7

# CLINICAL CARE AND TREATMENT

# 7.CLINICAL CARE AND TREATMENT

## PREPARATION AND MATERIALS

**OBJECTIVES**

- Know how to provide appropriate treatment and care and demonstrate clinical skills to respond to the needs of survivors of sexual assault within 72 hours after the assault and for those seeking care 72 hours or more after the assault
- Describe the use of the emergency contraception pill, and which patients should be offered ECP
- Describe the use of HIV PEP, and which patients should be offered HIV PEP
- Describe the use of STI prophylaxis, and which patients should be offered STI prophylaxis
- Demonstrate the skills to assess risk and to support safety planning
- Know what resources are available in the community, and demonstrate knowledge to help survivors access resources and services
- Describe common psychological reactions to sexual violence and demonstrate the ability to provide basic psychosocial support
- Know how to assess mental health issues and offer or refer to mental health care

**AVAILABLE TRAINING RESOURCES**

**Presentation**
**7.** Clinical care and treatment

**Facilitator guide**
**7.** Clinical care and treatment (below)

**Activities**
**2.1** Step by step guide to providing care and support
**7.1** Case studies on ECP
**7.2** Case studies on treatment for sexual assault
**7.3** Grab bag on medical care
**7.4** Role play Enhancing safety and offering support
**7.5** Case studies on referral to support services
**7.6** Brainstorm mental health consequences
**7.7** Story telling – mental health consequences
**7.8** Discussion on coping skills
**7.9** Stress reduction and relaxation techniques
**7.10** True or false – mental health care

**Videos**
**7.1** Preventing unwanted pregnancy
**7.2** Preventing HIV
**7.3** Preventing STIs
**7.4** Hepatitis B vaccination
**7.5** Enhancing safety and connecting with support
**7.6** Assessing and managing suicide

**Participant handouts**
**7.1** Post-rape treatment timelines
**7.2** Protocols for emergency contraception
**7.3** Protocols for emergency contraception using oral contraception
**7.4** Protocols for prevention and treatment of sexually transmitted infections
**7.5** Protocols for post-exposure prophylaxis of HIV infection
**7.6** Questions to assess immediate risk of violence and making a safety plan
**7.7** Strengthening positive coping methods and exploring social support
**7.8** Exercises to help reduce stress
**7.9** Checklist for follow-up visits with a rape survivor

**REQUIRED SUPPLIES & MATERIALS**

- Projector, laptop
- Pen and blank paper workbook for each participant
- Flip chart, markers
- Large space for participants to move around
- Sign with "yes" or "no"
- Print outs of activities – depending on which activities you choose

**KEY MESSAGES**

- Immediate treatment includes first-line support and, as needed, treatment of injuries, tetanus vaccination, ECP, HIV PEP, STI prophylaxis and hepatitis B prevention
- HIV PEP can be used up to 72 hours (3 days) to prevent transmission of HIV. It should be started as soon as possible after possible exposure to HIV.
- Emergency contraception pill (ECP) can be used within 120 hours (5 days) after the rape to prevent a potential pregnancy. It is more effective given as soon as possible after unprotected sex.
- Determine and offer appropriate care depending on the time of presentation. Discuss all available treatment options with the survivor.
- Risk assessment gauges immediate safety needs
- Trust your patient when she says that she faces severe danger
- Support the patient to make a plan to improve her safety
- Linking and referring her to support services that can respond to her needs is a key activity
- All front-line providers can offer basic psychosocial support
- Basic psychosocial support includes:
  - Assessing mental state, strengthening coping mechanisms, linking with social support and stress reduction exercises
  - Assessing survivors with thoughts of suicide or self-harm, continuing mental health symptoms for moderate–severe depression and PTSD and refer to MH specialists

**FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)**

- WHO (2019) Clinical management of rape and intimate partner violence survivors, Providing treatment, Enhancing safety and referring for additional support, pg 22-29, Additional care for mental health and psychosocial support, pg 33-35
- WHO Guidance on provider-initiated HIV testing and counselling in health facilities
- WHO Hepatitis B fact sheet
- WHO (2016). Guidelines for the treatment of Chlamydia trachomatis. Geneva
- WHO (2016). Guidelines for the treatment of Neisseria gonorrhoeae. Geneva.
- WHO (2016). Guidelines for the treatment of Treponema pallidum (syphilis). Geneva.
- WHO (2014) Clinical practice handbook for safe abortion. Geneva.
- International Consortium for Emergency Contraception (ICEC) (2018). Emergency contraceptive pills: medical and service delivery guidelines, fourth edition. Washington (DC).
- World Health Organization (WHO), United Nations High Commissioner for Refugees (UNHCR) (2015). mhGAP humanitarian intervention guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO.
- Norwegian Church Aid (2020) Integrating Therapeutic Interventions into Gender-based Violence Case Management

# CLINICAL CARE AND TREATMENT FACILITATOR GUIDE

## INTRODUCTION

**SLIDES 1-4 INTRODUCTION**

**Activity 2.1 Step by step guide to providing care and support**

Place **'Conditions found that need treatment', and 'Treat or refer**' on the wall, with tape with yes written on it between **'Take complete history and physical exam. Assess emotional state' and 'Treat or refer'.**
Place '**Within 72 hours since assault"', 'Within 5 days?', Offer HIV PEP' 'Offer emergency contraception, and 'Offer STI prevention/ treatment' on the wall.'** Connect the signs with tape indicated yes or no based on the Pathway for initial care after assault.

