Gender-based Violence Treatment Protocol for Healthcare Providers in Afghanistan

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Ministry of Public Health
of the Islamic Republic of Afghanistan

World Health Organization Afghanistan Country Office

with the United Nations Entity for Gender Equality
and the Empowerment of Women (UN Women)

Kabul, Afghanistan
2014

Cover photo: Rada Akbar/UNFPA Afghanistan 2014

Contents

Abbreviations

ARV	Anti-retroviral
BHC	Basic Health Center
BPHS/EPHS	Basic package of health services / Essential package of hospital services
CEDAW	United Nations Convention on the Elimination of all Forms of Discrimination Against Women
CHC	Comprehensive Health Care Center
DH	District Hospital
DOWA	Department of Women's Affairs
ECP	Emergency contraceptive pill
GBV	Gender-based violence
GDG	Guideline Development Group of the World Health Organization
HBV	Hepatitis B virus
HIV	Human immuno-deficiency virus
HP	Health Post
ICRC	International Committee of the Red Cross
IASC	Inter-Agency Standing Committee
IMC	International Medical Corps
IUD	Inter-uterine device
LEVAW	Law on the Elimination of Violence against Women
mhGAP	WHO Mental Health Gap Action Programme
MSF	Médecins Sans Frontières
MoPH	Ministry of Public Health
MoWA	Ministry of Women's Affairs
NGO	Non-governmental organization
PEP	Post-exposure prophylaxis
PH	Provincial Hospital
PTSD	post-traumatic stress disorders
RH	Regional Hospital
SOP	Standard Operating Procedures
STI	Sexually transmitted infection
TIG	Tetanus immunoglobulin
TT	Tetanus toxoid
UNFPA	United Nations Fund for Population Assistance
UNHCR	United Nations High Commission for Refugees
VCT	Voluntary counseling and testing
WHO	World Health Organization

Acknowledgments

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Foreword

It is my pleasure to present the Gender-based Violence (GBV) Treatment Protocol for Health Care Providers in Afghanistan, jointly developed by the Ministry of Public Health (MoPH) and World Health Organization (WHO) with the support of UN Women. This Protocol is based on WHO global guidelines launched in 2013 and we are very proud that Afghanistan is the first country to adapt the Protocol to a country context.

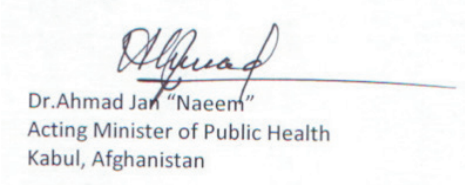
Gender-based violence is not only a major human rights violation but also a severe public health problem in our country. Violence damages women's health in many ways, some that are obvious and some that remain hidden. GBV includes sexual violence and rape, intimate partner violence, violence related to harmful traditional practices such as "honour" killings, child marriages and ba'd, the selling of women and girls to settle disputes. GBV can cause a wide range of physical and mental as well as sexual and reproductive health problems.

People who have been assaulted, abused and violated need proper care and support. Health care providers are often the first contacts GBV survivors speak to, making it absolutely essential for them to be able to recognize signs of GBV and respond safely and appropriately. This Protocol is therefore a much-needed intervention. It is a comprehensive tool and handbook for health practitioners containing detailed guidelines on administering quality care for GBV survivors.

Over the past several years, the MoPH has addressed gender disparities in health care and particularly the hardships women have faced in accessing health services. We remain committed to providing access to gender-sensitive health services to ensure healthy outcomes for the women and men of Afghanistan and to improving gender equity and equality within the health sector and society at large.

I would like to congratulate the Gender and Human Rights Directorate of MoPH and the World Health Organization for leading the development of this Protocol. Many vital partners and stakeholders in gender and health, including UN Women, UNFPA and several NGOs, have worked on developing and revising this Protocol and enriching it with their expert inputs. I would also like to take this opportunity to urge our partners to support this much-needed Protocol and to mobilize their resources to ensure harmonized and effective implementation of this crucial and novel endeavor for our country.

Sincerely,



Dr.Ahmad Jan "Naeem"
Acting Minister of Public Health
Kabul, Afghanistan

Message from the Ministry of Public Health Gender Directorate

This GBV Treatment Protocol for Healthcare Providers in Afghanistan has been developed with the technical and financial support of World Health Organization (WHO) and UN Women with the support of the technical team of the Ministry of Public Health (MoPH) Gender Directorate and other key stakeholders. I would like to extend the Gender Directorate's gratitude to the Policy and Planning Directorate of the MoPH for their support and inputs in the process of developing this Protocol. I would like to also take this opportunity to thank the MoPH Technical Advisory Group for enriching this document and providing valuable inputs.

This document is an essential tool for building the capacity of healthcare providers to enable them to provide better quality care to GBV survivors in Afghanistan. The Protocol will help to ensure that all survivors of GBV, regardless of their age, background or ethnicity, will be cared for in a proper and effective way when they enter a health facility. Health facilities are often the first entry points for GBV survivors – it is therefore crucial for healthcare providers to be skilled and well-equipped to administer care to survivors.

This Protocol highlights the importance of providing survivor-centered care with an empathetic attitude to those affected by GBV. The document includes sections on identifying GBV, taking medical history, maintaining confidentiality and privacy, and collecting medico-legal evidence. Sections focusing on clinical management of rape, burns and wounds are a critical part of this Protocol.

We hope that this Protocol will strengthen the capacity of healthcare providers to respond to GBV cases and improve the overall quality of care being offered at health facilities around the country. By improving the quality of care, we hope that more and more people suffering from GBV will be empowered and encouraged to seek care from skilled healthcare providers. With effective and timely implementation in all 34 provinces, we are confident that this Protocol will contribute to reducing morbidity and mortality while supporting women's human rights and gender equality across Afghanistan.

Sincerely,

Dr Hamrah Khan
Director, Gender Directorate of the Ministry of Public Health
The Islamic Republic of Afghanistan
October 2014

1. Introduction

Gender-based violence (GBV), particularly violence against women and girls (VAW/G), is widespread in Afghanistan and impacts all segments of Afghan society. Gender-based violence may take on different forms, including physical, mental and sexual violence, sexual exploitation, domestic violence as well as traditional harmful practices and is often condoned by and founded on deeply-entrenched norms that dictate a subservient status for women at the societal level.

In Afghanistan, some of the harmful practices identified as gender-based violence[1], may include, but not be limited to: forced marriage, child marriage, exchange marriage (Baadal), giving away girls to settle disputes (Baad), 'honor' killings, restriction on women's freedom of movement and denying the right to education, work and access to health services.

While women and girls are most likely to experience gender-based violence, men and boys, particularly adolescent boys, also experience gender-based violence through the traditional practice of sexual exploitation of adolescent males.

Although not exclusive to women and girls, the concluding observations on the combined initial and second periodic reports on CEDAW, the Committee expressed "deep concern at the high prevalence of violence against women in the State party, in particular domestic violence, rape, battery and laceration. It is also concerned at cases of stoning of women. The Committee is also "deeply concerned at the persistence of adverse cultural norms, practices and traditions which are harmful to women such as child marriage, *baad* (settlement of disputes by giving away girls), *badal* (exchange marriages), and forced marriages, including forced marriages of widows.

A desperate response adopted by many of those subjected to harmful traditional practices is the act of self-immolation, a truly tragic measure that is apparently rising in some parts of Afghanistan. 'Running away' or 'home escape' is another desperate remedy used by many female victims of gender-based violence, often resulting in the re-victimization of the woman/girl through a subsequent criminal charge of attempted adultery/adultery for which they risk imprisonment. Also raised by the CEDAW Committee as a response to harmful practices and violence against women and girls.

Incidents of violence and harmful practices in Afghanistan remain under-reported due to the subordinate role of women in the Afghan society, cultural beliefs and the victims' fear of retaliation by their family and of being stigmatized by their communities. There is concern about the sustainability of shelters for women victims of violence as well as about the need to increase their number.

Prevalence of GBV in Afghanistan

According to the 2013 annual report of the United Nations Assistance Mission in Afghanistan (UNAMA) and the United Nations High Commissioner for Human Rights[2], an estimated total of 1,669 incidents of violence against women were registered with the Department of Women's Affairs, police and prosecutors in the 16 concerned provinces. The report also highlighted that of those 1,669 registered incidents of violence against women, only 109 cases (seven percent) were processed by the formal justice system through the implementation of the Law on the Elimination of Violence Against Women (LEVAW). The crime of battery and laceration was the most prevalent form of violence against women among the registered cases documented in the said period.

The Global Rights' 2008 "National Report on Domestic Abuse in Afghanistan" reported that 87 percent of the women interviewed in 4,700 households in 16 provinces experienced at least one form of domestic violence and 62 percent experienced multiple forms of violence. Seventeen percent reported sexual violence (11 percent experienced rape), 52 percent were victims of physical violence, 59 percent were forced to marry and 74 percent were victims of psychological violence.

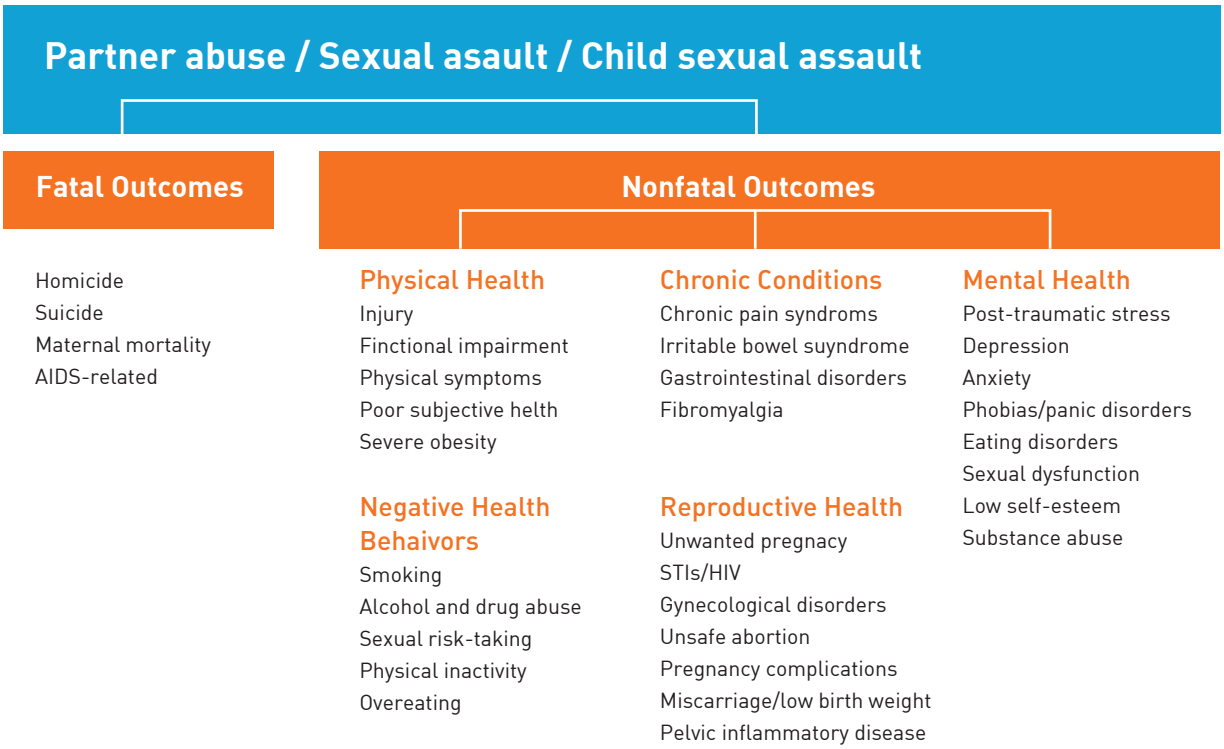
[1] UNAMA and OHCHR "Harmful Traditional Practices and Implementation of the Law on Elimination of Violence against Women", 2010
[2] UNAMA and OHCHR "A Way to Go: An Update on Implementation of the Law on Elimination of Violence against Women in Afghanistan", 2013

The Afghan Independent Human Rights Commission (AIHRC) reported that 4,154 cases of violence against women were registered by 1179 complainants at several AIHRC offices during the firsts six months of 2013. The majority of cases (1249 cases, 30 percent) were related to physical violence, 976 cases (24 percent) were related to verbal and psychological violence, 862 (21 percent) were forms of economic violence, 262 (6 percent) of cases were related to various forms of sexual violence and 805 cases (19.4%) were forms of other types of violence against women.

Consequences of GBV on health

Globally, violence against women, in particular physical and/or sexual violence by an intimate partner has been associated with a number of adverse health consequences[3]. Such violence may result in fatalities, including homicide, suicide, maternal mortality or aids-related death. It may lead to injuries, functional impairment, and other health effects such as headaches, back pain, abdominal pain, fibromyalgia, gastrointestinal disorders, limited mobility and poor overall health. It may also lead to unintended pregnancies, induced abortions, maternal health problems (miscarriage, still birth, low birth weight, prematurity), gynecological problems and sexually transmitted infections, including HIV. Such forms of violence may lead to depression, post-traumatic stress disorder, sleeping difficulties, eating disorders, emotional distress and suicide attempts. Sexual violence, particularly during childhood, may lead to misuse of drugs and alcohol, and to at-risk sexual behaviors in later life.

Figure 1: Health Outcomes of GBV[4]



[3] Prevalence and health effects of intimate partner violence and non-partner sexual violence, WHO, 2013
[4] Figure from the Center for Health and Gender Equity (CHANGE), as published in Heise L, Ellsberg M, Gottemoeller M (1999) Ending Violence Against Women. Population Reports, Volume XXVII, Number 4, Series L, Number 11

While the overall impact of GBV on the health of Afghans is unclear due to a marked lack of data, some general information is available. According to the Violence against Women Primary Database (VAWPD)[5] developed by UNIFEM in 2006, two percent of VAW cases result in the death of the victim, two percent in attempted suicide and 0.5 percent in suicide. The database includes recorded cases from the Department of Women's Affairs, UN agencies as well as the police, hospitals, provincial councils and women shuras, but does not provide a full account of actual cases of VAW around the country. Further research, to which the President's Adviser on Health Affairs contributed, indicated that around 2,300 Afghan girls and women commit suicide every year. The report of the VAWPD shows that 23 percent of VAW cases result in temporary physical injury and four percent in permanent physical injury.

For reproductive health related indicators, only general information is available. According to the Afghanistan Mortality Survey[6], maternal mortality stands at 327 per 100.000 births. In 2010, the President's Adviser on Health Affairs stated that 28 percent of women (around two million people) suffer from severe depression. Previous studies report higher rates of depression among women (58 percent[7], 73 percent[8] and 79 percent[9]). Two studies also mention the levels of anxiety (84 percent[10], 78 percent[11]) and PTSD (48 percent[12], 31 percent[13]). These mental health indicators are general. To date, no studies focusing on links between GBV and mental health have been undertaken in Afghanistan.

Background of the GBV treatment protocol

As a commitment under the Memorandum of Understanding (MoU) signed in January 2013[14] by UN Women, WHO and UNFPA, the Gender-Based Violence Treatment Protocol For Primary Health Care in Afghanistan is developed in order for the UN system to provide coordinated support to the Government of Afghanistan, including all relevant national ministries (the MoPH, MoWA, MoI and MoJ) and departments, to strengthen the overall capacity for the delivery of a multi-sectorial response to GBV in Afghanistan, particularly with regard to the prevention, response and management of GBV cases.

In 2012, UNFPA conducted an assessment of services provided to GBV-survivors by state and non-state agencies in pilot areas of three provinces[15]. The assessment showed that most service providers did not have units responsible for addressing the needs of GBV-survivors, that they lacked necessary policies, standard operating procedures and ethical safety guidelines and that the staff lacked specialized knowledge and skills to respond to GBV survivors. Especially the lack of female professionals had a negative effect on the GBV response of public agencies (health care, police and prosecutor). The services provided were not promoted among target population and no easy and fast access was provided to relevant services. The Assessment also found that healthcare facilities in rural and urban areas were often the only chance for GBV victims to seek assistance, although their ability to respond was seriously undermined by the staff's vulnerability to pressure from family members and local communities. Secondary and tertiary health facilities showed to be less affected by these societal pressures. In all locations healthcare facilities, MoWA offices and AIHRC offices served as entry points for GBV survivors, while police departments served as entry points in some locations. The assessment also showed weak communication and coordination between the agencies, resulting in problems in the referral system.

[5] UN Development Fund for Women (UNIFEM), Violence Against Women Primary Database Report, March 2008
[6] Mortality Survey 2010 , Afghan Public Health Institute, Afghan Ministry of Public Health, Afghan Central Statistics Organization, ICF Macro Calverton, Indian Institute of Health Management Research Jaipur, World Health Organization/EMR
[7] Scholte, W.F., Olff, M. Ventevogel, P., de Vries, G.J., Jansveld, E., Lopes Cardozo, B., Gotway, C. (2004). Mental health problems following war and repression in Eastern Afghanistan. JAMA 2004; 292:585-93
[8] Lopes Cardozo B, Bilukha OO, Crawford CA, Shaikh I, Wolfe MI, Gerber ML, Anderson M. Mental health, social functioning, and disability in postwar Afghanistan. JAMA 2004; 292:575-84.
[9] CARE. A survey among widows attending a humanatarian assistance programme. Kabul, CARE International/IRC 2004
[10] Lopes Cardozo B, Bilukha OO, Crawford CA, Shaikh I, Wolfe MI, Gerber ML, Anderson M. Mental health, social functioning, and disability in postwar Afghanistan. JAMA 2004; 292:575-84.
[11] Scholte, W.F., Olff, M. Ventevogel, P., de Vries, G.J., Jansveld, E., Lopes Cardozo, B., Gotway, C. (2004). Mental health problems following war and repression in Eastern Afghanistan. JAMA 2004; 292:585-93
[12] Lopes Cardozo B, Bilukha OO, Crawford CA, Shaikh I, Wolfe MI, Gerber ML, Anderson M. Mental health, social functioning, and disability in postwar Afghanistan. JAMA 2004; 292:575-84
[13] Scholte, W.F., Olff, M. Ventevogel, P., de Vries, G.J., Jansveld, E., Lopes Cardozo, B., Gotway, C. (2004). Mental health problems following war and repression in Eastern Afghanistan. JAMA 2004; 292:585-93
[14] Expiration of MoU 14 January 2014.
[15] The Assessment of Services Provided to Victims of Gender Based Violence (GBV) by State and Non-state Agencies in Pilot Areas, UNFPA, 2012

In mid-2013, a Knowledge, Attitudes and Practices study (KAP) of health personnel was conducted by Youth, Health and Development Organization (YHDO) and UN Women in six provinces[16]. The purpose of study was to acquire a better understanding of health care provider knowledge, capacity, and case management of GBV. Moreover the objective was to identify capacity gaps, map available treatment and health services for GBV survivors and gain knowledge of any existing systems for referral of GBV survivors and for case management. It is also anticipated that the KAP study would assist to inform the development of high quality health services and case management systems as a response to GVB.

According to the results of the study in which 548 health care providers were interviewed, an average of 22 GBV survivors had visited the health facility during the month prior to investigation (77 percent were victims of physical violence, 83 percent of emotional violence and 29 percent of sexual violence). Half of the respondents were well-informed about the health consequences of GBV. Slightly more than half of the respondents claimed to have informed and consulted their patients on the possibility of being a victim of GBV, but highlighted that several barriers to a proper consultation existed, such as time limitations, lack of space in the clinic to ensure privacy, little or no service facility for GBV victims in the facility, greater emphasis on other health issues, fear of police proceedings, lack of training to handle such issues, and a lack of referral facility in the province for GBV victims. Although most respondents felt that it is appropriate for health care providers to ask the patients questions regarding GBV, half of them expressed a view that they are uncomfortable when exploring such issues and the majority believe that women are themselves to blame for the occurrence of GBV. Further, the majority of respondents stated that they were capable of identifying GBV survivors and the subsequent care offered included listening, psychological support and for a minority, documentation of the case. Approximately 20 percent did not offer health care services. The majority stated a need for capacity building and increased knowledge on GBV issues, on indicators of GBV, on GBV interview and consultation techniques, on clinical examination and on the provision of services to victims. Approximately 30 percent of respondents also mentioned that visual privacy was not available at their health facility and a majority reported an absence of protocols and files to record and manage cases.

To ensure that health care providers and first responders in Afghanistan have the necessary knowledge and skills to provide appropriate care for GBV victims and refer cases of GBV to provide health, psycho-social, protection or legal services, an entire strategy should be developed, followed by a strategy and program for awareness raising and sensitizations, capacity building of medical personnel and first responders, advocacy for adaptation of BPHS and EPHS to include GBV care, development of a national treatment protocol in line with e.g. National Action Plans for Health and NAPWA, including training and supervision, establishment of integrated multi-sectorial system, funding mechanism and monitoring and evaluation.

Objective of the protocol

The overall objective of the protocol is to improve the quality of care offered to GBV-survivors.

Target population of the protocol

This protocol is intended to be most useful for:

- Health care providers: The protocol intents to offer detailed guidance and practical tools for the management of GBV survivors.
- Health managers: The protocol gives an overview of the basic package of care to GBV-survivors and gives some basic outlines on the organization of GBV-care into a primary health facility.
- Health facilities linked to the MoPH, to NGOs and to the private health sector. The protocol aims at giving basic recommendations and tools for the GBV care and can therefore be used in both public and private health care sector.

Users of this protocol are encouraged to consult also the Standard Operating Procedures for Healthcare Sector response to Gender-Based Violence, developed by the Ministry of Public Health[17] and the directory of organizations offering care to GBV survivors.

[16] Balkh, Badakhshan, Bamyan, Herat, Nangarhar, Parwan
[17] Standard Operating Procedures for Healthcare Sector response to Gender-Based Violence, MoPH, 2013

2. Definitions

Gender-Based Violence:

The IASC Guidelines[18] on "Gender-based Violence Interventions in Humanitarian Settings" (2005) describe GBV as *"an umbrella term for any harmful act that is perpetrated against a person's will, and that is based on socially ascribed (gender) differences between males and females"* (p. 7).

Globally, GBV has a greater impact on women and girls than on men and boys. The term "gender-based violence" is often used interchangeably with the term "violence against women." The term "gender-based violence" highlights the gender dimension of such acts of violence; in other words, the relationship between a female's subordinate status in society and her increased vulnerability to violence. It is important to note, however, that boys and some men may also be victims sexual violence.

The nature and extent of specific types of GBV varies across cultures, countries, and regions. In Afghanistan gender-based violence includes:

- Sexual violence, including sexual exploitation/abuse and forced prostitution
- Domestic violence
- Trafficking
- Forced/early marriage
- Honor killings

Harmful traditional practices, such as widow inheritance and others may also increase the risk of gender-based violence.

According to the Law on the Elimination of Violence against Women[19] (LEVAW) in Afghanistan the following acts shall be deemed as violence against women:

1. Sexual assault;
2. Forced prostitution;
3. Recording the identity of the victim and publishing it in a way that damages her personality;
4. Burning, using chemicals or other dangerous substances;
5. Forcing one to burn herself or to commit suicide or using poison or other dangerous substances;
6. Causing injury or disability;
7. Beating;
8. Selling and buying women for the purpose of or on the pretext of marriage;
9. Giving *Baad*;
10. Forced marriage;
11. Prohibiting from the right of marriage or right to choose spouse;
12. Underage marriage;
13. Abusing, humiliating, intimidating;
14. Harassment/persecution;
15. Forced isolation;
16. Forced addiction;
17. Depriving from inheritance;
18. Prohibiting to access personal property;
19. Prohibiting from the right to education, work and access to health services;
20. Forced labor;
21. Marrying more than one wife without observing Article 86 of Civil Code; and
22. Denial of relationship.

[18] Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, Inter-Agency Standing Committee, 2005

[19] Law on Elimination of Violence against Women (EVAW), MINISTRY OF JUSTICE, ISLAMIC REPUPLIC OF AFGHANISTAN, 2009

At present there are no clear statutory definitions to define at law the various GBV concepts listed above.

To ensure consistency in the understanding of the different forms of gender-based violence by health care professionals in Afghanistan, the following WHO definitions will be used.

1. **Sexual violence: According to WHO sexual violence is 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.**

2. **Sexual assault: A sub-category of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape. See definition below.**

1. Rape

According to the Rome Statute ratified by Afghanistan, rape can be defined[20]:

1. The perpetrator invaded the body of a person by conduct resulting in penetration, however slight, of any part of the body of the victim or of the perpetrator with a sexual organ, or of the anal or genital opening of the victim with any object or any other part of the body.

2. The invasion was committed by force, or by threat of force or coercion, such as that caused by fear of violence, duress, detention, psychological oppression or abuse of power, against such person or another person, or by taking advantage of a coercive environment, or the invasion was committed against a person incapable of giving genuine consent.

2. Sexual Assault

Sexual assault 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 vulva or anus with the penis, other body part or object through the legal definition of rape may vary and in some cases may also include oral penetration.

3. Physical assault

Physical assault[21] involves intentionally using or threatening to use physical force, strength, or a weapon to harm or injure the woman. *Examples include: hitting, slapping, choking, cutting, shoving, burning, shooting or use of any weapons, acid attacks or any other act that results in pain, discomfort or injury.*

4. Forced marriage

Forced marriage is defined as the marriage of an individual against her or his will. Apart from being a form of violence, forced marriage can further increase the risks of physical, sexual and psychological abuse.

