care for more severe mental health problems will be needed by a smaller group who has persistent symptoms and is assessed and diagnosed has having specific mental health conditions that need further treatment.

Assessment of mental status

As a front-line health-care provider, it important to assess the mental status of survivors as it provides important information about their mental health. You assess mental status at the same time that you do the general health examination. This requires observing and listening closely. Take note of the following:

Appearance and behaviour	Does she take care of her appearance? Are her clothing and hair cared for or in disarray? Is she distracted or agitated? Is she restless, or is she calm? Are there any signs of intoxication or misuse of drugs?
Mood, both what you observe and what she reports	Is she calm, crying, angry, anxious, very sad, without expression?
Speech	Is she silent? How does she speak (clearly or

	with difficulty)? Too fast/too slow? Is she confused?
Thoughts	Does she have thoughts about hurting herself? Are there bad thoughts or memories that keep coming back? Is she seeing the event over and over in her mind?

You can also gather information by asking general questions:

- "How do you feel?"
- "How have things changed for you?"
- "Are you having any problems?"
- "Are you having any difficulties coping with daily life?"

If your general assessment identifies problems with mood, thoughts or behaviour and she is unable to function in her daily life, she may have more severe mental health problems. See page 83 for discussion of depressive disorder and post-traumatic stress disorder.

Details on the assessment and management of all the problems mentioned below and other common mental health problems can be found in the mhGAP intervention guide and its annex on conditions specifically related to stress. http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

Imminent risk of suicide and self-harm

Some health care workers fear that asking about suicide may provoke the woman to commit it. On the contrary, talking about suicide often reduces the woman's anxiety around suicidal thoughts and helps her feel understood.

If she has:

- current thoughts or plan to commit suicide or to harm herself,

OR

- a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative, then **there is immediate risk of self-harm or suicide, and she should not be left alone.**

Refer her immediately to a specialist or emergency health facility.

Moderate-severe depressive disorder

Women who have suffered domestic/spousal violence or sexual assault may feel extreme emotions of continuing fear, guilt, shame, grief for what they have lost, and hopelessness. These emotions, however overwhelming, are usually temporary and are normal reactions to recent difficulties.

When a woman is unable to find a way to cope and these symptoms persist, then she may be suffering from mental disorders such as depressive disorder.

People develop depressive disorder even when not facing extreme life events. Any community will have people with pre-existing depressive disorder. If a woman has suffered from such depressive disorder before experiencing violence, she will be much more vulnerable to having it again.

As a front-line health care provider, you can assess whether the survivor needs further treatment for moderate-severe depression and refer to a trained specialist if she needs specialized treatment. The decision to refer for specialized treatment for moderate-severe depressive disorder should be made only if the woman has persistent symptoms over at least 2 weeks and cannot carry out her normal activities.

Typical presenting complaints of depressive disorder

- Low energy, fatigue, sleep problems
- Multiple physical symptoms with no clear cause (for example, aches and pains)
- Persistent sadness or depressed mood; anxiety
- Little interest in or pleasure from activities

Assessment of moderate-severe depressive disorder

1. Does the woman have moderate-severe depressive disorder?

Assess for the following:

A. The woman has had any of the following core symptoms of depressive disorder <u>for at least 2 weeks</u>:

- 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 of depressive disorder to a marked degree, or many of the listed symptoms to a lesser degree <u>for at least 2 weeks</u>:

- 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 functioning in personal, family, social, occupational, or other important areas of life.

Ask about different aspects of daily life, such as work, school, domestic or social activities.

If A, B *and* C – all 3 – are present for at least 2 weeks, then moderate-severe depressive disorder is likely.

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2. Are there other possible explanations for the symptoms (other than moderate-severe depressive disorder)?

- Rule out any physical conditions that can resemble depressive disorder.
  - Rule out or treat anaemia, malnutrition,hypothyroidism, stroke and medication side-effects (for example, mood changes from steroids).
- Rule out a history of manic episode(s) . Assess if she has had a period in the past when several of the following symptoms occurred at the same time:
  - Decreased need for sleep
  - Euphoric (intensely happy), expansive, or irritable mood
  - Racing thoughts; being easily distracted
  - Increased activity, feeling of increased energy, or rapid speech
  - Impulsive or reckless behaviours such as making important decisions without adequate planning
  - Unrealistically inflated self-esteem.

The woman is likely to have had a manic episode if several of the above five symptoms were present for longer than 1 week and the symptoms significantly interfered with daily functioning or were a danger to herself or others. If so, then the depression is

likely part of another disorder called ***bipolar disorder*** and she requires different management. Refer to a specialist.

- 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
  - there is no previous history of moderate-severe depressive disorder or manic episode, and
  - symptoms do not impair daily functioning significantly.

Management of moderate-severe depressive disorder

1. Offer psychoeducation

This step can be managed by a front-line health-care provider. Key messages for the woman (and caregiver if appropriate):

- Depression is a very common condition that can happen to anybody.
- The occurrence of depression does not mean that she is weak or lazy.
- The negative attitudes of others (e.g. "you should be stronger", “pull yourself together”) may relate to the fact that depression is not a visible condition (unlike a fracture or a scar) and the false idea that people can easily control their depression by sheer force of will.
- People with depression tend to have negative opinions about themselves, their lives and their future. Their current situation may be very difficult, but depression can cause unjustified thoughts of hopelessness and worthlessness. These views are likely to improve once the depression is managed.

- It usually takes a few weeks before the treatment starts working.
- Even if it is difficult, she should try to do as many of the following as possible. They will all help to improve her low mood:
    - Try to continue activities that were previously pleasurable.
    - Try to maintain regular sleeping and waking times.
    - Try to be as physically active as possible.
    - Try to eat regularly despite changes in appetite.
    - Try to spend time with trusted friends and trusted family.
    - Try to participate in community and other social activities, as much as possible.
- Be aware of thoughts of self-harm or suicide. If you notice these thoughts, do not act on them. Tell a trusted person and come back for help immediately.

2. Strengthen social support and teach stress management

This step can be managed by a front-line health-care provider (see pages 71 and73).

3. If trained and supervised therapists are available, consider referral for brief psychological treatments for depression whenever these are available:

- Problem-solving counselling
- Interpersonal therapy
- Cognitive behavioural therapy
- Behavioural activation.

4. Consider antidepressants

Prescribe antidepressants only if you have been trained in their use.

> Details on the assessment and management of moderate-severe depressive disorder, including prescription of antidepressants can be found in the mhGAP intervention guide:
> http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

5. Refer to a specialist when:

- She is not able to receive either interpersonal therapy, cognitive behavioural therapy or antidepressants

  OR
- She is at imminent risk of suicide/self-harm (see page73).

6. Follow-up

- **Offer regular follow-up**. Schedule the second appointment within one week and subsequent appointments depending on the course of the disorder.
- **Monitor her symptoms.** Consider referral if there is no improvement.

Post-traumatic stress disorder

Immediately after a potentially traumatic experience such as sexual assault, most survivors survivors 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 post-traumatic stress disorder (PTSD).

