

SUMMARY

Responding to intimate partner violence and sexual violence against women: clinical and policy recommendations

Introduction

Violence against women is a major public health and human rights issue, with intimate partner violence and sexual violence among the most pervasive forms of violence against women. Research, initially from North America and Europe, but increasingly from other regions, has demonstrated the high prevalence of violence against women globally and its adverse physical and mental health outcomes, in both short and long term (Campbell, 2002; Garcia Moreno et al, 2005; Ellsberg et al, 2007; Bott et al, 2012).

Although violence against women has been accepted as a critical public health and clinical care issue, it is still not included in the health-care policies of many countries. The critical role that the health system and health-care providers can play in terms of identification, assessment, treatment, crisis intervention, documentation, referral and follow-up, is poorly understood or accepted within the national health programmes and policies of various countries.

Women who have been subjected to violence often seek health care, including for their injuries, even if they may not disclose the associated abuse or violence, and a health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Women also identify health-care providers as the professionals they would most trust with disclosure of abuse (Feder et al, 2006)

Health professionals can provide assistance to these women by facilitating disclosure, offering support and referral, gathering forensic evidence — particularly in cases of sexual violence — or by providing the appropriate medical services and follow-up care.

Health-care providers who come into contact with women facing violence need to be able to recognize signs of it, and respond appropriately and safely. Individuals exposed to violence require comprehensive, gender-sensitive health-care services that address the physical and mental health consequences of their experience and aid their recovery. Women may also require crisis intervention services in order to prevent further harm. In addition to providing immediate medical services, the health sector is potentially a crucial gateway to providing assistance through referral pathways to specific services for violence against women—or to other aid that women may require at a later date, such as social welfare and legal aid. In all circumstances, there is a minimum first-line supportive response required and the first recommendation below outlines this minimum.

Violence against women is also a violation of a woman's human rights. Policies and laws need to be revised to ensure they do not discriminate against women and that they adequately penalize acts of violence, including those that take place within the home. Furthermore, services should aim to be, "delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives".¹

This document summarizes *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, the World Health Organization (WHO), 2013 publication,² developed by an international group of experts following a thorough review of evidence. It contains evidence-based recommendations for the introduction of policies into health services and programmes to improve responses within the health sector to violence against women. Each recommendation is classified as either "strong" or "conditional", on the basis of the generalizability of benefit across different communities and cultures, the needs and preferences of women to access services, as well as taking into consideration the level of human and other resources that would be required. Further clarifications are noted below some recommendations as remarks.

It is understood that these recommendations will need to be adapted to specific local and/or national circumstances, taking into account the availability of resources, as well as national policies and procedures.

Who are these recommendations for?

The recommendations are aimed at health-care providers because they are in a unique position to address the health and psychosocial needs of women who have experienced violence. They also seek to make health-care providers and policy-makers in charge of planning, funding and implementing health services and professional training more aware of violence against women, to encourage an evidence-informed health-sector response, and improve capacity building of health-care providers and other members of multidisciplinary teams. They should also prove useful to those responsible for developing training curricula in medicine, nursing and public health.

¹ CEDAW General Recommendation 24, para 22

² For full document, see <http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

1. Providing first-line women centred-care

Recommendation 1

Women who disclose sexual assault by any perpetrator or violence of any form by an intimate partner or other family member should be offered immediate support. Health-care providers should, as a minimum, offer first-line support when women disclose violence.

This includes:

- being non-judgmental, supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, without pressuring her to talk (care should be taken during sensitive topics when interpreters are involved)
- providing information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

It is important to ensure:

- that the consultation is conducted in private
- confidentiality, while informing women of the limits of confidentiality, for example if there is mandatory reporting.

Remarks

- (a) Any intervention must be guided by the principal to “do no harm”, ensuring the balance between benefits and harms, and prioritizing the safety of women and their children as the uppermost concern.
- (b) The privacy and confidentiality of the consultation, including discussing relevant documentation in the medical record and the limits of confidentiality with women, should be a priority. Therefore, good communication skills are essential.
- (c) Health-care providers should discuss options and support women in their decision-making. The relationship should be supportive and collaborative, while respecting women’s autonomy. Health-care providers should work with the women, presenting options and possibilities, as well as providing information, with the aim to develop an effective plan and set realistic goals, but the woman should always be the one to make the decisions.
- (d) In some settings, such as emergency care departments, as much as possible should be done during first contact, in case the woman does not return. Follow-up support, care, and the negotiation of safe and accessible means for follow-up consultation should be offered.

- (e) Health-care providers need to have an understanding of the gender-based nature of violence against women, and of the human rights dimension of the problem.
- (f) Women who have physical or mental disabilities are at an increased risk of intimate partner and sexual violence. Health-care providers should pay particular attention to their multiple needs. Women who are pregnant may also have special requirements (see recommendation 8).

2. Identification and care for survivors of intimate partner violence

2.1 Identifying women experiencing intimate partner violence

Box 1	Minimum requirements for asking about intimate partner violence against women
	<ul style="list-style-type: none"> ✓ A protocol/standard operating procedure ✓ Training on how to ask, first-line response or beyond ✓ Private setting ✓ Confidentiality ensured ✓ A system for referral in place

The issue of safe and effective identification within health-care settings of women experiencing partner (or domestic) violence is an important one. Studies have shown that while “screening” (i.e., asking all women who come for health care) increases identification of women with intimate partner violence, it does not reduce partner violence and has not been shown to have any notable benefit for women’s health. The following recommendations have been identified:

Recommendation 2

“Universal screening” or “routine enquiry” (i.e. asking women in all health-care encounters) should not be implemented.