5. Psychological/emotional abuse

Psychological or emotional abuse are defined as infliction of mental or emotional pain or injury. *Examples include: threats of physical or sexual violence, intimidation, humiliation, forced isolation, stalking, verbal harassment, unwanted attention, remarks, gestures or written words of a sexual and/or menacing nature, destruction of cherished things, etc.*

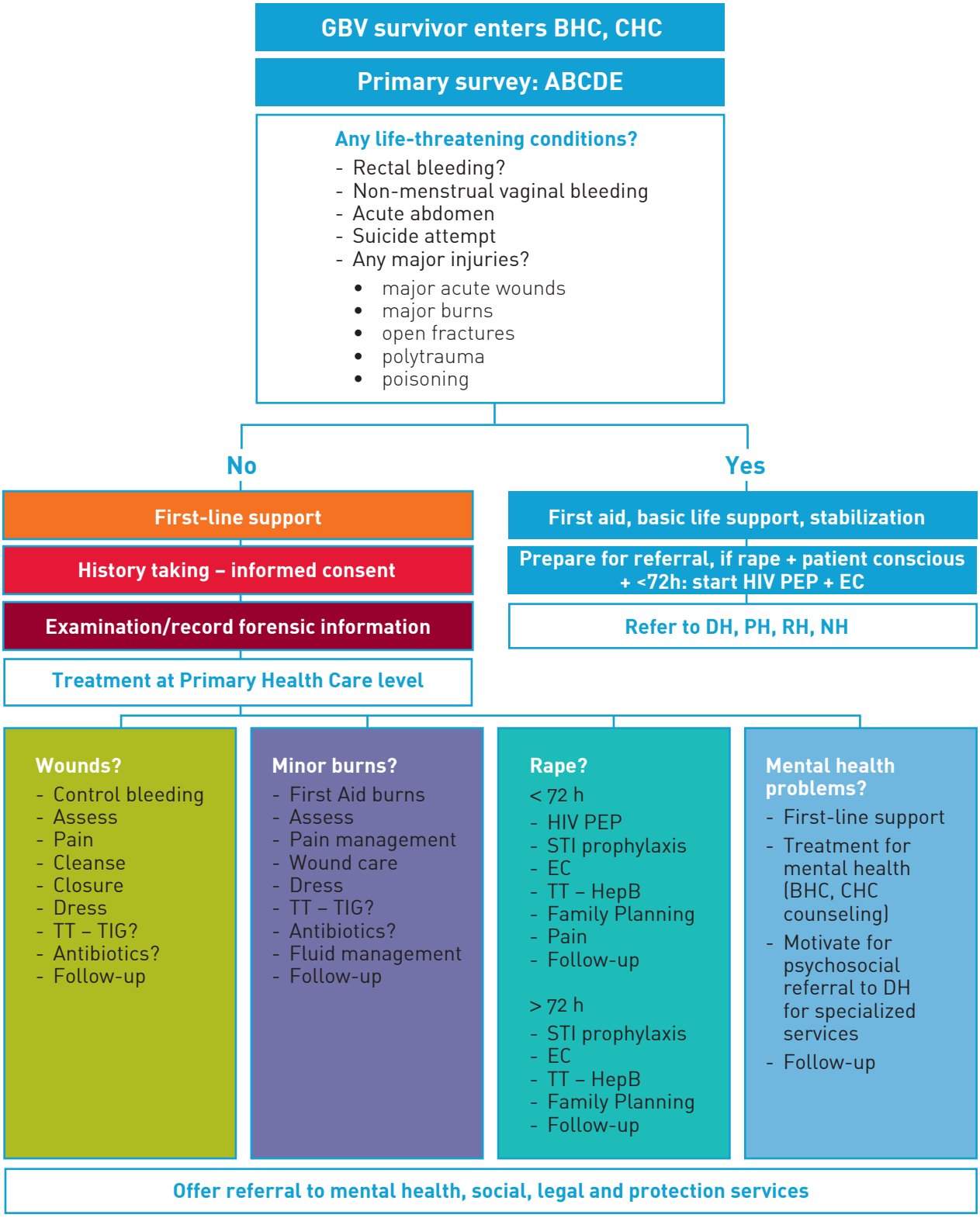
[20] The Elements of Crimes are reproduced from the Official Records of the Assembly of States Parties to the Rome Statute of the International Criminal Court, First session, New York, 3-10 September 2002 (United Nations publication, Sales No. E.03.V.2 and corrigendum), part II.B.
[21] Standard Operating Procedures for Healthcare Sector response to Gender-Based Violence, MoPH, 2013

Overview table:

	Category	Examples	Possible care offered
1	**Sexual assault**	Rape, including gang rape	Rape management First-line support Referral mental health support
2	**Sexual violence**	Sexual assault including rape Unwanted sexual comments or advances Acts to traffic	First-line support Referral for mental health support
3	**Physical assault**	Beating Kicking Biting Hair pulling Strangling Causing injury Causing disability Burning	First-line support Wound management Burn management Referral to next level of care Referral Mental health support
4	**Forced marriage**	Selling/buying women for marriage Giving *baad* Forced marriage Under-aged marriage	Referral to women's organization and other services for such cases
5	**Psychological / emotional abuse**	Verbal abusing / humiliating / intimidating Harassment / persecution Forcing to burn Forcing to suicide Forcing to use poison	First-line support Wound management Burn management Referral to next level of care Referral mental health support

3. Summary of Care for GBV Survivors

Algorithm care pathway GBV:



4. General Considerations for the Care of GBV Survivors

Priorities

According to WHO[22], when caring for GBV survivors, the overriding priority must always be the health and welfare of the patient. The provision of medico-legal services thus assumes secondary importance to that of general health care services (i.e. the treatment of injuries, assessment and management of pregnancy and sexually transmitted infections (STIs)). Performing a forensic examination without first addressing the primary health care needs of patients may be considered a negligent practice.

Concern for the welfare of the patient extends to ensuring that the dignity of patients is respected following an assault which in itself likely caused them to feel humiliated and degraded. In addition, medical and forensic services should be offered in such a way as to minimize the number of invasive physical examinations and interviews the patient is required to undergo.

Management of rape is in general considered as a medical emergency.

Legal framework

The rights of a survivor

The LEVAW stipulates in Article 6 that *"the victims of violence have the following rights:*

- *Prosecuting the offenders of violence based on provisions of the law;*
- *Having access to shelter or other safe place(s) with the consent of the victim;*
- *Having free access to emergency health services;*
- *Having an advocate or legal aid provider;*
- *Compensation to damage resulted from the act of violence;*
- *Confidentiality of relevant matter; and*
- *Other rights which have been stipulated in the legislative documents for the victim".*

Reporting

According to the LEVAW, **it is at the sole discretion of the survivor or her relatives to instigate formal criminal justice processes**. Paragraph 1 of Article 7 of the LEVAW on '*Referring to the Institutions*' states that "*(t)he victim of violence, by herself or her relatives, may complain in writing to police, Huqooq Department, courts and other relevant authorities*".

Mandatory reporting laws for GBV do not exist in Afghanistan and this approach is in line with relevant WHO recommendations[23] relating to principles of confidentiality and security for both patient and health care provider. Consequently, health care providers are NOT obliged to report matters of GBV to the police or any other competent authority.

Further, even if the victim of GBV is a child, no mandatory reporting is required by Afghan law.

Legal requirements with regard to forensic evidence

Women who experience sexual assault may need to undergo a medical examination for the purposes of documenting injuries, gathering medico-legal evidence and to provide treatment and care as appropriate. Prior to conducting such examinations, women need to be fully informed regarding the purpose, how the examination will be conducted, and about the confidentiality of the information collected. It is possible that women who are subjected to sexual

[22] Guidelines for medico-legal care for victims of sexual violence, WHO, 2003
[23] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, 2013

assault are accused of moral crimes. These women are routinely required to undergo medical examinations to determine whether she is a virgin and whether she recently/previously engaged in penetrative sexual activity. Such examinations have no scientific validity in determining "virginity" or sexual history[24]. The use of such examinations for these purposes is a violation of international human right standards and principles[25].

When an examination is performed in the context of a sexual assault case, it should not be with the aim of obtaining any information about the victim's virginity or sexual history.

Women need to be fully informed regarding the purpose of the medical examination and how the examination will be conducted and should give informed consent. Consent should be obtained separately for each part of the examination and women can refuse to consent for any specific part of the examination that they are not comfortable with. Even where women do not consent, treatment and care for injuries and for other health consequences need to be provided.

Procedure

According to Article 32 of the Interim Criminal Code for Courts, the judicial police are entitled to request the assistance of experts for performing activities which require special professional qualification in case of flagrante delicto[26] and whenever there are grounded reasons to believe that urgent action is needed. The judicial police must submit any subsequent report to the Primary Saranwal (prosecutor) who may either accept or disallow same. If the report is accepted by the Primary Saranwal, then in accordance with the provisions of Article 7 of the aforementioned code, a further investigation will begin and expert reports and evaluations may be submitted as relevant evidence. In the event that an indictment is drafted and the matter is submitted for trial, the expert author of any report tendered in evidence, following receipt of statutory notice, is obliged at law to give oral evidence of his findings to the Court.

Health care providers

All staff of the health facility should be sensitized about the health consequences of GBV and trained to identify and refer GBV survivors while ensuring confidentiality and respect, respond to survivors in a non-stigmatized way and provide clinical care according to the guiding principles set out by the Standard Operating Procedures for Healthcare sector response to Gender-Based violence[27]. It is critical that the training address health care providers' attitudes towards GBV and towards survivors.

Several health care providers should be identified as GBV focal points and trained to offer quality care to GBV survivors.

Ideally, the doctor should be of the same sex as the survivor. If no female doctor is available, clinicians (midwives or nurses) should consult with female patients and perform any physical/genital examination as necessary.

Setting

Generally, the provision of care for survivors of GBV should be organized at the different structures (BHC, CHC and DH) at the BPHS level. Although medical attention can be provided to GBV survivors by all services, it is preferable to integrate the care for GBV survivors into Out Patient Department (OPD), Reproductive Health (RH) and emergency care services.

[24] Fact sheet: Use of Virginity Examinations, Human Rights Watch.
[25] Art 7 of ICCPR, HRC Committee, General Comment 20. See also Art 16 and 24 of CRC.
[26] A legal term used to indicate that a criminal has been caught in the act of committing an offence
[27] Standard Operating Procedures for Healthcare Sector Response to Gender-Based Violence, Ministry of Public Health Afghanistan, 2013

Regardless of the service, the consultation room used for the care for GBV survivors should ensure confidentiality and privacy (a door which closes, curtains in front of the windows, auditory privacy, etc.). If possible, a division (with a screen, curtain) should be made in the room so that the place where the reception and interview take place are separate from the location of the medical examination.

The consultation room (rooms) used to offer care to GBV survivors must not be identifiable as such and must not 'only' be used for the care of GBV survivors, in order to avoid stigmatization or possible reprisals.

The management of survivors of rape (reception, history-taking, examination, treatment) should be provided in the same location, at the same time and by the same health care provider. At the level of the DH, any medico-legal and health services should be provided simultaneously.

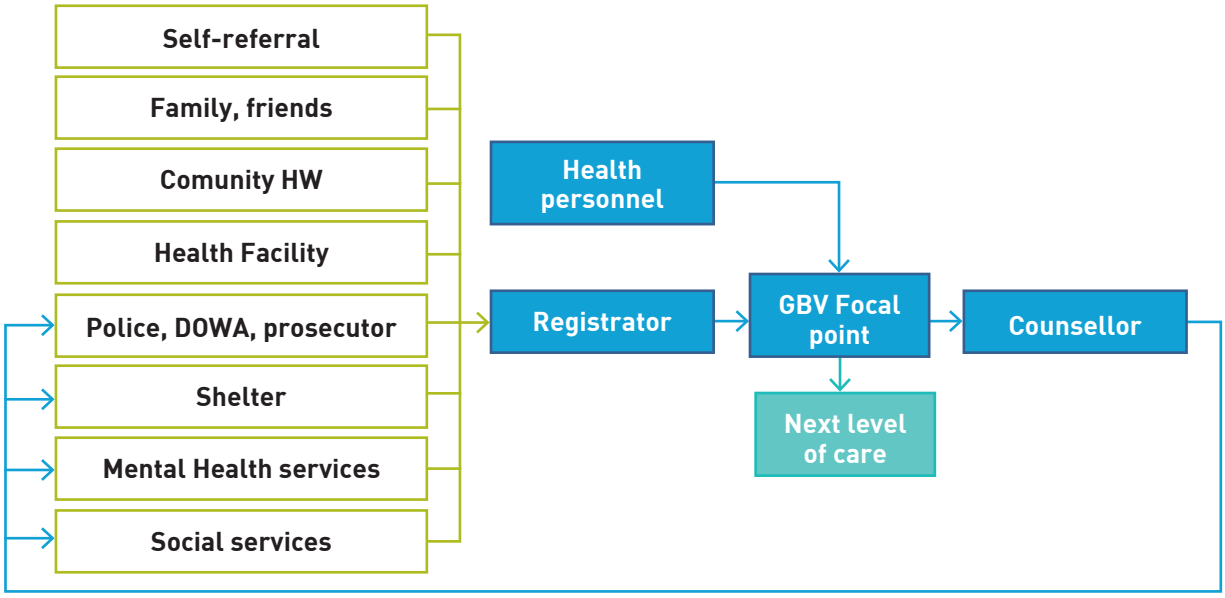
If possible, provide for the patient's need to wash and change clothes after the examination. Also if possible, provide latrines reserved for women close to the place of consultation.

Organization of patient-flow

When organizing care for GBV survivors, special attention should be given to the development of adequate patient-flows in order to uphold confidentiality and privacy. To avoid stigmatization of patients, a complete care package should be offered in a single consultation room and this room should not be identifiable as such. Moreover, the patient-flow should permit priority access for survivors of sexual assault, whilst mitigating the possibility of exposing them as such.

All personnel of the health facility should be informed on patient-flow principles for GBV survivors and on the ethical obligation to respect a patient's right to confidentiality. Further, community-workers should be trained on GBV in order to raise awareness of current patient-flow practices, including priority for survivors of sexual assault.

Figure 4-1: GBV survivor flow to, within and from health facility.



Confidentiality[28]

Confidentiality is one of the fundamental principles of medical ethics and is defined as *"the ethical principle or legal right that a physician or other health professional will hold secret all information relating to a patient, unless the patient gives consent permitting disclosure."* [29]

As stated in the LEVAW (see chapter 2) confidentiality is the legal right of a victim. Maintaining a strict level of confidentiality may protect the survivor from further threats and/or violence possibly caused by the very act of seeking assistance and may also protect health care providers from the perpetrators of the said violence or other family members.

Shared confidentiality within the health service means that some patient information may be shared with other medical colleagues on a "need to know basis" only. Information may be shared with colleagues if medically justified; i.e. the survivor is being referred to another health care provider such as a medical specialist or a counselor. Relevant matters should be explained to the survivor beforehand in order to ensure that she understands the process, including the type of information to be shared and with whom. If appropriate, consent to the process may also be obtained from the survivor at this time.

Patient information handling

Use: The information is used as a tool to inform health care providers on the appropriate medical treatment for the survivor. It may also be used in conjunction with the entire records of other survivors, (excluding identifying information) in order to obtain statistics on reported instances of GBV (including incidence, prevalence, type etc). Only those directly involved in the care of the survivor require the necessary information for the proper conduct of their role. Any other sharing of information should only take place with the consent of the survivor (unless viable exceptions to this rule exist – see below).

Store: All documents related to survivors of GBV must be kept separately in a locked, secured cupboard, drawer or file box. Access to same should be strictly limited to those directly involved in the care of survivors (for example, the health care provider or the counselor).

Share: Information on a survivor may be shared with other organizations or persons only with the consent of the survivor. The purpose of sharing information should be to facilitate protective measures and access to justice for the survivor. Information must be protected in accordance with the survivor's wishes. If the survivor does not consent to the sharing of information, then only de-identified information may be released to outside organizations.

De-identified data: Data that cannot be linked to a specific individual or group; all personal identifiers (name, address, location and date of incident) are removed. Other details may need to be removed depending on the circumstances (e.g. if there are only a small number of women in any given age group in a certain area, age could be an identifier).

[28] Adapted from 'Caring for Survivors of Sexual Violence in Emergencies', Training Pack, IASC Gender SWG/GBV AoR, 2010
[29] Editors of the American Heritage Dictionary, The American Heritage® Medical Dictionary. 2007, 2004, Houghton Mifflin Company.

Limits of confidentiality

Certain circumstances do exist however, where survivor/health care provider confidentiality may be ethically disregarded: life-threatening situations (when a person is a threat to her/himself or others) and suspected abuse or neglect of a child.

- If someone is suicidal, a duty exists to warn/contact a referral source or relative.
- If someone is a threat to another person(s), a duty exists to warn/contact the police.
- While many countries have mandatory reporting requirements in the case of suspected child abuse, a health care provider must always first consider the best interests of the child when considering a breach of confidentiality. There may be circumstances where reporting suspicions result in the subsequent protection of a child, but there also may be instances where the act of reporting puts a child survivor at further risk, especially in circumstances where there are no child protection services available.

Security

When organizing care for survivors of GBV it is crucial to revise and adjust or if necessary develop and implement security policies and procedures to ensure both the security of the survivors and the staff of the health facility. A risk assessment should be made involving all stakeholders (management, security guards and health staff) followed by the identification of different scenarios on what to do to prevent and what to do when something goes wrong. All staff needs to be informed and trained on the security procedures developed (how to take responsibility, how to be vigilant, how to ask questions, what to do in case of threat or suspicious event, who to call and to whom to report any and all threats or suspicious events).

Although all staff members have a role to play, it is up to the management of the health facility to develop the general framework and procedures to ensure security in the health facility.

Respecting confidentiality is an important measure to ensure the security of both the survivor and the health care provider. Privacy during the consultation (identification and clinical management) and confidentiality of data collection, record keeping, reporting and information sharing will decrease the potential for exposure of both patient and health care providers.

At the beginning of each consultation and before inquiring about GBV, each healthcare provider should make a quick security check for risks or imminent threats of harm (e.g. from violent husbands, family members) to both the patient and/or staff-members.

In the event that a health care provider feels uncomfortable or at risk, a referral may be made to another health care provider within the same health care facility or to the next level of care. Referral to the next level of care may only be made when the referral is considered feasible in all the circumstances and safe for the patient. Health care providers at the secondary health-level may be less exposed to threats from family, community or police. In case of direct threat, security procedures should be followed and security guards may need to alerted.

Any threats or acts of violence against health care providers must be reported to management and documented so that appropriate measures might be taken to guarantee the safety of all staff members.

When a patient has been identified as a survivor of GBV, an evaluation of potential risk to the safety of the survivor should be carried out, which is an essential step in the first-line support (as will be elaborated in chapter 8). This risk assessment is a participatory process, in which the health provider guides the survivor to estimate the immediate and future risks and identify the available resources. According to the needs, the health care provider can propose possibilities for referral and help the survivor develop an individual safety plan.

Provision of rape treatment kits

To facilitate the care for survivors of rape a 'rape'-treatment-kit could be prepared, containing all the necessary supplies to ensure the management of the instant consequences of rape. These kits should be available (together with the forms, files and material) in the consultation room that would be used to offer the complete package of care for rape survivors.

According to the protocol mentioned in chapter 10, two types of kits should be prepared, one kit for the survivors arriving within the first 72 hours after the assault and one kit for the survivors arriving after 72 hours after the assault.

The kit for survivors presenting within the first 72 hours after the incident should include: HIV PEP, presumptive treatment for STIs, emergency contraception, pregnancy test, HIV tests, hepatitis B and TT vaccines.

The kit for survivors presenting after 72 hours after the incident should include: presumptive treatment for STI's, emergency contraception, pregnancy test, HIV tests, hepatitis B and TT vaccines.

These kits need to be available for adults and children. Moreover a kit could be prepared with the different available methods of family planning.

The vaccines should be stored in a cool box when brought to the consultation room.

Documentation and reporting[30]

In general health workers are professionally obliged to record in writing the details of any consultation with a patient. In the case of GBV, health care providers need to explain what information will be recorded and why. If on the other hand, the survivor prefers that some information will not be recorded, then this wish should be followed unless it is absolutely necessary for the provision of care.

As medical records may be used in court as evidence, the recording of accurate and complete notes during the course of an examination is critical.

- Complete the patient-file for every patient.
- Document all aspects of the consultation, including consents given; medical history; account of the abuse; outcome of the physical examination; samples taken; tests and their results; treatments and medications prescribed; and schedule of follow-up care and referrals.
- For the purpose of accuracy, make all notes during, rather than after, the course of the consultation.
- Ensure that any assessment is impartial and represents a balanced recording of the findings. It is not the role of the health care provider to make any interpretations about whether or not the GBV took place. The health care provider should limit her/himself to documenting the findings
- No document (except the medical certificate) should include the victim's name – use codes.

[30] Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

Storage and access to records

Patient records and other supporting information are strictly confidential. All health care providers are professionally, legally and ethically obliged to maintain and respect patient confidentiality and autonomy. Records and information should not be disclosed to anyone except those directly involved in the case or as required by law[31].

All patient records (and any specimens) should be stored in a safe place. Biological evidence normally should be refrigerated or frozen; check with a laboratory regarding the specific storage requirements for biological specimens.

No information or document may be disclosed without the victim's consent and without the authorization of the director of the health structure.

Data collection

Statistical data concerning GBV-cases are being collected into a separate database system, only accessible to authorized staff members.

[31] Interim Criminal Code For Courts, 2004

Annex 4-1: Checklist staff, medical & non-medical equipment, drugs & vaccines

1 Protocol	
Medical protocol	
2 Staff	
Qualified health professionals, trained to offer care to GBV survivors	
Female staff for female victims, speaking the same language and with the same cultural background.	
If this is not possible, a female health worker should be present during examination	
Health staff, trained to ensure the reception and referral	
3 Infrastructure / furniture	
Private room (quiet, if possible with access to latrines)	
Screen or curtain (for division reception/examination area)	
Examination table	
Good lighting (preferable fixed lamp, a torch might frighten)	
Mirror	
Small Table	
Chairs	
Cupboard for medical equipment and drugs	
Access to autoclave for sterilization of material	
Access to laboratory equipment	
Weighting scale and measuring board for children	
4 Equipment	
Speculum different sizes	
Stethoscope	
Otoscope	
Sphygmomanometer	
Rectal thermometer	
Dressing material	
Suturing material	
Reanimation equipment	
Syringes and needles for testing	
Protection material: gloves, soap, different waste disposal bins	
Something to cover the victim (blanket, blouse…)	
Hygiene pads	
Urine catheter (different forms) + urine bags	
5 Tests	
Pregnancy tests	
HIV tests	
Hemocue	
6 Drugs	
Antiretroviral drugs for PEP	
Antibiotics for treatment of STI	
Antibiotics for wound care	
Emergency contraceptive pill	
Tetanus Toxoid vaccine, Human Tetanus Immunoglobulin (HTIG)	
Hepatitis B vaccine	
Pentavalent vaccine	
Analgesia	
Anxiolitica (for example Diazepam)	
Anaesthesia for suturing and wound care	
7 Stationary	
Register	
Medical file	
Consent form	
Medical certificate	
Directory with organizations for referral	
Safe/cupboard that can be locked	

5. Survivor-centered Care

Survivor-centered care is commonly understood as an approach whereby the focus rests on the survivor seeking care[32]. It is a standard of care that ensures that the patient/survivor is at the center of care.

Although various definitions exist with regard to survivor-centered care, a respectful attitude, effective listening and support for personal autonomy are key to ensure that that care offered is tailored to the individual needs of each survivor.

Attitude

A respectful attitude, whereby the value of a survivor as a unique individual is appreciated, comprises the first component of survivor-centered care. When working with GBV survivors, adopting a respectful attitude is fundamental to the development of a relationship of trust.

- Show respect
  - The survivor has suffered a traumatic experience. Her/his ability to survive the violence and her/his courage in seeking medical help merit the staff member's full respect.
  - The survivor might also feel shame, a lack of self-worth, isolation, and rejection by her/his partner or family circle at the time when she/he arrives at the health structure. The respect shown will help in her/his recovery.

- Do not judge
  - Believe the survivor without judging: the role of the health care provider is not to prove/disprove any allegations, nor whether rape has actually occurred.
  - Neither should health staff judge the survivor on the basis of the reaction experienced during the assault (e.g. no resistance) or after the assault (e.g. not seeking help). Listening with an open-minded and accepting attitude will enable the survivor to express herself/himself more freely.
  - Survivors often harbor feelings of guilt as to their behavior, believing that they failed to act properly to avoid the violence. It is important to stress that GBV is a violation of a survivor's human rights and that it is the perpetrator who is the guilty party. When people are paralyzed by fear or are unable to escape from the attack, they are often in shock and reacting in the only way possible for them at the time; any lack of resistance may ultimately result in a non-fatal outcome.

- Guarantee confidentiality
  - Assure the survivor that confidentiality is guaranteed by all persons involved in their care (doctor, midwife, nurse) and that no information will be released without her/his consent.
  - Confidentiality is crucial to protect the safety of the survivor and to respect her/his dignity and privacy[33].

- Be empathic
  - Put yourself in the survivor's place and try to understand what she/he is feeling. N.B. ask the survivor how she/he is and what she/he is feeling; she/he may not necessarily feel the same as you would in the same situation; each survivor reacts differently to similar incidents.

- Show patience
  - Do not pressure the survivor but let her/him express her/himself at her/his own pace, and show that you are listening.
  - Do not interrupt her/him but try to keep the interview to the subject, if necessary.
  - Allow for silences (but not so long that it becomes uncomfortable for the survivor), hesitation, repetition

- Adjust your attitude according to the characteristics of the survivor.

[32] Adapted from http://www.who.int/healthsystems/hss_glossary/en/index8.html
[33] Module 6: Practising Survivor-centered skills, IASC Gender SWG/GBV AoR, 2010

Effective listening

Effective listening is considered key to the survivor-centered approach in order to explore the survivor's complaints, to understand the individual, to ensure shared decision-making and to enhance the patient - health care provider relationship. Effective listening skills should be applied throughout the entire process of care delivery for survivors of GBV, starting from the moment of identification, through the provision of first-line support, history-taking, examination, treatment and during any follow-up stage.

- **Attending to body language (physical presence)**
  - Eye contact: always turn your head towards the survivor and look at her/him.
  - Body position: sit facing the survivor, close enough for eye contact but far enough away for her not to feel threatened.
  - Make sure your non-verbal behavior corresponds to your verbal behavior; avoid uncontrolled expressions of e.g. disgust, disapproval
  - Avoid sudden movement.
  - Use a soft tone of voice without being monotonous, and avoid sudden changes in volume that could disturb the survivor.
  - In case of rape, do not touch the survivor (e.g. a comforting hand on the shoulder), as victims of rape often fear physical contact, at least in the early stages following the assault.

- **Listen attentively and actively**
  - Give the survivor your full attention and show her/him you are listening through interested non-verbal behavior and encouraging responses (e.g. "mmm", "I see", "Yes").
  - To encourage the survivor to carry on talking and to show you are following her/his train of thought, apply « re-formulation » which means expressing back to the survivor the content of what she/he has said (in other words, summarizing what she/he said).
  - Listen carefully to what the survivor is saying by trying to capture the meaning of her/his words and phrases, of what she/he means (if necessary, check with her/him that you have understood what she/he meant).
  - Observe her/his body language, the sound of her/his voice, her/his movements, expressions, silences.
  - Do not concentrate solely on understanding the facts, but try to understand how she/he is feeling.

- **Ask questions**

  There are several types of question, each with a different purpose:
  - Closed questions (to which the only response is yes or no or responding with facts (e.g. how old are you?)) limit self-expression. It is easy to answer these questions and they may therefore be useful in beginning the interview (to get going) or when raising emotionally charged subjects. However, these questions should not be used to any great extent or the survivor will feel she/he is being submitted to an interrogation.
  - Open questions (e.g. how are you feeling?) encourage free expression. Specifically they allow the survivor to express her/his feelings. This type of question should be used wherever possible. However, if the survivor is not relaxed (at the beginning of the interview when emotionally charged subjects are raised, ...), she/he will find it difficult to respond to this type of question.
  - Avoid Questions
    - Beginning with the word « Why » (e.g. why did you do that at that moment?) as they will often seem like an implied accusation rather than an actual question.
    - Leading questions suggest the « right » answer should also be avoided.
      - Don't say « Are you feeling alright?», which will lead the survivor to respond « Yes, I am alright »
      - Rather say « How are you feeling? », which leaves the survivor free to choose her/his response.

