WHO/RHR/14.26

Health care for women subjected to intimate partner violence or sexual violence

A clinical handbook

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This is the field testing version of September 2014. It will be finalized following feedback from field-based partners.

We would be grateful if you could take some minutes to complete the Feedback questionnaire form which can be found online at:
www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/index.html

Your collaboration will help us ensure the Handbook is as useful and user-friendly as possible.

Thank you!

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Preface

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

- *Clinical management of rape survivors* (WHO, UNFPA and UNHCR, 2004)
- *Guidelines for medico-legal care for victims of sexual violence* (WHO, 2003)
- *Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection* (2007)
- *Psychological first aid: guide for field workers* (WHO, War Trauma Foundation & World Vision International, 2011)
- *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings* (WHO, 2010); *Clinical management of mental, neurological and substance use conditions during humanitarian emergencies* (WHO & UNHCR, forthcoming)

The final version of this handbook will be part of the health component of the UN Women and UNFPA Joint Global Programme on Essential Services for Women and Girls subject to Violence 2013-2017.

What is this handbook?

This handbook is for health-care providers like you. It can help you care for women who have been subjected to violence. This can be physical, sexual or emotional violence whether by a partner or in the case of sexual violence by any perpetrator.

Violence damages women's health in many ways, both immediate and long-term, both obvious and hidden. Women who have been abused or assaulted need care and support. As her health-care provider, you may be the first person that she talks to about the violence. This handbook is meant especially to help you respond appropriately.

What this handbook does

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

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

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

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

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

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

The guidelines on which this handbook is based do not directly address young women (under age 18) or men. Nonetheless, many of the suggestions for care may be applicable to young women or to men.

Men and sexual violence

Men also may be victims of partner violence and sexual assault. However, in general women experience more sexual violence, more severe physical violence, and more control from male partners.

While the focus here is on violence by men against women, much of the advice is also relevant to sexual violence against men and boys. It also applies to violence against women by other family members, such as a mother-in-law or a father.

Why is violence against women different?

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

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

Guiding principles for providing women-centred care

Woman-centred care. The woman's wishes determine the care that you give.

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

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

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

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

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

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

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

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

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

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

- reinforcing her value as a person
- respecting her dignity
- listening to her story, believing her, and taking what she says seriously
- not blaming or judging her
- providing information and counselling that helps her to make her own decisions.

Part 1
Awareness about violence against women

What is violence against women

This handbook focuses on violence against women by men, in particular sexual assault and intimate partner violence.

Sexual assault

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

Intimate partner violence

This refers to ongoing or past violence and abuse by an intimate partner or ex-partner —a husband, boyfriend or lover, either current or past.

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

Physical violence

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

Emotional/psychological abuse

This can include many types of behaviours such as:

- criticizing her repeatedly
- calling her names or telling her she is ugly or stupid

- threatening to hurt her or her children
- threatening to destroy things she cares about
- belittling or humiliating her in public.

Controlling behaviours

This includes, for example:

- not allowing a woman to go out of the home, or to see family or friends
- insisting on knowing where she is at all times
- often being suspicious that she is unfaithful
- not allowing her to seek health care without permission
- leaving her without money to run the home.

Sexual violence

This includes:

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

Identifying a woman who may be subjected to violence

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

Women subjected to violence in relationships often seek health care for related emotional or physical conditions, including

injuries. However, often they do not tell you about the violence due to shame or fear of being judged or fear of their partner.

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

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

You may also suspect a problem of violence if a woman's partner or husband is intrusive during consultations, if she often misses her own or her children's health-care appointments, or if her children have emotional and behavioural problems.

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

“What do I do if I suspect violence?”

Never raise the issue of partner violence unless a woman is alone. Even if she is with another woman, that woman could be the mother or sister of an abuser.

If you do ask her about violence, do it in an empathic, non-judgemental manner. Use language that is appropriate and relevant to the culture and community you are working in. Some women may not like the words “violence” and “abuse”. Cultures and communities have ways of referring to the problem with other words. It is important to use the words that women themselves use.