It should be noted that despite its name, PTSD is not necessarily the only or even the main condition that occurs after violence. As mentioned above, such events can also trigger development of many other mental health conditions, such as depressive disorder and drug use disorder. You can assess for symptoms of PTSD and refer to a trained provider for further management if she needs specialized therapy.

Typical presenting complaints of PTSD

Women with PTSD may be hard to distinguish from women suffering from other problems because they may initially present with non-specific symptoms such as:

- Sleep problems (e.g. lack of sleep)
- Irritability, persistent anxious or depressed mood
- Multiple persistent physical symptoms with no clear physical cause (e.g. headaches. pounding heart).

However, on further questioning they may reveal that they are suffering from characteristic PTSD symptoms.

Assessment for PTSD

If the violence occurred more than 1 month ago, assess the woman for post-traumatic stress disorder (PTSD) .

Assess for:

- **Re-experiencing symptoms –** repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (for example, frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror).
- **Avoidance symptoms –** deliberate avoidance of thoughts, memories, activities or situations that remind the woman of the violence. For example, avoiding talking about issues that are reminders of the event, or avoiding going back to places where the event happened.
- **Symptoms related to a heightened sense of current threat,** such as excessive concern and alertness to danger or reacting strongly to unexpected sudden movements (e.g. being "jumpy" or "on edge").
- **Difficulties in day-to-day functioning.**

If *all* of the above are present approximately 1 month after the violence, then PTSD is likely.

Check also if she has any other medical_conditions, moderate-severe depressive disorder, suicidal thinking and drug use problems.

Management of PTSD

1. Educate her about PTSD

This step can be managed by a front-line health-care provider. Explain that:

- Many people recover from PTSD over time without treatment. However, treatment will speed up recovery.
- People with PTSD often feel that they are still in danger, and they may feel very tense. They are easily startled ("jumpy") or constantly on the watch for danger.
- People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they had when the event was actually happening. They may also have frightening dreams.
- People with PTSD try to avoid any reminders of the event. Such avoidance can cause problems in their lives.
- (If applicable) people with PTSD may have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

Advise her to:

- Continue normal daily routines as much as possible.
- Talk to people she trusts about what happened and how she feels, but only when she is ready to do so.
- Engage in relaxing activities to reduce anxiety and tension.
- Avoid using drugs to cope with PTSD symptoms.

2. Strengthen social support and teach stress management

This step can be done by a front-line health-care provider (see pages 71 and73).

3. If trained and supervised therapists are available, consider referring for:

- Individual or group cognitive behavioural therapy with a trauma focus (CBT-T).

- Eye movement desensitization and reprocessing (EMDR)

4. Consult a specialist (if available)

- If she is not able to receive either cognitive behavioural therapy or EMDR

  OR

- she is at imminent risk of suicide/self-harm (see page77).

5. Follow-up

- Schedule a second appointment within 2 to 4 weeks and later appointments depending on the course of the disorder.

Part 5
Spousal violence and contraception: How family planning providers can help

Spousal violence often interferes with a woman's sexual and reproductive well-being and self-determination.

If a client discloses violence to you, or you suspect violence, you can help. In general, follow the LIVES steps (see pages - 15–38) to give her first-line support.

What is reproductive coercion?

Behaviours that interfere with contraceptive use and/or pregnancy have been called "reproductive coercion". These behaviours may come from someone who is, was, or wishes to be involved in an intimate marital relationship. These behaviours may include:

- Attempts to make a woman pregnant against her wishes
- Controlling outcomes of a pregnancy: putting pressure on her to continue or to terminate her pregnancy
- Coercing a spouse to have unprotected sex
- Interfering with contraceptive methods

A client who is seeking emergency contraception or abortion may be more likely to be experiencing spousal violence than your other clients. Be especially alert with these women for indications of violence.

You may suspect that a client visiting your family planning clinic is experiencing violence. There are a number of signs that may suggest that she is experiencing spousal violence such as:

- Refusal of specific contraceptive methods or insistence on a particular type of method.
- Resistance to contraceptive counselling.
- History of repeated pregnancies and/or request for medical termination.
- Insistence on tubal ligation.
- Insistence on reversal of tubal ligation.

To explore whether a client is experiencing spousal violence and to support her to disclose violence, you may ask situation-specific questions as illustrated below.

Situation	**Illustrative questions**
Refusal of specific contraceptive methods or insistence on a particular type of method	Contraceptive methods are widely used and have been found to be beneficial to the health of women and children. Is there any problem at home that makes you refuse this method?
Resistance to contraceptive counselling	We routinely offer all women counselling. FP procedures have important health benefits for women and children. Is there any problem/Do you have any worry which is preventing you from being counseled?
Insistence on tubal ligation	Although tubal ligation is routinely offered as one

	contraceptive method, is there any particular reason for your insistence on undergoing this procedure? Is there any problem at home which has made you take this decision?Is there anyone at home insisting on you getting this procedure done?
Looking anxious or depressed	You look very sad and I am very concerned about you. Can you tell me how I can help you?
Disclosure of insomnia or anxiety	We all need to have good sleep to lead a healthy life. Is there any particular reason for the state you are in? Is there something or someone at home that might be worrying you?

In particular, explore issues of violence when counselling about method choice. Your skills as a family planning provider can especially help a woman deal with this aspect of her situation.

To explore how violence affects her reproductive and sexual life, you can ask these four questions:

- Has your husband ever told you not to use contraception, blocked you from getting a method, or hid or taken away your contraception?
- Has your husband ever tried to force you or pressure you to become pregnant?
- Has your husband ever refused to use a condom?

- Has your husband ever made you have sex without using contraception so that you would become pregnant?

Discuss her answers and how she can make the best choices in these circumstances.

If your client wants a method that would be hard for her husband to interfere with, you can discuss:[1]

- **Injectable contraceptives.** Intramuscular injectable contraceptives leave no signs on the skin. The 2- and 3-month injectables often stop menstrual periods after a time. This could be a concern if her husband monitors her periods. In contrast, monthly injectables usually make monthly cycles more regular. Let her know that injectables require regular follow up visits.
- **Subcutaneously-administered depot medroxyprogesterone acetate** (DMPA-SC, 104 mg/0.65 mL). This is a new method added by WHO in its 2015 eligibility criteria for contraceptive methods[2]. It is highly effective and follows the same profile as DMPA intra-muscular. It also requires regular follow up.
- **Implants.** Once inserted under the skin, implants work for several years. Sometimes they can be seen and felt under the skin, however, many women will experience a change in their bleeding pattern. This

[1] Adapt this section depending on what modern methods are commonly available and used.

[2] For more information on this topic, see the World Health Organization 2015 *Medical elegibility criteria for contaceptive use. A WHO family planning cornerstone.* Fifth edition . Geneva, 2015 http://apps.who.int/iris/bitstream/10665/181468/1/9789241549158_eng.pdf?ua=1

can include no bleeding, intermittent and/or frequent spotting and bleeding, and rarely heavy/prolonged bleeding. Usually implants do not require regular follow up.