- **Accept physical and emotional reactions**
  - The reactions of a GBV survivor may vary from agitation to depression. She/he may feel fear, anger, helplessness, shame, and sadness, and may express her/his feelings in tears, shouting, silence, and aggression. This can make you feel uncomfortable. However, you must:
    - Allow the survivor to express her/his feelings. (If, for example, she/he cries, don't say «you should not cry » but remain calm and show you are with her/him; offer her/him a tissue. If the survivor is suspicious or aggressive, don't take it personally).
    - Reassure the survivor by explaining that her/his physical and emotional reactions are normal in reaction to the violence she/he has suffered.

Specific considerations for children[34]:

- Introduce yourself to the child and tell her/him your role using developmentally appropriate language.
- Avoid making assumptions about the nonverbal behavior of children at all developmental levels.
- Avoid making assumptions about the way the child feels about the perpetrator or the acts of GBV violence and exploitation (i.e., that the acts were painful, that the child hates the perpetrator).
- If possible, speak at eye level or below.
- Establish rapport with the child by discussing things other than the reason for their visit (e.g., school, siblings, etc.).

Empowerment

Survivor-centered care is also associated with patient choice, involving her/him in or giving her/him more control over decisions the interventions or forms of care that she/he may receive, in order to empower and enable her/him to participate more fully in her/his healthcare.

During a GBV assault, the victim may have been forced to endure a painful and humiliating experience over which she/he had no control. Following such a disempowering experience, it is essential to ensure that the survivor benefits from control of the medical process. Otherwise, the provision of medical care may be perceived by the survivor as yet another experience of abuse. Therefore it is important to inform the survivor fully about the care and various services to be provided, in order that she/he may be in a position to make fully-informed choices and that any treatment decision is a shared one.

- Inform the survivor fully about the offer of care and continue to do so during the various stages of the consultation.
- Explain to the survivor that she/he may choose at any stage to accept or refuse an examination, a test, a treatment, a referral, etc.
- Respect her/his wishes, rights and dignity[35].
- Respect and support her/his choices at all times.
- Stimulate self-control whenever possible.
- Always act in the best interests of the survivor.
- Always be guided by safety considerations for the survivor.

[34] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

[35] Standard Operating Procedures for Healthcare sector response to Gender-Based Violence, MoPH & UNFPA, 2013

Specific considerations for children[36]:

- Involve the child in the decision making:
  - Children have a right to participate in decisions that have implications in their lives
  - The level of a child's participation in decision making should be appropriate to the child's level of maturity and age, and local laws
  - Although service providers may not always be able to follow the child's wishes (based on best-interest considerations), they should always empower and support children and deal with them in a transparent, open manner with respect
  - If a child's wishes are not able to be followed, then the reasons behind not being able to follow them should be explained

- Strengthen children's resiliencies:
  - Each child has unique capacities and strengths, and possesses the capacity to heal
  - Identify and build upon the child's and family's natural strengths as a part of the recovery and healing process.
  - Factors that promote the child's resilience should be identified and built upon during the episode of care
  - In case of sexual violence, research has shown that children who have caring relationships and opportunities for meaningful participation in family and community life and who see themselves as strong will be more likely to recover and heal from sexual violence[37].

[36] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

[37] Perry, B. 2007. The Boy Who Was Raised as a dog: And Other Stories from a Child Psychiatrist's Notebook: What Traumatized Children Can Teach us about Loss, Love, and Healing. New York: Basic Books.

6. Primary Survey

The 'primary' survey is a first assessment done to identify life-threatening injuries such as airway obstruction, chest injuries with breathing difficulties, severe external or internal hemorrhage and abdominal injuries.

Steps:
- Airway
- Breathing
- Circulation
- Disability
- Exposure

This assessment should be done in 2-5 minutes.

The majority of patients with life-threatening injuries in Afghanistan will be transported immediately to secondary or third health care facilities where there is access to full range of diagnostic tools and treatment options.

In the event that GBV-survivors, with life-threatening injuries, are firstly brought to a primary health care facility, assessment and treatment options could be limited. Nevertheless, it will be important that primary health care providers are capable to identify life-threatening injuries resulting from GBV through a primary survey and to ensure that basic life-saving emergency measures are undertaken to stabilize the patient before referral to an appropriate health structure.

Airway

Assess the airway. Can patient talk and breathe freely?
If obstructed, the steps to be considered are:
- Chin lift/jaw thrust (tongue is attached to the jaw)
- Suction (if available)
- Guedel airway/nasopharyngeal airway
- Intubation. NB keep the neck immobilized in neutral position
- Cervical spine care

Breathing

Assess respiratory rate (12–20/min), chest wall movements, chest percussion, lung auscultation, pulse oximetry (97%–100%)'

Is the breathing sufficient?
If inadequate, the steps to be considered are:
- Oxygen (if available)
- Artificial ventilation
- Decompress pneumothorax
- Drain haemothorax

Circulation

Re-check oxygen supply, airway patency and breathing adequacy.

- Assess capillary refill time and pulse rate
- Inspect skin → color changes, sweating, and a decreased level of consciousness are signs of decreased perfusion.
- Perform heart auscultation, if a stethoscope is available
- Measure blood pressure measurements

If inadequate, the steps to be considered are:

- Stop external hemorrhage by direct pressure
- In case of hypovolemic shock, caused by significant blood loss:
  - Establish two large-bore intravenous lines and give crystalloid solution.
  - If the person does not respond to this, give type-specific blood, or give O-negative if this is not available. External bleeding is controlled by direct pressure.

Disability / neurologic assessment

- Assess level of consciousness – **AVPU**
  - Alert
  - Voice responsive
  - Pain responsive
  - Unresponsive
- Use the Glasgow Coma Scale to determine the level of consciousness
- Assess limb movements, pupillary light reflexes and if possible blood glucose
- For patients with a primary cerebral condition: stabilize the airway, breathing, and circulation.
- When the patient is only pain responsive or unresponsive, ensure airway patency must, by placing the patient in the recovery position, and call personnel qualified to secure the airway. Ultimately, intubation may be required.
- A decreased level of consciousness due to low blood glucose can be corrected quickly with oral or infused glucose.

Exposure

Check for clues to explain the patient's condition:

- Assess signs of trauma, bleeding, skin reactions (rashes), needle marks, etc.
- Respect the dignity of the patient, when clothing needs be removed to allow a thorough physical examination.
- Estimate body temperature by feeling the skin or use a thermometer when available.
- Treat suspected cause

Urgent referral of patients

Criteria for urgent referral:

Life-threatening conditions:

- Rectal bleeding?
- Non-menstrual vaginal bleeding
- Acute abdomen
- Suicide attempt
- Any major injuries?
  - Major acute wounds
  - Major burns
  - Open fractures
  - Polytrauma
  - Poisoning

The patient is ready for transfer when:

- Airway is secure.
- Patient is ventilated.
- IV fluids are initiated.
- Associated injuries/fractures are identified and stabilized to the best of the referring facilities' capabilities.
- Stomach is decompressed.
- In case of rape, start HIV PEP and EC when patient is stabilized and can take oral medication.

7. Identification

It is widely recognized that health care providers play a unique role in identifying, assessing and responding to GBV-survivors - in part due to the obvious effects of gender-based violence on an individual's health, but also due to the position of health service providers as the primary, perhaps only, point of contact with professionals equipped to recognize and intervene in the situation. Furthermore, the majority of women (and men) in Afghanistan avail of health care services at some point during their lives - whether for routine health care, pregnancy and childbirth, illness, injury, or in the role of caretaker for children or older people[38].

Therefore, health care providers should be alert to the physical, psychological and behavioral signs and symptoms associated with GBV. If health providers have a reason to suspect that a woman is being subjected to GBV, they sensitively enquire about possible exposure to GBV to provide appropriate treatment, skilled counseling and relevant information on shelters and other protective and legal services, if required[39]. The World Health Organization does not recommend universal screening for violence of women attending health care, but WHO does encourage health care providers to raise the topic with women who have injuries or conditions that they suspect may be related to violence.

Conditions associated with GBV

Women

A healthcare provider may suspect that a woman has been subjected to violence if she has the conditions described below, although having these conditions does not automatically indicate that she is experiencing violence. Moreover, she may have experienced physical or sexual assault in the past or recently or may be in an ongoing abusive relationship.

The following clinical conditions are associated with violence but do not of themselves automatically indicate violence. They should however alert the health care provider to consult with the individual in private and enquire about possible abuse[40].

Clinical conditions associated with violence in women:

1. **Physical violence**[41]
- Bilateral injuries, especially to extremities
- Injuries at multiple sites, pattern injuries, injuries suggesting a defensive posture
- Central distribution of injury (chest, breast, abdomen, face, neck, throat, and genitals)
- Fingernail scratches, cigarette burns, rope burns
- Bite marks, strangulation
- Abrasions, minor lacerations, welts
- Subconjunctival hemorrhage suggests a vigorous struggle between victim and assailant
- Patient explanation inconsistent for extent or type of injuries
- Violence during pregnancy

2. **Sexual violence**
- Unexplained chronic gastro-intestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genito-urinary symptoms, including frequent bladder or kidney infections

[38] Improving the Health Care Response to Domestic Violence: A Trainer's Manual for Health Care Providers, Anne L. Ganley, Ph.D., 1998
[39] US Preventive Services Task Force. Screening for family and intimate partner violence: recommendation statement. Ann Intern Med. 2004;140:382–386
[40] Responding to domestic abuse: a handbook for health professionals, UK Department of Health, 2005
[41] Domestic Violence Clinical Presentation, Lynn Barkley Burnett, MD, EdD, LLB(c); Chief Editor: Barry E Brenner, MD, PhD, FACEP, http://emedicine.medscape.com/article/805546-overview, sep 18, 2013.

- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss

3. Mental health signs associated with violence

- Symptoms of depression, anxiety, PTSD, sleep disorders
- Suicidality or self-harm
- Alcohol and other substance abuse
- Sleep disturbance
- Withdrawal from touch

4. Observations during consultation

- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations, partner continually speaks for the client and/or insists on remaining with the client.
- Patient is evasive or embarrassed about injuries.

Men

In general, men who have experienced some form of GBV are not likely to seek medical attention, unless they suffer significant physical injuries. Moreover, GBV against men is culturally very sensitive in Afghanistan. Some cases of domestic violence against men have been reported but are considered very rare. Sexual violence against men prisoners on the other hand, is been considered common, although no clear data exist currently in Afghanistan.

Some clinical conditions which are associated with GBV in men[42] [43]:

- Physical injuries in the ano-genital area
- Rectal injuries

Common mental health problems as a consequence of rape are:

- Depression, anxiety and PTSD
- Suicidal ideation and attempts
- Anger/hostility
- Sexual and relationship problems.

Men are likely to be particularly concerned about:

- Their masculinity
- Their sexuality
- Opinions of other people (i.e. afraid that others will think they are homosexual)
- The fact that they were unable to prevent the rape.

[42] Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

[43] Richard Tewksbury, Effect of Sexual Assaults on Men: Physical, Mental and Sexual consequences, International Journal of Men's Health, Vol. 6, No. 1, Spring 2007, 22-35

Children

Children of any age can be physically, emotionally or sexually abused, including babies. While the majority of perpetrators of sexual abuse are male, survivors can be of either sex. In Afghanistan, following children are at particular risk:

- Orphans and those without parental protection
- Street children
- Child soldiers, child policemen or children in armed groups
- Children in detention
- Children who have previously been sexually abused
- Children born of rape (harami)

Clinical conditions associated with violence in children:

1. Physical abuse:

The signs of physical abuse may includ[44]:

- Physical injuries like cuts, bruises, burns, broken bones, head injuries, and abdominal injuries may point to physical abuse when[45]:
  - They are unlikely to have been caused by an accident
  - Explanations change or do not adequately account for how an injury occurred
  - Evidence shows that injuries have occurred previously
  - Medical care for the injury is delayed
- Human bite marks
- Scalds, with upward splash marks,
- Multiple burns with a clearly demarcated edge

Changes in behavior that can also indicate physical abuse:

- Fear of parents being approached for an explanation
- Aggressive behavior or severe temper outbursts
- Flinching when approached or touched
- Reluctance to get changed
- Withdrawn behavior
- Running away from home

2. Emotional abuse[46]

Emotional abuse can be difficult to measure, as there are often no outward physical signs.

Changes in behavior which can indicate emotional abuse include:

- Neurotic behavior e.g. sulking, hair twisting, rocking being unable to play
- Fear of making mistakes
- Sudden speech disorders
- Self-harm
- Fear of parent being approached regarding their behavior
- Developmental delay in terms of emotional progress

[44] Adapted from Child protection fact sheet, The definitions and signs of child abuse, NSPCC, June 2010
[45] http://www.webmd.com/parenting/tc/child-maltreatment-symptoms
[46] Child protection fact sheet, The definitions and signs of child abuse, NSPCC, June 2010

3. Sexual abuse

The physical signs of sexual abuse may include:

- **STIs:** STIs in children beyond the neonatal period suggest sexual abuse but the significance varies by pathogen. Postnatally acquired gonorrhea; syphilis; and non transfusion, non perinatally acquired HIV are usually diagnostic of sexual abuse. Sexual abuse should be suspected when genital herpes is diagnosed[47].
- Pregnancy
- Pain, sores, bruising, bleeding and injury in the genital area
- Vaginal discharge or infection
- Stomach pains
- Discomfort when walking or sitting down

A number of behavior occur almost exclusively in children who have experienced sexual abuse[48]:

- Age inappropriate interest in sex
- Seduction behavior
- Sexual harassment of other children (beyond normal limits)
- Compulsive masturbation
- Inappropriate sexual play
- Sexual drawings

Other behavioral signs indicate distress in a child, which may point to sexual abuse or other causes:

- Secondary anal incontinence
- Encopresis/enuresis
- Compulsive washing
- Anorexia
- Inappropriate emotional responses to stressful situations
- Gender identity difficulties
- Secretiveness
- Overreaction to mistakes
- Physical, mental, emotional development delay, regression or disturbance
- Antisocial behavior, obvious lies, stealing
- Repeated running away
- Disruptive behavior
- Hostile/aggressive/bullying behavior
- Hostility towards men
- Truancy (=being absent without permission)
- Signs of fear such as nightmares, fear of specific situations or people, extraordinary fear, reluctance to go to school or to go home from school
- Relationship difficulties such as isolation, overly compliant, extreme passivity or aggression, poor peer relationships, attention-seeking, lack of trust
- Concentration difficulties
- Sudden changes in behavior
- Low-self-esteem

[47] CDC
[48] Pocket Guide SGBV, MSF-B, January 2013

Asking about GBV

When a health care provider notices that a patient exhibits one or more of the above mentioned conditions, it is crucial to consult with her/him in privately. Questions about whether the woman is experiencing violence should only be asked if there is a reason to suspect that the woman may be experiencing gender-based violence and not routinely. The overarching principle guiding the provider in the decision to ask about GBV should be safety of the woman. It is important to recognize that women who disclose their experience of violence can have their safety compromised if the perpetrator finds out that they have disclosed to the provider.

The following guidelines should be considered:

- Find a way to see the person alone. You can use for example the following approaches:
  - Ask the accompanying person to go out to get something
  - Ask the person to come with you for a test
- Ensure strict privacy:
  - Never ask about GBV when anybody else is present
  - Make sure you cannot be overheard
  - Make sure you won't be disturbed
- Take time to talk to the person, don't rush the person
- Don't push a person to reveal the GBV
- Think of your conversation as the start of a process, not a one-off event
- Never assume that someone else will take care of GBV issues – you may be the person's first and only contact.

Minimum requirements for asking about GBV:

- A protocol/standard operating procedure[49]
- Training on how to ask, minimum response or beyond
- Private setting
- Confidentiality ensured
- System for referral in place

Possible questions:

Before asking patients about GBV (family and sexual violence), it is important to give a brief explanation as to the reason for the query in order to reduce the person's suspicions and to minimize stigma[50].

"Many women (girls, boys,...) *in Afghanistan experience problems with their husband, or even with someone else they live with. I have seen women (girls, boys,...) with problems like yours who have experienced trouble at home. Experiencing such problems can have an important impact on our physical and mental health. Some people are too afraid or uncomfortable to bring it up themselves so I am asking about it myself because I want to help you. Anything you say to me will be kept between ourselves. Would it be ok for me to ask you some questions?*"

Here are some simple and direct questions that you can start with that show you want to hear about her problems. Depending on her answers, continue to ask questions and listen to her story. If she answers "yes" to any of these questions, offer her first-line support (see chapter 8).

- "Are you afraid of your husband or someone else at home?"
- "Has your husband or someone else at home ever threatened to hurt you or physically hurt you in some way? If so, when has it happened?"

[49] Standard Operating Procedures for Healthcare Sector response to Gender-Based Violence, MoPH, 2013
[50] Asking about intimate partner violence: advice from female survivors to health care providers. Chang JC, Decker MR, Moracco KE, Martin SL, Petersen R, Frasier PY.

- "Has your husband (or partner) or someone at home bullied you or insulted you?
- "Has your husband (or partner) tried to control you, for example not letting you have money or go out of the house?"
- "Were you forced into sex or forced to have any sexual contact you did not want?"
- "Has your husband (or partner) threatened to kill you?"

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

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

Special considerations for children[51]:

- All children should be approached with extreme sensitivity and their vulnerability recognized and understood.
- Try to establish a neutral environment and rapport with the child before beginning the interview.
- Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time, and that they may use terminology differently to adults making interpretation of questions and answers a sensitive matter.
- Ask the child if he/she knows why they have come to see you.
- Establish ground rules for the interview, including permission for the child to say he/she doesn't know, permission to correct the interviewer
- Ask the child to describe what happened, or is happening, to them in their own words.
- Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted.

Response when a patient discloses violence

If a patient reveals that she/he has been victim of GBV, appropriate responses are important to assist in obtaining the care and help that she/he needs. Disclosing GBV is a big step for the survivor and often carries an element of risk.

- Be sensitive to the emotional distress or fear the survivor may be experiencing.
- Affirm that the client has made an important step by talking about the violence.
- Ensure confidentiality.
- Listen to what she/he is saying.
- Acknowledge what she/he has told you "*That must have been frightening for you.*" "*You are a strong person to have survived that …*"
- Validate the survivor's feelings. (for example: when a survivor explains she is angry with her husband, you could say "*it is ok to feel angry…*".
- Reassure the survivor that her/his reaction to the abuse is normal (e.g. physical, emotional, behavioral reactions).
- Reinforce with the survivor that the violence is not their fault, that there is no excuse for violence and that the responsibility lies with the perpetrator.

After the initial response to a survivor's disclosure of any form of violence, the survivor should, as a minimum, be offered first-line support (See chapter 8). If the identifying health care provider is not trained or otherwise unable to provide first-line support, then an immediate referral to a qualified health care provider should be made.

[51] Adapted from Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

8. First-line support

The objective of 'First-line support' is to offer to all patients disclosing any form of GBV a minimum level of support and validation of the experience.

First-line support includes:

- Being non-judgmental, and supportive through validating what the survivor is saying
- Providing practical care and support that responds to her/his concerns, but does not intrude
- Asking about her/his history of violence, listening carefully, but not pressuring her/him to talk (care should be taken when discussing sensitive topics when interpreters are involved)
- Helping her/him access information about resources, including legal and other services that she/he might think helpful
- Assisting her/him to increase safety for herself/himself and her/his children, where needed
- Providing or mobilizing social support.

Providers should ensure:

- That the consultation is conducted in private
- Confidentiality, while informing survivor of the limits of confidentiality (e.g. when there is mandatory reporting)

According to the WHO guidelines[52] 'Responding to Intimate Partner Violence and Sexual Violence Against Women', individuals who experience intimate partner violence or sexual violence may have very different needs, depending on their circumstances and on the severity of the violence and its consequences. Furthermore, individuals in similar circumstances may require different types of support over time.

There are, however, a minimum set of actions and principles that should guide the health care response to patients suffering from violence (physical, sexual or emotional), whether by an intimate partner, relative, acquaintance or stranger, regardless of the circumstances.

Patients who disclose any form of violence should be offered immediate support. Health care providers should, as a minimum, offer first-line support when patients disclose violence. 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.

Check for safety

A brief assessment of both the health care provider's and the patient's safety should be carried out at the beginning of every consultation. The following questions[53] might be used:

- What dangers can you see in the environment (e.g. violent husbands, family members)
- Can you carry out the consultation without likely harm to yourself or others?
- If there is an immediate risk of harm (for example, a woman's partner is in reception and becoming aggressive) you should call the manager of health facility or respond according the security procedures developed. Never take on the responsibility of dealing with high-risk situations.

[52] Adapted from Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[53] Adapted from Psychological first aid: Guide for field workers, WHO, 2011

Establish contact

- (if not done before, introduce yourself, name and function)
- Help the survivor to feel comfortable.
- Ensure confidentiality (inform the survivor about confidentiality principles)

Ask about needs and concerns

- Always ask what the survivor needs and what her/his concerns are.
- Find out what is most important to her/him at this moment, and help her/him to work out what her/his priorities are.
- Help her/him to work out an action plan to address those needs and concerns

Listen

- Use emphatic attitude and effective listening skills (mentioned in chapter 5)
  - Ensure a respectful, non-judgmental attitude
  - Display attentive body language
  - Listen actively, ask questions and allow for the expression of emotions
- Ask the survivor about her/his history of violence, listen carefully but do NOT pressure her/him to talk.

If necessary, help the person to feel calm

Some survivors of GBV, when presenting in a health structure, may be overwhelmed with emotions or disorientated. According to the level of distress, consider the following incremental steps:

- Allow the survivor to express her/his feelings, give her/him some time before intervening, validate her/his emotions and give support
- Teach relaxation exercises (see annex 8-1)
- Use grounding technique (see annex 8-1)
- Refer for medical stabilization

Enhance survivor's safety

It is important to determine the extent of the danger faced by a survivor and evaluate whether she/he is at risk of immediate harm. Whether it is a single incident or an ongoing pattern of abuse, GBV can undermine a person physical and emotional safety. During this first visit it is important to get a better understanding of the violence the survivor is experiencing and to assess the future risk, without forcing the person to talk. Consequently helping the survivor making a safety plan, tailored to his/her individual needs and concerns can empower her/him to regain a sense of safety and security by addressing immediate needs and outlining strategies to help reduce future incidents harm. In the case of women with children, the safety needs of the children should also be assessed.

Assessing safety after sexual assault:

Most women who are assaulted know the person who assaulted her, and it often happens at home. If it was someone she knows, discuss whether it is safe for her to return home.

Assessing immediate risk of partner violence

Some women will know when they are in immediate danger and they are afraid to go home. If she is worried about her safety, take her seriously. Other women may need help thinking about their immediate risk. There are specific questions you can ask to see if it is safe for her to return to her home. It is important to find out if there is an immediate and likely risk of serious injury. If there seems to be immediate high risk, then you can say "I'm concerned about your safety. Let's discuss what to do so you won't be harmed." You can consider options such as contacting the police and arranging for her to stay that night away from home.

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

- Has the physical violence happened more often or gotten worse over the past 6 months?
- Has he ever used a weapon or threatened you with a weapon?
- Do you believe he could kill you?
- Has he ever beaten you while you were pregnant?
- Is he violently and constantly jealous of you?

If it is not safe for the woman to return home, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place that she can go (such as a friend's home).

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

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

Safety planning	
Safe place to go	If you need to leave your home in a hurry, where could you go?
Planning for children	Would you go alone or take your children with you?
Transport	How will you get there?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items in a safe place or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbor 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?

Discuss how to stay safer at home
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. Advise her to stay away from any room where there might be weapons. If she has decided that leaving is the best option, advise her to make her plans and leave for a safe place BEFORE letting her partner know. Otherwise, she may put herself and her children at more risk of violence.

Avoid putting her at risk
Talk about abuse only when you and she are alone. No one older than age 2 should overhear your conversation. Never discuss it if her husband or other family members or anyone else who has accompanied her—even a friend—may be able to overhear. You may need to think of an excuse to be able to see the woman alone, such as sending the person to do an errand or fill out a form. If her children are with her, ask a colleague to look after them while you talk.

Remember to maintain the confidentiality of her health records. Keep such documents in a safe place, not out on a desk or anywhere else that anyone can see them. Discuss with the woman how she will explain where she has been. If she must take paperwork with her (for the police, for example), discuss what she will do with the paper.

- If there are formal options for support (e.g. shelters, women's organizations), you can provide her with the information, but give her appropriate warnings about taking it home or keeping it in a place that others can't find.

Inform the survivor about common reactions to GBV

Stress reactions may be frightening or alarming for survivors ("*I am going crazy*", "*Something is wrong with me*")

- Offer psycho-education on common reactions, emphasizing that such reactions are understandable and normal.
- If appropriate, provide information on available mental health services and propose referral

Help the survivor to cope with problems[54].

A survivor may be overwhelmed with worries and fears. Use the following approaches to help the survivor regain control and feel stronger.

- Help her/him to consider her/his most urgent needs, and how to prioritize and address them. For example, ask her/him to think about what she/he needs to address now, and what can wait for later.
- Help her/him to identify support people in their life, such as friends or family, who can help her/him in the current situation
- Give her/him practical suggestions to meet her/his own needs
- Ask her/him to consider how she/he coped with difficult situations in the past, and affirm her/his ability to cope with the current situation;
- Ask her/him what helps her/him to feel better. Encourage them to use positive coping strategies and avoid negative coping strategies (see the following table).

Table 8-1: coping[55]

Encourage positive coping strategies	Discourage negative coping strategies
• Talk and spend time with family and friends • Discuss problems with someone you trust • Do activities that help you relax (pray, sing, play with children, ...) • Do physical exercise • Practice relaxation exercise • Use calming self-talk • Help others • Get enough sleep • Eat as regularly as possible and drink water	• Don't take drugs or narcotics or drink alcohol to cope • Don't isolate yourself from family and friends • Don't sleep all day • Don't over-eat or under-eat • Don't be violent • Don't neglect personal hygiene • Don't work all the time

Give information and help the person to access other services (psychological, social, legal and protection services) that she/he might think helpful, but provide appropriate warnings about taking it home and keeping it in a safe place where others cannot find it as this may further compromise their safety.

- Give plain and correct information about her/his rights, the importance of security and various available services (psychological, social, legal and protection)
- Provide contact details for the services with appropriate warnings about taking it home and keeping it in a place where others cannot find it.