**Slide 5 Time of consultation**
- Care depends on the time between the incident and the time survivors access care.

## TREATMENT OF INJURIES

**SLIDES 6-9 TREATMENT OF INJURIES**

**Slide 7 notes**
- Some **injuries can be life threatening** such as extensive wounds or injuries, to the genital region, head, chest or abdomen, facial wounds with swelling, vaginal bleeding for pregnant women, internal bleeding, severe acute pain, broken/fracture bones, burns, gun shot wounds, extensive bleeding, neurological deficits including inability to speak or problems walking, respiratory distress and sepsis, suicide attempts.
- Be aware of your hospital or health facilities capacity and referral procedures. **Provide emergency care or refer** immediately for urgent hospitalization and management. This must take precedence over all other forms of care offered to the survivor.
- However, if feasible before referring make sure the patient is stable and that you have provided painkillers.
- Also, if feasible **quickly evaluate the possibility to administer immediate treatment (STI prevention, HIV PEP; ECP)** and offer, as the effectiveness decreases with the passage of time. This is because we may not be aware of how long the referral process will take, given such factors as availability of transport, the state of roads, checkpoints among others.

**Slide 8 notes**
- Less severe injuries can usually be treated on site.

**Slide 9 notes**
- Simple injuries such as tears, superficial cuts, abrasions can be treated at site.
- Clean any tears, cuts and abrasions and remove dirt, faeces and dead or damaged tissue. Simple clean, fresh wounds within 24 hours can be sutured at site. After this time, they will have to heal by second intention or delayed primary suture.
- Do not suture very dirty wounds or human bites.
- If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.

**SLIDES 10-12 TETANUS VACCINATION**

**Slide 11 notes**
- **Tetanus toxoid** is available in several different preparations. It offers **active protection** against tetanus infection. Please check local vaccination guidelines for recommendations.
- **Tetanus immunoglobin** offers **passive protection,** is expensive and is not always available.

**Slide 12 notes**
- Use this table to decide whether to administer tetanus toxoid vaccination (which gives active protection) and tetanus immunoglobulin, if available (which gives passive protection).
- Offer only tetanus toxoid if wounds are clean and < 6 hours old or minor wounds
- Ask if they have received doses in the past. Many people, especially women who have given birth, may have received the

tetanus vaccination. Ask the survivor. If the survivor does not recall, or is not sure of her vaccination status, go ahead and give the vaccination. Do not miss any opportunity to offer vaccination.
- If the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes, and different sites of administration.
- Advise survivors to return to a health facility to complete the vaccination schedule for full protection (i.e. second dose at 4 weeks, third dose at 6 months to 1 year).

**Video 7.1 Tetanus vaccination**

**Discuss the video**
- What did the physician do well?
- What was missing? What could be improved?

# EMERGENCY CONTRACEPTION

**SLIDES 14-20 EMERGENCY CONTRACEPTION**

**Slide 15 notes**
- Emergency contraception pill (ECP) can be used **within 120 hours (5 days) after the rape** to prevent a potential pregnancy. It is more effective given as soon as possible after unprotected sex.
- You may ask the woman if she has been using an effective contraceptive method, such as oral contraceptive pills, injectables, implants, an intrauterine device (IUD) or female sterilization. If so, it is not likely that she will get pregnant
- There are **no absolute contraindications** to providing ECP. Any woman or girl can take EC pills; there is no need to screen for health conditions.
- For **pre-pubertal adolescent girls:** EC pills can be offered to those who have reached Tanner Stage 2 or 3 – that is, who have onset of secondary breast development – as they may face **risk of unwanted pregnancy** if they ovulate before the onset of menstruation.

**Slide 16 notes**
- Provide information, education and counselling so that she can make **an informed decision.** Allow her to ask any questions that she may have. The survivor should understand that it is her choice to whether or not use EC.
- It acts to delay the release of an egg.
- It is however **not 100% effective.** The efficacy decreases with passage of time. The longer the delay in taking ECP, the lower the effectiveness.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. You will find this information during the history taking process. A review of the gynae history can give you information to rule out an existing pregnancy.
- However EC does not cause termination or abortion of an existing pregnancy, or harm the pregnancy or fetus.
- ECP may cause **nausea and vomiting**. If someone vomits within 2 hours after taking EC pills, return for another dose as soon as possible. The side effects are usually minor.
- While EC pills, STI antibiotics treatment and HIV PEP **can be taken together at the same** time without harm. However, since nausea is a common side effect an anti-vomiting or antiemetic tablet can be given as well. EC and PEP can be taken together, and antibiotics can be taken at different times and along with food to reduce nausea.

**Slide 17 notes**
- Advise the survivor to **return** if their next menstrual period is **more than 1 week late.**
- EC pills are not meant for regular use. More effective continuing contraceptive methods are available. If she requires long-term contraception, provide contraception or refer her appropriately.
- However, if a woman chooses not to use long-term contraception and is at risk of unintended pregnancy she can also receive a supply of EC pills to take home and use for future need.

**Slide 18 Pregnancy test**
- A **pregnancy test is not required** or necessary before giving ECP.
- Taking ECP will cause no harm if the woman is already pregnant, it will not end an existing pregnancy or harm the fetus. ECP should not be delayed or denied if a test is not available of if the survivors does not want one.
- However a pregnancy test can provide helpful information.
- Remember that pregnancies take about 2 weeks to be detected in a pregnancy test. A positive test result within 5 days from the rape indicates a pre-existing pregnancy.
- Pregnancy testing after 72 hours from the rape will be discussed later on.

**Slide 19 notes**
- There are three regimens for EC pills.
- Combined ECP are less effective and have more side-effects than LNG or UPA.