- **Copper and hormonal (LNG) IUDs.** They remain out of sight in the uterus. A husband might feel the ends of the strings at the cervix, but if there is a need for secrecy, the strings could be removed. Copper IUDs are associated with increased menstrual flow, while hormonal IUDs can make the periods lighter or cause periods to stop.

  It is important to assess the risk of STIs before placing an IUD[1]. Since women subjected to Spousal violence are at higher risk of STI and HIV infection, health care providers should take into account prevalence and individual risk to judiciously assess IUD insertion and continuation. Usually IUDs do not require regular follow up.

It is very important to make clear that the above contraceptive methods **DO NOT protect against STI or HIV infection**. Provide the woman with information and offer

[1] IUDs cannot be initiated in women with current pelvic inflammatory disease (PID), current purulent cervicitis or Chlamydial infection, which are conditions that represent an "unacceptable health risk" for IUD initiation (MEC 4)(WHO. MEC, 2015). However if a woman has an IUD already in place, she can continue its use under mandatory appropriate treatment and close follow up. Women at increased risk of STI and HIV infections can generally continue use of IUD under careful follow up (MEC 2). Regarding women with high HIV risk, and asymptomatic or mild HIV infection, WHO advises that the advantages of using the IUD generally outweigh the theoretical or proven risks (MEC 2). For women with severe or advanced HIV clinical disease (AIDS stages 3 or 4), IUD should not be initiated (MEC 3). However, in these cases, IUD can be continued under careful follow up (MEC 2). (For more information see: the 2015 WHO Medical eligibility criteria for contraceptive use).

referral to support services for women's empowerment and skills building on condom use negotiation and safer sexual practices if available.

DUAL PROTECTION

When a risk of HIV and other STI transmission exists, it is important that health-care providers offer information on safer sexual practices to prevent transmission and strongly recommend dual protection to all persons at significant risk, either through the simultaneous use of condoms with other methods or through the consistent and correct use of condoms alone for prevention of both pregnancy and STIs, including HIV. Women and men seeking contraceptive advice must always be reminded of the importance of condom use for preventing the transmission of STI/HIV and such use should be encouraged and facilitated where appropriate. When used correctly and consistently, condoms offer one of the most effective methods of protection against STIs, including HIV. Female condoms are effective and safe, but are not used as widely by national programs as male condoms.

Emergency contraception (see pages 51-53 **)**

- Emergency contraceptive pills. The pills most commonly used for emergency contraception are levonorgestrel- only and combined estrogen-progestogen pills. In 2015, the WHO added the ulipristal acetate pills to the list of emergency contraceptive methods. Although it is usually more expensive and may not be included yet in the list of essential medicines, if available in the market and the woman is able to afford it, you may prescribe it. All these pills help prevent pregnancy if taken up to 5 days after unprotected intercourse. Clarify to the woman that emergency contraceptive pills are not designed to be used

as a regular contraceptive method, and that they do not protect from STIs and HIV infection. If you have the pills available, give her some to take straight away. If not, tell the woman where she can get the pills and how to use them correctly, and confirm that she has correctly understood all the information.

- **Copper and hormonal IUD** placed within 5 days after unprotected intercourse can be used as an emergency contraception method. In this case, IUD initiation should follow the same indications as when it is initiated as a regular contraceptive method (see above).

Part 6
Considerations for children and adolescent survivors of sexual abuse

Sexual abuse, including sexual assault or rape, of children and adolescents is a major global public health problem, a violation of human rights, and has many health consequences in the short and long term. The physical, sexual, reproductive and mental health consequences of such abuse are wide ranging and need to be addressed. Children and adolescent boys and girls who have been sexually abused need care that is appropriately tailored to their age, physical, cognitive and emotional maturity and capacities.

This section provides specific considerations for children and adolescents in delivering clinical care to child and adolescent survivors of sexual abuse[1]. It includes boys and girls who up to the age of 18 years who have been subjected to sexual abuse including sexual assault and rape. As such, this part must be read and used in conjuction with part 3 of this handbook on additional care for physical health after sexual assault which covers many of the aspects of clinical management of sexual assault that are relevant to women as well as children and adolescent survivors.

[1] This part is drawn from the *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines (2017).*

Definition of sexual abuse of childern and adolescents

The involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the survivor. It includes incest which involves abuse by a family member or close relative. Sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party including that of seekingpower over the child. Adolescents may also experience sexual abuse at the hands of their peers, including in the context of intimate relationships.

Three types of child sexual abuse are often distinguished: (i) non-contact sexual abuse (e.g. threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography); (ii) contact sexual abuse involving sexual intercourse (i.e. sexual assault or rape – see below); and (iii) contact sexual abuse excluding sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing.

Child sexual abuse is often carried out without physical force, but rather with manipulation (e.g. psychological, emotional or material). It may occur on a frequent basis over weeks or even years, as repeated episodes that become more invasive over time, and it can also occur on a single occasion.

Guiding principles for child and adolescent-centred care

Based on the United Nations Convention on the Rights of the Child (CRC)[1] and other human rights standards, the following overarching principles need to be observed when providing care

[1] Convention on the Rights of the Child. New York: United Nations; 1989 (http://www.ohchr.org/Documents/ProfessionalInterest/crc.pdf).

to children and adolescents who have, or may have, been sexually abused.

- Attention to the best interests of children or adolescents by promoting and protecting safety; providing sensitive care; and protecting and promoting privacy and confidentiality.
- 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.
- Ensuring the participation of children or adolescents in decisions that have implications for their lives, by soliciting their opinions and taking those into account, in delivery of care.

Recommendations for Clinical Care

A. Child or adolescent-centered, gender-sensitive first-line support

Health-care providers should provide first-line support that is gender sensitive and child or adolescent centred, in response to disclosure of sexual abuse. In addition to the five steps outlined in the jobaid LIVES (see pages 15-38). The following are additional considerations for children and adolescents:

- Providing age-appropriate information about what will be done to provide them with care, including whether their disclosure of abuse will need to be reported to relevant designated authorities.
- Making the environment and manner in which care is being provided appropriate to age, as well as sensitive to the needs of those facing multiple forms of discrimination.

- Attending to them in a timely way and in accordance with their needs and wishes.
- Prioritizing immediate medical needs and first-line support.
- Minimizing the need for the them to go to multiple points of care within the health facility and ensuring that an adult accompanies them if they need to go to multiple points of care.
- Empowering non-offending caregivers with information to understand possible symptoms and behaviours that the child or adolescent may show in the coming days or months and when to seek further help.

B. Taking medical history, conducting examination and documenting findings.

Taking medical history

In addition to the steps outlined in part 3 (see pages 42-50) for medical history, examination and documentation of findings, specific considerations for children and adolescents in this step include:

- Minimizing need to repeatedly tell their history.
- Interviewing the child or adolescent on their own (i.e. separately from their caregivers), while offering to have another adult present as support.
- Building trust and rapport by asking about neutral topics first.
- Conducting a comprehensive assessment of their physical and emotional health, in order to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/or referrals.
- Asking clear, open-ended questions without repetitions.