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

Asking about violence

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

- “Many women experience problems with their husband or partner, or someone else they live with.”
- “I have seen women with problems like yours who have been experiencing trouble at home.”

Here are some simple and direct questions that you can start with that show you want to hear about her problems. Depending on her answers, continue to ask questions and listen to her story. If she answers “yes” to any of these questions, offer her first-line support (see page 13).

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

Documenting partner violence

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

- Tell her what you would like to write down and why. Ask her if this is okay with her. Follow her wishes. If there is anything she does not want written down, do not record it.
- Enter in the medical record any health complaints, symptoms, and signs, as you would for any other woman, including a description of her injuries. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her.
- Do not write anything where it can be seen by those who do not need to know, for example on an X-ray slip or a bed chart.
- Be aware of situations where confidentiality may be broken. Be cautious about what you write where and where you leave the records.
- For greater confidentiality, some facilities use a code or special mark to indicate cases of abuse or suspected abuse.

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.

Part 2
First-line support for sexual assault and intimate partner violence

What is first-line support

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

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

> **Remember:** This may be your only opportunity to help this woman.

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

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

Please go to pages 17-34 for more about each of the 5 tasks of first-line support. A reminder card for the steps of LIVES appears on the last page of this handbook.

First-line support cares for emotional needs

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

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

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

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

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

You do <u>not</u> need to:

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

These actions could do more harm than good.

Tips for managing the conversation

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

Remember: Always respect her wishes.

LISTEN

Purpose

To give the woman a chance to say what she wants to say in a safe and private place to a caring person who wants to help. This is important to her emotional recovery.

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

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

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

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

Learn to listen with your

Eyes – giving her your undivided attention

Ears – truly hearing her concerns

Heart – with caring and respect

INQUIRE ABOUT NEEDS AND CONCERNS

Purpose

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

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

Techniques for interacting	
Principles	**Examples**
Phrase your questions as invitations to speak.	"What would you like to talk about?"
Ask open-ended questions to encourage her to talk instead of saying yes or no.	"How do you feel about that?"
Repeat or restate what the person says to check your understanding.	"You mentioned that you feel very frustrated."

<table>
<tr><td>Reflect her feelings.</td><td>“It sounds as if you are feeling angry about that…”
“You seem upset.”</td></tr>
<tr><td>Explore as needed.</td><td>“Could you tell me more about that?”</td></tr>
<tr><td>Ask for clarification if you don’t understand.</td><td>“Can you explain that again, please?”</td></tr>
<tr><td>Help her to identify and express her needs and concerns.</td><td>“Is there anything that you need or are concerned about?”
“It sounds like you may need a place to stay”.
“It sounds like you are worried about your children.”</td></tr>
<tr><td>Sum up what she has expressed.</td><td>“You seem to be saying that....”</td></tr>
<tr><td colspan="2">Some things to avoid</td></tr>
<tr><td colspan="2">Don’t ask leading questions, such as “I would imagine that made you feel upset, didn’t it?”</td></tr>
<tr><td colspan="2">Don’t ask “why” questions, such as “Why did you do that…?” They may sound accusing.</td></tr>
</table>

Purpose

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

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

Important things that you can say

- "It's not your fault. You are not to blame."
- "It's okay to talk."
- "Help is available." [Say this only if it is true.]
- "What happened has no justification or excuse."
- "No one deserves to be hit by their partner in a relationship."
- "You are not alone. Unfortunately, many other women have faced this problem too."
- "Your life, your health, you are of value."
- "Everybody deserves to feel safe at home."
- "I am worried that this may be affecting your health."

The following job aids suggests some ways that you can help women deal with various emotions and reactions.

Job aid

Helping women cope with negative feelings

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

ENHANCE SAFETY

Purpose

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

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

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

Assessing safety after sexual assault

A woman who is assaulted often knows the person who assaulted her, and it often happens at home. 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 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.