**Slide 20 Copper IUD**
- A copper IUD, sometimes called an intrauterine contraceptive device (IUCD), can also be used as a **method of emergency contraception.**
- The copper IUD works by preventing sperm from fertilizing the egg (by inhibiting sperm motility, reducing sperm function and survival).
- This option is more effective for EC than EC pills. The IUD offers long-term pregnancy protection and can be maintained for years after insertion. Fertility returns with no delay after this IUD is removed.
- IUD insertion may be distressing or traumatic after rape.
- A **negative pregnancy test is required before insertion.**
- If an IUD is inserted, make sure you **give full STI treatment** as per the protocol.
- Insertion of IUCD is a sterile and invasive procedure. It **requires skilled health care worker.**

**Video 7.2 Preventing unwanted pregnancy**

**Discuss the video**
- What did the physician do well?
- What was missing? What could be improved?

**Explain** that the doctor should also explain how ECP works, the side effects, ask if the patient wants to take ECP and explain when to expect her next period to come and discuss methods for ongoing contraception.

**Activity 7.1 Emergency contraception case studies**

## HIV POST-EXPOSURE PROPHYLAXIS (PEP)

**SLIDE 23-29 HIV POST-EXPOSURE PROPHYLAXIS**

**Slide 23 notes**
- Start HIV PEP as **soon as possible and up to 72 hours** after possible exposure to HIV.

**Slide 24 notes**
- Health-care providers should **provide information on risk factors** for HIV transmission so that survivors are able to make an **informed decision** about whether to take HIV PEP.
- There is a **risk of HIV transmission** if the survivor has been exposed to bodily fluids that may pose a risk of HIV infection through wounds, broken skins or tears in other mucous membranes. Body fluids with potential to transmit HIV through wounds or tears in other mucous membranes include: blood, blood-stained saliva, genital secretions, rectal fluids blood, blood-stained saliva, genital secretions and rectal fluids.
- There is a **higher risk of HIV transmission with rape compared to consensual sex** due to potential physical force or violence contributing to vaginal abrasions, tears or lacerations – including non-visible injuries.

**Slide 25 notes**
- However there are instances when the risk is much higher

**Slide 26 notes**
- HIV PEP should be started **as soon as possible and up to 72 hours** after possible exposure to HIV. All survivors of rape are at risk of HIV infection.
- HIV PEP is **not recommended if the survivor presents after 72 hours,** it is no longer effective.
- HIV PEP is **not recommended,** even within 72 hours, **when the survivor is living with HIV.** If the survivor is living with HIV and not taking antiretroviral therapy, she should be referred for HIV treatment immediately.
- Not all survivors need PEP. If there is no penetration with a penis, or no contact with bodily fluids PEP is not indicated.

**Slide 27 HIV testing**

- **HIV test is recommended** before PEP but **NOT mandatory.**
- A positive HIV test within the window period of 3 months indicates the patient had a pre-existing HIV infection.
- **Offer HIV counselling** using language that the survivor is able to understand including: a brief and simple explanation of HIV, the different ways the virus can get into the body, window/Incubation period, testing procedure (waiting time, 1 line, 2 lines), the benefits of knowing one's HIV status.
- When a survivor is too overwhelmed, distressed or traumatized to receive an HIV test and declines the HIV test, offer HIV PEP without the HIV test. Offer for the patient to return for an HIV test.
- Do not offer HIV testing if you do not have the possibility to offer care or refer to care. If the test is not available, give the full course of PEP.

**Slide 28 notes**

- Taking PEP to prevent HIV is the survivor's decision. Provide adequate information for the survivor to make an **informed decision,** encourage the survivor to ask questions.
- Review with the risk factors for HIV infection (such as whether there was more than one perpetrator or whether the exam found lacerations).
- HIV PEP can lower her chances of acquiring HIV, but it is **not 100% effective.**
- The medication needs to be taken for **28 days,** either once or twice daily depending on the regimen used.
- It is important to **complete the full course of PEP** to ensure protective efficacy.
- **Side-effects** include nausea, tiredness and headaches. For most people, the side-effects decrease in a few days. Ensure that the survivor understands that these are not permanent and suggest that if they experiences any of the side effects, do not stop the drugs on her own but take her dose as prescribed. Advise the patient to return to the clinic if she experiences side-effects that do not go away in a few days, if she is unable to take the medications as prescribed, or if she has any other problems.

**Slide 29 notes**

- Administer HIV PEP **as soon as possible**. To avoid delay, PEP can be started before the complete history and physical.
- Choose drugs based on national guidelines or current WHO ARV guidelines
- Triple therapy (three medications) of antiretroviral (ARV) regimen is preferred, but 2 drug regimen is also effective.
- Where applicable, choose the fixed dose combinations. This reduces the number of pills the survivor has to take daily, enhancing adherence.
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals that can lead to a higher likelihood of PEP discontinuation.
- HIV PEP is safe for pregnant women and for children with dosage adjustment.
- A 28-day prescription of ARVs should be provided. The first visit may be the only opportunity for consultation. There are many barriers to coming back.
- If you don't have HIV PEP in your health facility, refer the survivor as soon as possible (within 72 hours) to a clinic where this service can be provided.

**Slide 30 notes**

- **Adherence** is an important element of delivering PEP. Discuss:
  1. 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.
  2. 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.
  3. Offer reminder calls or messages if safe and appropriate.
- Educate survivor what to do **in case of a missed dose of HIV PEP:**
  1. If it is a once daily regimen: if the survivors forgets to take medication on time and if it is less than 12 hours late should still take it, if it is more than 12 hours late she should wait and take the next dose at the regular time.
  2. If it is a twice-daily regimen and if a dose is missed, the survivor should not take two doses at the same time

- **If test result is positive: refer** for HIV treatment and care.
- Do not offer HIV testing if you do not have the possibility to offer care or refer to care.

**Video 7.3 Preventing HIV**

**Discuss** the video

- What did the physician do well?
- What was missing? What could be improved?

**Explain** that the doctor should explain what the side effects are, how to manage them, and discuss strategies to improve adherence.