Remarks

- (a) There is strong evidence of an association between intimate partner violence and mental health disorders among women. Women with mental health symptoms or disorders could be asked about intimate partner violence as part of good clinical practice, particularly as this may affect their treatment and care.
- (b) Intimate partner violence may affect disclosure of HIV status or jeopardize the safety of women who disclose, and affect their ability to implement risk-reduction strategies. Asking women about intimate partner violence could be considered in the context of HIV testing and counseling, although further research to evaluate this is needed.

- (c) Antenatal care is an opportunity to enquire routinely about intimate partner violence because of the dual vulnerability of pregnancy. There is some limited evidence from high-income settings to suggest that advocacy and empowerment interventions (e.g., multiple sessions of structured counselling) following identification through routine enquiry in antenatal care, may result in improved health outcomes for women, and there is also the possibility for follow-up during antenatal care. However, certain things need to be in place before this can be done (see Box 1 on minimum requirements).

Recommendation 3

Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence (see Box 2 for examples of associated clinical conditions), in order to improve diagnosis, identification and subsequent care (see recommendation 30).

Remarks

- (a) A minimum condition for health-care providers to ask women about violence is that it is safe to do so (i.e. the partner is not present); they must be trained on the correct way to ask and on how to respond to women who disclose violence (see Box 1 on minimum requirements). This should at least include first-line support for intimate partner violence (see recommendation 1).
- (b) Providers need to be aware of, and knowledgeable about, resources available to refer women to when asking about intimate partner violence.

Box 2 Examples of clinical conditions associated with intimate partner violence^a

- Symptoms of depression, anxiety, post-traumatic stress disorder (PTSD), sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genito-urinary symptoms including frequent bladder or kidney infections
- Adverse reproductive outcomes including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

^a Adapted from Black MC Intimate partner violence and adverse health consequences; implications for clinicians. *American Journal of Lifestyle Medicine*, 2011, 5:428-439.

Recommendation 4

Written information on partner violence should be available in health-care settings, in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms. This information should be accompanied by appropriate warnings about taking them home if an abusive partner is there.

2.2 Providing care to women survivors/living with partner violence

Effective interventions to support women survivors of intimate partner violence were broken into four categories:

- Psychological interventions
- Advocacy/empowerment interventions
- Mother-child interventions
- Other interventions (i.e. expressive writing and yogic breathing).

The following recommendations were made:

*Psychological interventions***Recommendation 5**

Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depressive disorder or alcohol use disorder) who are experiencing intimate partner violence, should receive mental health care for the disorder in accordance with the WHO mhGAP Intervention guide 2010a delivered by health-care professionals with a good understanding of violence against women.

Remarks

- a) Use of psychotropic medications in women who are either pregnant or breastfeeding requires specialist knowledge and is best provided in consultation with a specialist where available. For details on management of mental health issues in these two groups please see the mhGAP guidelines (WHO, 2010a).

Recommendation 6

Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) interventions, delivered by health-care professionals with a good understanding of violence against women, are recommended for women who are no longer experiencing violence but are suffering from PTSD.

*Advocacy/empowerment interventions***Recommendation 7**

Women who have spent at least one night in a shelter, refuge, or safe house should be offered a structured programme of advocacy, support, and/or empowerment.

Remarks

- a) The extent to which this may apply to women leaving the household in situations where shelters do not exist is not clear.

- (b) This may be considered for women disclosing intimate partner violence to health-care providers, although the extent to which this may apply in circumstances outside of shelters is not clear and should be researched further.
- (c) In populations where the prevalence of intimate partner violence is high, priority should be given to women experiencing the most severe abuse. (The guideline development group did not agree whether this should extend to severe psychological abuse.)
- (d) Interventions should be delivered by trained health-care or social care providers or trained lay mentors, tailored to the woman's personal circumstances and designed to combine emotional support and empowerment with access to community resources.

Recommendation 8

Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.

Remarks

- (a) Information about exposure to violence should be recorded unless the woman declines, and this should always be conducted in a discreet manner (i.e. not with labels or noticeable markings that can be stigmatizing for women, especially when health-care professionals label them as “battered”). Women may not wish to have information recorded in their clinical history files, in the fear that their partner may find out. Women's preferences need to be balanced against the need to ensure adequate forensic evidence in circumstances where women decide to pursue a legal case, and the reporting policies at each health-care facility.
- (b) A woman should be helped to develop a plan to improve her safety and that of her children, when relevant.
- (c) Attention should be paid to self-care for providers, including the potential for vicarious trauma (see Glossary).