Job aid

Questions to assess immediate risk of violence

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

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

Adapted from Snider, 2009.

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

Making a safety plan

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

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

Job aid

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

SUPPORT

Purpose

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

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

How to help

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

Possible resources

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

- helpline

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

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

Do not expect her to make decisions immediately.

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

Referrals

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

Tips on giving referrals

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

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

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

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

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

Job aid

Referral chart

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

Taking care of your own needs

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

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

Questions and answers

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

"Why not offer advice?"

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

"Why doesn't she just leave him?"

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

- She depends on her partner's income. In some societies it is difficult for a woman to earn her own living.
- She believes that children should be raised with a father and thinks that her own welfare is less important than this ideal.
- She thinks that violence is normal in relationships and that all men will be violent and controlling.
- She fears an extreme and violent reaction to her leaving.
- Her self-esteem is low and she believes that she cannot manage on her own.
- She feels she has no place to go or no one to turn to for support.

- She still loves him and thinks he will change.
- She thinks that he needs her.
- She does not want to be alone.
- She is afraid of being abandoned by the community for having left her partner.

"How did she get herself into this situation?"

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

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

First-line support ("LIVES") is the most helpful care you can give. It does not necessarily take long, and it does not require additional resources. Also, you can learn about resources in the health-care system and in the community that can help her. (See page 29.) You might even consider whether you could help a confidential community support group get started.

"That wasn't the way we were taught."

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

and help her feel she has the strength to make and carry out important decisions.

"What if she decides not to report to the police?"

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

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

If your law requires you to report violence to the police, you must tell her this. You can say, for example, "What you tell me is confidential, that means I won't tell anyone else about what you share with me. The only exception to this is….."

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

"What if she starts to cry?"

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

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

Do not try to force her to disclose. (Your suspicions could be wrong.) You can still provide care and offer further help. See page 12 for more details.

“What if she wants me to talk to her husband.”

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

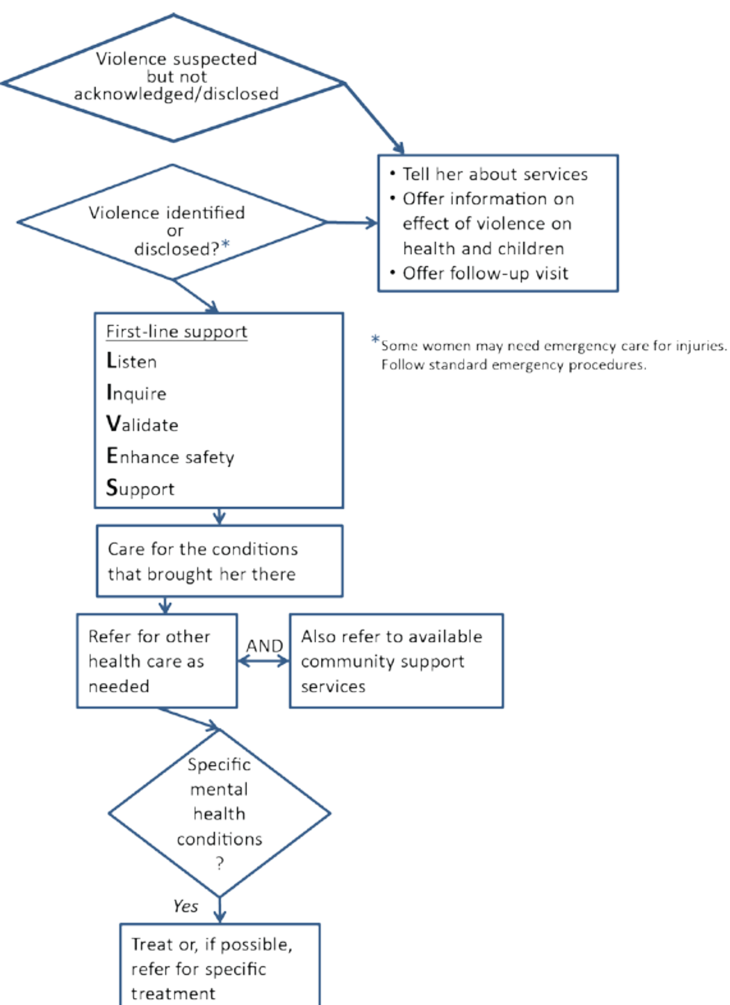
“What if the partner is one of my clients, too?”