**SLIDE 32-33 CASE STUDY**

**Slide 32 notes**
A 26 year old woman comes into your clinic, she was raped by 2 men at a checkpoint while fleeing her village 1 day ago. She is worried about contracting HIV.
**What do you do?**
**A.** Inform her the risk of HIV is low, re-assure her that she is healthy.
**B**. Ask her to tell you where the check point is and test the men at the checkpoint for HIV.
**C.** Offer her 28 days of HIV PEP and give her information on the risks, benefits and side effects.
**D.** Offer the patient 1 weeks of HIV PEP and ask them to come back

**Slide 33 notes**
**Correct answer C.**
Offer her 28 days of HIV PEP and give her information on the risks, benefits and side effects.

**SLIDE 34-35 CASE STUDY**

**Slide 34 notes**
This woman does not want to take an HIV test now, she just wants the HIV PEP to reduce her risk of HIV and needs to get back to her children.

**What do you do?**
**A.** Inform her you cannot give her the HIV PEP without an HIV test.
**B.** Explain the benefits of taking an HIV test now.
**C.** Respect her decision and offer that she can return for an HIV test in the future.
**D.** Both B and C.

**Slide 35 notes**
**Correct answer D.**
Both B and C. Explain the benefits of taking an HIV test now and Respect her decision and offer that she can return for an HIV test in the future.

**SLIDE 36-37 CASE STUDY**

**Slide 36 notes**
The patient returns to the clinic several days later. She complains of nausea and vomiting and is worried that she is seriously ill. She reports that she has been taking all her medications.

**What is the appropriate response?**
**A.** Advise the patient to stop the PEP treatment right away.
**B.** Reassure the patient that nausea and vomiting are common side effects of PEP.
**C.** Give the patient anti-nausea (anti- emetic) medication and encourage her to complete the treatment course.
**D.** Both answers B and C.

**Slide 37 notes**
**Correct answer D.**
Both answers B and C Reassure the patient that nausea and vomiting are common side effects of PEP. Give the patient anti-nausea (anti- emetic) medication and encourage her to complete the treatment course. Nausea and vomiting are well-recognized side effects of the medications used for HIV PEP. Patients should be encouraged to complete the regimen. Care-providers can provide anti-nausea (anti-emetic) medication to make the PEP medications more tolerable.

# STI PREVENTION

**SLIDES 38-41 STI PREVENTION**

**Slide 40 notes**

- Do not wait to see if the survivor develops STI symptoms to offer medication.
- **Offer all survivors at risk of STIs prophylaxis/prevention/presumptive treatment** in their first visit. STIs can be asymptomatic and can cause infertility.
- Check the national protocols for types of drugs and doses available for STI prevention/treatment. Often it is a combination of antibiotics.
- Some antibiotics are not safe in pregnancy. If a woman is pregnant she should be treated according to appropriate guidelines.
- Adopt the combinations that are easy-to-take and are to be taken for a shortest period of time.
- Where there is access to a laboratory, **STI testing** can be offered.
- For **syphilis** use rapid point-of-care test if available. If the result is positive, offer treatment. Another test may be useful after 4 weeks if the initial result is negative. However, if a rapid test is not available, presumptive treatment is preferable, as many may not return for care.
- Negative test results, however, do not necessarily indicate a lack of infection. If the sexual assault was recent, the test results will most likely be negative unless the survivor already has an STI.
- You can also assess for STI/clinical symptoms, and offer syndromic management of vaginal or urethral discharge for gonorrhea, chlamydia, trichomoniasis, or of symptoms of herpes simplex virus, syphilis and chancroid, particularly in settings where lab testing is not feasible.

**Video 7.4: Preventing STIs**

# HEPATITIS B VACCINE

**SLIDES 43-46**

**Slide 44 notes**

- If available, please include the prevalence of Hepatitis B in your setting and the dosage and vaccination schedule for the type of HB vaccine available in your setting.

**Slide 45 notes**

- The **hepatitis B virus** can be **sexually transmitted.** Hepatitis B can cause **liver cirrhosis.** Hepatitis B is more easily transmitted than HIV. Hepatitis B is preventable through vaccination. Therefore, people subjected to sexual violence should be offered immunization for hepatitis B, particularly in high-prevalence settings.
- Routine pre-vaccination serological testing is not recommended. Where lab facilities are available and cost-effective and hepatitis B vaccination status is unknown, a blood sample can be screened for hepatitis B before vaccination. If already immune (presence of hepatitis B surface antibody in serum), no further vaccination is needed. If testing is not possible, vaccinate.
- Several hepatitis B vaccines are available, each with different recommended dosages and schedules.
- Your choice will be guided by availability and the country protocols.

**Slide 46 notes**

- Several **hepatitis B vaccines** are available, each with different recommended dosages and schedules. Check and use the type of vaccine, dosage and immunization schedule **based on local protocols or guidelines.**
- In many settings hepatitis B vaccination is part of the national vaccination schedule, and many people will have already been vaccinated with the required 3 doses.
- **Ask about vaccination**. If the survivor has already been completely vaccinated, do not offer the vaccine.
- Survivors may not be aware of their immunization status for Hep B. Offer the vaccine. Do not miss the opportunity to offer vaccination to a survivor.
- If not vaccinated or the series was not completed, follow the guidance on the slide.
- Give the vaccine intramuscularly in the deltoid region of the arm.

**Video 7.5 Hepatitis B vaccination**

**Explain** that the video states “advise the person to return at 1 and 6 months to complete the immunization” but check with your national protocol or guidelines.

# PROVIDE INFORMATION, DISCUSS SELF-CARE AND PLAN FOLLOW-UP

**SLIDE 48-49 PROVIDE INFORMATION, DISCUSS SELF-CARE AND PLAN FOLLOW-UP**

**Slide 48 notes**
- Provide information on the importance of **returning for treatment if signs or symptoms occur.**

**Slide 49 notes**
- Advise them to **use condoms** during sexual intercourse at least until for 7 days after STI prophylaxis/treatment and/or until HIV status has been determined at the 3- or 6-month visit – if it is safe to negotiate condom use with their partner.