[54] Psychological First Aid, Guide for Fieldworkers, WHO, 2012
[55] Psychological First Aid, Guide for Fieldworkers, WHO, 2012

- Refer the survivor directly
  - If possible and appropriate, accompany the person to the service
  - Call the service and make an appointment
- Provide follow-up for the referral, if needed

Help the survivor to connect with family/ family networks and other social support[56].

GBV survivors who have good social support will cope better.

- Explain the importance of social support
- Help her identify people from within her social network with whom she can reach out to and that she trusts in case she wants to talk about her experience.
- If a survivor lets you know that prayer, religious practice or support from religious leaders might be helpful for them, try to connect them with their spiritual community.

[56] Social Support Protects against the Negative Effects of Partner Violence on Mental Health, Mary Ann Liebert, JOURNAL OF WOMEN'S HEALTH & GENDER-BASED MEDICINE Volume 11, Number 5, 2002

Annex 8-1: Relaxation and grounding exercise

1. Simple relaxation exercise

Introduction:

"Tension and anxiety are common when experiencing violence. Unfortunately, they can make it more difficult to cope with what you went through. There is no easy solution to cope with what you went through, but taking time during the day to calm yourself through relaxation exercises may make it easier to sleep, concentrate, and have more energy. Here is a basic breathing exercise that may help":

For Adults:

- Inhale slowly (one-thousand one; one-thousand two; one-thousand three) through your nose and comfortably fill your lungs all the way down to your belly.
- Silently and gently say to yourself, "My body is filled with calmness." Exhale slowly (one-thousand one; one-thousand two; one-thousand three) through your mouth and comfortably empty your lungs all the way down to your stomach.
- Silently and gently say to yourself, "My body is releasing the tension."
- Repeat five times slowly and comfortably.
- Do this as many times a day as needed.

For Children:

- "Let's practice a different way of breathing that can help calm our bodies down.
- Put one hand on your stomach, like this [demonstrate].
- Okay, we are going to breathe in through our noses. When we breathe in, we are going to fill up with a lot of air and our stomachs are going to stick out like this [demonstrate].
- Then, we will breathe out through our mouths. When we breathe out, our stomachs are going to suck in and up like this [demonstrate].
- We are going to breathe in really slowly while I count to three. I'm also going to count to three while we breathe out really slowly.
- Let's try it together. Great job!"

2. Grounding

Introduction:

"After a experiencing violence, you can sometimes find yourself overwhelmed with emotions or unable to stop thinking about or imagining what happened. You can use a method called 'grounding' to feel less overwhelmed. Grounding works by turning your attention from your thoughts back to the outside world. Here's what you do...."

For adults:

- Sit in a comfortable position with your legs and arms uncrossed.
- Breathe in and out slowly and deeply.
- Look around you and name five non-distressing objects that you can see. For example you could say, "I see the floor, I see a shoe, I see a table, I see a chair, I see a person."
- Breathe in and out slowly and deeply.
- Next, name five non-distressing sounds you can hear. For example: "I hear a woman talking, I hear myself breathing, I hear a door close, I hear someone typing, I hear a cell phone ringing."

- Breathe in and out slowly and deeply.
- Next, name five non-distressing things you can feel. For example: "I can feel this wooden armrest with my hands, I can feel my toes inside my shoes, I can feel my back pressing against my chair, I can feel the blanket in my hands, I can feel my lips pressed together."
- Breathe in and out slowly and deeply.

For children:
You might have children name colors that they see around them. For example, say to the child, "Can you name five colors that you can see from where you are sitting. Can you see something blue? Something yellow? Something green?" If none of these interventions aids in emotional stabilization, consult with medical or mental health professionals, as medication may be needed. Modify these interventions for a person who has difficulty with vision, hearing, or expressive language.

Annex 8-2: Risk Assessment and Safety Planning

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

CONFIDENTIAL

Safety assessment – Safety plan for family violence

Note to the health care provider:
Consider only the steps/questions that respond to the survivor's individual situation.

A. Risk assessment with survivors of family violence:

When a woman answers "yes" to at least three of the following questions, she may be at especially high immediate risk of violence:

1. Are you in immediate danger?	**☐ yes**	**☐ no**
2. Has the physical violence happened more often or gotten worse over the past six months?	**☐ yes**	**☐ no**
3. Has he ever used a weapon or threatened you with a weapon?	**☐ yes**	**☐ no**
4. Do you believe he could kill you?	**☐ yes**	**☐ no**
5. Has he ever beaten you while you were pregnant?	**☐ yes**	**☐ no**
6. Is he violently and constantly jealous of you?	**☐ yes**	**☐ no**

If the survivor feels at risk, give her/him information about her/his rights and referral options.

- For safety: Provide concrete information about legal, protection and mediation services.
- For emotional safety: Provide information and motivate for mental health referral.
- Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

When the survivor, accepts the referral, ensure direct referral.
When the survivor does not accept the referral at the moment:

- Help her/him to make a safety plan
- Make an appointment for a follow-up consultation

B. Safety plan for survivors of family violence

Note to the health care provider:
Explain to the survivor that a she/he does not have control over the violent behavior of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself (and the children) to safety.

If you need to leave your home in a hurry, where could you go?

_____

_____

Would you go alone or take your children with you?

_____

_____

How will you get there?

_____

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?

_____

Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?

_____

Is there a neighbor 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?

_____

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

CONFIDENTIAL

Safety assessment – Safety plan for non-family violence

Note to the health care provider:
Consider only the steps/questions that respond to the survivor's individual situation.

A. Risk assessment with survivors of **non-family violence**:

1. **Is there a possibility to meet the aggressor(s) again?** ☐ **yes** ☐ **no**
   If yes, explain: _____

2. **What information, if any, does the aggressor have about where you live, work, go to school or about places you go to on a regular basis?** _____

3. **Do you believe the aggressor could kill you?** ☐ **yes** ☐ **no**

4. **Has the aggressor contacted you since the incident?** ☐ **yes** ☐ **no**
   a. If yes, explain: _____

5. **Does the aggressor have access to your housing?** ☐ **yes** ☐ **no**
   If yes, explain: _____

6. **Is there anybody (own family, in-law family, neighbors, friends, community) who you that could talk to for advice or that could play a protective role?** ☐ **yes** ☐ **no**
   If yes, explain: _____

   If the survivor feels at risk, give her/him information about her/his rights and referral options.
   - For safety: Provide concrete information about legal, protection and mediation services.
   - For emotional safety: Provide information and motivate for mental health referral.
   - Provide referral to secondary level of care. Sometimes a hospitalization can be proposed to ensure the survivors safety in order to find appropriate solution to guarantee her/his safety.

   When the survivor accepts the referral, ensure direct referral.
   When the survivor does not accept the referral at the moment:
   - Help her/him to make a safety plan
   - Make an appointment for a follow-up consultation

B. Safety plan for survivors of **non-family violence**

Note to the health care provider:
Explain to the survivor that a she/he does not have control over the violent behavior of her/his aggressor(s), but that she/he does have a choice about how she/he responds to the aggressor(s) and how to best get her/himself to safety.

1. **What places does the perpetrator frequent?**

   _____

   Explain the survivor to be conscious about those places

2. **Who can help and protect you (even without informing them)?**

   _____

3. **What strategies can you use to improve the safety at home?**

   _____

4. **Who can accompany you when you leave the house, when you go to school or to work?**

   _____

The experience of violence is usually exhausting and emotionally draining. Explain to the survivor that is important that she/he tries to conserve her/his emotional energy and resources and tries to avoid emotional difficult situations.

a. **What are things that you might do if you came into contact with the aggressor?**

   _____

   _____

b. **What can say to yourself to give you strength whenever the aggressor is trying to put you down, control or abuse you?**

   _____

   _____

   _____

c. **Who can you contact for support?** _____

9. Taking the History

Objective of the history-taking:

- The primary purpose of taking a medical history is to obtain information that may assist in the medical management of the survivor or may help to explain subsequent findings, e.g. easy bruising or loss of consciousness or memory loss.
- To assess the psychological state of the survivor.

General guidelines

- If the interview is conducted in the treatment room, cover the medical instruments until they are needed.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Let the survivor tell her/his story the way she/he wants to.
- Questioning should be done gently and at the survivor's own pace. Avoid questions that suggest blame, such as "*what were you doing there alone?*"
- Take sufficient time to collect all required information, without rushing.
- Avoid any distraction or interruption.
- During the history-taking, do not ask questions that have already been asked and documented by other people involved in the case.
- Explain what you are going to do at every step.

Before beginning the interview

- Explain the objective of the interview (importance of understanding the circumstances of the GBV in order to provide appropriate treatment).
- Remind the survivor of GBV that she/he has the right to terminate the interview at any time.
- If the survivor refuses to talk about the violence, don't pressure her/him but explain that the health care provider will always be available if she/he wants to talk at a later date.
- Study any papers the survivor may give you (particularly if she/he has come from a police station or another organization) in order to avoid asking questions which have already been recorded.

General information

- CODE, district, sex, date of birth.
- Date and time of the examination and the names and function of any staff or support person (someone the survivor may request) present during the interview and examination.

- This may be a way of « getting things going » for the survivor, as she/he is not immediately faced with distressing questions, but simple facts. It is one way of establishing a relationship of trust which is crucial to the remainder of the interview. Do not neglect this stage by going through it like an official in an administration department[57].

Description of the incident

- Ask the survivor to describe what happened. Allow her/him to speak at her/his own pace. Do not interrupt to ask for details; follow up with clarification questions after she/he finishes telling her/his story. Explain that she/he does not have to tell you anything she/he does not feel comfortable with.

[57] Care for Victims of Sexual Violence, Situation with Displacement of Population, MSF Belgique, 2007

- Survivors may omit or avoid describing details of the assault/the abuse that are particularly painful or traumatic, but it is important that the health care provider understands exactly what happened in order to check for possible injuries and to assess the risk of pregnancy and STI or HIV. Explain this to the survivor, and reassure her/him of confidentiality if she/he is reluctant to give detailed information.
- At the end of her/his story, more details can be asked:
  - Date and time of the incident
  - Type of violence
  - The circumstances of the aggression (number of aggressors, kidnapping, drugs/alcohol, ...)
  - In case of rape: penetration site, penetration object, ejaculation, condom used,
  - See form in Annex 9-1
- If the survivor does not reply to a question or is clearly ill-at-ease, do not persist. On the contrary, reassure her/him by saying you understand how difficult it is to talk about such a painful experience and that she/he is not obliged to answer all the questions if she/he feels uncomfortable with them.

Medical history

- In case of sexual assault and the incident occurred recently, determine whether the survivor has bathed, urinated, defecated, vomited, used a genital douche or changed her/his clothes since the incident. This may affect the availability of forensic evidence.
- Information on existing health problems, allergies, use of medication, and vaccination and HIV status will help you to determine the most appropriate treatment to provide, any counseling if necessary, and follow-up health care.
- Evaluate for possible pregnancy; ask for details of contraceptive use and date of last menstrual period.
  → Offer pregnancy test
- Evaluate mental state.
  - Observe her/his behavior
  - Look for signs of acute or post-traumatic stress
  - Look for signs of common mental health disorder
  - Ask about previous psychiatric history: does the survivor takes psychotropic drugs affecting her/his appearance and/or behavior?

Children[58]

Just as for adults, the purpose of the medical history is to obtain all relevant medical and psychosocial information regarding the child's health, as well as the specific circumstances of the assault. Prior to obtaining relevant medical and incident history, however, it is critical that the health care provider establish an effective rapport with the child. Because a child's communication ability changes dramatically from developmental stage to developmental stage, the provider's knowledge and comfort with those stages can play an important role in care (see following table).

Specific communication techniques for children:

- Children under the age of four are not generally able to give a detailed history. The history is generally obtained by the caregiver presenting with the child, but no information is specifically solicited from the child. However, the child may spontaneously disclose information to the provider during the exam. These spontaneous statements should be recorded in quotations by the health care provider.
- When developmentally appropriate, the history-taking should occur solely between the child and the health care provider.
- Whenever possible, open-ended questions should be utilized. Examples of open-ended questions are: "*Do you know why you are here today?*", "*Can you tell me more about...?*", "*What do you mean by.....?*"

[56] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

- Leading questions are questions where the health care provider suggests the answer, and they should be avoided. "*Did he put his hands on your breasts?*" is an example of a leading question. To make the question non-leading, one could say, "*Where were you touched on your body?*"
- Give the child the ability to make choices throughout (e.g., "Would you like this blanket or that blanket?"). This allows the child to regain control and feel empowered.
- Avoid using the words "why" or "how come" because this tends to assign blame to the child.
- Ask one question at a time.
- Avoid the use of prepositions. Children may not developmentally understand concepts like inside, outside, on, under, etc.
- Young children have no accurate sense of time and should not be questioned with regard to when something may have happened to them.

Specific consideration for History Taking with children

Table 9-1: General considerations for History Taking[59]

Developmental Stage	Considerations for History-Taking
Infants / toddlers / preschool (birth to 4 years old)	• Children in this age group have limited to no verbal skills and should not be asked to provide any history (see communication techniques above). • Non-offending caregivers or adults presenting with the child for care are the primary sources of information about the child and suspected sexual violence and exploitation.
School-aged children (5–9 years old)	• Children in this age range should provide a history whenever possible. • Caregivers, parents, and guardians may provide supplemental information but should not be involved in the history-taking unless the child refuses to separate. • Providers should use non-leading language (see communication techniques above).
Early and later adolescents (10–18 years old)	• Children in this age range should provide their own history. • Caregivers, parents, and guardians should not be involved in the history-taking to allow the child to express their own viewpoint on what has happened to them. • Parents or guardians can inhibit this age group from sharing all information.

Table 9-2: Special considerations for history taking[60]

Developmental Stage	Considerations for History-Taking
The child who will not speak	• If a child cannot or will not speak to the provider, the provider should continue to talk with the child, and explain all of the examination process, but have no expectation that the child will give them a history. • It is not unusual for a child who initially will not speak to begin speaking as the examination progresses, and they begin to feel more comfortable with the examiner. • It is possible that children may present that have not experienced violence or exploitation. • Some children may not be willing to talk about the abuse—forcing them to talk about this is traumatizing and should not be done.

[59] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

[60] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

Children with disabilities	• Children with disabilities should be communicated with in the manner in which they are most comfortable (e.g., sign language, Braille, plain language/pictures, or audio aids). • It should never be assumed that because a child has some form of disability that they are not capable of communication. • Some disabilities affect the way that children and adolescents communicate. It can be difficult to understand them, and difficult for them to understand others, which can also lead to misunderstandings that further impede comprehension. • It is important to remember that children with disabilities are at greater risk of sexual violence and exploitation. • It is important to respect that some children with disabilities may not wish to have the physical exam as they may not want to share or expose their body with a stranger. • It is important to consider the best interest of the child and not use force when a child with disabilities may not be able to communicate on their own.

- In children, much of this information may need to be obtained from a parent, caregiver, or guardian; however, when developmentally able, the violence history should be obtained directly from the child or adolescent.
- The process for taking a history should proceed in a similar manner to any other medical history-taking.
- The limitations in attention span due to developmental age and stage will limit the amount of time appropriate for history-taking. As a general rule, history-taking will not take more than an hour with children.
- Be non-leading and non-suggestive and document all information as close to the reporting as possible; include observations of the interactions between, and emotional states of, the child and his/her family.
- The following pieces of information are essential to the medical history; suggested phrasing of the corresponding questions, if directed to children, is given alongside in italicized typeface[61]:

Table 9-3: Example questions for history taking[62]

Event	Example question
Obtain information from caretaker / social worker / law enforcement separate from child	*Include past medical, developmental and behavioral history.* *Ask about exposure to violence, drugs, and pornography.*
Interview child alone in a safe environment that is comfortable for the child. Establish rapport with the child. Determine child's verbal and cognitive abilities, level of comfort, and attention. Establish rules: If I ask questions you don't know, "I don't know" is an OK answer. If I make a mistake or misunderstand you please correct me. If you need a break, please ask.	*What's your name? How old are you? Where do you live? Who else lives with you? Do you have any pets? Names? What grade are you in? What do you like best about school?*
Ask about daily living and intimate relationships.	*Where do you sleep? Where do mommy/daddy sleep? Who gives you a bath?*
Determine if child knows the difference between truth and lies and remind the child to tell the truth	*If I told you that this rabbit was an elephant, what would that be? (truth or lie) Let's only talk about things that are true, that really happened.*
Ask the child to identify body parts, including names for genitalia and anus (use a diagram). Use child's name for the body part. Ask about different types of touch; include kisses, hugs, tickles, spankings, and pinches or bite	*Identify hair, eyes, nose, mouth, belly button, breasts, and private parts. Who gives you kisses? Hugs? Spankings? Etc.? Show me where kisses go? Hugs? Spankings? How do hugs make you feel? Kisses? Spankings?*

[61] TGuidelines for medico-legal care for victims of sexual violence, WHO, 2003
[62] Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient, ACEP, 2013

Try to determine what happened. Begin with open-ended questions. Use more focused questions for younger or reluctant children.	*Do you know why you came to see me today?* *Did something happen to you?* *A focused question is, "Have you had a touch on your bottom (use child's name for body part) that hurt or bothered you?" Can you tell me about that?*
If child begins to disclose, ask easier questions first. Work up gradually to the harder details. Ask younger child to show you what happened. (use dolls or diagrams to aid demonstration, if specially trained) Avoid questions that contain the answer. Avoid questions that can be answered yes	*Where were you when that happened? Where was Mommy? Daddy? Was anyone else there? Who did it? What did he/she do? How did it make you feel? How did it make your "peepee" feel? Did he/she say anything? Did you tell anyone? Whom? What did he/she say when you told?*
Elicit the details of the abuse from the child. Use the diagram to ask about all possible abusive touches and ask about any other times (places) it happened. Descriptors of odor, texture, sensations are extremely valuable in substantiating the event	*Ask the child specifically about the penis. Who has one? What is it for? What did it look like? What did you see/feel it do? Where did it go? Anything come out of it? What? Where did it go? Who cleaned it up?*
For the older child or adolescent, questions can be more specific. Last consensual sexual content if within the last five days	*Obtain date and time of assault. Oral, breast, rectal, or genital contact or penetration.* *Ask about ejaculation and bathing, brushing teeth, urinating, defecating, douching, changing clothes since assault, and saving clothes or bedding.* *Obtain menstrual history and whether patient is sexually active and/ or uses contraceptives.* *Were any lubricants or a condom used?*
Conclude the interview	*Tell the child he/she did a good job and that it was good that he / she told so we can help.* *Assure them that they are not in trouble.*

Psychological assessment of children[63]

The psychological assessment of the child should include the developmental stage of the child, and any signs of distress the child may be experiencing as a result of the violence and exploitation they have experienced.

→ Assess the child for:

- Signs of depression
- Anxiety
- Symptoms associated with posttraumatic stress disorder such as avoidance, numbing, hyper-arousal
- Inappropriate sexual behavior
- Loss of social competence
- Cognitive impairment
- Substance abuse
- Alterations in body image
- Suicidal ideations

[63] The clinical management of children and adolescents who have experienced sexual violence, Technical considerations for PEPFAR Programs, USAID, February 2013

Annex 9-1: Consent form[64]

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

CONFIDENTIAL
Consent form

Note to the health worker:
This form should be read to the patient or guardian in her/his first language. Clearly explain to the patient what the procedure for the medical examination involves and allow her/him to choose any or none of the options listed. The patient can change his/her mind at any time and a new form can be completed.

I, _____ *(name of patient)*,
give my permission to _____ *(Medical Facility)*
to perform the following (select one option for each, do not leave blank):

1. A medical examination:	☐ **yes** ☐ **no**
2. A pelvic and anal examination:	☐ **yes** ☐ **no**
3. A speculum exam (if medically necessary):	☐ **yes** ☐ **no**
4. Collection of evidence, such as body fluid samples.	☐ **yes** ☐ **no**
5. HIV test	☐ **yes** ☐ **no**
6. Provision of evidence and medical information to the police, prosecutor and/or court; this information will be limited to the results of this examination and any relevant follow-up care.	☐ **yes** ☐ **no**

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

Patient _____ Signature:

Guardian _____ Signature (if the patient is a minor):

Date: _____

[64] Adapted from Consent form MSF, 2011

10. Medico-legal evidence

The main purpose of an examination of a rape survivor is to determine the type of medical care to be provided. Forensic evidence may also be obtained in order to assist the survivor pursue legal redress where possible.

The survivor may decline the procedure. Respect her/his choice[65].

At primary health care level, the conditions required for obtaining forensic samples will rarely be met. Therefore, a referral should be proposed to the next level of care and depending on the informed decision of the survivor a referral can be made.

However, in all cases it is possible to obtain a minimum of proofs confirming the facts stated by the survivor:

- Record the survivor's story in a medical file
- Note your observations during the clinical examination
- Complete a medical certificate

Referral to forensic medicine

- Inform the survivor about her legal rights and about the forensic examination or a clinical examination followed by a medical certificate.
- Propose a referral for forensic examination.
- It is the survivors' decision to accept or decline the proposition for referral for forensic examination. Respect her choice.
- The informed voluntary consent of the survivor must be obtained before referral is made.
- If appropriate, offer an initial dose of HIV PEP before forensic evidence is obtained. Only in cases of confirmed oral sex, an oral swab should be taken before offering the initial dose of HIVPEP[66].

Completing a medico-legal certificate

- The medical certificate is a confidential medical document that the doctor must hand over to the survivor. The medical certificate constitutes an element of proof and is often the only material evidence available, apart from the survivor's own story.
- The medico-legal certificate is obligatory for the clinician and a right of the victim.
- It is covered by medical secrecy: it is personal and confidential.
- It is the only document which may help to prove the offence. The survivor must be able to assert her/his rights before a national or international tribunal (so that the perpetrator can be convicted and/or the victim gets financial compensation).

How to document a case[67]?

- Use the standardized medico-legal certificate for adults or children (Refer to certificates attached in this chapter).
- Record the interview and the results of any examination in a clear, complete, objective, non-judgmental way.
- It is not the health care provider's responsibility to determine whether or not a woman has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.

[65] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005
[66] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007
[67] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005

- Completely assess and document the physical and emotional state of the survivor.
- Document all injuries clearly and systematically, using standard terminology and describing the characteristics of any wounds. Record your findings on pictograms. Do not make interpretations, just describe injuries in as much detail as possible (see Table 1), without speculating on their cause, as an incorrect analysis may have profound consequences for either the survivor or alleged assailant.
- It may be important to note any details related to the incident that explain the absence of injuries – not all sexual assault will necessarily result in injuries and any information provided by the survivor to explain why there may not be any injuries should be documented. This is because absence of injuries can be interpreted by courts as an absence of evidence that the sexual assault has taken place.
- Record precisely, in the survivor's own words, important statements made by her/him, such as reports of threats made by the assailant. Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied.

Table 10-1: Describing features of physical injuries[68]

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

[68] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005

Annex 10-1: Medical certificate for an adult[69]

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

MEDICAL CERTIFICATE FOR AN ADULT - GBV

Confidential document - covered by medical confidentiality

I, _____(last name, first name), medical staff working for _____ in _____ certify that at _____ (time, day, month, year) I examined, at his/her request, Mr, Mrs or Miss _____ _____(last name, first name), born on _____ (day, month, year), living at _____ (precise address).

(S)he declares to have been the victim of a sexual assault at _____ (time, day, month, year) in _____ (place) by _____ (one/several aggressors, known/unknown, armed/non-armed)

During the consultation, (s)he told me:

«_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____»

(quote as faithfully as possible the person's words without looking to interpret them, do not forget threatening elements, constraints or violence linked to the circumstances and, if advisable, the identity of the aggressor)

Mr, Mrs, Miss _____ presented the following signs:

[68] Adapted from Medical Certificate, MSF 2011

On general examination: _____

_____

_____

_____

_____

_____

(detail the behaviour, prostration, agitation, calm, fright, muteness, tears, etc.).

On somatic examination: _____

_____

_____

_____

_____

_____

(describe in detail all lesions observed on the entire body: signs of abrasion, cuts, scratches, bites, swelling strangulation, burns, etc. Indicate the location, extent, number, character (recent or old), severity etc.).

On genital examination: _____

_____

_____

_____

_____

_____

(traumatic lesions, genital infections etc.).

On anal examination: _____

_____

_____

_____

_____

_____

(detectable traumatic lesions, etc.).

Examinations carried out (particularly samples taken): _____

_____

_____

_____

_____

Certificate drawn up in duplicate on the_____ (day, month, year) one copy handed over to _____ for the attention of whom it may concern.

"The absence of physical injuries does NOT indicate that no sexual assault took place"

Name of medical staff:

_____

Signature of medical staff

Name of the director of Health Facility:

_____

Signature of the Director of Health Facility

Name of the Director of Provincial Health Hospital

_____

Signature of the Director of Provincial Health Hospital

Stamp of Health Facility

Stamp of the Director of Provincial Health Hospital

Annex 10-2: Medical certificate for a child[70]

INCIDENT CODE	REGISTER NUMBER	PERSONEL CODE

MEDICAL CERTIFICATE FOR AN ADULT - GBV

Confidential document - covered by medical confidentiality

I, _____ ***(last name, first name), medical staff working for*** _____ ***in*** _____ ***certify that at*** _____ ***(time, day, month, year) I examined, at his/her request of*** _____ ___***(father, mother, legal representative), the child*** _____ ***(last name, first name), born on*** _____ ***(day, month, year), living at*** _____ _____ ***(precise address of parents or the child's residence).***

(S)he declares to have been the victim of a sexual assault at _____ ***(time, day, month, year) in*** _____ ***(place) by*** _____ ***(one/several aggressors, known/unknown, armed/non-armed)***

(S)he declares to have been the victim of _____ (type of Gender-Based Violence) at _____ (time, day, month, year) in _____ _____ (place)

During the consultation, the child me:

«_____
_____
_____
_____
_____
_____
_____»

(quote as faithfully as possible the person's words without looking to interpret them, do not forget threatening elements, constraints or violence linked to the circumstances and, if advisable, the identity of the aggressor)

During the consultation, _____(name of person accompanying the child) ***declared***:

«_____
_____
_____
_____
_____
_____

[70] Adapted from Medical Certificate MSF, 2011

_____
_____»

This child presents the following signs:
On general examination: _____
_____
_____
_____
_____
_____
(detail the behaviour, prostration, agitation, calm, fright, muteness, tears, etc.)

On somatic examination: _____
_____
_____
_____
_____
_____
(describe in detail all lesions observed on the entire body: signs of abrasion, cuts, scratches, bites, swelling strangulation, burns, etc. Indicate the location, extent, number, character (recent or old), severity etc.).

On genital examination: _____
_____
_____
_____
_____
_____
(traumatic lesions, genital infections etc.)

On anal examination: _____
_____
_____
_____
_____
_____
(detectable traumatic lesions, etc.).