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

“What if I think her partner is likely to kill her?”

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

Pathway for care for violence by intimate partner



Part 3

Additional care for physical health after sexual assault

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

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

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

1. Take a history and conduct the examination (page 40).
2. Treat any physical injuries (page 48).
3. Provide emergency contraception (page 49).
4. Prevent sexually transmitted infections (STIs) (page 52).
5. Prevent HIV (page 55).
6. Plan for self-care (page 57).

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

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

The following pages explain the six steps. Also, the care pathway on page 38 shows the order of steps.

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

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

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

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

- Provide first-line support (page 13)
- Offer STI prevention and treatment (page 52)
- Offer hepatitis B immunization (page 54)
- Test for pregnancy and HIV .
- Assess mental health and provide care as needed (see Part 4, page 67).

1. Take a history and examine

This step involves the following actions:

- Take a history—overall medical history, information about the assault, and gynaecological and mental health assessments.
- Prepare for the examination and obtain informed consent (page 43).
- Do a head-to-toe physical examination (page 45).

A. Take a history

The history-taking includes: (1) general medical information, (2) questions about the assault (only ask about what is needed for medical care (e.g. penetration, oral, vaginal, anal?), (3) a gynaecological history, (4) an assessment of mental state (see Part 4).

The history and exam form on pages 89–98 suggests questions.

General tips

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

(1) Ask about general medical information

General medical information should cover any current or past health problems, allergies, and any medications that the woman is taking. See the history and exam form on pages 89–98 for questions to ask.

This information may help with understanding examination findings.

(2) Talk about the assault

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

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

Communicate

- Politely ask the woman to briefly describe the events.

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

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

(3) Take a gynaecological history

The examination form on pages 89–98 suggests the questions to ask.

The purpose of taking a gynaecological history is to:

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

(4) Assess mental health

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

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

B. Prepare for the exam and obtain informed consent

Communicate

- Ask the woman's permission to do a physical exam and obtain informed consent for each step.
- Ask if she wants a specific person to be present for support, such as a family member or friend.
- If you are a male provider, ask if she is comfortable with you examining her. If not, find a female provider to do the exam.

Have an observer there

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

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

Obtain informed consent

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

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

Talking to a woman about reporting to the police

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

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

- If she wants evidence collected, call in or refer to a specifically trained provider who can do this.
- Even if the forensic evidence is not collected, the full physical exam should be done and well documented (see form page 89). The exam can be useful if a woman decides to pursue a legal case.

For further details on forensic examinations, see the following guidelines: *Clinical management of rape survivors*, 2004 at http://www.who.int/reproductivehealth/publications/emergencies/924159263X/en/ and *Guidelines for medico-legal care for victims of sexual violence*, 2003 at http://www.who.int/violence_injury_prevention/publications/violence/ med_leg_guidelines/en/.

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

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

Communicate

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

Examine

- Make sure equipment and supplies are prepared.
- Take the patient's vital signs—pulse, blood pressure, respiratory rate and temperature.
- Work systematically. Use the chart on page 47.
- Be unhurried. Give time to the examination.
- Record all your findings and observations clearly and fully on a standard exam form (see page 89).
- Document carefully and fully any injury or other mark as this can be important evidence.

Do genito-anal examination

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

- Help the woman feel as comfortable as possible.
- Let her know when and where you will touch her.
- Help the woman to lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her body. It should be drawn up at the time of the examination.
- Work systematically. Have a good light source to view injuries. Follow the chart on page 47.
- Record all your findings and observations clearly and fully on a standard exam form (see page 89).