- Using language and terminology that is appropriate to age and non-stigmatizing.
- Allowing the child or adolescent to respond in the manner of their choice, including, for example, by writing, drawing or illustrating with models.

Conducting examination

In conducting **physical examinations** and, where needed, **forensic investigations,** specific considerations for children and adolescents include:

- Maximizing efforts to have them undergo only one examination.
- Offering information about the implications of positive or negative findings.
- Minimizing delays while conducting the examination in accordance with the child's or adolescent's wishes.
- Explaining what will be done, prior to each step.
- Making sure there is another adult present during the examination.
- Using age-appropriate visual aids and terms to explain the examination procedures.
- Using examination instruments and positions that minimize physical discomfort and psychological distress.
- Not routinely using speculums, anoscopes and digital or bimanual examinations of the vagina or rectum of pre pubertal children, unless medically indicated; if they are used, sedation or general anaesthesia should be considered.

Documenting findings

In **documenting findings of the medical history, physical examination and forensic tests,** specific considerations for children and adolescents include:

- Noting down discrepancies between the child´s or adolescent´s and the caregivers´ account, if any, without interpretation;
- Where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur;
- Documenting the child's or adolescent's emotional state, while noting that no particular state is indicative of sexual abuse;

C. HIV Post-Exposure Prophylaxis (PEP)

In addition to the steps described in part 3, section 2.4 Provide PEP (see pages 58-61), specific considerations for providing PEP and adherence support to child and adolescent survivors of sexual assault are:

- The need to offer age-specific adherence support to the child or adolescents. For example for infants and young children, it will be important to engage the caregivers in the adherence counselling. For adolescents, depending on their age and maturity, it will be important to engage them in developing an adherence plan respecting their autonomy and wishes (e.g. in ascertaining wheter or not they wish to involve caregivers).
- For adolescents, based on their age and maturity to understand the information provided, HIV risk should be discussed to determine use of PEP. The limitations, side effects and likelihood of HIV transmission should be discussed with age-appropriate information. For younger children, this information should be discussed also with the non-offending caregivers.

D. Pregnancy prevention and management

The guidance for emergency contraception – regimen, dosage and counselling are the same for adolescent girls as they are for women and as described on page 51-53 in part 3 of this handbook. In addition:

- It is important to note that emergency contraception can be offered to adolescent girls who have attained menarche as well as pre-pubertal girls who have the onset of secondary breast development because they are likely to be ovulating prior to the onset of menstruation.

E. STI treatment and vaccination for preventable STI

The guidance for presumptive treatment for STI is the same as that for women and as described in Part 3, section 2.3 (see pages 54-57). In addition, specific considerations for children and adolescents who have been sexually abused include:

- Offering human papillomavirus vaccination (HPV) to girls in the age group 9–14 years, as per national guidance.

F. Additional care for mental health

The guidance for provision of basic psychosocial support and additional mental health care for symptoms of post-traumatic stress disorder remain the same as that for women (see part 4, page 70-72 and 83-87): Specific considerations for children and adolescents are as follows:

- Offer/continue to offer child and adolescent-centred gender-sensitive first line support as outlined in LIVES (pages 15-38) for symptoms of acute traumatic stress within the first month.

- For those children and adolescents who are assessed with symptoms of post-traumatic stress, psychoeducation and stress management as outlined on pages 73-74 and 81 should also include non-offending caregivers as appropriate.
- For those who are referred to a trained specialist for cognitive behavioural therapy with a trauma focus, the therapy also needs to include non-offending caregivers where it is safe and appropriate to do so.
- For children and adolescents with emotional and behavioural disorders, refer to a trained specialist who can offer CBT and interpersonal psychotherapy and also offer caregiver skills training to non-offending caregivers.

G. Tips for reporting child and adolescent sexual abuse

Whether health-care providers have to comply with a legal or policy requirement, or they are guided by an ethical duty to report known or suspected cases of child or adolescent sexual abuse, they need balance the best interests of that child or adolescent and the child or adolescent's evolving capacities to make autonomous decisions. Specific actions include

- Assess the implications of reporting for the child or adolescent's health and safety.
- Take steps to promote their privacy and safety.
- First provide immediate medical care and first-line support.

- Before taking history, inform the child or adolescent and their non-offending caregiver about the obligation to report, the limits of confidentiality, what information will be reported and to whom and what may happen next practically and legally.
- Document what is reported, while ensuring that this information is stored in a confidential way, especially if the perpetrator is a caregiver who could access the child or adolescent's file.
- If the perpetrator of sexual abuse is another child or adolescent, that child or adolescent should be also be referred to appropriate health or welfare or social services as needed.
- Reporting consensual sexual activity between adolescents or informing the caregivers where the adolescent, depending on their age and maturity, has expressed preference to not involve the caregiver is not in line with the taking into account their evolving capacity and respecting their wishes, unless that adolescent's safety is at risk;

Facilitate timely uptake of services

As a health care provider, you can conduct outreach and be an advocate with communities in order to facilitate timely uptake of care for children and adolescents who have been sexually abused. Actions include:

- Raise public awareness of the signs, symptoms and health consequences of sexual abuse, and the need to seek timely care.
- Publicize the availability of services.
- Advocate to reducing stigma related to sexual abuse.

- Advocating to reduce policy-related and practical barriers to accessing care (e.g. for example, requiring police reports as a condition for providing medical care and first-line support).
- Improve referrals within and between health and other services (for example, police, child protection and legal services).

Part 7

Strengthening medico-legal response to sexual violence

Beyond health, survivors of sexual violence may also have needs for justice in holding perpetrators accountable. Medico-legal evidence is at the intersection of medical and justice processes. The provision of medico-legal services to survivors of sexual violence requires the involvement health and social service providers, forensic medicine, forensic lab services, police, and the legal system, including lawyers and judges.

The collaboration and coordination for case management, service provision, planning and policy development at different levels ensures efficient, timely and of good quality medico-legal response that encourages survivors to access services as well as to report cases, and that is more effective in holding perpetrators accountable. This section is for those providers who are required to conduct and collect medico-legal evidence as part of their responsibilities in providing care to survivors of sexual assault.

The key guiding principle in medico-legal response is that of survivor-centered approach. Most of these are covered in the preface of this document (page 4-6). In addition, specific considerations for medico-legal response are:

- The importance of providing the survivor with the information they need in order to make informed decisions about their case including obligations to report to designated authorities, information that will be shared with the police and relevant authorities and the documentation (e.g. medico-legal certificates) that will be given to facilitate further investigations.
    - For child and adolescent survivors, the non-offending caregivers must be empowered with the relevant information.
- Unless mandated by the law, the choice of whether to take the case to the legal authorities needs to be given to the survivor. If mandated by law or policy, the survivor should be told about this before interviewing them.
- Confidentiality must be maintained in sharing the information with those who need to know.
- Provision of immediate health and first-line support/psychosocial support must be prioritized over other aspects of the medico-legal response.

Know the relevant laws

All those working in the medico-legal system should familiarize themselves with:

- the relevant laws and policies about (see Annex 2 page 120-122)
    - what is defined as sexual violence including what is considered a crime
    - who is allowed to collect medico-legal evidence and/or testify as a professional or expert witness in cases of sexual assault;
    - informed consent
    - reporting of sexual abuse including for children

    - age of sexual consent
- any informal or traditional justice systems that may be in place.