Examinations carried out (particularly samples taken): _____
_____
_____
_____
_____

Certificate drawn up in duplicate on the_____ (day, month, year) one copy handed over to _____for the attention of whom it may concern.

"The absence of physical injuries does NOT indicate that no sexual assault took place"

Name of medical staff:

_____

Signature of medical staff

Name of the director of Health Facility:

_____

Signature of the Director of Health Facility

Name of the Director of Provincial Health Hospital

_____

Signature of the Director of Provincial Health Hospital

Stamp of Health Facility

Stamp of the Director of Provincial Health Hospital

11. Physical and Genital Examination[71]

The primary objective of the physical examination is to determine the type of medical care to be provided to the survivor.

Work systematically and in accordance with the medical examination form (see sample form in Chapter 9).

The form/content of the physical examination will ultimately depend on the type of violence experienced and on how soon after the incident the survivor presents to the health facility. Follow the steps in Part 11.2 if the survivor reports physical violence, while distinguishing those survivors presenting within 72 hours of the incident and post 72 hours; Part 11.3 is applicable to survivors who report rape, making the same distinction. The general guidelines apply in both cases.

General guidelines

- Make sure the equipment and supplies are prepared.
- Obtain voluntary informed consent for the physical examination (see consent form: annex 9-1).
- For minors, ensure that the consent is obtained from both a caregiver and the child. If a child refuses, explore the reasons for refusal. Consider providing an examination on the lap of the caregiver or on an examination table with the mother close by. If the child still refuses, abandon the examination. Consider sedation only if the child denies permission but conditions require medical attention (bleeding, ...)[72]
- Prepare the survivor for the medical examination by explaining the procedure and its importance.
- Always tell her/him what you are going to do and ask her/his permission before you do it
- Assure the survivor that she/he is in control, can ask questions, and can stop the examination at any time.
- Always first observe the survivor before touching her/him and note her/his appearance and mental state.
- Always maintain a gentle and kind manner.
- Take the survivor's vital signs (pulse, blood pressure, respiratory rate and temperature).
- The initial assessment may reveal severe medical complications that should be treated urgently and for which the survivor should be admitted to hospital. Such complications may include:
  - Extensive trauma (to genital region, head, chest or abdomen),
  - Asymmetric swelling of joints (septic arthritis),
  - Neurological deficits,
  - Respiratory distress.
  - The treatment of these complications is not covered in this protocol.
- Provide analgesic and/or sedative medication, if necessary.
- Record all your findings and observations as clearly and completely as possible on a standard examination form (see annex 9-2).
- In cases where a genital examination is required:
  - Begin with the vitals, then carry out the physical examination. Take your time before introducing the genital examination.
  - Be extra sensitive in respecting the modesty of the survivor.
  - Use a sheet to cover the abdominal area and legs.

[71] Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced
[72] Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

Physical violence only

Physical examination

a. **Survivor presents within 72 hours of the incident**
   - Respect the modesty of the survivor by uncovering her/him partially and progressively as the examination proceeds
   - Minutely and systematically examine the survivor's body. Start the examination with vital signs and then hands and wrists rather than the head, since this approach is more reassuring for the survivor. Do not forget to look in the eyes, nose, and mouth (inner aspects of lips, gums and palate, in and behind the ears, and on the neck. Check for signs of pregnancy. Note the pubertal stage.
   - Look for signs consistent with the survivor's story, such as bite and punch marks, restraint-marks on the wrists, patches of hair missing from the head, or torn eardrums, which may be a result of being slapped. If the survivor reports being throttled, look in the eyes for petechial haemorrhages.
   - Note all your findings carefully on the examination form and the body figure pictograms (see annex 9-2), taking care to record the type, size, color and form of any bruises, lacerations, ecchymoses and petechiae.
   - Take note of the survivor's mental and emotional state (withdrawn, crying, calm, etc.).

b. **Survivor presents more than 72 hours after the incident**
   It is rare to find any physical evidence more than one week after an assault. If the survivor presents within a week of the rape, or presents with complaints, do a full physical examination as above. In all cases:
   - Note the size and color of any bruises and scars;
   - Note any evidence of possible complications resulting from the rape (deafness, fractures, abscesses, etc.);
   - Note the survivor's mental state (normal, withdrawn, depressed, suicidal).

Rape

Physical examination

Perform the physical examination in accordance with the above instructions. For female survivors that arrive more than 14 days after the rape, check for signs of pregnancy.

Examination of the genital area

a. **Survivor presents within 72 hours of the incident**

Women

Even when female genitalia are examined immediately following a rape, identifiable damage exists in less than 50% of cases. Carry out a genital examination as indicated below. Note on the pictogram and the examination form the location of any tears, abrasions and bruises.

- Systematically inspect, in the following order, the mons pubis, inner thighs, perineum, anus, labia majora and minora, clitoris, urethra, introitus and hymen:
  - Note any scars from childbirth.
  - Look for genital injury, such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
  - Look for any sign of infection, such as ulcers, vaginal discharge or warts.

  - Check for injuries to the introitus and hymen by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards. Hymenal tears are more common in children and adolescents.

- For the anal examination the survivor may have to change position. Note the position during each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination).
  - Note the shape and dilation of the anus. Note any fissures around the anus, the presence of faecal matter on the perianal skin, and bleeding from rectal tears.
- If there has been vaginal penetration, gently insert a speculum, lubricated with water or normal saline:
  - Under good light inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
- If indicated by the history and the examination itself, carry out a bi-manual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.
- If indicated, carry out a recto-vaginal examination and inspect the rectal area for trauma, recto-vaginal tears or fistulas, bleeding and discharge. Note the sphincter tone. If there is bleeding, pain or suspected presence of a foreign object, refer the survivor to a hospital.

Girls[73]

- When carrying out a genital examination of a girl, ask the child to lie supine in the frog-leg position, and/or, if comfortable, in the knee-chest position.
- In most cases, the hymen and surrounding structures will be easily identified. If not, use the following technique:
  - Separate the labia with gentle lateral movement or with anterior traction (i.e. by pulling labia slightly towards examiner);
  - After forewarning the child, gently drop a small amount of warm water on the structures; this may cause the structures to "unstick" and become more visible;
  - Ask the child to push or bear down.
    Describe the location of any injuries using the face of a superimposed clock, paying close attention to the area between 4 and 8 o'clock, the most probable location of a penetrating injury.
- Most examinations in pre-pubertal children are non-invasive and should not be painful. Speculums or anoscopes and digital or bi-manual examinations should not be used in child sexual abuse examinations. They should be performed on the pre-pubescent child only in cases of suspected foreign bodies or deep vaginal wounds, and only using a speculum adapted for this age group (« virgin speculum »). If a speculum examination is required, sedation or anaesthesia is highly recommended.
- To examine the anal area (in boys and girls), place the child in the lateral position and apply gentle traction to part the buttock cheeks. Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

Elderly women

Elderly women who have been vaginally raped are at increased risk of vaginal tears and injury, and transmission of STI and HIV. Decreased hormonal levels following the menopause result in reduced vaginal lubrication and a thinner and more friable vaginal wall. Use a thin speculum for genital examination. If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum.

[73] Guidelines for medico-legal care for victims of sexual violence, WHO, 2003

Men

- For the genital examination:
  - Examine the scrotum, testicles, penis, peri-urethral tissue, urethral meatus and anus.
  - Note if the survivor has been circumcised.
  - Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele), torsion of testis, bruising, anal tears, etc.
  - Torsion of the testis is an emergency and requires immediate surgical referral.
  - If the urine contains large amounts of blood, check for penile and urethral trauma.
  - If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.

b. Survivor presents more than 72 hours after the incident

If the survivor presents more than 72 hours, but less than one week post incident, note any healing injuries to genitalia and/or recent scars.

If the survivor presents more than one week post assault, and there are no bruises or lacerations and no complaints (e.g. of vaginal or anal discharge or ulcers), any requirement to undertake a pelvic examination is minimal.

Even when the presence of injury is considered unlikely, the survivor may nevertheless sincerely believe that she/he has been injured and such belief may be the primary motivation for her/him to attend at a medical facility. Accordingly, a careful inspection with subsequent reassurance that no physical harm has been done may be of great relief and benefit to the survivor.

12. Management of Wounds[74]

The primary goals for wound care are to attain a functional closure, decrease potential risk for infection, and minimize scar formation.

Steps:
- Control the bleeding
- Assess the wound
- Cleanse the wound (and remove debris)
- Closure of wound
- Provide appropriate dressing
- Consider antibiotics
- Consider tetanus prophylaxis (TT and TIG)
- Consider pain relief
- Offer follow-up

GBV survivors may sustain acute wounds as a consequence of the violence. Most of these wounds are classified as '**traumatic wounds**'[75 76] (like abrasions, lacerations, punctures, incisions), as they are the result of tissue damage caused by trauma, including blunt force, projectiles, heat, electricity, chemicals or friction. An acute wound is by definition expected to progress through the phases of normal healing, resulting in the closure of the wound.

Depending on its level, all acute wounds may have serious short and long-term consequences. Therefore, all GBV survivors with wounds should have their wounds appropriately assessed by a trained health worker as soon as possible after their arrival at the medical facility.

All aspects of wound care, including assessment, treatment and evaluation, should be documented clearly and comprehensively by progress notes and treatment plans.

The procedures described below are not a substitute for professional judgment, but are intended for use as a resource to support the clinical decision-making process relating to the assessment and management of wounds, in-line with individual professional competence.

Control the bleeding

The first step of acute wound management is to stop profuse bleeding.
- Apply direct pressure to the wound
- Use a tourniquet if required (applied for no longer than 15 minutes at a time above systolic blood pressure)
- Elevate the affected area

Wound assessment

Assessment of the wound is the first step in the management of the wound. As wound healing is determined by the general health of the patient, a comprehensive assessment of the survivor is crucial when planning and evaluating treatment.

[74] Medical Care and Management of Rape Survivors, MSF-Suisse, 2011
[75] Clinical Guidelines (Nursing): wound care, The Royal Children's Hospital Melbourne
[76] Acute wounds also include by definition 'surgical wounds'.

Considerations for assessment:

- **Wound bed:** granulation, epithelization, slough, necrotic, hypergranulation
- **Wound measurement:** measure length, width and depth of the wound
- **Wound edges:**
  - Color: pink edges indicate growth of new tissue; dusky edges indicate poor wound healing and erythema indicates physiological inflammatory response or cellulites
  - Raised – wound edges may indicate pressure or malignant changes
  - Rolled – wound edges may indicate wound stagnation or wound chronicity,
  - Contraction – wound edges are sign of healing
  - Sensation – increased pain or the absence of sensation should be noted
- **Exudate**: It is important to assess and document the type, amount and odor of exudate to identity any changes
- **Infection:** If any of the below clinical indicators are present, medical review should be instigated and microscopy, culture and wound swabs should be considered

  Local infection indicators:
  - Redness (erythema or cellulitis) around the wound
  - Increased amounts of exudate that is purulent in nature
  - Change in color of exudates
  - Malodor
  - Localized pain and/or warmth around the wound
  - Delayed or abnormal healing
  - Wound breakdown

  Systemic infection indicators:
  - Increased systemic temperature (> 38° Celsius)
  - General malaise
  - Increased leucocyte count
  - Lymphangitis
- **Surrounding skin:** healthy, macerated, dry, eczematous, black, fragile, edema, erythema, cellulitis, induration (hardening)
- **Pain:** Accurate assessment of pain is essential with regard to choice of the most appropriate dressing. Assessment of pain before, during and after a dressing change may provide vital information for further wound management. Adequate pain relief medication must be provided to the survivor if needed

Wound cleansing

The second essential step is wound cleansing, defined as the delivery of a fluid to the wound surface by a mechanical force in order to remove debris, dressing residue and excess exudate to reduce the bacterial count and irrigate the wound.

Principles:

- Use aseptic technique procedure (see table 12-1)
- Excessive wound cleansing should not be done , avoid removal of 'normal' exudate
- Cleansing should be performed in a way that minimizes trauma to the wound
- Wounds are best cleansed with **sterile isotonic saline or water**
- The less we disturb a wound during dressing changes the lower the interference to healing
- Fluids should be warmed to 37°C to support cellular activity
- Skin and wound cleansers should have a neutral pH and be non-toxic
- Avoid alkaline soap on intact skin as the skin pH is altered and resistance to bacteria decreases

- Avoid delipidising agents as alcohol or acetone as tissue is degraded
- Antiseptics are not routinely recommended for cleansing the inside of the wound and should only be used sparingly for infected wounds and skin.
- Start cleansing with the cleanest area of the wound and progressing to the dirtiest

Table 12-1: Antisepsis

PLAIN SKIN Antisepsis	Choice 1	Choice 2
Hand washing	Water and soap	
Hand rub	Alcohol based hand rub	Chlorine 0.05%
Antiseptic hand washing	Iodine Povidone scrub 7.5% 30 sec	Water and soap Rinse with water Alcohol based hand rub 30 sec
Surgical hand scrub	Iodine Povidone scrub 7.5% 3 min (1 min + 1 min + 1 min)	Scrub: water and soap (1 min) Rinse and dry Alcohol based hand rub (3 min)
SC – IM – IV injection	Iodine Povidone 10% Let dry	Chlorhexidine 0.05% Let dry
Surgical site preparation Pleural puncture Catheter insertion	Iodine Povidone scrub 7.5% Rinse and dry Iodine Povidone 10% twice Let dry before incision	
BASIC WOUND Antisepsis	**Choice 1**	**Choice 2**
Cleaning of superficial non infected open wound or suture	NaCl 0.9%	
Disinfection of superficial open wound or suture	Iodine Povidone 10%	Chlorhexidine 0.05%
First treatment of soiled (traumatic) wounds	Iodine Povidone scrub 7.5% Rinse with NaCl 0.9% Apply Iodine Povidone 10%	Chlorhexidine scrub 4% Rinse with water Apply chlorhexidine 0.05%
Cleaning and disinfection of purulent wounds	Iodine Povidone scrub 7.5% Rinse with NaCl 0.9% Apply Iodine Povidone 10%	Chlorhexidine scrub 4% Rinse with water Apply Chlorhexidine 0.05%
Candidiasis (oral, mammary, diaper dermatitis), Superficial skin infections	Gentian Violet	

Irrigation:

Proper irrigation reduces bacterial contamination and helps prevent contamination. Irrigation is the preferred method for cleansing open wounds. Gauze swabs and cotton wool should be used with caution as they may cause mechanical damage to new tissue.

- For heavily contaminated wounds, use high pressure irrigation (>8 psi), using a 30-to-60-ml syringe and an 18 gauge needle (and if available a splatter shield).
- If appropriate, remove all debris.

Protocol for irrigation of wounds[77]

Numerous wound irrigation techniques exist. Here syringe irrigation will be described.

Equipment:

- Waterproof trash bag
- Linen-saver pad
- Emesis basin
- Clean gloves
- Sterile gloves
- Goggles
- Gown, if indicated
- Prescribed irrigant
- Sterile water or normal saline solution
- Soft rubber or plastic catheter
- Sterile container
- Materials as needed for wound care
- Sterile irrigation and dressing set
- Commercial wound cleaner
- 35-mL piston syringe with 19-gauge needle or catheter
- Skin protectant wipe

Anesthesia

- Anesthetize the wound bed before irrigation, when appropriate
- Perform wound decontamination, including brushing off any dry chemicals, prior to irrigation.

Preparation

- Prepare irrigation solution and irrigation delivery device in the consultation room.
- Never use any solution that has been opened longer than 24 hours.
- Place a waterproof trash bag near the patient's bed.
- Turn down the top of the trash bag, creating a cuff, to provide a wide opening and prevent instruments or gloves from touching the bag's edge.

Positioning

- Position the patient so the solution runs from the upper end of the wound downward.
- Place a waterproof bed pad and clean basin or irrigating pouch under the area to be irrigated.

Technique:

- Assess the patient's condition and identify any allergies, specifically to povidone-iodine or other topical solutions or medications.
- Assess the wound, including the amount and character of drainage and the size and condition of the wound and surrounding tissue.
- Irrigation should be performed using strict aseptic technique.
- Wash hands. If necessary, wear a protective gown. Put on clean gloves.
- If applicable, remove soiled dressing and discard with gloves.
- Put on goggles, if needed.
- Hold the filled syringe just above the top edge of the wound and gently instill fluid into the wound, slowly and continuously until the syringe is empty. Be sure the solution flows from the clean to dirty area of the wound. Use enough force to flush out debris, but do not squirt or splash fluid. Irrigate all portions of the

[77] Wound Irrigation, Medscape, Allen Gabriel, MD; Chief Editor: Erik D Schraga, MD

wound. Do not force solution into the wound's pockets. Repeat irrigation procedure until the prescribed amount of solution is administered or the solution draining from the wound is clear.

- Remove and discard disposable irrigation equipment in trash bag.
- Clean the peri-wound area with normal saline solution; wipe intact skin with skin protectant wipe. Gently pat dry the wound's edges, unless the wound should be covered with a wet-to-dry dressing (dry only surrounding skin). Work from cleanest to most contaminated part of wound.
- The patient should be positioned comfortably to allow further drainage into the basin.
- Apply dressings as ordered
- Record the date and time of irrigation, amount and type of irrigant, appearance of the wound, sloughing tissue or exudate, amount of solution returned, skin care performed around the wound, dressings applied, and the patient's tolerance of the treatment.

Complications:
Wound irrigation may cause excoriation and increased pain. Pressures over 15 psi may traumatize the wound and force bacteria back into the tissue.

Wound closure

The third step will be to evaluate the most appropriate treatment option that will lead to a functional closure of the wound in order to decrease any potential infections and minimize scar formation.

I. Non-surgical

a) Dressing only

For managing simple lacerations (small, superficial wounds which are not gaping or contaminated), there are a number of different dressings and techniques available.

Not all wound dressings are suitable for all wounds, but the general rule is to keep it as simple as possible. A wound will require different management and treatment at various stages of healing; therefore frequent assessment of the wound is required.

Considerations when dressing a wound:

- Maintain a moist environment at the wound site /dressing interface
- Be able to control (remove) excess exudates. A moist wound environment is good, a wet environment is not beneficial
- Do not use adhesive dressings on a wound because removal of same may cause trauma to the wound or surrounding tissue and disrupts epithelisation.
- Protect the wound from the outer environment - bacterial barrier
- Good adhesion to skin
- Sterile
- Aid debridement if there is necrotic or slough tissue in the wound (caution with ischemic lesions)
- Keep the wound close to normal body temperature
- Ensure the dressing conforms to body and does not interfere with body function
- Be cost-effective

Remark : Puncture wounds are usually best left open although they may require exploration or debridement if deep or contaminated.

For a detailed overview of possible local therapies for wounds for wounds see following table.

Table 12-2: Local Therapies for Wounds[78]

Therapy	Examples	Advantages	Disadvantages	Uses
Topical antimicrobial agents				
Silver sulfadiazine	Silvadene	Wide antimicrobial coverage, painless	Requires frequent dressing changes, delays reepithelialization, stains tissue, may cause allergic reaction, may cause transient leukopenia	Deep burns, weeping burns, heavily contaminated or infected burns
Mafenide acetate	Sulfamylon	Wide antimicrobial coverage, penetrates eschar	Painful, may cause metabolic acidosis, may delay reepithe-lialization	Deep burns with eschar
Bacitracin		Painless, inexpensive, does not cause staining	Narrower antimicrobial cover age, requires frequent dress ing changes, may cause allergic reaction	Facial burns, small burns, abrasions, lacerations, bites
Mupirocin	Bactroban	Painless, good coverage of gram-positive organisms	Expensive, requires frequent dressing changes	Facial burns, abrasions, bites
Triple antibiotic		Wide antimicrobial coverage, inexpensive, painless	Requires frequent dressing cha	Facial burns, small burns, abrasions, lacerations, bites
Nonabsorptive dressings				
Impregnated, non-adherent	Xeroform, Adaptic, Vaseline gauze	Painless, inexpensive	No antimicrobial activity, messy	Superficial burns and abra-sions, lacerations
Nonabsorptive poly- urethane film	OpSite, Tegaderm	Reduces pain, transparent	Promotes maceration	Minor abrasions, dry superficial burns
Silver-impregnated dressings	Acticoat, Actisorb, Aquacell	Wide antimicrobial coverage, reduces pain	Expensive, needs to be kept moist	Burns
Silicone	Mepitel	Painless, allows seepage of exudate into secondary dressing	Expensive	Burns, deep abrasions
Absorptive dressings				
Hydrocolloids	DuoDERM, Tegasorb	Reduce pain	Malodorous, opaque	Weeping burns, deep abrasions, skin tears
Hydrogels	Aquasorb, Vigilon, Curagel, FlexiGel, Nugel	Rehydrate dry wounds		Weeping burns, deep abrasions, crusted surface exudate
Alginates		Absorb exudate	Require frequent dressing changes, nonadhesive, has been less extensively studied than other dressings	Weeping burns

[78] Adam J. Singer, M.D. and Alexander B. Dagum, M.D., Current Management of Acute Cuteous Wounds, The New England Journal of Medicine, 2008, 359:1037-46.

Protocol: Dressing acute wounds, without a drain[79]

Acute wounds are the result of surgical or traumatic injury to healthy tissue.

Equipment:
- Clean tray or work surface
- Alcohol-based solution
- Clean drape
- Three-instrument dressing set and/or sterile disposable gloves
- Normal saline
- Povidone-iodine 7.5% soap, if needed
- Antiseptic: povidone-iodine or chlorhexidine-cetrimide
- Sterile compresses
- Prescribed dressing (alginate, paraffin, etc.)
- Non-sterile disposable gloves
- Bandage
- Adhesive tape
- Screen, if needed

Preparation:
- Prepare the materials on the tray or work surface
- Explain the procedure to the patient
- Position the survivor
- Place a clean drape under the wound
- Wash your hands, or disinfect them with an alcohol-based solution
- Put non-sterile gloves on
- Remove the dressing
- Discard the dressing
- Remove gloves
- If dressing is being done with sterile gloves, prepare the sterile materials and don sterile gloves

1. Simple wound dressing

Indications
- Small wound without tissue loss
- Sutured wound (e.g. surgical incision)

How often to change dressing
- Clean, sutured wound: remove dressing 24 hours to several days after surgery, according to the physician's orders
- Clean, non-sutured wound: if no complications, twice a week until healed
- Infected wound, sutured or not: daily

Procedure
- Observe the condition of the incision or wound, looking for signs of inflammation or infection. In case of infection, notify the physician so that he or she can adjust the orders appropriately.

[79] Medical Care and Management of Rape Survivors, MSF-Suisse, 2011

- Clean the wound:
  * Clean, sutured wound: clean the sutures, then the surrounding area with normal saline-soaked compresses
  * Infected, sutured wound: clean the area around the wound, and then the sutures, with compress soaked with povidone-iodine soap
  * Non-sutured wound: clean the area around the wound, and then the wound itself, with compress soaked with normal saline, or povidone-iodine soap if the wound is infected
- Rinse, if necessary, and pat dry
- For sutured wounds that are infected (pus discharge between the stitches, either spontaneously or by pressing here and there on the wound): remove 1 or 2 stitches to allow the pus to drain
- Apply antiseptic to the wound
- Cover the wound, or not:
  * Clean, uninfected wound: leave the wound uncovered, or cover with a dry dressing of sterile compresses held in place by a bandage or adhesive tape. The decision to cover the wound or leave it exposed to the air depends on its condition and location, the context, and local customs.
  * Infected wound: cover with a dry dressing of sterile compresses held in place by a bandage or adhesive tape.
- Dispose of waste
- Wash your hands, or disinfect them with an alcohol-based solution
- Record the procedure in the survivor's file

2. Dressing an acute open wound

Indications
- Wound with tissue loss: post-traumatic wound, open amputation stump, small bite wound, etc.
- Graft or flap dressing

How often to change dressing
- Uninfected wound: depends on the stage of wound healing and the type of dressing used
- Infected wound: daily

Procedure
The procedure is usually painful, and requires that provision be made for analgesic administration prior to dressing change, if needed.
- Observe the condition of the wound:
  * Look for signs of inflammation or infection: appearance of wound borders; wound color and odor
  * Assess the progress of the wound: depth and area
  * Assess the healing stage
- Clean the area around the wound with compresses soaked with normal saline, or povidone- iodine soap if the wound is infected
- Rinse, if necessary, and pat dry
- Clean the wound with compresses soaked with normal saline, or povidone-iodine soap if the wound is infected
- Rinse, if necessary, and pat dry
- Apply a dressing according to the healing stage, the wound characteristics and the physician's orders:
  * Inflammatory stage:
    - Exudative wound, infected or not: alginate or wet-to-dry dressing

- Dry wound or necrotic patch on uninfected wound: wet-to-dry dressing
- Bleeding wound: alginate dressing

* Granulation stage:
  - Normal granulation: paraffin gauze (tulle gras) dressing
  - Hypertrophic granulation: hydrocortisone ointment
* Epithelialization stage:
  - Paraffin gauze or dry dressing

- Cover with sterile compresses held in place by a bandage or adhesive tape
- Reposition the survivor
- Dispose of waste
- Wash your hands, or disinfect them with an alcohol-based solution
- Record the procedure on the wound dressing follow-up card

Note: For wet-to-dry dressings, remove the dressing without moistening it, in order to remove all the impurities.

b) Tissue adhesive ("glue")

- Can be used on wounds which are not actively bleeding, have clean edges, do not require deep sutures and are not under tension.
- Best for wounds of less than 3 – 5 cm in length with edges easily held together.
- Do not use on mucosal surfaces.
- If the wound is on or near the forehead or the eyelids, padding should be applied over the eyes and the eyelids for protection to avoid any glue dripping into the eye or onto the eyelashes.
- Approximate the edges of the wound and apply very small amount of glue to the surface, holding the edges together for at least 30 seconds to 1 minute.
- Do not allow glue to enter wound itself (non-absorbable - acts as foreign body), generates heat (may be uncomfortable if applied too thickly)
- Care should be taken not to apply too much tissue glue and to avoid placement over currently bleeding wounds as the polymerization is exothermic and the survivor will notice a heat sensation. The tensile strength of the bond will also be reduced.
- Does not require removal; comes off in 1-2 weeks.

c) Adhesive strips ("Steristrips")

- May be adequate in simple lacerations which require approximation of slightly separated wound edges.
- They do not remain in place for long periods, and should not be used if there is movement or tension across the wound.
- Prepare skin with tincture of benzoic compound to aid adhesion.
- Place strips with sufficient space between each to allow drainage of exudate from the wound to avoid infection.
- Keep dry for 72 hours.

II. Surgical

Suturing or staples are indicated where the wound edges are more difficult to align and where increased tension is anticipated.

For clean wounds staples/sutures should be applied within 24 hours. After the expiration of this 24-hour time period, or in the case of deeper or contaminated wounds, the wounds will have to heal by second intention or delayed primary suturing. In most cases, very dirty wounds or bite wounds should not be sutured.