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

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

Job Aid

Physical exam checklist

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

Record findings and treatment

Health-care providers often must answer questions from police, lawyers or the courts about injuries to women they have treated. Careful documentation of findings and treatment on the history and exam form (pages 89–98) will make it easier for you to answer accurately.

Issues that the authorities want to know about:

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

2. Provide treatment

2.1 Treat physical injuries or refer

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

Complications that may require urgent hospitalization:

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

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

The following medications may be indicated:

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

Cautions

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

2.2 Provide emergency contraception

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

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

Facts about emergency contraception pills

- 2 kinds of pills are commonly used for EC:
    - **Levonorgestrel-only**
      Works better and causes less nausea and vomiting than combined.
      Preferred dosage: 1.5 mg levonorgestrel in a single dose.

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

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

Emergency contraception counselling points

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

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

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

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

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

Instructions

- She should ***take the EC pills as soon as possible*.** She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes.
- EC pills may cause nausea and vomiting. If she vomits within 2 hours after taking EC pills, she should return for another dose as soon as possible. If she is taking combined pills for EC, she can take medicine (meclazine hydrochloride) 30 minutes to 1 hour before the EC pills to reduce nausea.
- She may have spotting or bleeding a few days after taking EC pills.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. EC pills will not work, but they will not harm the pregnancy.
- She should return if her next menstrual period is more than 1 week late. Safe abortion should be offered where it is within the law.

Emergency copper IUD

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

2.3 Prevent sexually transmitted infections

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

Fill in the chart on next page with dosage information based on the national protocol for your further reference.

Job aid

STI treatments (fill in)

STI	Medication	Dosage and schedule
Chlamydia		
Gonorrhoea		
Trichomonas		
Syphilis (if common locally)		
Other locally common STIs (fill in)		

Hepatitis B

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

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

Has she been vaccinated for hepatitis B?

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

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

2.4 Prevent HIV

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

When should PEP be considered?

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

Communicate

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

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

If she takes HIV PEP

- Start the regimen as soon as possible and in any case no later than 72 hours after the assault.
- Ensure follow-up at regular intervals.
- The choice of PEP drugs should be based on national guidelines (new WHO guidance will be issued in late 2014).
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals.
- Offer HIV testing at the initial consultation.
- Retest at 3 or 6 months or both.
- In the case of a positive test result, refer for HIV treatment and care.

PEP adherence counselling

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

- It is important to remember to take each dose, and so it is helpful to take it at the same time every day, such as at breakfast and dinner. Taking the pills at regular intervals ensures that the level in the blood stays about the same.
- An alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can help remember.
- If she forgets to take her medicine on time, she should still take it, if it is less than 12 hours late.
- If it is more than 12 hours late, she should wait and take the next dose at the regular time.
- She should not take 2 doses at the same time.
- She should return to the clinic if side-effects do not go away in a few days, if she is unable to take the drugs as prescribed, or if she has any other problems.

2.5 Plan for self-care

Explain your examination findings and treatment

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

Care of injuries

- Teach the woman how to care for any injuries.

- Describe the signs and symptoms of wound infection—warm, red, painful, or swollen wound; blood or pus; bad smell; fever. Ask her to return or to see another health-care provider if these signs develop.
- Explain the importance of completing the course of any medications given, particularly antibiotics. Discuss any likely side-effects and what to do about them.

Prevention of STIs

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

Follow-up

- Plan follow-up visits at 2 weeks, 1 month, 3 months and 6 months after the assault.