Mother –child interventions

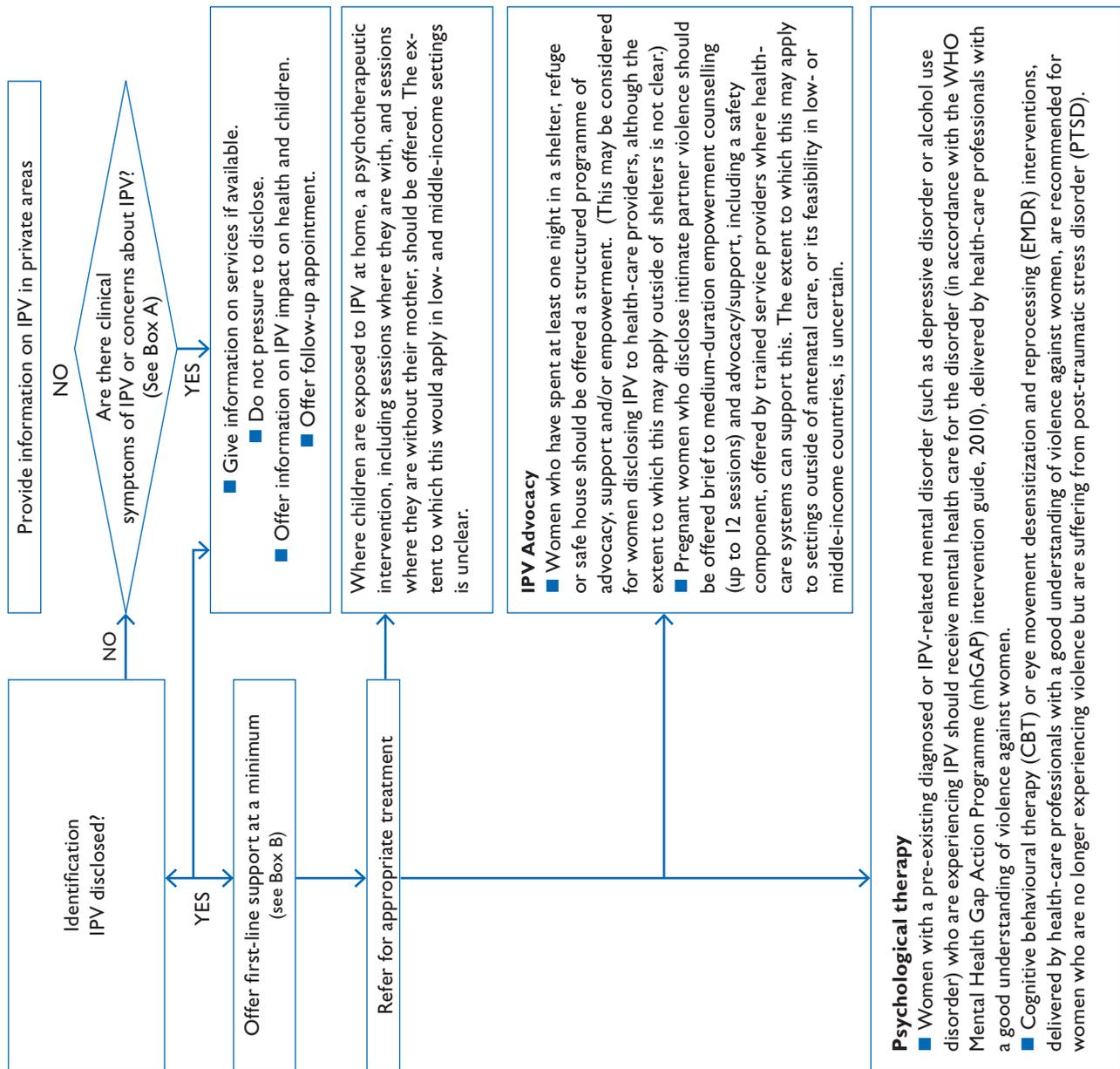
Recommendation 9

Where children are exposed to intimate partner violence at home, a psychotherapeutic intervention, including sessions with and without their mother, should be offered, although the extent to which this would apply in low- and middle-income settings is unclear.

Remarks

- (a) The cost of intensive psychotherapeutic interventions focusing on the mother–child, and lack of providers trained to deliver this type of intervention, makes it challenging to implement them in resource-poor settings.

Figure 1. Care pathway for intimate partner violence (IPV = intimate partner violence)



Box A – Clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, PTSD, sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Box B – First-line support

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. This includes:

- ensuring consultation is conducted in private
- ensuring confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)
- being non-judgemental, supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken with the use of interpreters for sensitive topics)
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

3. Clinical care for survivors of sexual assault

Sexual assault is a traumatic experience that may have a variety of negative consequences on women's mental, physical, sexual and reproductive health. Women may require acute and, at times long-term health care, particularly mental health care. The gathering of forensic information is also important, particularly for those women who would want to pursue a legal course of action. This is not covered in this current guideline, but further information can be found in the following guidelines: WHO *Guidelines for medico-legal care for victims of sexual violence* (2003) and the WHO/ UNHCR *Guidance on clinical management of rape* (2004) and e-learning programme (WHO/UNHCR/UNFPA, 2009).

3.1 Interventions during the first five days after the assault (see Figure 2, page 15)

Recommendation 10

Offer first-line support to survivors of sexual assault by any perpetrator.

This includes:

- providing practical care and support, which responds to the woman's concerns, but does not intrude on her autonomy
- listening without pressuring her to respond or disclose information
- offering comfort and help to alleviate or reduce her anxiety
- offering information and helping her to connect to services and social supports.