Requirements for medico-legal response

The basic infrastructure, personnel, supplies and medications needed are detailed below.

Personnel

- Trained (local) health-care professionals (on call 24 hours a day). In order to conduct a full forensic medical examination, health care providers must be specifically trained and have supervised experience. However, all health providers should be able to, as a minimum, provide medical care and first-line support to the survivor, as well as document the survivor's story, conduct a medical examination and record any injuries.
- A "same-language" same-sex health worker or a translator, with the offer of a reletive or support person in the room during examination

Furniture/setting

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

Supplies

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

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

Medications

- For prophylaxis or treatment of sexually transmitted infections (see pages 54-57)
- Antiretroviral drugs for HIV post-exposure prophylaxis for HIV
- Emergency contraception
- Analgesics (e.g. paracetamol)
- Antibiotics for wound care
- Tetanus prophylaxis
- Hepatitis B vaccination
- Human Papilloma Virus vaccination

Administrative supplies

- Medical chart with pictograms/body charts
- Consent forms

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

The forensic medical examination

The forensic medical examination should be done at the same time the physical examination done to address health issues and provide medical care. It is done to collect materials required to assist a criminal investigation. By its very nature, the examination is time consuming, intrusive, possibly traumatizing to the survivor, and often challenging. While it may be the role of health workers to document injuries and to collect other forms of medico-legal evidence, it is not their role to determine whether sexual assault has occurred.

- A careful explanation should be provided to the survivors. This should include the reasons for, and the extent of, the proposed examination, any procedures that might be conducted, the collection of specimens and photography. A sensitive and specific explanation of any genital or anal examination is required.
- Prior to commencing the examination, it is important to ensure that the facility is clean and secure, a chaperone (agreed to by the subject) is present and all relevant equipment is accessible.

- Consent to undertake the examination should be obtained from the survivor, or in the case of children or adolescents their non-offending caregivers. The consent should be specific to each procedure (and particularly the genital examination), to the sharing of findings and specimens, and to any photography. The survivor may consent to some aspects and not others and may withdraw consent. The consent should be documented by signature or fingerprint.
- Digital examinations of the vagina and anus are rarely warranted. They should not be used to assess the tone or elasticity of the vagina or anus, or to comment on likelihood or frequency of penetration.
- The general appearance and functioning of the individual (demeanour, mental status, drug effects, cooperation) should be documented, as well as the identity of the examiner and the date/time/location of the examination.
- Any limitations to the examination (lighting, cooperation etc.) should also be documented.
- A comprehensive examination should be performed, directed by the history provided. The sites examined/not examined should be documented.
- All recent and old injuries should be recorded and described in detail, recording any pertinent negative findings.
- The survivor should be informed that some injuries might become more visible after some days and that, if this happens, she/he should return for examination and documentation
- A note should be made of any specimens collected, photography undertaken, diagnostic tests ordered or treatment initiated.
- The individual should be given a detailed explanation of the findings and their treatment and follow-up.

Medico-legal evidence in sexual violence

All parties involved in managing cases of sexual assault should be aware of the evidence that might be collected or require interpretation. Collection of specimens from individuals alleging sexual violence may provide investigators (and a court) with information to support or negate allegations. The objectives of evidence collection can include: to prove a sexually violent act and some of its circumstances, to establish a link between the perpetrator and the survivor, to link facts and persons to the crime scenes, and to identify the perpetrator.

- Only medico-legal evidence that can be collected, properly stored, analysed and used should be gathered, and only with the full informed consent of the survivor.
- The physical examination is primarily conducted to address health issues. If it is performed within 5 days of the assault, there may be value in collecting forensic specimens. All examinations should be documented.
- Consent for the collection and release of the specimens (to investigators) should be obtained from the survivor. The impact of the collection of specimens on the survivor (both physically and psychologically) should be carefully considered.
- Take precautions against contamination: restrict access to examination facilities, ensure facilities are cleaned between cases and change gloves frequently.
- There are different purposes and processes for the collection of specimens for health (pathology) and legal (forensic) investigations.
    - **Pathology specimens** are analysed to establish a diagnosis and/or monitor a condition.

- **Forensic specimens** are used to assess/corroborate whether an offence has been committed, whether there was contact between individuals or between an individual and and location. Pathology specimens may have a significant forensic importance, especially if a sexually transmitted infection is found.

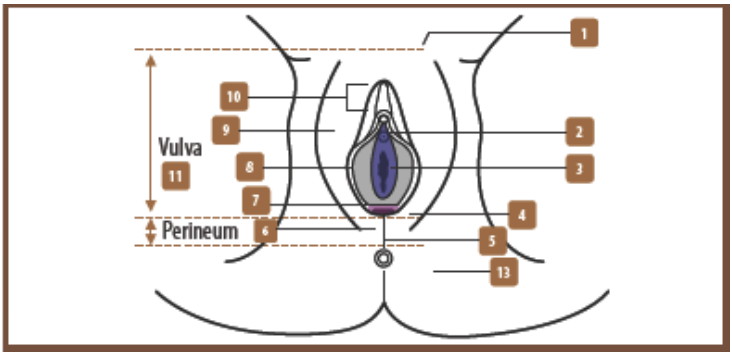
- The account of the assault by the survivor and the time between the assault and the examination will dictate whether and what forensic specimens are collected. If in doubt, collect.
- Collect specimens from locations where biological material might have been deposited
- Persistence of biological material is variable. It will be affected by time, activities (washing) and contamination from other sources. Evidence of contact occurs at the time of the offence but disappears quickly. The maximum agreed time interval (time of assault to time of collection) for routine collection is:
  - skin including bite marks – 72 hours;
  - mouth – 12 hours;
  - vagina – up to 5 days;
  - anus – 48 hours;
  - foreign material on objects (condom/clothing) – no time limit;
  - urine (toxicology) 50 mL – up to 5 days;
  - blood (toxicology) 2 × 5 mL samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate.
- Hair – cut scalp hair may be useful if there is concern of covert drug administration.
- Collect blood and urine samples for toxicological analysis if there are allegations of covert or non-consenting drug administration.

- Clothing (especially underwear) and toxicological samples should be collected if required.
- Photographs provide a useful adjunct to injury documentation. Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital photographs are taken) need to be addressed and agreed with the survivor.
- Sexual violence should be considered during an autopsy examination. Documentation and specimen collection should occur in such cases.
- If sexual assault results in a pregnancy, then consideration should be given to collection of specimens for paternity testing.
- Allow any wet specimens to dry. Do not use culture media for forensic specimens.
- Careful labelling, storage and chain-of-custody recording is required in all cases. The forensic laboratory requires information about the specimen (time, date, patient name/ID number, nature and site of collection) and what is being looked for. Document transfer of specimens (chain of custody): what, to whom and when transfer occurred. Alternatively, ensure specimens are stored appropriately.
- Results of analysis must be interpreted carefully, objectively and in the context of the investigation; it is exceedingly rare for a case to proceed on a single piece of evidence, e.g. DNA, fingerprint.
- Penetrative sexual activity of the vagina, anus or mouth rarely produces any objective signs of injury. The hymen may not appear injured even after penetration has occurred. Hence, the absence of injury does not exclude penetration. The health care provider cannot make any comment on whether the activity was consensual or otherwise.