Protocol for basic laceration repair[80]

Purpose:
To describe the criteria and procedure for repair of lacerations as a treatment to avoid infection, promote good wound healing, minimize scarring, obtain good cosmetic results, and repair loss of tissue integrity due to trauma

Indication:
Simple or intermediate laceration to the skin, after assessment to rule out artery, bone, ligament, nerve, or tendon involvement.

Contraindications/Consultation Required:
1. Complex & deep lacerations - consult with physician prior to closure.
2. Involvement of artery, bone/joint capsule, ligament, nerve, or tendon – refer to Orthopedic or Vascular Surgery.
3. Do not suture infected or contaminated wounds, missile wounds, human or animal bites, without physician consultation.
4. Do not suture wounds older than 2 weeks – refer to a surgeon.
5. If suspect foreign body (metal, glass, etc...), refer to a surgeon (preferably a plastic surgeon) for X-ray and management

Considerations:
- Consider tetanus history and prophylaxis if needed.
- Never use local anesthetics with epinephrine to anesthetize wounds on fingers, toes, ears, penis, or tip of nose.
- Use local anesthetics with epinephrine cautiously in survivors with cardiovascular disease, hypertension, hyperthyroidism, diabetes mellitus or narrow angle glaucoma.

Procedure:
A. Equipment:
- Normal saline sterile solution (irrigation bottle)
- Betadine solution
- Laceration repair suture kit (needle holder, forceps with teeth, iris scissors)
- 4x4 gauze pads
- Sterile towels
- Sterile gloves
- Local anesthetic (lidocaine 1% with or without epinephrine)

[80] Protocol: Laceration Repair, Vanderbilt University Medical Center, Nurse Practicioner Protocols

- Syringes with 18g & 25g needles
- Appropriate suture material

B. General Guide in Choice of Suture Material

- Face: 6 – 0 nylon
- Hands: 5 – 0 nylon
- Trunk, extremities, foot, sole: 4 – 0 nylon
- Scalp and knee: 3 – 0 nylon
- Absorbable (Vicryl) for subcutaneous: 4 – 0, 3 – 0, 2 – 0
- Oral cavity beyond mucosal border: 5 – 0 chromic gut or vicryl

C. Procedure

1. Position patient so that the laceration is easily accessible
2. Irrigate wound with normal saline – for average – sized wounds, 100 – 300 mL should be used (greater volumes may be required for larger or heavily contaminated wounds) – use 35 cc syringe and 18 Ga. angiocath for irrigation or irrigate via holes punched with 18 Ga. Needle through saline irrigation bottle top (25 – 40 psi); irrigation should continue until all visible, loose particulate matter has been removed
3. Betadine prep and sterile drape wound
4. Anesthetize wound via direct infiltration of wound edges with local anesthetic – lidocaine 1% with or without epinephrine (check allergy history prior to administration); maximum allowable dose at one time of lidocaine 1% without epinephrine is 4 mg/kg (20 cc per average adult), with epinephrine is 7 mg/kg.
5. Reassess wound for nerve, vessel, and /or tendon injury, joint capsule involvement, foreign body, and extent / depth of wound
6. Debride devitalized tissue as needed with iris scissors or #15 blade
7. Place sutures using appropriate suture material and suture technique (interrupted, running continuous, vertical mattress, horizontal mattress, buried, subcuticular, flap repair); for deep lacerations, place deep layered sutures with Vicryl or lessen dead space and provide less tension on skin sutures; place skin sutures with good approximation and eversion of wound edges, and with minimal tension
8. May use skin staples to approximate long, linear lacerations involving the scalp or areas of less cosmetic importance (never use staples on the face)
9. Apply antibiotic ointment (Bacitracin if not allergic), and dressing if needed.
10. Write procedure note in survivor's medical record documenting: length of wound, type of laceration – complex or simple, local anesthetic used and amount, amount of saline used for irrigation, type of suture material used, suture techniques used to repair laceration, how the procedure was tolerated and if any complications.

E. Patient Teaching

- Keep wound dry for 24 – 48 hours
- May shower / keep clean with Dial soap and water 48 hours after procedure
- After 48 hours, observe wounds for signs of infection and return if: fever, redness, pus or odorous drainage, red streaks, swelling, or increased pain.

Follow–up

- Hand injuries, complicated lacerations, and infection – prone wounds should be re evaluated in 24 – 48 hours.

- Return to clinic for suture removal as indicated
- Guide for Length of Time Sutures Should be Left in Place:
  * Face: 3 – 4 days
  * Neck: 5 days
  * Scalp: 6 – 7 days (sutures or staples)
  * Arms and back of hand: 7 days
  * Chest and abdomen: 7 – 10 days
  * Legs and top of feet: 10 days
  * Back: 10 – 12 days
  * Palms of hands, soles of feet: 14 days

Protocol: Suture removal[81]

Sutures are removed by order of the physician, or according to established protocols, usually 3 to 10 days after suturing.

Materials

- Clean tray or work surface
- Alcohol-based solution
- Clean drape
- Three-instrument dressing set
- Normal saline
- Povidone-iodine 7.5% soap, if needed
- Antiseptic: povidone-iodine or chlorhexidine-cetrimide
- Sterile compresses
- Non-sterile disposable gloves
- Adhesive tape
- Screen, if needed

Procedure

- Prepare the materials on the tray or work surface
- Explain the procedure to the patient
- Position the patient and place the drape
- Wash your hands, or disinfect them with an alcohol-based solution
- Don non-sterile gloves and remove the dressing, if there is one
- Remove gloves
- Examine the incision: in case of delayed healing or wound separation, do not remove the sutures, and inform the physician
- Clean the wound with compresses soaked with normal saline, or povidone-iodine soap if the wound is infected (see Simple wound dressing)
- Rinse, if necessary, and pat dry
- Place a dry compress alongside the incision for depositing sutures after removal
- Remove the sutures: external suture material should never enter the subcutaneous tissue

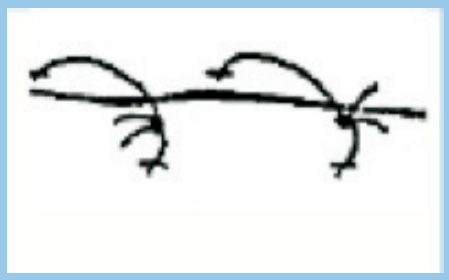
[81] Sophie Lauzier, Nursing guidelines, A handbook for MSF missions, Wound dressing, 139-162, MSF-France

Removal of interrupted sutures

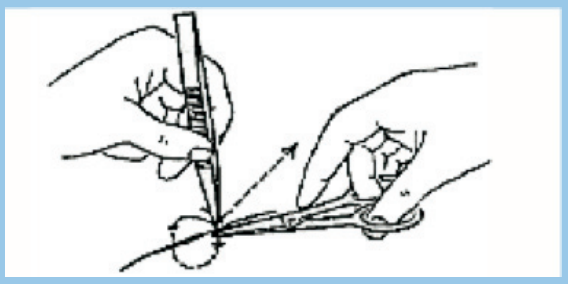
If the incision is long, start by removing every other stitch, making sure that the wound is well- healed before removing the rest.

- Grasp both ends of the knot with sterile forceps. Move the knot around to unstick it.
- Cut one side of the stitch flush with the skin and gently pull the suture out.
- Drop the suture onto the compress and verify that it is all there (the knot + 3 strands)
- Repeat this operation for each stitch, verifying that each one has been completely removed

Interrupted sutures



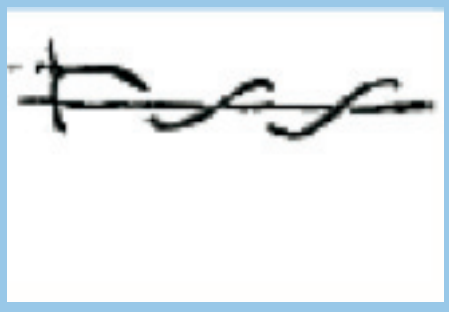
Removal of interrupted sutures



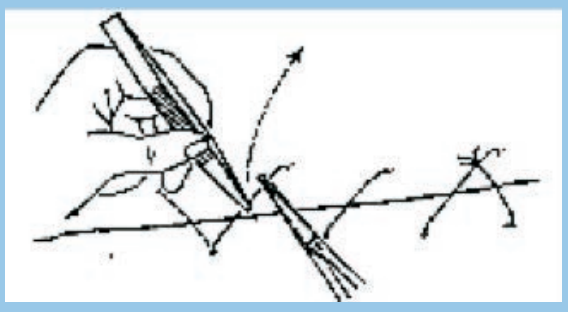
Removal of running suture

- Hold the starting knot with sterile forceps and cut the suture flush with the skin
- Grasp the suture with sterile forceps, cut it flush with the skin at its entry point, then pull the suture out and drop it onto the compress
- Cut the next stitch, again flush with the skin and at its entry point, then pull the suture out
- Repeat this operation for each stitch, dropping each piece of suture material on the compress
- When you have reached the end stitch, cut the suture flush with the skin on the knot side, and pull the suture out

Running Sutures



Removal of running sutures



- Clean the wound again with compresses soaked with normal saline, or povidone-iodine soap if the wound is infected
- Rinse, if necessary, and pat dry
- Apply antiseptic
- Leave the scar uncovered, or cover with a dry dressing of sterile compresses and adhesive tape.
- Reposition the patient
- Dispose of waste
- Wash your hands, or disinfect them with an alcohol-based solution
- Record the procedure in the patient's chart

Anesthesia:

Proper wound assessment and wound cleansing can be painful. Evaluate and use adequate anesthesia for complete examination, cleansing, debridement and repair of wounds if necessary.

- Topical anesthesia
  - ALA (adrenaline/lidocaine/amethocaine) 0.1 ml/kg.
  - EMLA or AnGel applied to the wound (most effective on limb wounds)
- Local anesthesia
  - eg. 1% lidocaine with adrenaline slowly infiltrated into the wound,
  - ATTENTION , care should be taken not to use adrenaline on finger tips, nose, penis, toes and ears.

Tetanus prophylaxis

Prevention of tetanus in wound management depends on risk and pre-exposure vaccination status.

Use the following table from chapter 14 to decide whether to administer tetanus toxoid (which gives active protection) and anti-tetanus immunoglobulin, if available (which gives passive protection).

Antibiotics

Antibiotics are not indicated for clean wounds. They are usually given for bites and wounds with extensive tissue damage, or massive contamination, where decontamination plays a primary role and antibiotics play a secondary role. Recommended antibiotics are procaine penicillin 25-50 mg/kg IM once and augmentin/amoxicillin (10-20 mg /kg) 8-hourly for 5 days.

Follow-up care

Management of complications and troubleshooting.

Inappropriate management of wounds may lead to delayed healing, deterioration of the wound and sometimes even wound breakdown. As stated above, wounds should be carefully reassessed with every dressing change in order to ensure that the most appropriate products are used.

If unsure, refer to an experienced health worker or specialized health structure.

Discharge planning and community-based management.

Provide parents/care takers with appropriate discharge information.

Care takers should be given a plan for the on-going management of the wound at home and provided with appropriate dressing products. Parents/Care takers should be advised on recognizing infections.

Special Considerations[82]

In case of rape, wounds 'may' occur in the vulva/vaginal, in the ano-rectal or/and in the mouth area. The absence of physical injuries in the penetrated area does not indicate that no sexual assault took place. According to different studies, only a minority of rape survivors sustain physical injuries in the genital area (between 20%-40 going up to 50-60%)[83 84]. If forced anal intercourse occurred, injury was more likely[85].

Vulva/vaginal wounds

Sometimes patients suffer from intra-vaginal bruises and wounds. If these are superficial and non-penetrating, follow the same wound care principles as above, first obtaining patient consent.

The vagina is vascular. Be cautious with (unnecessary) debridement. Superficial wounds usually heal well without topical treatment.

If wounds appear to be deep, irrigate them thoroughly with normal saline.

More serious injuries may result from use of excessive force, from objects thrust into the vagina or from rape by multiple aggressors. This may cause a (urethra-) vesico-vaginal fistula (VVF) or a recto-vaginal fistula (RVF) or a combination of both. Cases of fistula can be referred to specialized hospitals.

Ano-rectal wounds:

Superficial wounds and lacerations can be cleaned with sodium chloride 0.9%. No antibiotics required. Provide analgesics.

Deep wounds with involvement of anal sphincter are difficult to assess. If evidence, or doubt of lesions of the anal sphincter exist, then the patient should be referred rapidly to a surgical facility. The wound should be cleaned, adequate analgesics should be provided and antibiotics should be prescribed wherever necessary.

Perforations of the rectum are life-threatening (leading to sepsis, peritionitis and acute abdomen). Patients should be referred to emergency care following stabilization (fluid resucitation intravenously) and antibiotic therapy (Amoxy-clavunic acid + Metronidazole + Gentamycin)

Remember that for non-surgical staff, lesions in the anus and rectum are difficult to assess, even under anesthesia. If in doubt, it is always better to refer.

Mouth wounds:

Superficial wounds and lacerations: cleaning with sodium chloride 0.9%.

Deeper wounds can be sutured with reabsorbable suture. Provide antibiotic treatment ((Amoxy-clavunic acid + Metronidazole during 48h) and analgesics.

[82] Medical Care and Management of Rape Survivors, MSF-Suisse, 2011
[83] Lucy Bowyer Registrar, Maureen E. Dalton Consultant, Female victims of rape and their genital injuries, An International Journal of Obstetrics and Gyneacology, May 1997, Vol 104, Issue 5, 617-620.
[84] Marilyn Sawyer Sommers, Defining Patterns of Genital Injury from Sexual Assault, Trauma Violence Abuse. Author manuscript; available in PMC 2011 July 25.
[85] Richard Tewksbury, Effects of Sexual Assault on Men: Physical, Mental and Sexual Consequences, International Journal of Men's Health, Vol.6, No.1, Spring 2007, 22-35.

13. Management of Burns

The aims of burn management are to avoid infection, reduce pain, promote effective wound healing, minimize scarring and psychological trauma and restore or replace damaged skin and normal movement.

As with any wound or trauma, the management of burns follows a series of standard measures:

1. First aid
2. Resuscitation.
3. Tetanus prophylaxis.
4. Analgesia.
5. Prophylactic antibiotics.
6. Nutrition.
7. Avoid Hypothermia
8. Wound management.

In general, burns are a major public health issue in Afghanistan. According to a study carried out by the Esteqlal hospital, women were admitted for burn injuries more often than men and the prevalence of death among females was much higher[86]. Although no specific data exists, it is commonly known that burning is a type of violence used against women and girls and that a number of Afghan females choose self-immolation as a suicide option.

Pathology

Type of burn[87]

Flame and scald burns are the most common. Flame burns are usually deep and appear so at presentation, whereas scald burns may appear much less severe at first. Contact flame burns are typically deep at the center.

Electrical burns fall into 2 categories: flash burns and high-voltage burns. Flash burns occur when a person causes a short circuit resulting in an electrical flash, but no current travels through the body. These may be treated as regular thermal injuries. High voltage (>1,000 volts) electrical conduction injuries – the current travels through the body and is characterized by the "can't let go" phenomenon – are "iceberg injuries", as they usually present with small cutaneous wounds and severe deep-tissue damage.

Friction burns (also described as 'gravel rash') occur when the skin comes into contact with a rapidly moving object such as a car or a road.

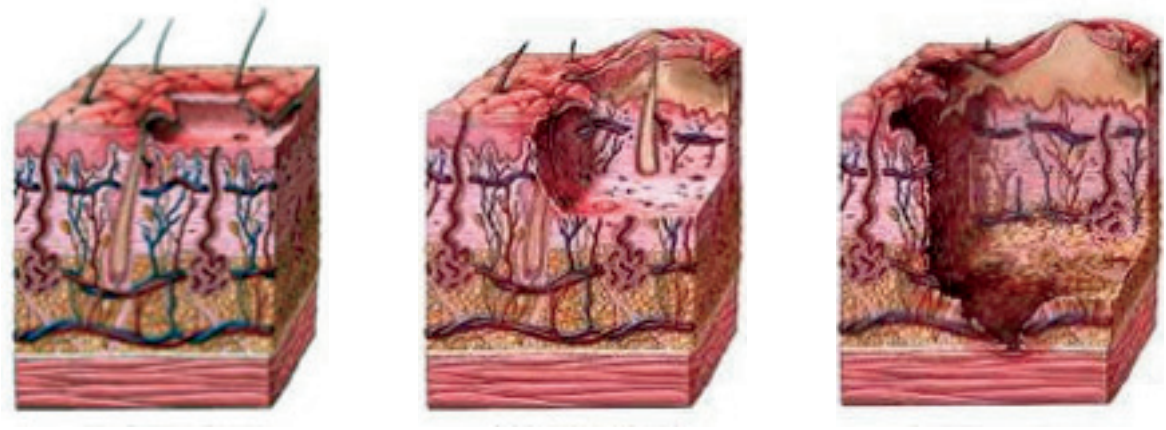
Chemical burns are caused by particular agents: acids, alkalis, and specific compounds (napalm, phosphorus, vesicants, etc.), with their individual characteristics.

Burn depth

Burns involve varying amount of injury to the skin, partial or full thickness, and classically correspond to 3 degrees of burn depth of increasing severity. It is important to estimate the depth of the burn to assess its severity and to plan future wound care.

[86] Epidemiology and outcome of burns in Esteqlal Hospital of Kabul, Afghanistan. Padovese V, De Martino R, Eshan MA, Racalbuto V, Oryakhail MA., Burns. 2010 Nov;36(7)
[87] Burn Injuries, War Surgery, ICRC

Figure 13-1: Burn degree



1st degree burn | 2nd degree burn | 3rd degree burn

Table 13-1: Classification according degree of burn

Depth	Cause	Characteristics	Sensation	Healing	Scaring
1st degree	Sunburn, very short flash	Erythema, blanches with pressure	Intact, mild to moderate pain	3-6 days	Without scarring
2nd degree (partial thickness)	Water scald, short flash	Erythema, blisters, moist, elastic; blanches with pressure	Intact, severe pain	1-3 weeks	Scarring unusual
Superficial Deep	Flame, contact with hot liquids	White appearing with erythematous areas, dry, waxy, less elastic; reduced blanching to pressure	Decreased; may be less painful	>3 weeks	Often with scarring and contractures
3rd degree (full thickness)	Fire, prolonged exposure to hot surface or hot liquids, chemical, electricity or lightning	White, charred, tan, thrombosed vessels; dry and leathery; does not blanch	Anesthetic; not painful (although surrounding areas of 2nd degree burns are painful)	Does not heal	Severe scarring and contractures

It is common to find all three types within the same burn wound and the depth may change with time, especially if infection occurs[88]. Any full thickness burn is considered serious.

Extent of burns

Measuring burn surface area is important during the initial management of survivors with burns, particularly with regard to estimating fluid requirements and to determining the need to transfer to a burns service

The simplest calculation is best done using the "Rule of Nines" (Figure 15.3). The size of the patient's hand (including palm and fingers) is about 1 % of TBSA[89].

[88] Management of burns, WHO Surgical Care at the district Hospital, reformatted 2007
[89] Burn Injuries, War Surgery, ICRC

Although it is difficult to grade the severity of burn wounds, the following provides a rule of thumb[90]:

Minor:

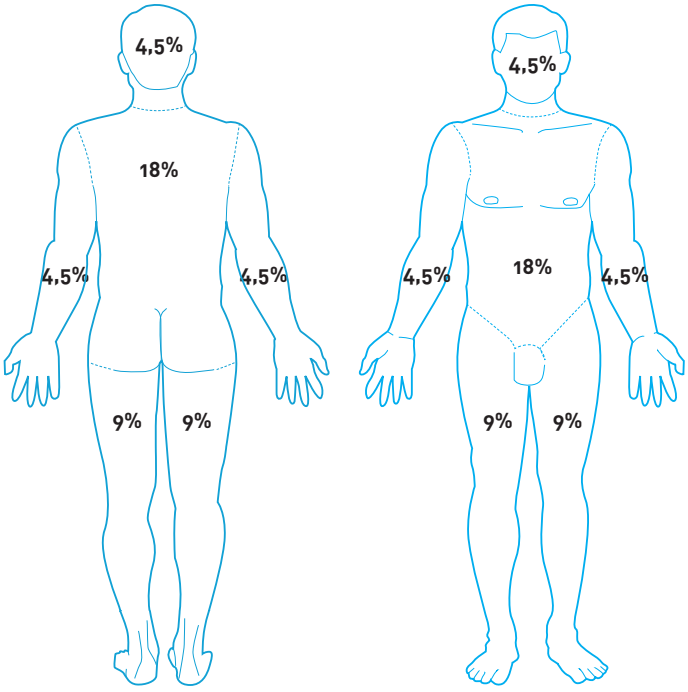
- Second degree less than 15 % TBSA;
- Third degree less than 3 % TBSA.

Moderate:

- Second degree 15 – 25 % TBSA;
- Third degree less than 10 % TBSA.

Major:

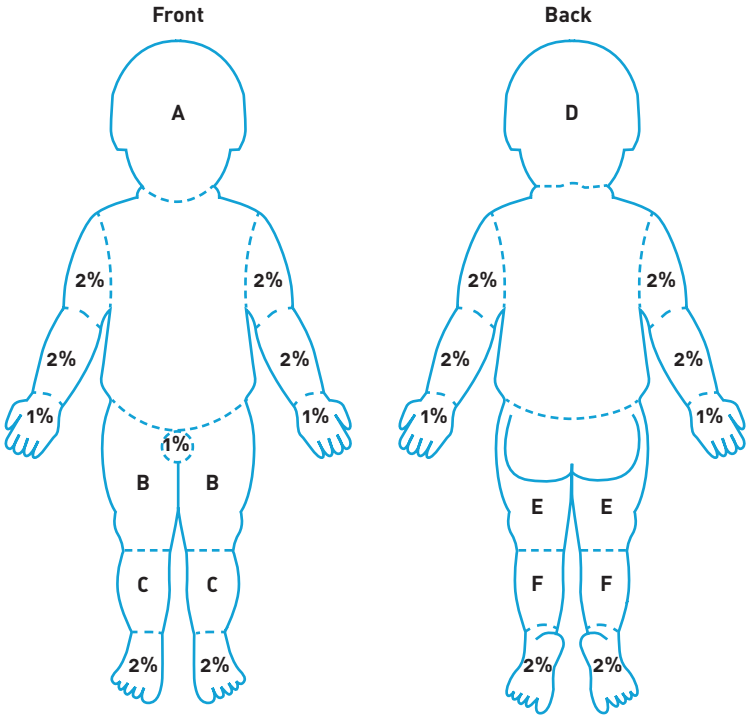
- Second degree more than 25 % TBSA;
- Third degree more than 10 % TBSA
- **Adults**
  - The "Rule of 9's" is commonly used to estimate the burned surface area in adults.
  - The body is divided into anatomical regions that represent 9% (or multiples of 9%) of the total body surface (Figure below). The outstretched palm and fingers approximates to 1% of the body surface area.
  - If the burned area is small, assess how many times your hand covers the area.
  - Morbidity and mortality rises with increasing burned surface area. It also rises with increasing age so that even small burns may be fatal in elderly people.



- **Children**
  - The 'Rule of 9's' method is too imprecise for estimating the burned surface area in children because the infant or young child's head and lower extremities represent different proportions of surface area than in an adult (see Figure below).
  - Burns greater than 15% in an adult, greater than 10% in a child, or any burn occurring in the very young or elderly are serious.
  - Figure: Estimating the burned surface area in children[91]:

[90] Burn Injuries, War Surgery, ICRC
[91] Surgical Care at the district Hospital, WHO 2003

Estimating the burned surface area in children



Area By age in years				
	0	1	5	10
Head (A/D)	10%	9%	7%	6%
Thigh (B/E)	3%	3%	4%	5%
Leg (C/F)	2%	3%	3%	3%

Non-accidental burns

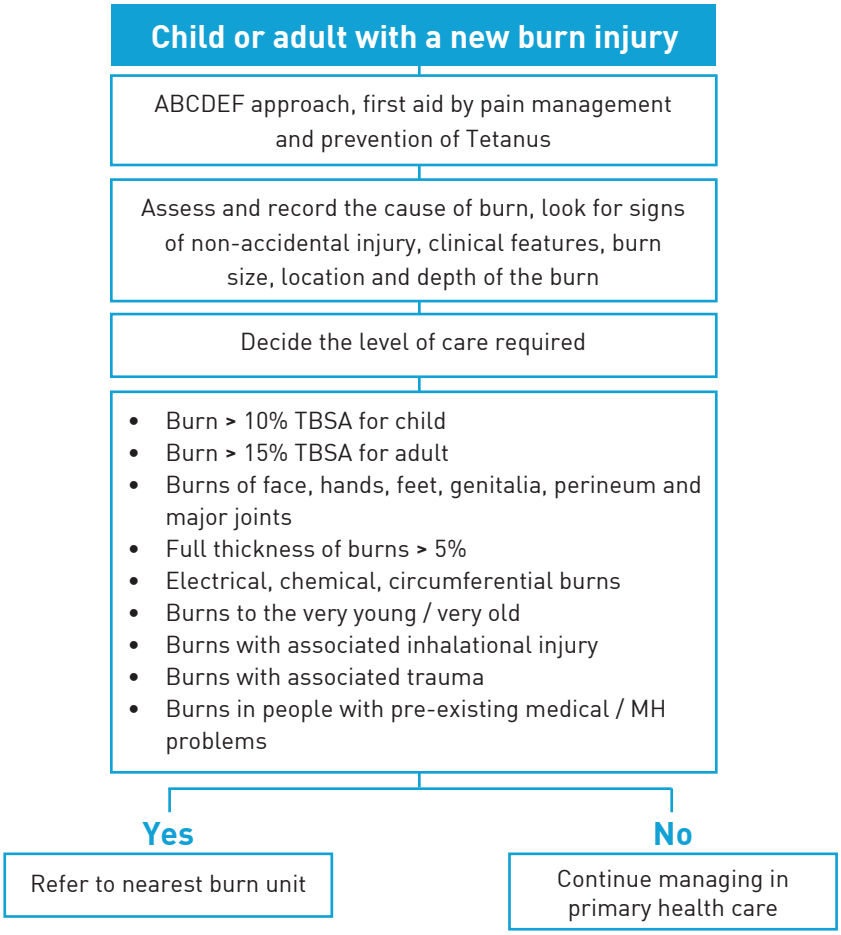
In order to provide comprehensive care for a patient, it is important to distinguish intentional burns from accidental burns.