3. Follow-up after sexual assault

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

Job aid

2-week follow-up visit		
Injury	• Check that any injuries are healing properly.	☐
STIs	• Check that the woman has completed the course of any medications given for STIs. • Check adherence to PEP, if she is taking it. • Discuss any test results.	☐ ☐ ☐
Pregnancy	• Test for pregnancy if she was at risk. If she is pregnant, tell her about the available options. If abortion is permitted, refer her for safe abortion.	☐
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If any problems, plan for psycho-social support and stress management, such as progressive relaxation or slow breathing. *For more details, see Part 4, pages 67–84.*	☐ ☐

Job aid

2-week follow-up visit

Planning	• Remind her to return for further hepatitis B vaccinations in 1 month and 6 months and HIV testing at 3 months and 6 months, or else to follow up with her usual health-care provider.	☐
	• Ask her to return for follow-up if emotional and physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by 1 month after the event.	☐
	• Make next routine follow-up appointment for 1 month after the assault.	☐

Job aid

1-month follow-up visit

STIs	• Give second hepatitis B vaccination, if needed. Remind her of the 6-month dose.	☐
Mental health	• Continue first-line support and care.	☐
	• Assess her emotional state and mental status. Ask if she is feeling better. If new or continuing problems, plan for psycho-social support and stress management.	☐
	• For depression, alcohol or substance use, or post-traumatic stress disorder, *please see Part 4 (pages 67 to 84) for primary care.* Or, if possible refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐
Planning	• Make next routine follow-up appointment for 3 months after the assault.	☐

Job aid

3-month follow-up visit

STIs	• Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care.	☐
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If new or continuing problems, plan for psycho-social support and stress management. • For depression, alcohol or substance use, or post-traumatic stress disorder, *please see Part 4 (pages 67 to 84) for primary care.* Or, if possible, refer for specialized care to a specifically trained health-care provider with a good understanding of sexual violence.	☐ ☐ ☐
Planning	• Make next follow-up appointment for 6 months after the assault. Also, remind her of the 6-month dose of hepatitis B vaccine, if needed.	☐

Job aid

6-month follow-up visit

STIs	• Offer HIV testing and counselling if not done before. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care. • Give third dose of hepatitis B vaccine, if needed.	☐
Mental health	• Continue first-line support and care. • Assess the patient's emotional state and mental status. If there are new or continuing problems, plan for psycho-social support and stress management. • For depression, alcohol or substance use, or post-traumatic stress disorder, refer if possible for specific care to a specifically trained health-care provider with a good understanding of sexual violence. *For details and additional response, see Part 4, pages 67–84.*	☐ ☐ ☐