**SLIDE 50 KEY MESSAGES**

*Choose 1 or both of the activities:*

**Activity 7.2 Case studies on treatment for sexual assault and/or**
**Activity 7.3 Grab bag on medical care**

**Ask** what questions the participants have.

# TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT

**SLIDE 52–58 TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT**

**Slide 52 notes**
- This section includes **delayed treatment** of days, weeks or months.

**Slide 54 notes**
- When a survivor comes to the clinic **more than 72 hours** after the assault the examination and treatment will depend on their condition and history. Consider:
  1. treatment of injuries
  2. pregnancy prevention
  3. symptomatic treatment of STIs
  4. HIV counseling and testing
  5. vaccination against hepatitis B and tetanus
  6. information and referrals for other support services
- All survivors – including those who come months and years after - can receive first-line support (LIVES), and some may need additional mental health care. Information, referrals, and first line support can help the survivor heal and are important no matter how long it has been since the assault.

**Slide 55 notes**
- Depending on the time the survivor presents, and based on the history, exam and look for any signs of injuries, healing or unhealed wounds, fractures or abscesses, complications caused by injuries sustained during the assault.
- Also remember some survivors will not present with any wounds at all.
- If **simple healing wounds** are present, **manage** at site.
- Assess for any **large or complicated wounds** and **refer** accordingly.

**Slide 57 notes**
- If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, **emergency contraceptive (EC) pills** will reduce the chance of a pregnancy. ECP is most effective if taken within 72 hours, but it is still moderately effective **within 120 hours** after unprotected intercourse.

- The effectiveness of an IUD is higher than ECP from 72 to 120 hours
- If an IUD is inserted, make sure you give full STI treatment as per the protocol, and test for pregnancy before insertion.
- Insertion of IUCD is a sterile and invasive procedure. It requires skilled health care worker.
- If a woman presents 5 or more days after the incident, EC will not be effective.

**Slide 58 notes**

- Most women are likely to be very concerned about the possibility of becoming pregnant as a result of rape.
- All patients should be **assessed for pregnancy status.**
- **Offer a pregnancy test.** Remember that pregnancy tests take approximately 2 weeks from the rape/unprotected sex to become positive.
- If positive, give emotional support and clear information in a non-judgmental way that a woman can understand and **discuss the choices available,** allow her to make her own decisions and **respect her choice.**
- **Safe abortion** may be available in your health facility – if service providers have the right training, and the appropriate methods available (medication or vacuum aspiration) depending on the gestational age. If you are unable to provide safe abortion, find out where it is available to provide accurate information and refer if requested, if they choose this option
- Also provide information on **antenatal care, parenting support, adoption and foster care services** as available.
- Also, be aware of any adoption or foster care services in your area. Inform the survivor, and if they choose this, give detailed information and facilitate their referral.
- Some survivors may require safe houses to stay during the pregnancy period. Have this information, and contacts to the referral centers.
- In very few countries abortion is completely restricted. In many countries, the law allows the termination of a pregnancy resulting from rape or to protect the mental and physical health of the woman. Find out whether this is the case in your setting: https://reproductiverights.org/worldabortionlaws

**DISCUSS**

**Ask**

- What is the **current law and practice** with respect to safe abortion for survivors of rape/sexual assault? To save the life of a woman?
- What are the **barriers** that may delay women and girls from accessing abortion services?
- What might happen to a woman who has a child as a result of rape?
- What are cultural and social norms about children born of rape? And the women pregnant from rape?
- Discuss **alternative options** where abortion is not permitted or possible and/or when a woman does not choose this option, including care for pregnancy and delivery, adoption, foster care and parenting support? What are the options (if any) available to women in your setting who become pregnant as a result of rape?

*Depending on the context these discussions can be very sensitive and taboo and participants may not feel comfortable engaging in these discussions. Consider if this discussion is appropriate in your context.*

**SLIDE 60-63 CASE STUDIES**

**Slide 60**

A 17 year old girl comes to your clinic 8 days after being raped by another student at her university. She is worried about pregnancy. You do a pregnancy test and it is negative.

**What support do you provide her?**

**A.** Offer the Emergency contraception pill
**B.** Inform her that she is not pregnant, but it is too early to know if she is pregnant from the rape and advise her to come back to the clinic if she does not see her menstrual period.
**C.** Inform her that she is not pregnant from the rape.

**Slide 61**

**Correct answer B.**

Inform her that she is not pregnant, but it is too early to know if she is pregnant from the rape and advise her to come back to the clinic if she does not see her menstrual period.
Emergency contraception can only be given within 5 days or 120 hours of condomless sexual intercourse or rape.
Most pregnancy tests take approximately 2 weeks to become positive after sexual intercourse or rape. If she is not taking contraceptive prior to the rape consistently and correctly, she should return for another pregnancy test or do a pregnancy test at home if her menstrual period does not return.

## SLIDE 62-63 CASE STUDY

**Slide 62**
The 17 year old girl returns to your clinic 3 weeks after being raped by another student at her university. She is worried about pregnancy. You do a pregnancy test and it is positive.

**What support do you provide her?**
**A.** Inform her that she has come too late for emergency contraception, there is no further help you can provide.
**B.** Advise her that the best option is to continue the pregnancy and parent the child.
**C.** Provide her emotional support, and discuss her options – including safe abortion, adoption or parenting.

**Slide 63**
**Correct answer C.**
Provide her emotional support, and discuss her options – including safe abortion, adoption or parenting.
If positive, give emotional support and clear information in a non-judgmental way that a woman can understand and discuss the choices available, allow her to make her own decisions and respect her choice.