Recommendation 11

Take a complete history, recording events to determine which interventions are appropriate, and conduct a complete physical examination, i.e. head-to-toe and including genitalia.³

The history should include:

- time since assault and type of assault
- risk of pregnancy
- risk of HIV and other STIs
- mental health status.

3.2 Emergency contraception

The following recommendations were made:

Recommendation 12

Offer emergency contraception to sexual assault survivors presenting within five days of sexual assault, ideally as soon as possible after the exposure, to maximize effectiveness.

Remarks

- (a) If used, emergency contraception should be initiated as soon as possible after the rape, as it is more effective if given within 3 days, although it can be given up to 5 days (120 hours).

³ See WHO, 2011

Recommendation 13

Health-care providers should offer levonorgestrel, if available. A single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart.

- If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available.
- If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine device (IUDs) may be offered to women seeking ongoing pregnancy prevention. Taking into account risk of STIs, the IUD may be inserted up to five days after sexual assault, for those who are medically eligible (see WHO (2010b), Medical eligibility criteria for contraceptive use).

Remarks

- (a) The GDG discussed some of the contraindications and side-effects of the drugs. Emergency contraceptive pills on the market are extremely safe and well tolerated and meet the criteria for over-the-counter provision.
- (b) Ulipristal acetate is a relatively new drug that appears to be as effective as, or more effective than, levonorgestrol. While the side-effect profile seems similar to that of levonorgestrol, it is not yet included in the WHO essential medicines list (WHO, 2011), although further evidence may change this. Levonorgestrel remains less expensive and is available in most settings.
- (c) The higher risk of STIs following rape should be considered if using a copper-bearing IUD. IUDs are an effective method of emergency contraception and should be made available to women seeking emergency contraception.
- (d) A pregnancy test is not required, but if one was done and the result was positive, emergency contraception would not be necessary or effective.

Recommendation 14

If a woman presents after the time required for emergency contraception (five days), emergency contraception fails, or the woman is pregnant as a result of rape, safe abortion should be offered, in accordance with national law.

Remarks

- (a) Where abortion is not permitted, other options such as adoption should be explored with the woman.

3.3 Post-exposure prophylaxis (PEP) for HIV

Sexual assault may be associated with the transmission of HIV. While the rate of sexual transmission of HIV is estimated at less than 0.01% per sexual contact, it is difficult to establish risk and there are characteristics of sexual assault (potential for tears, multiple perpetrators) that can increase this risk. Therefore, in settings with high HIV prevalence, there are strong ethical arguments to support the provision of PEP for HIV infection.

The following recommendations were made:

Recommendation 15

Consider offering HIV PEP for women presenting within 72 hours of sexual assault. Use shared decision-making with the survivor to determine whether HIV PEP is appropriate (see WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, (WHO, 2007).

Remarks

- (a) PEP should be initiated as soon as possible after the assault, ideally within a few hours and no later than 72 hours after the exposure.
- (b) In low-prevalence settings, policies on offering routine HIV PEP will need to consider the local context, resources and opportunity and other costs of offering it.

Recommendation 16

Discuss HIV risk to determine the use of PEP with the survivor, including:

- HIV prevalence in the geographic area
- limitations of PEP⁴
- perpetrator HIV status and characteristics, if known
- assault characteristics, including the number of perpetrators
- side-effects of the antiretroviral regime used in the PEP regimen
- likelihood of the HIV transmission.

⁴ In two cohort studies of HIV PEP, seroconversion rates ranged from 0% to 3.7%.

Recommendation 17

If HIV PEP is used:

- start regimen as soon as possible and before 72 hours
- provide HIV testing and counselling at the initial consultation
- ensure patient follow-up at regular intervals
- two-drug regimens (using a fixed dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side-effects
- the choice of drug and regimens should follow national guidance.

Remarks

- (a) The choice of PEP drugs should be based on the country's first-line antiretroviral regimen for HIV.

Recommendation 18

Adherence counselling should be an important element in PEP provision. Health-care providers should be aware that adherence is particularly difficult for survivors of sexual assault, as it can trigger painful thoughts of the rape.

Remarks

- (a) Many female survivors of sexual assault provided with HIV PEP do not successfully complete the preventive regimen because HIV PEP results in physical side-effects such as nausea and vomiting, may trigger painful thoughts of the rape, and may be overtaken by other issues in the lives of survivors. Health-care providers should be aware that adherence is very difficult to attain and efforts should be made to ensure that it is maintained. Currently, no effective intervention to promote adherence has been identified.

General remarks 3.3

- (a) It is important to determine the circumstances of the rape and whether HIV PEP is appropriate. The joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (WHO, 2007, p.52) recommend the following eligibility criteria for HIV PEP post sexual assault:
- rape (penetration) took place less than 72 hours ago
 - the HIV status of the perpetrator is positive or unknown
 - the exposed individual is not known to be HIV infected (need to offer HIV testing at time of consultation)

- defined risk of exposure, such as:
 - receptive vaginal or anal intercourse without a condom or with a condom that broke or slipped; or
 - contact between the perpetrator’s blood or ejaculation and mucous membrane or non-intact skin during the assault; or
 - recipient of oral sex with ejaculation; or
 - the person who was sexually assaulted was drugged or otherwise unconscious at a time of the alleged assault and is uncertain about the nature of the potential exposure; or
 - the person was gang-raped.
- (b) HIV testing is recommended prior to giving PEP but should not preclude PEP being offered. However, people with HIV infection, should not be given PEP and should be linked to care and provided with antiretroviral therapy.
- (c) Health policy-makers should consider whether to include routine offer of HIV PEP for post-rape care, based on local prevalence, and ethical and resource considerations.