Indicators of possible non-accidental burns or scalds include the following:

- Delay in seeking help
- Historical accounts of injury differ over time
- History inconsistent with the injury presented or with the developmental capacity of a survivor
- Past history of abuse or family violence
- Inappropriate behavior/interaction between survivor and husband/family members
- Glove and sock pattern scalds
- Scalds with clear-cut immersion lines
- Symmetrical burns of uniform depth
- Restraint injuries on upper or lower limbs
- Other signs of physical abuse or neglect.

Burn management

Algorithm: Initial assessment and management of burns[92]



1. **First aid**

- If the patient arrives at the health facility without the prior administration of first aid, irrigate the burn thoroughly with cool water to prevent further damage and remove all burned clothing.
- If the burn area is limited, immerse the site in cold water for 30 minutes to reduce pain and edema and to minimize tissue damage (useful up to 3 hours after burn).
- Irrigate chemical burns with copious volumes of water for 1 hour.
- Also chemical burns to the eye should be treated with copious water irrigation for at least 30 minutes
- Do not apply ice or gel burn products as first aid.
- If the area of the burn is large, after it has been irrigated with cool water, apply clean wraps about the burned area (or the whole patient) to prevent systemic heat loss and hypothermia.
- Hypothermia is a particular risk in young children.
- Administer adequate analgesia
- The first 6 hours following injury are critical; transport the patient with severe burns to a hospital / burns unit as soon as possible.

[92] Management of Burns and Scalds in Primary Care, New Zealand Guidelines Group, June 2007

2. Resuscitation

The burned patient has the same priorities as all other trauma patients.

- Assess:
  - Airway maintenance with cervical spine control
  - Breathing: beware of inhalation and rapid airway compromise
  - Circulation with hemorrhage control
  - Disability – neurological status (Assess Glasgow Coma Scale)
  - Exposure: percentage area of burn
  - Fluid resuscitation proportional to burn
- Assess the burn, determined by:
  - Burned surface area
  - Depth of burn
  - Other considerations

- Fluid resuscitation:
  - Burns of > 10% body surface area in children and >15% in adults warrant fluid resuscitation
  - Give fluids:
    - 24-hour requirement: 3-4ml crystalloid solution per kg per% burn (Parkland Formula)
    - Plus maintenance fluids for children
    - Give half of the fluids over the first 8 hours, the remainder over the next 16 hours
    - Monitor urine output as following:
    - Adult 0.5 – 1 ml / kg / hr
    - Children 0.5 – 2ml / kg / hr – * aim for 1 ml/kg/hr*
  - Most minor burns presenting less than 10% TBSA for children and less than 15% TBSA for adults, (second degree damage) do not require formal I.V. fluid resuscitation, but can be managed with oral fluids
  - If transportation time exceeds 30 minutes, the indications for fluid resuscitation include thermal injuries involving greater than 20% of TBSA and evidence of burn shock

→ **Serious burns requiring hospitalization**

- Greater than 15% burns in an adult
- Greater than 10% burns in children
- Any burn in infants and children, the elderly or the infirm
- Any full thickness burn
- Burns of special regions: face, ears, eyes, hands, feet, perineum or a major joint, even less than 5-10%
- Circumferential burns
- Chemical burns
- Electrical injuries (including lightning)
- Inhalation injury
- Associated trauma or significant pre-burn illness: e.g. diabetes , malignancy
- Suspected non-accidental injuries
- Nomads and refugees[93]

→ **Transfer of patients to burn unit of hospital for assessment**

- If time from burn to arrival at burns center is <6 hours and the burn is clean:
  → Wash with saline, cover with plastic cling wrap for transfer (do not wrap circumferentially), allowing for easy assessment at the burns center without undue discomfort from removal of dressings.

[88] Indira Gandhi Institute of Child Health, Kabul, Afghanistan

- If transfer is likely >6 hours or burn is dirty:
  → Dirty or charred burns should be washed with aqueous chlorhexidine 0.1% and dressed with Acticoat™ (or SSD cream if the former unavailable).
  → Clean burns should be dressed with a low-adherent dressing - (eg Mepitel™).

3. Tetanus prophylaxis

The patient's tetanus vaccination status should be assessed and updated if needed. Please refer to chapter 14 for tetanus prophylaxis.

4. Pain relief

- Immediate oral analgesia should be provided - paracetamol and oral opiates should be used.
- Fentanyl (intranasal) – 100 mcg/dose (not more than 4 times in 24 hours and only for adults).
- In addition, parenteral opiates may be effective: Morphine (IV) - 0.1 mg/kg given in titrated boluses.
- Inhaled nitrous oxide can be useful for dressing applications combined with appropriate oral analgesia.
- Ongoing oral analgesia
- Refer to national analgesia & sedation guidelines

5. Prophylactic antibiotics.

Systemic antibiotics are no longer prescribed to prevent burn wound infections but good follow-up is needed to monitor infection.

6. Avoid hypothermia[94]

- Once first aid has been completed, the patient must be kept warm. People with large surface area burn injuries are at high risk of hypothermia which can compound the injury and complicate further management. Children have a particularly high risk of hypothermia due to their large body surface area relative to body size.
- Several methods can be used to achieve this:
  - Cover wounds to exclude air and prevent evaporative cooling with cling film.
  - Use a space blanket with normal blankets over the top
  - Heat room
  - Use warming air blankets
  - Warm intravenous fluids

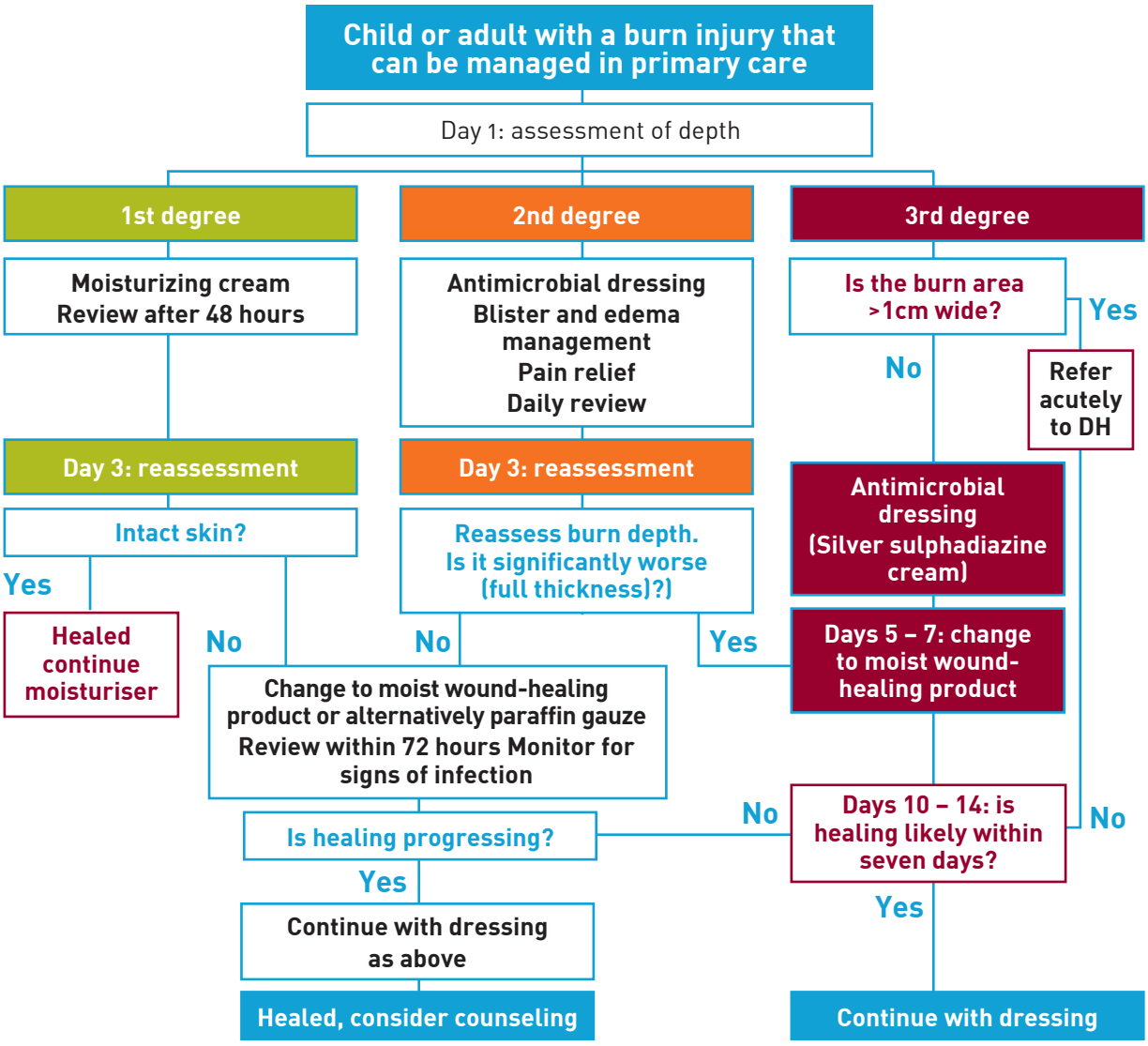
7. Nutrition[95]

- Patient's energy and protein requirements will be extremely high due to the catabolism of trauma, heat loss, infection and demands of tissue regeneration. If necessary, feed the patient through a nasogastric tube to ensure an adequate energy intake (up to 6000 kcal a day).
- Anemia and malnutrition prevent burn wound healing and result in failure of skin grafts. Eggs and peanut oil and locally available supplements are good.

[94] http://www.vicburns.org.au/about.html
[95] Surgical Care at the district Hospital, WHO 2003

Burn wound management

Algorithm: Ongoing assessment and management of burns in primary care[96]



Burn wound cleansing

The goal of wound cleansing is to remove devitalized skin, dirt and debris while minimizing pain and additional trauma to the burn wound. Remember that any burn wound is initially sterile.

- Make sure that the patient is pre-medicated for pain before starting any manipulation of the wound
- Clean the burn and surrounding surface GENTLY with saline and pat dry.
- If treatment is delayed or wound is dirty, use aqueous chlorhexidine 0.1% then saline.
- Management of blisters
  - Preferably leave small blisters intact unless likely to burst or interfere with joint movement
  - If necessary, drain fluid by snipping a hole in the blister.
- Management of edema
  - Where possible, elevate affected area
  - Remove jewelry or constricting clothing.

[96] Management of Burns and Scalds in Primary Care, New Zealand Guidelines Group, June 2007

Burn wound dressing[97]

The burn wound dressing should keep the wound moist and clean, promote optimal function of affected joints, protect the wound from additional trauma, and provide for patient comfort.

- Superficial wounds:
  - Use moisturizer (e.g. Vaseline or Vaseline based creams)
  - If necessary, apply cool compresses
  - Can be treated by exposure
  - In infants who show a tendency to blister or scratch, a protective, low-adherent dressing (eg. Mepitel™ + Melolin™) with crepe bandage may be helpful.
- Superficial partial-thickness burns:
  - Treat with a topical antimicrobial ointment, such as bacitracin, other over-the-counter antimicrobials, or vitamins A and D ointment.
  - Cover with a nonadhering layer
  - Cover with dry gauze and secure with flexible elastic netting
  - Change 1 to 2 times per day, depending on the amount of drainage
  - Avoid the use of occlusive dressings as they do not allow absorption or drainage of exudates and lead to skin maceration and an anaerobic environment.
- Deep partial-thickness burns:
  - Treat with silver sulfadiazine 1%.
  - For pregnant women, use:
    - Docosanol beheny alcohol[98]
    - Silver Nitrate[99]

Special considerations:

- Burn wounds in the face, head or neck:
  - Superficial burns only require Vaseline™ to be applied twice daily
  - Open-dressing method can be used, as contamination is unlikely
  - Apply a thin film of bacitrican ointment if appropriately
  - In case of silver sulfadiazine 1% can be applied without a dressing
- Joints: make sure that the dressing facilitates ranges of motion
- Fingers: wrap each finger individually
- SSD and related agents should not be used in women who are pregnant or breast feeding or in infants younger than 2 months old.[100]

Infection[101]

- Signs of infection
  - Surrounding redness, increasing pain, increased exudate/pus, swelling, fever or local wound temperature increase, lymphangitis or increased irritability in a child.
- Suggested management
  - Cleanse the wound (after administering analgesia)
  - Consider re-starting topical silver sulphadiazine
  - Consider starting oral antibiotics
  - For more serious infection, refer acutely to secondary care.

Psychological consequences of burns[102]

- Monitor stress disorders and depression
- Be aware of the risk of sleep disorders
- Offer counseling to survivor and the family affected by the psychological impact of burn injuries

[97] Adapted from Lee S. Moss, Treatment of the Burn Patient in Primary Care, The Nurse Practitioner, August 2010, 35(8), 24-31
[98] Reference http://en.wikipedia.org/wiki/Docosanol
[99] http://med.uvm.edu/surgery/downloads/burnmanual.pdf
[100] Schonfeld N. Outpatient management of burns in children. Pediatr Emerg Care 1990; 6:249
[101] [102] Management of Burns and Scalds in Primary Care, New Zealand Guidelines Group, June 2007

14. Clinical Management of Rape

Table 14.1: Rape management at glance[103]

	General remark	Women	Girls	Men /Boys
Pregnancy Test		Yes	Yes if puberal	N/A
(Hiv test)	If available, recommended at 1st visit or follow up session. If positive, refer to HIV clinic for staging, follow up and treatment			
HIV PEP	HIV test NOT pre-requisite According to risk assessment	If < 72 hrs Bi-therapy (AZT/3TC)	Same as for women	Same as for women
STI Prophylaxis	Always whatever delay	See protocol	See protocol	See protocol
Emergency contraception	Pregnancy Test not pre-requisite	If < 120hrs	If puberal and If < 120hrs	N/A
Hepatitis B prophylaxis	Always if not fully immunized, Better prophylaxis if within 14 d	Hep B vaccine Schedule: d0-d7-d28 (1 booster dose, 1 year later)	< 5 yrs old Pentavalent Schedule: d0-d30-d60 > 5 yrs old same as for women	Men as women Boys as girls
Tetanus prophylaxis	Always if not fully immunized	TT Schedule: -M0-M1-M6	< 5yrs old Pentavalent Schedule: d0-d30-d60	Men as women Boys as girls
	If wound dirty and > 6 hr	250 IU IM	Same as for women	Same as for women
Wound management	Control bleeding, assess the wound, clean the wound (and remove debris), close by dressing or applying sutures if required, provide adequate pain relief, consider antibiotics and tetanus vaccination if required, screen for complications, and refer if needed			
Family Planning	Promote use of condoms for at least 6 months	Propose additional family planning methods	Propose additional family planning methods for married girls	

HIV Post-exposure prophylaxis (HIV PEP)

Rape, compared to regular sexual intercourse, presents a higher risk of HIV and other STI transmission because often the act is violent and may entail traumatic lesions of vaginal, anal or oral mucous membranes. Menstruation, bleeding during intercourse, genital ulcers, STI's and exposure to more than one assailant leads to a higher risk of HIV transmission[104].

If the exposed survivor is an adolescent girl, the immaturity of the vaginal and cervix cells increases the susceptibility of HIV and STI's infections.

Recommended steps for HIV PEP[105]

- Consider offering HIV PEP for survivors presenting within 72 hours of a sexual assault following risk assessment.

[103] Adapted from Medical Care and Management of Rape Survivors, MSF-Suisse, 2011
[104] Adapted from Medical Protocol for Sexual Violence, MSF Sexual & reproductive health working group, 2011
[105] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013

- Discuss HIV risk to determine use of PEP with the survivor, including:
  - HIV prevalence in the geographic area
  - limitations of PEP
  - the 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.
- If HIV PEP is used
  - start the regimen as soon as possible and before the expiration of 72 hours post assault
  - if possible, provide HIV testing and counseling at initial consultation
    - offer bi-therapy (see protocol, below)
    - provide adherence counseling (see script, annex 14-1)
    - ensure survivor follow-up at regular intervals

Risk assessment

The decision to propose PEP must be based primarily on the risk related to the nature of the exposure, and not on the risk of the rapist being HIV positive.

The assessment of risk should be based on what happened during the attack (i.e. whether there was penetration, the number of attackers, injuries sustained, etc.) and HIV prevalence in the region. Risk of HIV transmission increases in the following cases: if there was more than one assailant; if the survivor has torn or damaged skin; if the assault was an anal assault; if the assailant is known to be HIV-positive or an injecting drug user.

If the HIV status of the assailants is not known, even in low prevalence context, assume they are HIV-positive[106].

→ **Recommended risk assessment, HIV PEP eligibility criteria among rape survivors[107]**

1. Rape (penetration) took place less than 72 hours ago
   and
2. HIV status of perpetrator positive or unknown
   and
3. Exposed individual not known to be HIV infected (need to offer HIV testing at time of consultation)
   and
4. 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 assault and is uncertain about the nature of the potential exposure;

   or
   - the person was gang-raped.

[106] APost-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007

[107] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007

Proposing HIV PEP to the survivor:

The information provided to the survivor concerned must cover:

- The risk of HIV transmission and the potential benefits of PEP.
- The treatment: duration, possible side effects and the importance of complying with the treatment even if side effects are present.

Shared decision-making with the survivor should be used to determine whether HIV PEP is appropriate[108].

HIV PEP should not be given without informed consent, although this consent may be given verbally. In case of children, adolescents, survivors that are too traumatized or unconscious or survivors with mental disabilities that impair their understanding, parents or guardians can be asked to provide consent. In emergency cases, a designated official can provide the consent to initiate PEP, where consent cannot immediately be obtained.

→ **The survivor decides not to accept the PEP:** invite the survivor for a second consultation 24 hours later; as long as this is in keeping with the 72 hours post-exposure timescale.

→ **The survivor decides to accept the PEP**
HIV PEP consists of 2 antiretroviral (ARV) drugs given for 28 days.

HIV PEP should be initiated as soon as possible after the assault, ideally within a few hours and no later than 72 hours after exposure[109].

Because of the need of early administration, HIV PEP can be administered before any HIV-testing or forensic procedure (except where oral sex was performed and the survivor requests a forensic examination. Then an oral swab should be obtained before the taking of any medicine)[110]. If rapid HIV testing is available it should always be offered as part of the post-exposure prophylaxis service package based on informed consent with standard pre-test and post-test counseling according to national or local protocols. HIV testing should not, however, be mandatory nor a prerequisite for providing PEP drugs, and the testing results should be treated in the strictest confidence[111]. HIV PEP can start on the same day as emergency contraception and preventive STI regimens, although the doses should be spread out and taken with food to reduce side-effects, such as nausea[112].

Victims of sexual assault presenting later than 72 hours post-incident would not normally be considered eligible for PEP. However, in cases of prolonged sexual assault occurring over a number of hours or days, the 72 hour time-limit should be applied to the most recent potential exposure[113].

People infected with HIV should not be given PEP, but should be linked to appropriate health care mechanisms and provided with antiretroviral therapy.

HIV PEP - ARV regimen:

Prescription of HIV PEP bi-therapy for adolescents < 40 kg and adults

Category of weight	Antiretrovirals	Doses of tab/caps	Dosage	Duration
> 40 kg et adults	Zidovudine and Lamivudine [AZT/3TC]	300/150 mg	1 cp x 2/j	28 days

[108] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[109] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[110] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007
[111] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007
[112] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005
[113] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007

Adverse effects:

- Nausea, vomiting, headache, debility, muscle pain, upset stomach, diarrhoea. While not very serious medically, these side effects can compromise treatment adherence. Inform the survivor that they may occur and stress the importance of continuing the treatment
- There is a rare, but possible, risk of severe anaemia. Stop treatment immediately in case of heart failure
- PEP containing AZT is contraindicated if the survivor presents with pre-existing severe anaemia (Hgb<7.0g/dl). Treat the anaemia and substitute Zidovudine/Lamivudine (AZT/3TC (300mg + 150mg) with Stavudine/ Lamivudine (D4T/3TC (30 mg + 150 mg)
- There is no contra indication for [AZT/3TC] for pregnant and lactating women

Considerations:

- If the survivor has difficulties to adhere to the therapy, presents side effects
- It is recognized that victims of sexual assaults have as higher rate of therapy defaulting
- If the survivor is too distraught to decide about PEP, offer the first doses of medication and re-open the discussion about treatment within the next 24 hours

Prescription of HIV PEP bi-therapy for children < 10 kg[114]

Category of weight	Antiretrovirals	Drug formulation	Dosage according to the weight		Duration
5 – 9 kg	Zidovudine AZT	10mg/ml syrup	5 kg	6 ml x 2/d	28 days
			6 kg	7 ml x 2/d	
			7 kg	8 ml x 2/d	
			8 kg	9 ml x 2/d	
			9 kg	10 ml x 2/d	
	Lamivudine 3TC	10 mg/ml syrup	5 – 6 kg	3 ml x 2/d	
			7 – 9 kg	4 ml x 2/d	

Prescription of HIV PEP bi-therapy for children >10 kg – 39kg[115]

Category of weight	Antiretrovirals	Drug formulation	Dosage according to the weight		Duration
10 – 19 kg	Zidovudine AZT	100 mg caps	10 – 13 Kg	1 caps am – 1 pm	28 days
			14 – 19 Kg	2 caps am – 1 pm	
	Lamivudine 3TC	10 mg/ml syrup	10 – 11	5 ml x 2/d	
		150 mg tab	12 – 13	6 ml x 2/d	
			14 – 19	½ tab am – ½ tab pm	
20 – 39 kg	Zidovudine AZT	300 mg caps	20 – 24	½ tab am – ½ tab pm	28 days
			25 – 29	1 tab am – ½ tab pm	
			30 – 39	1 tab am – 1 tab pm	
	Lamivudine 3TC	150 mg tab	20 – 24	1 tab am – ½ tab pm	
			25 - 39	1 tab am – 1 tab pm	

[114] Developing dosing guidance for formulations of paediatric antiretrovirals, WHO 2012
[115] Developing dosing guidance for formulations of paediatric antiretrovirals, WHO 2012

Special considerations for children:

- AZT/3TC tablets for children are dispersible in water and can be split. They can be dispersed into a small volume of water or crushed and mixed into food
- Clinicians must be aware of issues of consent for children and children's specific problems of adherence and should therefore take time for thorough counselling to these children and their parents/caregivers
- A bottle of syrup should be discarded 15 days after being opened

Options for dispensing PEP at the initial consultation:

- An initial supply of medicine to last 1–7 days (starter packs). A second supply of medicine for the next week for 7 days and the last supply of medicine for 2 weeks. This supply system allows follow-up, encourages adherence, minimizes waste of medicine and is in line with vaccination schedule and return for pregnancy testing.
- The full 28-day course of medicine supplied at the initial visit (maximizing the likelihood of completion if follow-up is a concern)[116].

Adherence counseling:

Many survivors of sexual assault provided with HIV PEP fail to complete the preventive regimen, particularly when taking HIV PEP may result in physical side-effects such as nausea and vomiting, may trigger painful memories 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 so marked efforts should be made to ensure that it is maintained[117].

Prevention and treatment of sexually transmitted infections (STI)

The risk that victims of sexual violence may become infected with an STI due to the rape is elevated. The particular feature of STI, especially gonorrhoea and chlamydia, is that they are asymptomatic in more than 60% of cases among women, compared with 10% among men. For these reasons all rape victims should be given prophylactic treatment for chlamydia, gonorrhoea, syphilis cancroids and trichomoniasis.

As soon as possible post rape, all survivors should receive systematic prophylactic treatment for sexually transmitted infections (chlamydia, gonorrhoea, trichomonas, syphilis and hepatitis B). Even when medical care is sought after a longer period, full prophylactic treatment for STI's should be given[118]. A follow up of STIs is highly recommended, 2 weeks and 6 months post incident[119].

Prophylactic STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV/AIDS (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

The Guideline Development Group of the WHO does not recommend testing prior to treatment for the purpose of avoiding unnecessary delays[120].

As adherence to follow up visits is traditionally low, any adult/adolescent survivor who presents for sexual assault should be offered prophylaxis for STI under the shortest course of antibiotics available[121].

[118] Post-Exposure Prohpylaxis to Prevent HIV Infection, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, WHO & ILO, 2007
[117] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[118] Medical Protocol for Sexual Violence, MSF Sexual & reproductive health working group, 2011
[119] Medical Care and Management of Rape Survivors, MSF-Suisse, 2011
[120] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[121] Evaluation and Management of the Sexually Assaulted or Sexually Abused Patient | ACEP , 2013

Prophylactic regimen:

Adult prophylactic treatment STI's						
Adults	Product	Presentation	Strength	Dosage	Duration	Pills
	Cefixime	Tablet of capsule	200mg	400mg	stat	2
	Azithromycin		250mg	<72h 2g		8
				>72h 2g		8

Adult prophylactic treatment for trichomoniasis						
Adults	Product	Presentation	Strength	Dosage	Duration	Pills
	Metronidazole or Tinidazole	Tablet of capsule	250mg or 500mg	2g	stat	8 or 4

Children's prophylactic treatment STI's					
Children	Product	Presentation	Strength	Dosage	Duration
5-12kg	Cefixime	Powder for suspension	100mg/5ml	8mg/kg	Stat
	Azithromycin		200mg/5ml	20mg/kg	
12-25kg	Cefixime	Tablet or capsule	200mg	200mg	
	Azithromycin		250mg	500mg	
25-45kg	Cefixime		200mg	400mg	
	Azithromycin		250mg	2g	

Children's prophylactic treatment for trichomoniasis					
Children	Product	Presentation	Strength	Dosage	Duration
<45kg	Tinidazole	Tablet +/-Powder for suspension	500mg	50mg/kg (max 2g)	Stat
	Metronidazole		250mg or 500mg or 125mg/ml	30mg/kg/day in 3 dosages	7 days

When using 2g Azithromycin single dose, the survivor is covered for both incubating and post- incubating syphilis. There is then no need for syphilis testing to determine if prophylaxis or treatment is required. If the survivor presents with genital ulcers the survivor should receive 2g Azithromycin stat regardless of hours passed since the rape (or alternatively Benzathine Penicillin G 2.4 MU IM stat).

Contra indications

- Cefixime is not to be administered in known cases of allergy to cephalosporin's.
  A single dose of Ceftriaxone 250mg IM can be used as alternative prophylactic regime
- Administer with care to persons allergic to penicillin: crossover allergy in 5- 10% of cases
  Ceftriaxone should be avoided if persons are allergic to penicillin.
- No contraindications for Azithromycin and Cefixime for pregnant and lactating women
- For pregnant and lactating survivors divide Metronidazole or Tinidazole into smaller doses and avoid prolonged use.

Adverse effects

- Gastrointestinal disorders, headaches, dizziness, allergic reactions (rash, pruritis, fever) and vomiting

Precautions

- If the survivor vomits within 2 hours of receiving the treatment, the dose should be repeated
- If the survivor is taking EC and PEP, instruct the survivor to take the STI drugs with the next meal to avoid nausea.