## SLIDE 64-67 TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT

**Slide 64 notes**
- HIV PEP is **not effective after 72 hours** of rape. **Do not offer** prevention for HIV (PEP) to survivors presenting past 72 hours. However, offer information on HIV, **assess the risk of HIV** transmission, and **offer a HIV test.**
- In some settings, HIV testing can be done as early as 6 weeks after rape. If the test is done at 6 weeks, it should be repeated after 3 months. WHO recommends **HIV testing at least 3-6 months** after rape to avoid the need for repeat testing. Check the HIV testing protocols in your settings.
- If the survivor's **HIV test is positive,** offer **support and refer** for HIV management.
- Do not carry out a HIV test if you do not have the ability of offer or refer to antiretrovirals. Ensure you check the HIV services available in your settings.

**Slide 65 notes**
- **Assess for signs and symptoms of STI,** such as foul smelling vaginal or urethral discharge, lower abdominal pains, pain when passing urine, sores or blisters in the genital area etc. Remember that STI infection may be **asymptomatic.**
- You may be able to carry out laboratory screening for STIs. If available, carry out the tests and treat according to the results.
- Where there is no capacity to test, **offer syndromic treatment** for STIs – including vaginal or urethral discharge for gonorrhea, chlamydia, trichomoniasis, and for genital ulcer for herpes simplex virus, syphilis and chancroid. Follow your country's protocols.

**Slide 66 notes**
- Hepatitis B can be sexually transmitted.
- It has an **incubation period** of 2-3 months. Sometimes, the incubation period can last for 6 months.
- Examine for **any signs of Hepatitis B infection.** Some of the signs include: jaundice, fever, abdominal pain and unexplained fatigue, lasting from weeks to months. If you see signs of an acute infection, refer the person for treatment,
- Offer **Hep B vaccine** to the survivor if they have not been vaccinated, no matter how long it has been since the incident.

## SLIDE 67-68 CASE STUDY

**Slide 67**
A 27-year-old female presents for care 4 days after being raped. The genital exam is normal and her pregnancy test is negative. She has multiple healing abrasions on her legs without signs of infection and was last vaccinated against tetanus as a child.

**This patient should be given preventative care against all of the following except:**
**A.** Gonorrhea and chlamydia
**B.** HIV
**C.** Pregnancy
**D.** Hepatitis B
**E.** Tetanus

**Slide 68**
**Correct Answer: B.**
- PEP against HIV infection needs to be started within 72 hours (three days) after the rape. Although more effective if given earlier, ECP are still quite effective up to 120 hours (five days) after rape or sexual intercourse.
- Hepatitis B, gonorrhea, and chlamydia medications can also be provided within this time frame.
- Ideally, a tetanus vaccine booster is administered within 72 hours of a break in the skin, but it can also be given later.

**Slide 69 Key messages**

**DISCUSS**

**Ask** what questions they may have.

# ENHANCING SAFETY AND FACILITATE SUPPORT (LIVES)

**Activity 2.1 Step by step guide to providing care and support**
Place **'First line support, ensure safety and make plan, support – connect with community and health resources'** on the wall.

**SLIDE 73-78 ENHANCING SAFETY AND FACILITATING SUPPORT**

**Slide 74 notes**

- It is vital to acknowledge safety concerns, help a survivor to **assess the immediate risks** of violence, and **plan for safety.**
- Enhancing safety means helping a woman to assess her situation and make a plan that helps her to stay safer in the future. It is not possible to eliminate the risk of violence completely; however, it is possible to enhance her safety, even if only slightly, within a given situation. It often involves small, incremental steps that can reduce the risk or severity of further violence.
- **Assess safety after sexual violence:**
  1. Survivors of sexual violence often know the person who assaulted them, and sexual violence often happens at home. If it was someone she or he knows, discuss whether or not it is safe to go home.
  2. Survivors may be at risk of retaliation or reprisals.
  3. Some survivors, adolescent girls or unmarried women may be at risk of violence by their own family related to norms around honour and virginity.
  4. Male survivors of SV by another male, or sexual and gender minorities, may be at risk of violence by their family or community related to views of homosexuality, discrimination, persecution and criminalization of same-sex relationships.
- **Assess safety after intimate partner violence:**
  1. Survivors of intimate partner violence face the risk of ongoing harm, injury and even death
  2. Many women who have been subjected to violence have fears about their safety. Other women may not think that the violence will happen again.
  3. Explain that partner violence is not likely to stop on its own. It tends to continue and may over time become worse and happen more often.
  4. Harm, injury and death related to intimate partner violence is not spontaneous or random, it is often predictable and preventable.
- If she is worried about her safety, take her seriously. Ask specific questions to see if any situations or people continue to place her at risk.
- Explore existing safety and support strategies that she has used.
- Discuss any available and safe referral options (if she wishes to).
- Emphasize that you are there for her and encourage her to come back at any time.

**Slide 75 notes**

- Women who answer "yes" to at least 3 of these questions may face especially **high immediate risk**
- Women are often at **highest risk when they leave** their partners.
- Regardless of the above risk assessment, **trust your patient** if she tells you she is in severe danger.

**Slide 76 notes**

- **If it is not safe for the woman to return home,** make referrals to shelter, safe housing or help identify a safe place where she can go, a family or friends home, a local NGO that supports survivors, a church or mosque.
- Help to **make a safety plan if she chooses to leave**
  - **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?
  - 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 partner know. Otherwise, she may put herself and her children at more risk of violence.