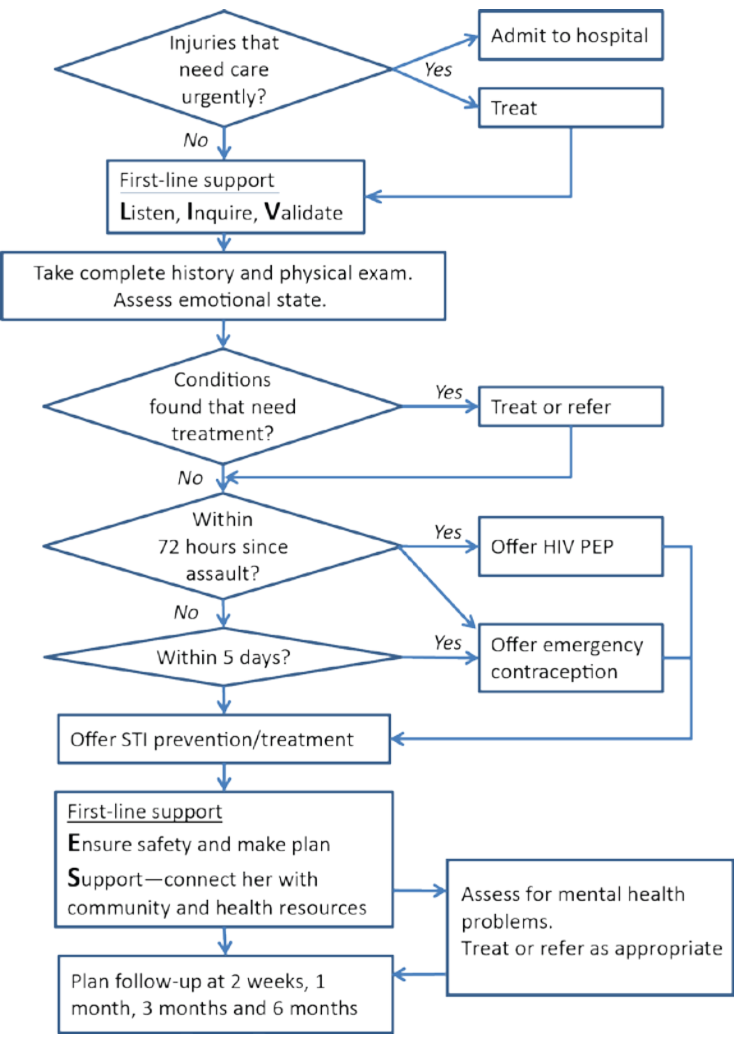
Testing schedule

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

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

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

Pathway for intial care after assault



Part 4
Additional care for mental health

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

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

Basic psychosocial support

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

- Offer first-line support at each meeting (see LIVES, page 14).
- Explain that she is likely to feel better with time.
- Help strengthen her positive coping methods (see next page).
- Explore the availability of social support (see next page).
- Teach and demonstrate **stress reduction** exercises. (See pages 70-71. These pages can be copied and given to the woman to take home, if that is safe.)
- Make regular follow-up appointments for further support.

Strengthening her positive coping methods

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

Encourage her to:

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

Encourage her to return if these suggestions are not helping.

Explore the availability of social support

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

You can ask:

- “When you are not feeling well, who do you like to be with?”

- “Who do you turn to for advice?”
- “Who do you feel most comfortable sharing your problems with?”

Note: Explain to the woman that, even if there is no one with whom she wishes to share what has happened to her, she still can connect with family and friends. Spending time with people she enjoys can distract her from her distress.

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

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

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

Exercises to help reduce stress

1. Slow breathing technique

- Sit with your feet flat on the floor. Put your hands in your lap. After you learn how to do the exercises, do them with your eyes closed. These exercises will help you to feel calm and relaxed. You can do them whenever you are stressed or anxious or cannot sleep.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about two minutes. As you breathe, feel the tension leave your body.

2. Progressive muscle relaxation technique

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

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

Helping with more severe mental health problems

Assessment of mental status

You assess mental status at the same time that you do the general health examination. Assessing mental status begins with observing and listening closely. Take note of the following:

Appearance and behaviour	Does she take care of her appearance? Are her clothing and hair cared for or in disarray? Is she distracted or agitated? Is she restless, or is she calm? Are there any signs of intoxication or misuse of drugs?
Mood, both what you observe and what she reports	Is she calm, crying, angry, anxious, very sad, without expression?
Speech	Is she silent? How does she speak (clearly or with difficulty)? Too fast/too slow? Is she confused?
Thoughts	Does she have thoughts about hurting herself? Are there bad thoughts or memories that keep coming back? Is she seeing the event over and over in her mind?

You can also gather information by asking general questions:

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

If your general assessment identifies problems with mood, thoughts or behaviour and she is unable to function in her daily life, she may have more severe mental health problems. See page 80 for discussion of depressive disorder and post-traumatic stress disorder.

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

Imminent risk of suicide and self-harm

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

If she has:

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

OR

- a history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative,

then **there is immediate risk of self-harm or suicide, and she should not be left alone.**

Refer her immediately to a specialist or emergency health facility.

Moderate-severe depressive disorder

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

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

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

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

Typical presenting complaints of depressive disorder

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

Assessment of moderate-severe depressive disorder

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

Assess for the following:

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

- Persistent depressed mood (for children and adolescents: either irritability or depressed mood)
- Markedly diminished interest in or pleasure from activities, including those that were previously enjoyable.