Treatment of STI's

For treatment of STI's use syndromic approach according to national protocols. To use the Syndromic Approach correctly, a medical history from the survivor and a clinical examination should always be carried out[122].

WHO-recommended STI treatments for adults (may also be used for prophylaxis)[123]

STI	Treatment	
Gonorrhoea	ciprofloxacin cefixime ceftriaxone	500 mg orally, single dose (contraindicated in pregnancy) or 400 mg orally, single dose or 125 mg intramuscularly, single dose
Chlamydial infection	azithromycin doxycycline	1 g orally, in a single dose (not recommended in pregnancy) or 100 mg orally, twice daily for 7 days (contraindicated in pregnancy)
Chlamydial infection in pregnant women	erythromycin amoxicillin	500 mg orally, 4 times daily for 7 days or 500 mg orally, 3 times daily for 7 days
Syphilis	benzathine benzyl penicillin	2.4 million IU, intramuscularly, once only (give as two injections in separate sites.)
Syphilis, survivor allergic to penicillin	erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for **14 days**
Syphilis in pregnant women allergic to penicillin	erythromycin	500 mg orally, 4 times daily for 14 days (Note: this antibiotic is also active against chlamydia)
Trichomoniasis	metronidazole	2 g orally, in a single dose or as two divided doses at a 12-hour interval (contraindicated in the first trimester of pregnancy)

NB. For female survivors, who might be pregnant after rape or for lactating women, propose presumptive treatment that is not contraindicated in pregnancy.

NB. Pregnancy can only be detected a minimum of 2 weeks after insemination.
If survivors are presenting themselves within the first 14 days after the incident, avoid all Medication that are contraindicated in pregnancy

[122] Medical Care and Management of Rape Survivors, MSF-Suisse, 2011
[123] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005

WHO-recommended STI treatments for children / adolescents (may also be used for prophylaxis)[124]:

STI	Weight or age	Treatment	
Gonorrhoea	< 45 kg	ceftriaxone spectinomycin cefixime	125 mg intramuscularly, single dose **or** 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose **or** (if > 6 months) 8 mg/kg of body weight orally, single dose
	> 45 kg		Treat according to adult protocol
Chlamydial infection	< 45 kg	azithromycin doxycycline	20 mg/kg orally, single dose **or** 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	> 45 kg but < 12 years	erythromycin amoxicillin	500 mg orally, 4 times daily for 7 days **or** 1 g orally, single dose
	> 12 years		Treat according to adult protocol
Syphilis	benzathine benzyl penicillin	benzathine benzyl penicillin	50 000 IU/kg intramuscularly (up to a maximum of 2.4 million IU), single dose
Syphilis, survivor allergic to penicillin		erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for **14 days**
Trichomoniasis	< 12 years	metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	> 12 years		Treat according to adult protocol

Remember, these WHO-recommend STI-treatments for adults and children may also be used for presumptive treatment. In case, first mentioned molecules are not available

Prevention of Pregnancy

Most female victims of rape are concerned about the possibility of becoming pregnant as a result of the assault. According to research, rape carries a 5% risk of pregnancy[125]. For women assaulted by intimate partners the percentage of rape-induced pregnancy can rise to 20%[126], while the pregnancy percentage of a single act of intercourse is 3.1%[127]. Intimate partner violence and rape are significantly associated with unwanted pregnancy, which can lead to unsafe abortions practice (Pallitto et al., 2013). Deaths due to unsafe abortion remain close to 13% of all maternal death[128].

[124] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005
[125] Holmes MM, Resnick HS, Kilpatrick DG, Best CL. Rape-related pregnancy: estimates and descriptive characteristics from a national sample of women. Am J Obstet Gynecol 1996; 175: 320-324
[126] McFarlane J et al. Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. Obstetrics and Gynecology, 2005, 105 (1):99–108.
[127] Wilcox AJ & all, Likelihood of conception with a single act of intercourse: providing benchmark rates for assessment of post-coital contraceptives. Contraception, 2001, 63 (4): 211- 215.
[128] http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/

A. Determining pregnancy[129]

Whether the survivor has become pregnant as a result of the rape or was already pregnant prior to the rape can be important for her to determine. Determining whether a survivor was pregnant prior to the rape is not a pre-requisite for using emergency contraceptives, as these will not harm a pre-existing pregnancy.

1. Determining pregnancy by pregnancy test

Determining pregnancy by testing		
Result	Timing of test	Conclusion
Test +	< 2 weeks after the rape	The survivor is pregnant The pregnancy is probably NOT the result of the rape
Test +	> 2 weeks after the rape	The survivor is pregnant If survivor NOT sexually active, probably the result of the rape If survivor sexually active, impossible to determine if the pregnancy is the result of the rape or not
Test -	< 2 weeks after the rape	Probably NO pre-existing pregnancy. Repeat the test 2 weeks later
Test -	> 2 weeks after the rape	The survivor is not pregnant and will not become pregnant as a result of the rape.

NB a pregnancy can only be detected a minimum of 2 weeks after insemination

2. Determining pregnancy by history

When a pregnancy test is not available, assessment of the survivor to establish if she was pregnant prior to the rape can be made by applying the following checklist[130]:

Determining pre-existing pregnancy by history			
	Questions	YES	NO
1	Have you given birth in the last 4 weeks?		
2	Are you less than 6 months post-partum AND exclusively breastfeeding AND free from menstrual bleeding since the birth of your last child?		
3	Did your last menstrual period start within the past 7 days?		
4	Have you had an abortion or miscarriage in the past 7 days?		
5	Have you gone without sexual intercourse (other than the incident) since your last menstrual period?		
6	Have you been using a reliable contraceptive method consistently and correctly? (-ask further with specific questions about the form of contraception used)		

If the survivor answers YES to at least one question, and signs and symptoms of pregnancy are absent, she is unlikely to be pregnant prior to the rape. She may however have become pregnant as a result of the rape. Inform the survivor of the possibilities of emergency contraception (see below).

If a survivor says NO to all the questions, a pregnancy prior to the rape cannot be out ruled or determined –unless of course she has signs and symptoms of pregnancy.

[129] Adapted from Medical Protocol for Sexual Violence, MSF Sexual & Reproducitive health working group, 2011
[130] This checklist can assist to determine approximately 88% of pregnancies, according to Medical Protocol for Sexual Violence, MSF Sexual & Reproducitive health working group, 2011

B. Emergency contraception

If a woman seeks health care within a few hours and up to five days post sexual assault, emergency contraception should be offered.

If accepted, 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 day five.

If the survivor presents more than 5 days after the assault, she should be advised to return for pregnancy testing if she misses her next menstrual period.

1. Survivor presents within first 120 hours after the assault:

The provision of emergency contraception must be automatic for all women of childbearing age (from the onset of puberty, first period) if not already pregnant prior to the assault.

Emergency contraceptive pills work by interrupting a woman's reproductive cycle - by delaying or inhibiting ovulation, blocking fertilization or preventing implantation of the ovum. ECPs do not interrupt or damage an established pregnancy and thus they are not considered by the WHO to be a method of abortion[131].

A pregnancy test is not required to start EC, but if a pregnancy test was provided and the result was positive, emergency contraception is neither necessary, nor effective.

The use of emergency contraception is a personal choice to be made by the woman herself.
Women should be offered objective counseling on this method for the purpose of making an informed decision (see annex 14-3). If the survivor is a child who has reached menarche, discuss emergency contraception with her and her parent or guardian, who may help her to understand and take the regimen as required.

There are two regimes of emergency contraception:

- **Emergency Contraceptive Pill (ECP):**
- **Intrauterine Contraceptive Devices (IUD)**

a. Emergency contraceptive pill

WHO recommends levonorgestrel for emergency contraceptive pill use[132]. Ideally, this progestogen-only method should be taken as a single dose (1.5 mg) within five days (120 hours) of unprotected intercourse.

Based on reports from nine studies including 10 500 women, the WHO-recommended levonorgestrel regimen is 52–94% effective in preventing pregnancy. The regimen is more effective the sooner after intercourse it is taken.

Emergency contraceptive pills							
Product	Brand name	Strength	Dosage	Duration	Pills	1st dose	2nd dose (12h later)
Levonorgestrel	Postinor-2	0.75mg	1.5mg	Stat	2	2	0

If pre-packaged ECP's are not available in your setting, emergency contraception can be provided using regular oral contraceptive pills:

- Levonorgestrel-only regimen (greater efficacy and fewer side effects but a high pill burden)
- Combined estrogen-progestogen regimen (Yuzpe) 2 doses with 12 hours interval

[131] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005
[132] Emergency Contraception Factsheet N°244, WHO, July 2012

Regimen	Pill composition (per dose)	Common brand names	First dose (number of tablets)	Second dose 12 hours later (number of tablets)
Levonorgestrel only	750 µg	Levonelle, NorLevo, Plan B, Postinor-2, Vikela	2	0
	30 µg	Microlut, Microval, Norgeston	50	0
	37.5 µg	Ovrette	40	0
Combined	EE 50 µg + LNG 250 µg or EE 50 µg + NG 500 µg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, Tetragynon/PC-4, Preven, E-Gen-C, Neo-Primovlar 4	2	2
	EE 30 µg + LNG 150 µg or EE 30 µg + NG 300 µg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4	4

Counsel the survivor about (See annex 14-3):

- Possible side effects and the effect of the pills on her next menstrual period.
- Fact that EC's do not prevent pregnancy from sexual intercourse occurring after their use.
- **Adverse effects**
  - Nausea
    → reduce the risk of nausea, suggest that the survivor eats something before taking EC pills
  - Vomiting
    - if the woman vomits within 2 hours after taking EC, she should take another dose (and consider adding an anti-emetic).
    - if vomiting occurs more than 2 hours after taking the EC she does not need extra pills
- Precautions
  - Inform the survivor that her next menstrual period may start several days earlier or later than expected.
  - If her next period is very different from normal she should come back for consultation

Provide her with condoms for use in the immediate future and for dual protection.

Discuss the options of a possible pregnancy if there is no menstruation within 21 days, or within 5 to 7 days after the expected date, if the date is known. Instruct the survivor to return if effects such as headache, dizziness, or abdominal pain continue for longer than 1 week after taking the EC .

b. Intrauterine contraceptive devices (IUDs)

If the survivor presents within five days after the rape (and if there was no earlier unprotected sexual act in this menstrual cycle), insertion of a copper-bearing IUD is an effective method of emergency contraception. It will prevent more than 99% of expected subsequent pregnancies[133]. Insertion of a copper-bearing IUD becomes effective immediately after insertion.

As it presents contra-indications, especially in case of rape, it only should be used if ECP is not available.

A skilled provider should counsel the survivor and insert the IUD. If an IUD is inserted; make sure to give full STI treatment (See 14.2).

The IUD may be removed at the time of the woman's next menstrual period or left in place as contraception.

[133] Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons, WHO, 2005

Contra-indications[134]

- Known or suspected pregnancy
- Puerperal sepsis
- Immediate post-septic abortion
- Unexplained vaginal bleeding
- Women with cervical cancer who are awaiting treatment, or endometrial cancer
- Distorted uterine cavity (any congenital or acquired abnormality interfering with IUD insertion)
- Known pelvic tuberculosis
- Current malignant gestational trophoblastic disease
- Current purulent cervicitis infection with chlamydia or gonorrhoea, or current PID
- Other contraindications might include insertion by survivors with recent postpartum endometritis, gynecologic malignancy, genital bleeding of unknown cause, and gestational trophoblastic disease.

Adverse effects[135]

- Changes in bleeding patterns (especially during the first 3 to 6 months) including: prolonged and heavy monthly bleeding, irregular bleeding, increased cramping and pain during monthly menstruation
- Miscarriage, preterm birth or infection in the rare case that the woman becomes pregnant with the IUD in place
- Perforation risk during insertion (rare) and Pelvic inflammatory disease (rare)

2. Survivor presents more than 120 hours after the assault

Emergency contraception is no longer effective after 120 hours.

If a woman presents after the expiration of the time-limit for emergency contraception (5 days), if the emergency contraception provided is ineffective, or if the woman is already pregnant as a result of the rape, she should be offered counseling.

C. Family Planning

Apart from emergency contraception, a family planning method should be suggested to all female rape survivors. Following an act of sexual aggression, the survivor needs time to recover psychologically. An unplanned pregnancy in the months following the attack may destabilize the survivor and delay her return to physical, sexual and psychological well-being. The survivor should be advised to use a condom with her partner for a period of 6 months (or until STI/HIV status has been determined).

Prophylaxis Hepatitis B (HBV)

Approximately 30% of the world's population, or about two billion people, have serologic evidence of current or past HBV infection. Of these, an estimated 361 million persons have chronic HBV infection. Persons with chronic HBV infection are at increased risk of cirrhosis of the liver and hepatocellular carcinoma. WHO estimates that around 600 000 persons die each year due to HBV-related chronic liver disease[136]. Although there are currently no systematic countrywide data available about the actual prevalence rate of HBV, it appears to be that Afghanistan remains at an early epidemic phase[137].

[134] Medical Protocol for Sexual Violence, MSF Sexual & reproductive health working group, 2011
[135] Medical Protocol for Sexual Violence, MSF Sexual & reproductive health working group, 2011
[136] http://applications.emro.who.int/docs/EM_RC56_3_en.pdf
[137] Share of afghanistan populace in hepatitis B and hepatitis C infection's pool: is it worthwhile? Sanaullah Khan, Sobia Attaullah ; Virol J. 2011; 8: 216. Published online 2011 May 11. doi: 10.1186/1743-422X-8-216

The risk of transmission of hepatitis B is significantly higher than that of HIV (100 times higher).

Every survivor should be offered prophylaxis for hepatitis B as soon as possible after the incident. Survivors of rape should receive post-exposure immunization with hepatitis B vaccine within the first 14 days, (or within the first 3 months of the incident), if possible. This gives maximum prophylactic protection after the assault. If a survivor presents more then 3 months after the incident, Hepatitis B vaccine should always be given, to ensure future protection against Hepatitis B for the survivor.

Hepatitis B has an incubation period of 2-3 months on average. If signs of an acute infection are apparent, the survivor should be referred if possible or provided counseling.

Hepatitis B vaccination should be offered without hepatitis B immune globuline.

In order to avoid unnecessary delays, presumptive treatment is preferable to testing for STI's[138]. If hepatitis B tests are available in the health facility, take blood for hepatitis B status prior to administering the first vaccine dose. If the survivor is immune, no further course of vaccination is required.
The vaccine is safe for pregnant women and for people who have chronic or previous HBV infection. It may be given at the same time as a tetanus vaccine.

The vaccine does not interfere with the immune response to any other vaccine and may be given simultaneously with other vaccines. It may be administered at the same time as the anti-tetanus vaccine, but the vaccines should not be combined in the same syringe.

Vaccine is administered by intramuscular injection in the anterolateral aspect of the thigh (children <2 years) or in the deltoid muscle (adults and older children). Administration in the buttock is not recommended, as the immune reaction is insufficient.

Dosages and schedule

1. **Adults, adolescents and children > 5 years**
   - The dose for an adult is: 20µg/injection
   - The dose for children under 12 years is: 5 to 10µg/injection

The accelerated vaccination schedule below is designed to assist survivors in completing the full schedule. This schedule provides early protective immunity, lasting up to 1 year. For life-long protection, the booster at 1 year would need to be provided[139].

Schedule Hepatitis B vaccination	
Dose	**Day**
HBs1	Day 0
HBs2	7 days after HBs1
HBs3	21 - 28 days after HBs2
HBs4	12 months after HBs3

[138] Responding to intimate partner violence and sexual violence against women, WHO clinical and policy guidelines, WHO 2013
[139] UK National Guidelines on The Management of Adult and Adolescent Complainants of Sexual Assault 2011

2. Children < 5 years

For children under 5 years pentavalent vaccine is recommended.

Schedule should be adapted according to the vaccination status of the child. See tetanus prophylaxis

Contra-indications, adverse effects, precautions

- May cause minor local or systematic reactions -pain or redness at injection site, fever, headache, myalgia etc.
- Very rare: anaphylactic reaction, serum-disease-like reaction, lymphadenopathy, peripheral neuropathy
- History of hypersensitivity reaction to any component of the vaccine
- Assess risk/benefit if known multiple sclerosis
- Pregnancy and breastfeeding: no contra-indication
- No contra-indication in cases of symptomatic or asymptomatic HIV infection

Storage:

- Between 2 and 8°C (never freeze)
- After opening, the 10 dose vial of vaccine may be kept for 1 month

Tetanus prophylaxis

The risk of tetanus infection depends on the nature and violence of the assault. However, within the specific framework of a rape, maximum protection against tetanus infection must be ensured. Therefore, tetanus prophylaxis should always be given (even if the survivor presents months or years after the incident), unless the survivor has been previously fully vaccinated. Administer tetanus toxoid (TT), which gives active protection.

Indication:

Prevention of tetanus in wound management depends on risk and pre-exposure vaccination status:

- **Tetanus Toxoid (TT) vaccine:** Any survivor, who presents with breaks in skin or mucosa, based on immunisation status.
- **Human Tetanus Immunoglobulin (TIG):** Dirty wounds are an increased risk for tetanus unless fully immunized. Provide HTIG in survivors non- immunised or incompletely immunised or in survivors whose immunisation status is unknown, in combination with tetanus vaccine.

Use Table to decide whether to administer tetanus toxoid (which gives active protection) and antitetanus immunoglobulin, if available (which gives passive protection).

Schedule for Tetanus Toxoid (TT) and Human Tetanus Immunoglobulin (TIG)				
RISK	Complete vaccination (≥ 4 doses) Time since administration of latest dose:			Incomplete vaccination (<3 doses) or no vaccination/ unknown vaccination status
	< 5 years	5-10 years	> 10 years	
Clean, minor wounds	none	none	TT: one booster	Start* or complete TT
Dirty, major wounds (deep wounds, substantial tissue loss, foreign bodies, necrosis)	none	TT: one booster	TT: one booster	Start* or complete TT AND administer TIG
*At least 2 doses administered 4 weeks apart. For long lasting immunity add 3 additional doses				

1. **Tetanus Toxoid vaccine:**

Dosages and schedule

a. Adults, adolescents and children > 5 years

Tetanus Toxoid vaccine: 0.5 ml/injection IM (adults and children10). The first two doses of TT are scheduled the same as the rapid hepatitis B vaccine schedule providing 80% protection within 4 weeks. This is relevant to the management of the assault rather than providing extended protection. In most programs TT3, TT4, and TT5 will be given in the regular vaccination program.

Schedule for Tetanus Toxoid Vaccination			
Dose	Calendar	Effectiveness of protection	Duration of protection
TT1	Day 0	0%	None
TT2	4 weeks after TT1	80%	1 to 3 years
TT3	6 months after TT2	95%	5 years
TT4	1 year after TT3	99%	10 years
TT5	1 year after TT4	99%	10 years

Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

b. Children < 5 years

For children less than 5 years old, Pentavalent (DTP-Hib-HepB)[140] vaccine is preferred to tetanus toxoid alone. Schedule should be adapted according to the vaccination status of the child.

Pentavalent vaccine:

- Dose 1: given at the first visit to the clinic
- Dose 2: 4 weeks after the first dose
- Dose 3: 4 weeks after the second dose
- Booster: after 12 to 18 months

Tetanus toxoid alone: 0.5 ml per injection; same schedule as in adults.

2. **Human Tetanus Immunoglobulin (TIG):**

TIG: 250 international units (IU) in 1ml by IM injection into the deltoid or gluteus region.

- If more than 24 hours has elapsed between being injured and seeking medical care the dosage should be doubled (500 IU).
- If TT and HTIG are given at the same time, different needles, syringes and injection sites must be used.
- For children < 5 years: same dosage and indications as in adults.

Contra-indications, adverse effects, precautions

- Known allergy to tetanus toxoid vaccine and TIG
- Rare and mild local reaction: redness and pain at the injection site
- No contra-indications for pregnant and breastfeeding women.
- No contra-indication in cases of symptomatic or asymptomatic HIV infection.

Storage

- Between 2 and 8°C (never freeze)
- After opening, the 10 dose vial of vaccine may be kept for 1 month.

[140] Comprehensive Multi- Year Plan (cMYP) For National Immunization Program (NIP), 2011-2015, Ministry of Public Health DG of Preventive Medicine National Immunization Program (NIP), 2012

Annex 14-1: Script: Adherence counseling

I want to explain to you how to take the medicine you have been prescribed.

Post-exposure prophylaxis medicine works best when the level in your blood stays roughly the same throughout the day. To make this happen, it is important that you take your medicine at regular intervals. In other words, you need to take the dose that you have been prescribed at certain times. For instance, if the medicine needs to be taken twice a day, you should take one dose in the morning, at regular times when you have breakfast or get up, and one in the evening, for example, when you eat dinner or go to bed. For some medicine, there are other instructions: for example, they must be taken with or without food.

These instructions must also be followed.

It is also important that you remember to take each dose. We should think about what you do every day to see if there is anything that might make you miss taking the medicine or if there is anything that might remind you to take it at set times. The full course of medicine is four weeks, so we need to think about what you might be doing over the next four weeks.

I have some tips that might help you take your medicine correctly.

- Use daily life events as cues to take your medicine, such as brushing your teeth or eating meals.
- Establish a set place to take your medicine.
- Try taking medicine with food as this can help to reduce nausea, a common side effect of this medicine. Is food available when you need to take your medicine?
- Consider your work or school patterns and whether taking medicine will mean telling colleagues or family members about post-exposure prophylaxis.
- Think about the days when your routine is different. For example, on weekends, a change in your routine could make you more likely to forget a dose. If you are planning to be out in the evening, it's okay to take a dose a bit early or to take a dose with you.
- Some people find that, when they lie down, although they do not intend to fall asleep, occasionally they do. If you think there is a chance that you might fall asleep if you lie down, you should consider taking the medicine before lying down, even if you do not expect to sleep.
- Set a mobile phone, or some other form of alarm, as a reminder for taking your pills.
- If you feel you can, you could ask family or friends to help you remember to take your medicine.
  If you do forget to take your medicine at the right time, you should still take it if it is less than halfway to the time for your next dose. For example, if you usually take your medicine at around 10 in the morning and again at 10 in the evening, but forget the dose at 10 in the morning, you can still take it if you remember to do so before, say 3 in the afternoon. However, if you don't remember until after 4 in the afternoon, then don't take it, but take the next dose at 10 in the evening as usual. Never take a double dose of your medicine.

Speak to your health care worker or doctor if you have any problems or questions.

Annex 14-2: Script: Side-effect counseling

I want to talk about the post-exposure prophylaxis medicine you will be taking. As for any medicine, you may experience some side effects (unwanted symptoms) caused by the medicine. Not everybody experiences side effects, but about half the people taking PEP do, and these can be worse for some people than for others. Most of these symptoms are mild and will disappear in few days, but you need to know what you should do if you get any of these.

It is important for you to let us, know if you get any symptoms, because we can usually help you to find a way to reduce these symptoms or we may possibly change your medicine.

About half the people who take zidovudine experience fatigue, nausea or headache. For most people, these symptoms are relatively mild and improve within a few days. A couple of more serious side effects are associated with taking zidovudine, but these are extremely rare among people taking the drug for only 28 days. One is inflammation of the liver, which is called drug- induced hepatitis, and the other is suppression of the bone marrow, which can cause you to have fewer red or white blood cells. A decrease in red blood cells is called anaemia and can cause fatigue and shortness of breath. A decrease in white blood cells is called neutropaenia, and this can make you more susceptible to certain kinds of infections. As I said before, both of these side effects would be extremely unusual with a 28-day course of medicine, but if they occur, we would expect that both your liver and bone marrow would return to normal after you had finished your course of medicine. However, it is important for you to understand that we cannot guarantee that you will not have serious side effects from taking this medicine. But as far as we know, no one who has taken zidovudine for 28 days has ever had any long-term side effects.

Annex 14-3: Instructions and formation for survivors prescribed ECP

Survivors who are offered emergency contraception to prevent pregnancy following sexual assault must be made aware of the following facts about ECPs:

- The risk of becoming pregnant as a result of an assault will be decreased if the ECP's are taken within 5 days of the assault.
- ECP's are not 100% effective.
- ECP's do not cause abortion. They prevent or delay ovulation, block fertilization, or interfere with implantation; they will not affect an existing pregnancy.

Instructions for survivors prescribed ECPs are as follows:

- Take pills as directed (see 14.3). (Note: The number of pills varies depending on the type of regimen prescribed).
- The pills may cause nausea and vomiting. If vomiting occurs within 1 hour of taking the ECP's, repeat the same dosage regimen.
- In most cases, the survivor's next menstrual period will occur around the expected time or earlier. If it is delayed, a pregnancy test should be performed to assess the possibility of pregnancy. ECP's do not cause immediate menstruation.
- Finally, survivors should be advised that if they experience any of the following symptoms, they should seek help immediately:
  - Severe abdominal pain;
  - Severe chest pain;
  - Shortness of breath;
  - Severe headaches;
  - Blurred vision or loss of vision;
  - Severe pain in the calf or thigh.

15. Care for the Healthcare Provider

Responding to survivors of GBV can be stressful and overwhelming. Health care providers may be negatively affected by the stories of survivors, or may be affected by violence in her/his own family situation. For a health care provider, it is important to pay extra attention to her/his own wellbeing and to be sure that she/he is physically and emotionally equipped to help others.

- Take care of yourself so that you can best care for others.
- If working in a team, be aware also of the wellbeing of your colleagues.

Consider how stress may be best managed, to support and be supported by your colleagues or supervisor. The following suggestions may be helpful in managing your stress.

- Think about what has helped you cope in the past and what you can do to stay strong.
- Try to take time to eat, rest and relax, even for short periods.
- Practice brief relaxation techniques during the workday
- Try to keep reasonable working hours so you do not become too exhausted.
- GBV survivors may have many problems. You may feel inadequate or frustrated when you cannot help people with all of their problems. Remember that you are not responsible for solving everyone's problems. Do what you can to help survivors help themselves.
- Check in with colleagues to see how they are doing, and have them check in with you. Find ways to support each other.
- Talk with friends, loved ones or other people you trust for support.
- Try to do exercise
- Try to increase doing things you enjoy
- Minimize your intake of alcohol, caffeine and avoid non-prescription drugs.

Health care providers may experience a number of stress responses, which are considered common when working with GBV-survivors:

- Increase or decrease in activity level
- Difficulties sleeping
- Feeling sad, nervous
- Numbing
- Irritability, anger, and frustration
- Upsetting thoughts or memories about the traumatic events disclosed by survivors
- Confusion, lack of attention and difficulty making decisions
- Physical reactions (headaches, stomach aches, being easily startled)
- Symptoms of depression or anxiety
- Decrease in social activities
- Substance abuse

It is important to recognize these symptoms, increase self-care activities and get support from someone you trust.

If these difficulties continue for more than one month, try to speak to a counselor or a mental health specialist if available.