- If **she chooses not to or cannot leave, respect her decision.**
- Discuss how she can **reduce the harms of violence to herself or her children if it happens again.**
- Discuss what she has done in the past, praise her for her skills and strength and ability to survive so far. Empower her to build on those skills.
- Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?
- Identify family, friends or neighbours who could intervene if violence occurs or provide protection,
- Provide a GBV hotline or helpline if available.
- Notify a trusted neighbors to watch for signs of violence and to call others for help
- If she cannot avoid discussions that may escalate with her partner, advise her to try to have the discussions in a room or an area that she can leave easily.
- If violence can't be avoided, advise her to stay away from any room where there might be weapons, or try to move to a room with an easy exit - a door or window to escape.

**Slide 77 notes**

- If she must take paperwork with her (for the police or agencies such as UNHCR, for example), discuss what she will do with the papers so that they will not put her safety at further risk.
- Talk about abuse alone.
- No one older than 2 years of age should overhear your conversation. Never discuss it if her husband or other family members or anyone else who has accompanied her – even a friend – may be able to overhear, unless it is her wish to be accompanied in this conversation.

**Slide 78 notes**

- Survivors often do not only have medical needs, but have multiple needs – psychological, social, economic, livelihood, safety, security, legal and justice supports
- Discuss **social support** – "Do you have a family member, friend, or trusted person in the community whom she could talk to?" "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?"
- **Provide information about support services** and **offer referral** to support services. Use a referral pathway, provide clear information about what the support service offers, the name of a specific person, the address or contact information, how to get there
- Discuss ways to **help her access support services**
  1. Offer to call on her behalf, offer to make a call with her, Offer the survivor the option to call from a phone at the clinic and a private place where she can call. Accompany them to the support services
  2. Help her solve any practical problems that might interfere – no transportation, no childcare
  3. 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.
  4. If possible, arrange for a trusted person to accompany her on the first appointment.

| ✖ DO NOT: | ✔ RESPECT THEIR DECISION: |
|---|---|
| Try to convince her to leave a violent relationship, or try to convince her to go to the police or courts. | If they decide not to report to the police or access other supports. |

- There are many potential risks of reporting to the police – repercussions, retaliation, lack of privacy and confidentiality, family and community rejection and exclusion, even the risk of further violence and death. The survivor is the best person to make a decision for themselves and their safety.

**Video 7.6: Enhancing safety and connecting with support**

**Clarify** that the doctor said "everything we discuss is confidential unless you and your son are in danger". However be aware of the mandatory reporting laws in your context, and potential risks of reporting as well.

**Ask**

- How did the health provider in the video enhance safety?
- How did the health provider facilitate support?
- What could have been improved?

**Explain** that the doctor did assess the risk to the survivor's safety and let her know she can come back at anytime, but did not support her to discuss safety strategies and plans. This could be improved.

**Activity 7.4 Role play Enhancing safety and offering support**
**and/or**
**Activity 7.5 Case studies on referral to support services**

**Slide 81 Key messages**

# ASSESSING MENTAL HEALTH AND PROVIDING PSYCHOSOCIAL SUPPORT

**SLIDE 82-83 INTRODUCTION AND OBJECTIVES**

**Activity 2.1 Step by step guide to providing care and support**
Place assess for mental health problems. Treat or refer as appropriate.

**Activity 7.6 Brainstorm mental health consequences**
**and/or**
**Activity 7.7 Story telling – mental health consequences**

**SLIDE 86-89 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT**

**Slide 86 notes**

- Survivors are at an increased risk of a range of symptoms, including feelings of guilt and shame, anger, anxiety, fear, nightmares, suicidal thoughts or attempts, numbness, substance abuse, sexual dysfunction, medically unexplained somatic complaints and social withdrawal.
- Explain that it is **common** to experience emotional distress, strong negative emotions or numbness after rape. **These reactions are normal and common** in people who are have gone through a stressful and frightening experience.
- These emotions, however overwhelming, are **usually temporary** and are normal reactions to recent difficulties.
- These psychological or emotional problems **will likely get better,** especially if she has received practical and emotional support from others. **Most people recover.**
- **Provide information** about normal stress reactions to an experience of violence. This can **bring relief** to survivors and **help them to cope** better.

**Slide 87 notes**

- Medical care for survivors of rape includes **assessing for psychological and emotional problems.** Assessment of mental state is an important part of history-taking so that any mental health issues can be followed up. The purpose is to: assess the need for mental health referral, identify positive coping strategies and assess her sources of support.
- Pay attention to her **mental health status,** including:
- Overall appearance (e.g. taking care of her appearance);
  - 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?
- Behaviour (e.g. agitation);
- Facial expression, mood (e.g. crying, anxious, without expression);
  - Is she calm, crying, angry, anxious, very sad, without expression?
- Body language (e.g. posture, eye contact); and
- Speech (e.g. fast, slow, silent)
  - Is she silent?
  - How does she speak (clearly or with difficulty)? Too fast/too slow? Is she confused?
- Thoughts (e.g. recurrent memories).
  - 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?

- Ask general questions about how she is feeling and what her emotions; for example:
  - How do you feel?
  - What is your biggest worry these days? Are you having any problems?
  - What are your most serious problems right now? How are these problems or worries affecting you? How has (the violence) been affecting you? How have things changed for you?
  - How do you deal/cope with these problems day by day? Are you having any difficulties coping with daily life? To what extent are your difficulties affecting your life, such as relationships with family and friends, or your work or other activities?
- ***IMPORTANT: There is no particular mental state that indicates, or is typical of, sexual abuse.***

**Slide 89 notes**

- If the survivor expresses guilt or shame, explain gently that **rape is never the fault of the survivor.** Assure her that she did not deserve to be raped, that the incident was not her fault, and that it was not caused by her behaviour, manner of dressing, or anything else. **Do not blame or judge** the survivor.

**Activity 7.8 Discussion on coping skills**

**SLIDE 91-93 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT**

**Slide 91 Encourage positive coping strategies**

- Explore **positive coping strategies** that are feasible for her, in a supportive and non-judgemental manner.
- Ask what is going well currently and how they have coped with difficulties in the past
- Encourage engaging in relaxing activities to reduce anxiety and tension (e.g. walk, sing, pray, play with children).