- Only evidence that has been correctly collected, stored and analysed should be used in the investigation/court proceedings.

Fact sheet

Female genitalia: definitions and comments



Definitions

1. **Mons pubis:** where the labia majora meet in front and covered with hair after puberty
2. **Urethral opening**: opening of the urethra to external environment to allow urine to be expelled
3. **Hymen *(shaded):*** membrane at the vaginal opening, almost always with a visible opening
4. **Posterior fourchette:** where the labia minora meet at the back in the midline
5. **Perineal raphe:** the visible line running from the genitalia to the anus
6. **Perineum:** region between the thighs that is bounded by the vulva in the front and the anus at the back
7. **Fossa navicularis:** the concave area between the back of the vaginal wall and the posterior fourchette
8. **Labia minora:** skin folds that cover or partially cover the hymen and vagina
9. **Labia majora:** broad skin fold that surrounds the labia minora (covered with hair after puberty)

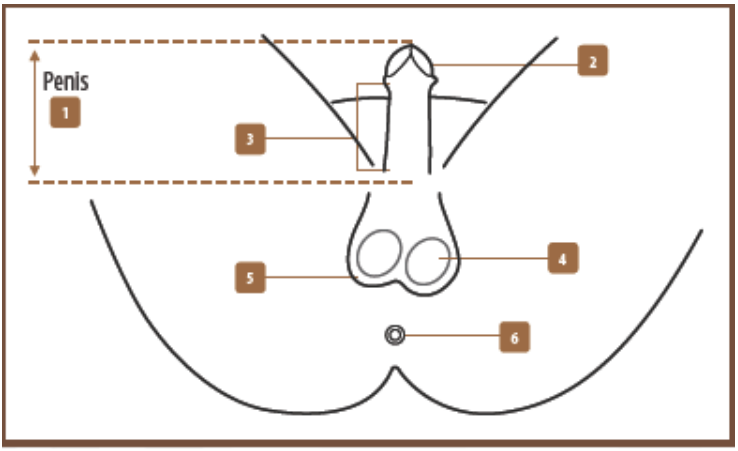
10. **Clitoris:** erectile tissue that expands when stimulated
11**. Vulva:** all of the components of the external genitalia, including the mons pubis, labia majora, labia minora, clitoris and vaginal orifice
12. **Vagina** (not displayed): a tubular canal between the cervix and the hymen
13. **Anus:** outlet for faeces

Comments

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

Fact sheet

Male genitalia: definitions and comments



Definitions

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

Comments

- The uncircumcised male has a retractable piece of skin that may cover the glans – **the foreskin.**
- In most cases, **penetration** (or repeated penetration) of the anus does **not** result in injury or other changes.

- **Digital examination** of the anus is rarely indicated. This procedure should not be used to assess the tone of the orifice or to comment on the likelihood or frequency of penetration.
- **Sexual activity** (touching, sucking, masturbation or intercourse) rarely causes any objective changes to the male genitalia.
- **The passage of hard stools**, some medical conditions (e.g. Crohn disease), and sometimes chronic diarrhoea, may cause anal fissures and other changes.

Annex 1

Caution concerning prescribing benzodiazepines

Do not prescribe benzodiazepines or antidepressants for acute distress.

In exceptional cases, in adults, when psychologically oriented interventions (for example, relaxation techniques) are not feasible, short-term treatment (3–7 days) with benzodiazepines (for example, diazepam 2–5 mg/day or lorazepam 0.5–2 mg/day) may be considered as a treatment option for insomnia that severely interferes with daily functioning. In that case the following precautions should be taken into account:

- In some people use of benzodiazepines can quickly lead to dependence. Benzodiazepines are often overprescribed.
- They should be prescribed for insomnia only in exceptional cases and for a very short time.
- During pregnancy and breastfeeding benzodiazepines should be avoided.
- For concurrent medical conditions: before prescribing benzodiazepines, consider the potential for drug/disease or drug/drug interaction.

Annex 2: Laws pertaining to gender-based violence in Pakistan

This job aid includes information on the selected laws in Pakistan that cover legal description of offences of different types of sexual violence; punishments for these offences; complete medico-legal procedures including examination of survivor and accused as well as legal essentials for report; case investigation, reporting and recording; care for survivors, privacy, confidentiality and consent. Moreover, the legal provisions for trial and appeal are also included for the capacity building of service providers.

Job aid

Relevant laws		
Name of law/policy	**Relevant Provisions**	**What it means for you**
Pakistan Penal Code, 1860 Criminal Law (amendment offences relating to Rape) Act , 2016	**Section- 376A Disclosure of identity of survivor of rape**	• In addition to the medical code, it is not allowed by law for anyone to publish or print the name of a survivor of rape unless explicit consent is provided by the survivor or their guardian.
	Section-186 (2):	• Intentionally obstructing an investigation, inquiry, prosecution or providing false reports is punishable with imprisonment for a term extending to 3 years or with fine or both. • However, the medical examiner is obliged to abide by the provision of Section 376-A and in such case Section 186 is not applicable as intentional hampering or

		obstructing an investigation.
Code of Criminal Procedure, 1898; Criminal Law (amendment offences relating to Rape) Act , 2016	**Section-53A Examination of person accused of rape by medical practitioner**	• A registered medical practitioner in a government hospital or employed by a local authority can undertake examinations of ***accused perpetrators*** of sexual violence. • If the accused does not cooperate for the examination reasonable force may be used to conduct the examination • The information to be collected: 1. Name and address of the accused and of the person by whom he was brought; 2. Age of the accused; 3. Marks of injury, if any, on person of the accused; 4. Description of material taken from person of the accused for DNA profiling; and 5. Other material particulars in reasonable detail. 6. Exact start and end time of the examination 7. Collect relevant DNA samples • Name the reason for each conclusion • The report needs to be sent to the investigating officer immediately
	Section -154 Information in cognizable cases	• Information about the sexual assault (committed or attempted) is to be recorded in the presence of a female police officer or a female family member or any other person with the consent of the complainant. • If survivor is distressed than such information is to be recorded at her residence or at a convenient place of her choice, in the presence of a female police officer or a female family member or any other person with the consent of

		complainant.
	Section- 164A Medical examination of survivor of rape and medico-legal report **And** **Section- 164B DNA test of survivor & accused**	• Where a complaint has been registered with the police and is under investigation, a female registered medical practitioner should perform a physical examination of a female survivor of sexual assault immediately when the survivor arrives in the medical facility. • Obtain informed consent of the survivor before each step of the examination and register the informed consent in the report. If the consent is not given by the survivor, this should be recorded in the report. • Prepare a report stating: a. name and address of the survivor and of the person by whom she was escorted; b. age of the survivor; c. description of material taken from body of the survivor for DNA profiling; d. marks of injury, if any, on body of the survivor; e. general mental condition of the survivor f. other material particulars in reasonable detail; g. exact start and end time of the examination; h. informed consent of the survivor • Collect relevant DNA samples • Name the reason for each conclusion • The report needs to be sent to the investigating officer immediately • Follow the pathway of care after sexual assault and the examination form to collect all relevant information.