3.4 Post-exposure prophylaxis (PEP) for STIs

The following recommendations were made:

Recommendation 19

Sexual assault survivors should be offered prophylaxis/presumptive treatment for STIs including chlamydia, gonorrhoea, trichomonas and syphilis depending on prevalence. The choice of drug and regimens should follow national guidance.

Recommendation 20

Hepatitis B vaccination without hepatitis B immune globulin should be offered as per national guidelines.

- Take blood for hepatitis B status prior to administering first vaccine dose.
- If immune, no further course of vaccination is required.

Remarks

- (a) Presumptive treatment is preferable to testing for STIs, in order to avoid unnecessary delays. Therefore, the GDG does not recommend testing prior to treatment.

3.5 Psychological/mental health interventions (see Figure 2)

Recommendation 21

Continue to offer support and care described in recommendation 10.

Recommendation 22

Provide written information on coping strategies for dealing with stress (with appropriate warnings about taking printed material home if an abusive partner is there).

Recommendations 23

Psychological debriefing should not be used.

General remarks 3.5

- (a) Consider the potential harms of psychotherapy (including CBT) when not administered properly to potentially vulnerable survivors. Informed consent and attention to safety is essential. A trained health-care provider with a good understanding of sexual violence should implement therapy.
- (b) Pre-existing mental health conditions should be considered when making an assessment and planning care and, where necessary, treatment or referral provided as per the WHO mhGAP Intervention guide (WHO, 2010a). Women with mental health and substance abuse problems may be at greater risk of rape than other women, so there is likely to be a disproportionate burden of pre-existing mental health and substance abuse problems among rape survivors. Similarly, pre-existing traumatic events (e.g. sexual abuse in childhood, intimate partner violence, war-related trauma, etc.) should be considered.
- (c) It is important to recognize that sexual assault is sometimes perpetrated by a person the woman lives with, other than her current or former partners. This may include other family members, such as a stepfather, in-law, friend of the family, or other.
- (d) Most women should have access to group or individual lay support, ideally based on the principles of Psychological first aid (WHO, 2011).

Figure 2. Psychological/mental health interventions
Interventions during the first 5 days after the assault:

Recommendations 10 and 21

Offer first-line support to survivors of sexual assault by any perpetrator.

This includes:

- providing practical care and support, which responds to her concerns, but does not intrude on her autonomy
- listening without pressuring her to respond or disclose information
- offering comfort and help to alleviate or reduce her anxiety
- offering information and helping her to connect to services and social support.

Recommendations 11

Take a complete history, recording events to determine which interventions are appropriate, and conduct a complete physical examination, i.e. head-to-toe and including genitalia.¹

The history should include:

- time since assault and type of assault
- risk of pregnancy
- risk of HIV and other (STIs)
- mental health status.

Recommendations 22

Provide written information on coping strategies for dealing with severe stress (with appropriate warnings about taking printed material home if an abusive partner is present).

Recommendations 23

Psychological debriefing should not be used.

Up to 3 months post trauma:

Continue to offer support and care described in recommendation 10

Is the person depressed? Does she have problems with alcohol or drug use or any psychotic symptoms? Is she suicidal or self-harming?

→
YES to one or more of these questions

Provide care in accordance with the *WHO MhGAP intervention guide, 2010a*

↓
NO to all questions

Does the person have difficulty functioning in day-to-day tasks?

→
YES

Recommendation 26

Arrange for cognitive behaviour therapy (CBT) or eye movement desensitization and reprocessing (EMDR). This should be provided by a health-care provider with a good understanding of sexual violence.

↓
NO

Recommendation 25

Apply "watchful waiting" for one to three months after the event. Watchful waiting involves explaining to the person that she is likely to improve over time and offering the option to come back for further support by making regular follow-up appointments.

From 3 months post trauma:

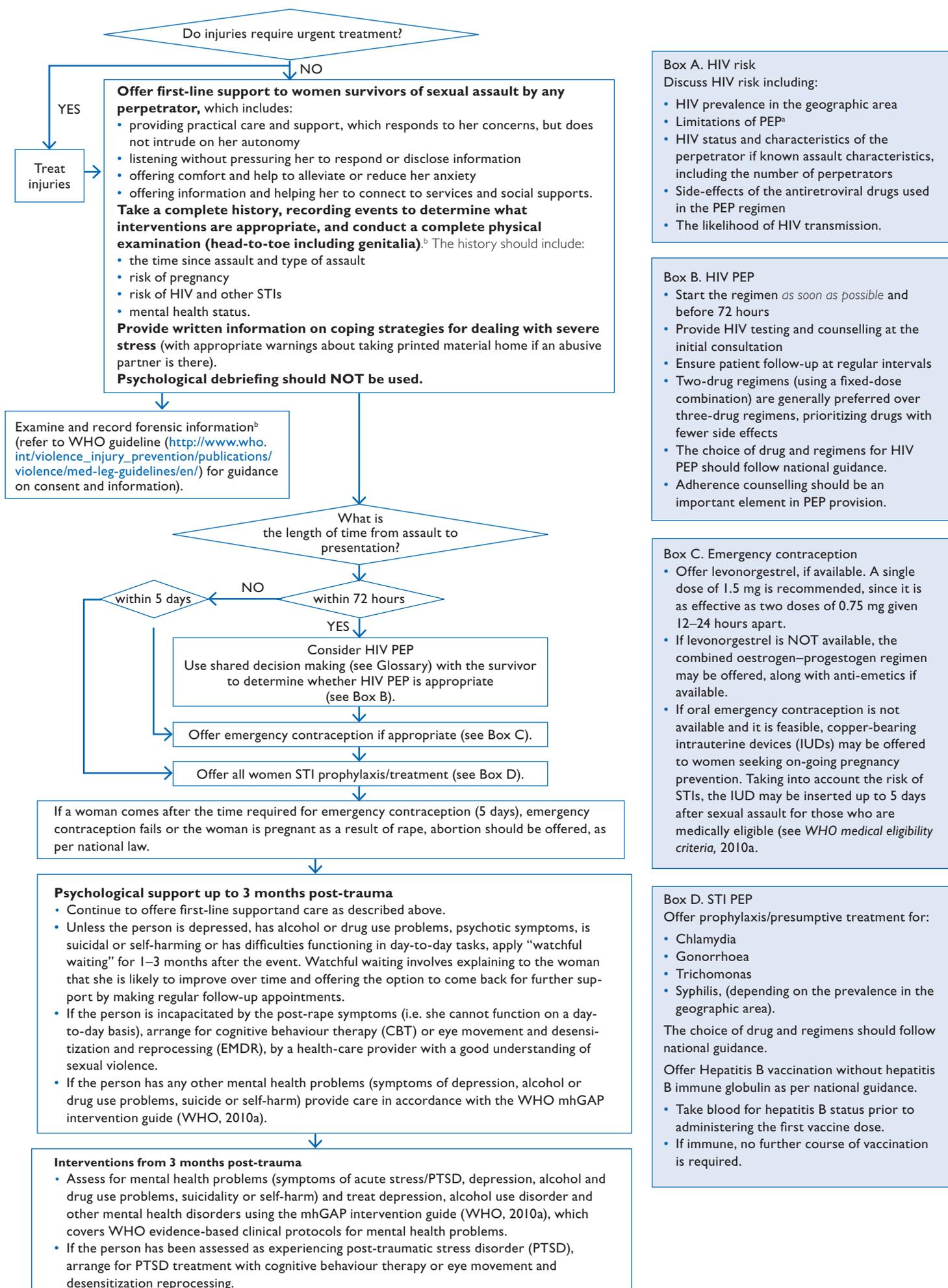
Recommendation 28

Assess for mental health problems. These include symptoms of acute stress/PTSD, depression, alcohol and drug use problems, suicidality or self-harm. Treat depression, alcohol use disorder and other mental health disorders using the *WHO MhGAP intervention guide, 2010a*.

Recommendation 29

If the person has been assessed as experiencing PTSD, arrange for PTSD treatment with CBT or EMDR).

Figure 3. Woman presents following sexual assault

**Box A. HIV risk**

Discuss HIV risk including:

- HIV prevalence in the geographic area
- Limitations of PEP^a
- HIV status and characteristics of the perpetrator if known assault characteristics, including the number of perpetrators
- Side-effects of the antiretroviral drugs used in the PEP regimen
- The likelihood of HIV transmission.

Box B. HIV PEP

- Start the regimen *as soon as possible* and before 72 hours
- Provide HIV testing and counselling at the initial consultation
- Ensure patient follow-up at regular intervals
- Two-drug regimens (using a fixed-dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side effects
- The choice of drug and regimens for HIV PEP should follow national guidance.
- Adherence counselling should be an important element in PEP provision.

Box C. Emergency contraception

- Offer levonorgestrel, if available. A single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart.
- If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available.
- If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking on-going pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (see WHO medical eligibility criteria, 2010a).

Box D. STI PEP

Offer prophylaxis/presumptive treatment for:

- Chlamydia
- Gonorrhoea
- Trichomonas
- Syphilis, (depending on the prevalence in the geographic area).

The choice of drug and regimens should follow national guidance.

Offer Hepatitis B vaccination without hepatitis B immune globulin as per national guidance.

- Take blood for hepatitis B status prior to administering the first vaccine dose.
- If immune, no further course of vaccination is required.

^a In two cohort studies of HIV PEP, seroconversion rates ranged from 0% to 3.7%.^b See WHO, 2003; WHO/UNHCR, 2004 and WHO/UNHCR/UNFPA, 2009.

4. Training for health-care providers

Recommendation 30

Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault should be given to health-care providers, in particular doctors, nurses, and midwives.

Remarks

- (a) The health-care provider may have experience of gender-based violence, as either a victim or a perpetrator. This needs to be addressed in training.

Recommendation 31

Health-care providers offering care to women should receive in-service training, ensuring it:

- enables them to provide first-line support (see recommendations 1 and x)
- teaches them appropriate skills, including when and how to enquire and the best way to respond to women (see Sections 2 and 3) and how to conduct forensic evidence collection where appropriate (refer to WHO, 2003, Guidelines for medico-legal care for victims of sexual violence and WHO/UNHCR e-learning 2009).
- addresses basic knowledge about violence, including laws, knowledge of existing services and support available locally and inappropriate attitudes among health-care providers

Remarks

- (a) Training should be intensive and content-appropriate to the context and setting.
- (b) Attention should be paid to self-care for providers, including the potential for vicarious trauma.