**Slide 92 Explore social support**

- People who experience abuse or violence 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.
- Good social support is one of the most important protections for anyone suffering from stress-related problems.
- 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?"
- Explain to the woman that, even if there is no one with whom she wishes to share what has happened to her, she still can connect with family and friends. Spending time with people she enjoys can distract her from her distress.
- Help them to identify past social activities or resources that may provide direct or indirect psychosocial support (ex 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 her with resources for social support such as: community centres, self-help and support groups, income-generating activities and other vocational activities, formal/informal education.

**Slide 93 Encourage stress-management and relaxation techniques**

- Relaxation techniques is one way to reduce reactions or symptoms of anxiety or panic that threaten to overwhelm a survivor.
- Always remember to invite the survivor to participate, let it be an open invitation. If they does not feel ready to participate in an exercise, respect their wish

**See Activity 7.9 Relaxation techniques**

**SLIDE 95-98 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT**

**Slide 95 Assess for mental health conditions**

- If your assessment identifies problems with mood, thoughts or behaviour and if the woman is unable to function in her daily life (e.g. problems getting out of bed, taking care of children, going to work or doing housework), she may have more severe mental health problems.

**Slide 96 Assessing suicide and self-harm**

- Some health care workers fear that asking about suicide may provoke the woman to commit it.
- Talking about suicide often **reduces the woman's anxiety** around suicidal thoughts and **helps her feel understood.** It does not lead to suicide attempts.
- Ask a series of questions where any answer naturally leads to another question.
  - How do you feel?
  - You look sad/ upset. I want to ask you a few questions about it?
  - How do you see your future? What are your hopes for the future?
- If the survivor expresses hopelessness, **ask if she has current – or a history of – thoughts or plans to commit suicide or to harm herself.**
  - Some people with similar problems have told me that they felt life was not worth living.
  - Do you go to sleep wishing that you might not wake up in the morning?
  - Do you think about hurting yourself?
  - Have you made any plans to end your life? If so, how are you planning to do it?
  - Do you have the means to end your life? Have you considered when to do it?
  - Have you ever attempted suicide?

**Slide 97 Assessing suicide and self-harm**

- If a referral to a specialist is not possible work with the survivor to identify someone they trust in their life who can be with them at the clinic and when they go home. Provide info on a suicide hotline if available and safety plan for if/when thoughts become severe/high risk.

**Slide 98 Managing suicide**

Use this slide **only if there are no MH specialists available for referral.**

- Remove all possible means of self-harm/ suicide and, if possible, offer a separate, quiet room. However, do not leave the person alone. Have carers or staff stay with the person at all times.
- Instead, try to instil hope. Search together for solutions to the problems. Focus on the person's strengths by encouraging them to talk of how earlier problems have been resolved.
- Mobilize carers, friends, other trusted individuals and community resources to monitor and support the person if they are at imminent risk of suicide. Explain to them about the need for 24-hour-per-day monitoring. Ensure that they come up with a concrete and feasible plan (e.g. who is monitoring the person at what time of the day). Advise the person and carers to restrict access to means of self-harm/suicide (e.g. pesticides/toxic substances, prescription medications, firearms, etc.) when the person has thoughts or plans of self-harm/suicide.
- Make sure there is a concrete plan for follow-up sessions and that the carers take responsibility for ensuring follow-up.
- Maintain regular contact (e.g. via telephone, text messages or home visits) with the person.
- Follow up frequently in the beginning and decrease frequency as the person improves
- Follow up for as long as the suicide risk persists. At every contact, routinely assess suicidal thoughts and plans.

**Video 7.7 Assessing suicide**

https://www.youtube.com/watch?v=4gKIeWfGIEI

⚠ Use this video only if there are no MH specialists available for referral.

**Slide 100 Assess mental health conditions**

- If your assessment identifies problems with mood, thoughts or behaviour and if the woman is unable to function in her daily life (e.g. problems getting out of bed, taking care of children, going to work or doing housework), she may have more severe mental health problems. Conduct a more detailed mental health assessment if needed. Assess for pre-existing mental health conditions, depressive disorder, post-traumatic stress disorder (PTSD).
- If a survivor has suffered from MH problems before experiencing violence, they will be much more vulnerable to suffering from them again. Pre-existing mental health problems may be exacerbated or reoccur if they experience IPV or sexual violence.
- Assess for **moderate-to-severe depressive disorder.** When a person is unable to cope, has difficulty with daily functioning of normal activities and cannot carry out her normal activities, these symptoms persist over at least 2 weeks, they may have depressive disorder. Symptoms can include: 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
- Assess for **PTSD:** The following symptoms are present about 1 month after the violence:
  1. Re-experiencing symptoms: Repeated, unwanted recollections of the violence, frightening dreams, flashbacks or intrusive memories with intense fear or horror
  2. Avoidance symptoms: Deliberate avoidance of thoughts, memories, activities or situations that are reminders of the violence (e.g. avoiding talking reminders of the violence, or avoiding going back to places where the violence happened)
  3. Heightened sense of current threat: Excessive concern and alertness to danger, reacting strongly to loud noises or unexpected movements, being "jumpy" or "on edge"
  4. Considerable difficulty with daily functioning

**Activity 7.9 True or false – mental health care**

**Slide 102 Key messages**

**DISCUSS**

**Ask** what questions they have.

## PROVIDE FOLLOW-UP CARE

**Slide 104 Provide follow up care**

**Activity 2.1 Step by step guide to providing care and support**
Place **'Plan follow-up at 2 weeks, 1 month, 3 months and 6 months'** on the wall.

**SLIDE 105-108 FOLLOW UP CARE AND SUMMARY**