Annex 3: Sample facility register for recording cases of gender-based violence

Department/unit_____ ☐☐ Month ☐☐☐☐ Year Page _____of_____
Health facility name_____ District name_____

Instructions: Please complete the register for all clients who are identified or who disclose Gender based Violence or sexual violence and who receive a service from your department/unit.

Personal information (to be kept separately under lock & key)

S/N	Client number	Client's name	Client can be reached at	Sex (M, F)	Date of birth (dd/mm/yy)	Marital Status	Other information

Date of consultation (dd/mm/yy)	Client number	Reporting (see codes)[1]	If first visit, referred by (see codes)[2]	Presenting symptoms/ conditions (Y, N)				Type of violence (Y, N)					Perpetrator (see codes)[9]	Assessments & clinical care provided to all survivors (Y, N)					Additional care given to rape survivors seen within 72 or 120 hours (Y, N)								External referrals (Y, N)									Provider's initials
				Injuries	Sexual/reproductive health conditions[3]	Mental/emotional problems[4]	Other (specify)[5]	Physical violence[6]	Sexual violence[7]	Rape (if arrived within 72hours,addcode"72")	Psychological/emotional[8]	Other (specify)		First-line support[10]	Safety assessment	Injuries & wound care	Tetanus prophylaxis	Other (specify)	Head-to-toe &genital examination	Emergency contraception	Pregnancy test	PEP for HIV	HIV test	STI prevention/treatment	Forensic evidence selected	Other (specify)		levelfacility[11]	Crisis intervention/counselling	Police	Shelter or housing	Legal aid	Child protection	Livelihood support	Other (specify)	
Totals																																		

1. Codes for **Reporting**: Provider asked about violence (A); Client disclosed/reported violence (D); Provider suspects violence (S).
2. Codes for **Referred by**: Self (S); Family/acquaintance (F); other health facility/unit (OH); Police (P); NGO (N); other government unit (OG).
3. **Sexual/reproductive health conditions** include sexually transmitted infection (STI), unwanted pregnancy, vaginal bleeding, pelvic pain, sexual dysfunction, pregnancy terminations, adverse birth outcomes.
4. **Mental/emotional issues** include symptoms of stress, anxiety, depression, post-traumatic stress disorder (PTSD), sleep disorders, suicidality or self-harm (including thoughts, plans, acts), misuse of alcohol or drugs.

5. **Other symptoms** can include chronic headaches, pain syndromes, gastrointestinal problems, kidney and bladder infections, cognitive problems, hearing loss.
6. **Physical violence** includes hitting, slapping, beating, kicking, shoving/pushing, hurting with a weapon.
7. **Sexual violence** includes using force, intimidation or coercion to have sex or to perform sexual acts that the survivor (women, adolescent girls and boys, male and female child) does not want. It also includes harming a person during sex. It includes **rape**, and attempted rape, which involves use of force, intimidation, coercion or drugs/alcohol to obtain penetration of the vulva/vagina, anus or mouth by one or multiple perpetrators including by spouse, family member and relative.
8. **Psychological/emotional violence** includes criticizing repeatedly, calling names or insults, threats to hurt loved ones or to destroy things that the person cares about, belittling or humiliation in public.
9. Codes for **Perpetrator**: spouse (IP); Family member in household (FH); Family member/acquaintance living elsewhere (FLE); Stranger (S).
10. First line support includes basic counselling or psychosocial support that can be implemented using the **LIVES** approach which involves: empathic **L**istening, **I**nquiring about needs and concerns, offering a **V**alidating response to survivor's experience, assessing and helping her **E**nhance her safety, and supporting her by connection to information, services and social support.
11. **Referral to higher-level facility** could include, for example, care for mental health, forensic evidence collection or treatments for conditions that cannot be managed within the primary health facility.

Codes

Reporting	Code	**Referred by**	Code	**Perpetrators**	Code
Provider asked about violence	A	Self	S	Spouse	IP
Client disclosed/reported violence	D	Family/acquaintance	F	Family member in household	FH
Provider suspects violence	S	Other health facility/ unit	OH	Family member/ acquaintance living elsewhere	FLE
		Police	P		
		NGO	N	Stranger	S
		Other government unit	OG		

Annex 4: Sample history and examination form

Tips for talking with clients

- Show that you are listening and that you care: Make eye contact, acknowledge her feelings (for example, you can nod, and you can say "I understand" or "I see how you feel").
- Sit at the same level as the client.
- Respect her dignity. Do not express negative judgments about her or others.
- Be gentle. Encourage her to answer but do not insist.
- Ask one question at a time. Speak simply and clearly. Ask for clarification or detail if needed.
- Give her time to answer and allow silences. Do not rush.

CONFIDENTIAL CODE:

Medical History and Examination Form for Sexual Assault

May I ask you some questions so that we can decide how to help you?
I know that some things may be difficult to talk about. Please try to answer. But you do not have to answer if it is too difficult.

1. GENERAL INFORMATION

Family name (use code)		Given name (Use code)
Address		
Sex	Date of birth _____ / _____ / _____	Age

	DD MM YY	
Date and time of examination _____ / _____ / _____ ; _____ DD MM YY		In the presence of

2. GENERAL MEDICAL INFORMATION

Existing health problems
Do you have any ongoing health problems? ☐ Yes ☐ No If "yes", what health problems?
Do you have any allergies? If so, to what?
Are you taking any medicines, herbs or potions?
Vaccination status
Have you been vaccinated for... ...tetanus? ☐ Yes When? _____ / _____ / _____ DD MM YY ☐ No ☐ Does not know ...hepatitis B? ☐ Yes ☐ No ☐ Does not know
HIV/AIDS status

Have you had an HIV test? ☐ Yes When? _____ / _____ / _____ DD MM YY ☐ No
If "yes", may I ask the result? ☐ Negative ☐ Positive ☐ Not disclosed

3. DESCRIPTION OF INCIDENT

Date of incident: _____ / _____ / ____ **Time of incident:**
DD MM YY

Could you tell me what happened, please?

Has something like this happened before? ☐ Yes ☐ No

If "yes": When was that? _____ / _____ / ____
DD MM YY

Was the same person responsible this time? ☐ Yes ☐ No

Physical violence	**Describe type and location on body**
Type (beating, biting, pulling hair, strangling, etc.)	
Use of restraints	
Use of weapon(s)	

Drugs/alcohol involved

In cases of sexual assault

Penetration	Yes	No	Not sure	Describe (oral, vaginal, anal)
Penis	☐	☐	☐	
Finger	☐	☐	☐	
Other (describe)	☐	☐	☐	
Ejaculation	☐	☐	☐	
Condom used	☐	☐	☐	

Actions after assault

After this happened, did you …

Vomit?	☐ Yes	☐ No
Urinate?	☐ Yes	☐ No
Defecate?	☐ Yes	☐ No
Brush your teeth?	☐ Yes	☐ No
Rinse your mouth?	☐ Yes	☐ No
Change your clothes?	☐ Yes	☐ No
Wash or bathe?	☐ Yes	☐ No
Use a tampon or pad?	☐ Yes	☐ No

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method?