Recommendation 32

Training on intimate partner violence and sexual assault for health-care providers should include different aspects of the response to intimate partner violence and sexual assault (e.g., identification, safety assessment and planning, communication and clinical skills, documentation and provision of referral pathways).

Remarks

- (a) Intensive multidisciplinary training (e.g. involving different kinds of health-care providers and/or police and advocates) delivered by domestic violence advocates or support workers should be offered to health-care professionals where referrals to specialist domestic violence services are possible.

- (b) Using interactive techniques may be helpful.
- (c) Training should go beyond the providers and include system-level strategies (e.g. patient flows, reception area, incentives and support mechanisms), to enhance the quality of care and sustainability.

Recommendation 33

Training for both intimate partner violence and sexual assault should be integrated in the same programme, given the overlap between the two issues and the limited resources available for training health-care providers on these issues.

General remarks 4

- (a) Priority for training should be given to those most likely to come into contact with women survivors of intimate partner violence and/or sexual assault, for example health-care providers in antenatal care, family planning or gynaecologic services, and post-abortion care, mental health and HIV, as well as primary care providers and those in emergency services.
- (b) Training should include clinical examination and care for intimate partner violence and sexual assault, as well as attention to cultural competency, gender equality and human rights considerations.
- (c) Training should take place within the health-care setting, to promote attendance.
- (d) There should be reinforcement of initial training and the provision of continual support. Regular follow-up and quality supervision are extremely important.
- (e) A clear care pathway of management and referral, a designated and accessible worker specializing in (domestic) violence against women, and regular reminders (e.g. computer prompts) were shown in one study to be helpful in sustaining the benefits of training.

5. Health-care policy and provision

Recommendation 34

Care for women experiencing intimate partner violence and sexual assault should be integrated into existing health services rather than as a stand-alone service (see Box 3 below.)

Remarks

- a) A multicomponent programme including training of health-care providers to identify common injuries and clinical conditions commonly associated with intimate partner violence, how to provide first-line support is preferable. A clear referral pathway may also increase effectiveness. This training needs to be repeated regularly, in order to sustain the benefit (see section 2, Identification and care for survivors of intimate partner violence).
- (b) Offering vertical stand-alone services may be difficult to sustain and have potentially harmful effects. For instance, there might be a risk that a currently understaffed mental health service would be further weakened if it had to provide

Box 3	Minimum requirements for a health sector response to violence against women
Policies and protocols	Local policies and protocols defining roles and responsibilities, and procedures related to identification and management of survivors need to be developed and implemented (with appropriate training and continual support).
Management support/ Finance	Management backing, often with financial support, is important, especially for the long-term sustainability of the integration of violence against women issues.
Comprehensive care	Ensure the provision of all aspects of medico-legal care either by provider/linked providers in health services, or through the support of NGOs or community-based organizations (CBOs) or community efforts, in a way that minimizes the number of contacts required.
Links with CBOs/NGOs	Build relationships with local NGOs and community-based organizations (CBOs). (It should be noted that it is a state responsibility to ensure the provision of services, so this should not rely exclusively on NGOs and CBOs).
Intersectoral collaboration	Establish clear working protocols, including the referral pathway of survivors, between services offered by the same facility or by different sectors, and establish regular (monthly) meetings to ensure coordination.
Resource material	Ensure the availability of some resource material (posters, pocket cards and/or leaflets).
Surveillance and recording	Develop systems for maintaining records and conducting surveillance that are confidential and do not put women in any risk.
Monitoring and evaluation	Implement a system for monitoring and evaluation, based on local policy and procedures, including considerations related to safety.
Support for the carers	Provide support to those delivering care.

services specifically for victims of violence, rather than ensuring that all clients (including survivors of violence) get the best possible care.

- (c) Providing support and debriefing to the carers should also be part of the health-systems response, although this requires additional human resources. It is also important for the health services to meet regularly with other agencies such as police or social workers, to ensure that there is coordination and coherence across services and that referrals are working effectively.

Recommendation 35

A country needs multiple models of care for survivors of intimate partner violence and sexual assault at different levels of the health system. However, priority should be given to training and service delivery at the primary level of care.

Recommendation 36

A health-care provider who is trained in gender-sensitive sexual assault care and examination should be available at all times of day or night at a district/area level.

General remarks 5

- (a) Until there is further evidence of the effectiveness of different models, countries need to have multiple models to provide care, but evaluation should be promoted to identify what works best and is most cost effective in different settings.
- (b) One-stop centres, where appropriate, are best located within health services, where the priority for provision of services is women's health rather than being based on legal outcomes. They appear to be best suited for areas with high population density, whereas integrated services within or across health facilities may be more cost effective in rural areas.
- (c) Whichever model is used, it should aim to reduce the number of services and providers that a woman has to contact (and tell her story to), and facilitate access to services she may need, in a manner that respects her dignity and confidentiality and prioritizes her safety.
- (d) Violence against women is also a violation of a woman's human rights. Policies and laws need to be revised to ensure they do not discriminate against women and that they adequately penalize acts of violence, including those that take place within the home.

6. Mandatory reporting

Recommendation 37

Mandatory reporting of intimate partner violence by the health-care provider to the police is not recommended, however health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this, and is aware of her rights as well as the risks of reporting.

Recommendation 38

Child maltreatment and life-threatening incidents must be reported by the health-care provider to the relevant authorities where there is a legal requirement to do so.

Remarks

- (a) It is noted, however, that there is growing consensus that countries with mandatory child-reporting laws should allow children and families greater access to confidential services where they can receive support on a voluntary basis.
- (b) Furthermore, the usefulness of mandatory reporting is particularly questionable in situations where there is no functioning legal or child-protection system to act on a report.

Glossary

Advocacy: In the context of services for intimate partner violence, the meaning of the term “advocacy” varies within and between countries, depending on institutional settings and historical developments of the role of advocates. Broadly speaking, “advocates” engage with individual clients who are being abused, with the aim of supporting and empowering them and linking them to community services. In some health-care settings, “advocates” may also have a role in bringing about systemic change, catalysing increased recognition by clinicians of women experiencing abuse. In these guidelines, we define the core activities of advocacy as support that includes: provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; informal counselling; ongoing support; and provision of safety planning advice. In our recommendations, we have made a distinction between advocacy and psychological interventions, which reflects a relatively clear distinction in the research evidence, with the latter being based on explicit psychological methods or theories.

Case-finding or clinical enquiry: In the context of intimate partner violence, this refers to the identification of women experiencing violence who present to health-care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from “screening” or “routine enquiry”.

Crisis intervention services: These are services that offer specialist support, advocacy, counselling and information in confidence, in a safe and non-threatening environment.

Cognitive behavioural therapy (CBT): CBT is based on the concept that thoughts, rather than external factors such as people or events, are what dictate one’s feelings and behaviour. People may have unrealistic or distorted thoughts, which, if left unchecked, could lead to unhelpful behaviour. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts), as well as a behavioural component. CBT varies, depending on the specific mental health problems.

Cognitive behavioural therapy with a trauma focus: Cognitive-behavioural interventions that involve a focus on the traumatic event (e.g. through imagined or in vivo exposure treatment and/or direct challenging of maladaptive cognitions related to the event and its sequelae).

Empowerment: Helping women to feel more in control of their lives and able to take decisions about their future, as articulated in Dutton’s empowerment theory. Dutton notes that battered women are not “sick”, rather they are in a “sick situation” and responses need to demonstrate an understanding and take into account their differing needs for support, advocacy and healing. Empowerment is a key feature of advocacy interventions and of some psychological (brief counselling) interventions.

Eye movement desensitization reprocessing (EMDR): This therapy entails standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations, and (b) bilateral stimulation, most commonly in the form of repetitive eye movements. Unlike CBT with a trauma focus, EMDR therapy involves treatment that is conducted without detailed descriptions of the event, without direct challenging of beliefs, and without extended exposure.

First-line support: This refers to the minimum level of (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health-care (or other) provider. It shares many elements with what is being called “psychological first aid” in the context of emergency situations involving traumatic experiences.

Health-care provider: An individual or an organization that provides health-care services in a systematic way. An individual health-care provider may be a health-care professional, a community health worker, or any other person who is trained and knowledgeable in health. This can include lay health-care workers who have received some training to deliver care in their community. Organizations include hospitals, clinics, primary care centres and other service delivery points. In these guidelines, the term “health-care provider” usually refers to the primary care provider (nurse, midwife, doctor or other).

Intimate partner: A husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover.

Intimate partner violence: Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife/spouse battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting.

Mandatory reporting: Refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Psychological interventions: Formal counselling, psychotherapy or a range of different psychological techniques provided by a person trained in these interventions. These approaches are provided in sex- or non-sex-specific groups or couples, or on an individual basis. This can take many forms, one of the most common being therapies that are loosely catalogued as cognitive behavioural therapies or CBT. (See also CBT and EMDR.)

Sexual violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to, home and work.

Sexual assault: A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration.

Routine enquiry: Sometimes used to refer to investigating intimate partner violence without resorting to the public health criteria of a complete screening programme; it can also be used to denote a low threshold for women being routinely asked about abuse in a health-care setting, but not necessarily all women.

Screening (universal screening): Large-scale assessment of whole population groups, whereby no selection of population groups is made.

Shared decision-making: When clinicians and patients make decisions together using the best available evidence. In partnership with their clinicians, patients are encouraged to consider available options and the likely benefits and harms of each, to communicate their preferences, and help select the course of action that best fits these.

Shelter: Also known as a safe house or refuge, this is usually a place, often at a secret location, where women can flee from abusive partners. Usually run by a nongovernmental organization (NGO), it was the first social and political response to partner violence from the feminist movement in high-income countries in the 1970s. However, it can also refer to a church, community group, or other setting that provides a safe haven for women.

Support: For the purposes of these guidelines, "support" includes any or a combination of the following: the provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; and psychological interventions and provision of safety planning advice.

Vicarious trauma: Defined as the transformation of the health-care provider's inner experiences as a result of empathetic and/or repeated engagement with (sexual) violence survivors and their trauma material.

Violence against women: A broad umbrella term, defined by the United Nations as "any act of gender-based 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". It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

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