☐ IUD ☐ Sterilization

☐ Pill ☐ Condom

☐ Injectable ☐ Other _____

Were you using this method when the incident happened?

☐ Yes ☐ No

Menstruation and pregnancy

When did your last menstrual bleeding start? ____ / _____ / ____
DD MM YY

Were you menstruating at the time of event?

☐ Yes ☐ No

Do you think you might be pregnant?

☐ Yes ☐ No

If "yes", number of weeks pregnant: ____ weeks

Have you ever been pregnant?

☐ Yes ☐ No

If "yes", how many times? _____ times

History of consenting intercourse
(only if samples taken for DNA analysis in assault case)

When was the last time you had sex willingly? ____ / ____ / ____
DD MM YY

Who was it? (for example, husband, boyfriend, stranger)

5. COMPLETE PHYSICAL EXAMINATION

Weight	Height	Pubertal stage (pre-pubertal, pubertal, mature)	
Pulse rate	Blood pressure	Respiratory rate	Temperature

Physical findings

Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document type, size, colour, form and other particulars. Describe as completely and accurately as possible. 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

6. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	Introitus and hymen	Anus	
Vagina / penis	Cervix	Bimanual / rectovaginal examination	Evidence of female genital mutilation? (where relevant) ☐ Yes ☐ No
Position of patient (supine, prone, knee–chest, lateral)			
For genital examination		For anal examination	

7. MENTAL STATE

Appearance (Clothing, hair cared for or in disarray? Distracted or agitated? Restless? Signs of intoxication or misuse of drugs?)

Mood

Ask: *How have you been feeling?*

Also observe. For example, is she calm, crying, angry, anxious, very sad, without expression?

Speech (Silent? Speaking clearly or with difficulty? Confused ? Talking very fast or very slow?)

Thoughts

Ask: *Have you had thoughts about hurting yourself?*

☐ Yes ☐ No

Are there bad thoughts or memories that keep coming back?

☐ Yes ☐ No

Are you seeing the event over and over in your mind?

☐ Yes ☐ No

8. INVESTIGATIONS DONE

Type and location	Examined / sent to laboratory	Result

9.EVIDENCE TAKEN

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

10. TREATMENTS PRESCRIBED

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

11. COUNSELLING, REFERRALS, FOLLOW-UP

Client plans to report to police *OR* has already made report?
☐ Yes ☐ No

Client has a safe place to go? ☐ Yes ☐ No	Has someone to accompany her/him? ☐ Yes ☐ No

Counselling provided:

Referrals made (for example, housing, mental health care, support group):

To:	Purpose:

Follow-up agreed with client? ☐ Yes ☐ No

Date of next visit:: _____/ _____/ _____
DD MM YY

Name of health-care provider conducting the examination / interview:

Title: _____

Printed name: _____

Signature: _____

Date: _____/ _____/ _____
DD MM YY

Annex 5: Key resources

Department of Health (2005). Responding to domestic abuse: a handbook for health professionals. London: Department of Health.
ttp://www.domesticviolencelondon.nhs.uk/uploads/downloads/DH_4126619.pdf

Inter-Agency Standing Committee Sub-Working Group on Gender in Humanitarian Action (2010). Caring for survivors of sexual violence in emergencies: training guide. Geneva: IASC. http://www.unicefinemergencies.com/downloads/eresource/docs/GBV/Caring%20for%20Survivors.pdf

National Health Service (2009). Rape and sexual assault: what health workers need to know about gender-based violence. Glasgow: National Health Service, Gender Based Violence Programme. http://www.gbv.scot.nhs.uk/wp-content/uploads/2009/12/GBV_Rape-Sexual-Assault-A4-4.pdf

Snider C et al. Intimate partner violence: development of a brief risk assessment for the emergency department. Acad Emerg Med, 2009, 16(11):1208–1216. http://onlinelibrary.wiley.com/doi/10.1111/j.1553-2712.2009.00457.x/pdf

South African AIDS Training Programme (2001). Counselling guidelines on domestic violence. HIV Counselling Series No. 4. Harare: South African AIDS Training Programme. http://www.preventgbvafrica.org/sites/default/files/resources/dvcounseling.tool.safaids.pdf

World Health Organization (2003). Guidelines for medico-legal care for survivors of sexual violence. Geneva: WHO. http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/

World Health Organization (2007). Post-exposure prophylaxis to prevent HIV infection : joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection. Geneva, World Health Organization. http://www.who.int/hiv/pub/guidelines/PEP/en/

World Health Organization (2010a). Adolescent job aid. Geneva, WHO. http://whqlibdoc.who.int/publications/2010/9789241599962_eng.pdf

World Health Organization (2010b). mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings. Geneva: WHO. http://www.who.int/mental_health/publications/mhGAP_intervention_guide/en/

World Health Organization (2011). Psychological first aid: guide for field workers. Geneva: WHO. http://whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf

World Health Organization (2013a). mhGAP module assessment management of conditions specifically related to stressadapted from mhGAP. Geneva: WHO.

World Health Organization (2013b). Psychological first aid: Facilitator's manual for orienting field workers. Geneva: WHO. http://apps.who.int/iris/bitstream/10665/102380/1/9789241548618_eng.pdf

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

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

World Health Organization, Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs. Family planning: a global handbook for providers. Geneva and Baltimore: WHO and CCP.
http://whqlibdoc.who.int/publications/2011/9780978856373_eng.pdf?ua=1

World Health Organization, United Nations High Commissioner for Refugees (2004). Clinical management of rape survivors. Geneva: WHO, UNHCR.
http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/

World Health Organization, United Nations Population Fund, United Nations High Commissioner for Refugees (2009). Clinical management of rape survivors: e-learning programme. Geneva: WHO, UNFPA, UNHCR.
http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/

Copy or cut out this reminder card and fold for your pocket.

Asking about violence

You might say: "Many women experience problems with their husband or partner, but this is not acceptable."

You might ask:

- "Are you afraid of your husband (or partner)?"
- "Has he or someone else at home threatened to hurt you? If so, when?"
- "Has he threatened to kill you?"
- "Does he bully you or insult you?
- "Does he try to control you – for example, not letting you have money or go out of the house?"

Signs of immediate risk

- Violence getting worse
- Threatened her with a weapon
- Tried to strangle her
- Beaten her when pregnant
- Constantly jealous
- "Do you believe he could kill you?"

Listen

Inquire about needs and concerns

Validate

Enhance safety

Support

Listen closely, with empathy,not judging.

Assess and respond to her needs and concerns – emotional, physical, social and practical.

Show that you believe and understand her.

Discuss how to protect her from further harm.

Help her connect to services, social support.