B. The woman has had several of the following additional symptoms of depressive disorder to a marked degree, or many of the listed symptoms to a lesser degree <u>for at least 2 weeks</u>:

- Disturbed sleep or sleeping too much
- Significant change in appetite or weight (decrease or increase)
- Beliefs of worthlessness or excessive guilt
- Fatigue or loss of energy
- Reduced ability to concentrate and sustain attention on tasks
- Indecisiveness
- Observable agitation or physical restlessness
- Talking or moving more slowly than normal
- Hopelessness about the future
- Suicidal thoughts or acts.

C. The woman has considerable difficulty functioning in personal, family, social, occupational, or other important areas of life.

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

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

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

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

The woman is likely to have had a manic episode if several of the above five symptoms were present for longer than 1 week and the symptoms significantly interfered with daily functioning or

were a danger to herself or others. If so, then the depression is likely part of another disorder called ***bipolar disorder*** and she requires different management. Consult a specialist.

- Rule out **normal reactions** to the violence. The reaction is more likely a normal reaction if:
    - there is marked improvement over time without clinical intervention
    - there is no previous history of moderate-severe depressive disorder or manic episode, and
    - symptoms do not impair daily functioning significantly.

Management of moderate-severe depressive disorder

1. Offer psychoeducation

Key messages for the woman (and caregiver if appropriate):

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

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

2. Strengthen social support and teach stress management

See pages 68 and 70.

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

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

4. Consider antidepressants

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

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

5. Consult a specialist when:

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

  OR
- She is at imminent risk of suicide/self-harm (see page 70).

6. Follow-up

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

Post-traumatic stress disorder

Immediately after a potentially traumatic experience such as sexual assault, most women experience psychological distress. For many women these are passing reactions that do not require clinical management. However, when a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened

sense of current threat) persists for more than a month after the event, she may have developed post-traumatic stress disorder (PTSD).

It should be noted that despite its name, PTSD is not necessarily the only or even the main condition that occurs after violence. As mentioned above, such events can also trigger development of many other mental health conditions, such as depressive disorder and alcohol use disorder.

Typical presenting complaints of PTSD

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

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

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

Assessment for PTSD

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

Assess for:

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

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

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

Management of PTSD

1. Educate her about PTSD

Explain that:

- Many people recover from PTSD over time without treatment. However, treatment will speed up recovery.

- People with PTSD often feel that they are still in danger, and they may feel very tense. They are easily startled ("jumpy") or constantly on the watch for danger.
- People with PTSD repeatedly experience unwanted recollections of the traumatic event. When this happens, they may experience emotions such as fear and horror similar to the feelings they had when the event was actually happening. They may also have frightening dreams.
- People with PTSD try to avoid any reminders of the event. Such avoidance can cause problems in their lives.
- (If applicable) people with PTSD may have other physical and mental problems, such as aches and pains in the body, low energy, fatigue, irritability and depressed mood.

Advise her to:

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

2. Strengthen social support and teach stress management

See pages 68 and 70.

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

- Individual or group cognitive behavioural therapy with a trauma focus (CBT-T)
- Eye movement desensitization and reprocessing (EMDR).

4. Consult a specialist (if available)

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

  OR
- she is at imminent risk of suicide/self-harm (see page 74).

5. Follow-up

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

Annex 1

Caution concerning prescribing benzodiazepines

Do not prescribe benzodiazepines or antidepressants for acute distress.

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

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

Key resources

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sample history and examination form

Tips for talking with clients

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

CONFIDENTIAL CODE:

Medical History and Examination Form for Sexual Assault

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

1. GENERAL INFORMATION

<table>
<tr><td colspan="2">Family name</td><td colspan="2">Given name</td></tr>
<tr><td colspan="4">Address</td></tr>
<tr><td>Sex</td><td colspan="2">Date of birth ______ / ______ / _______
DD MM YY</td><td>Age</td></tr>
<tr><td colspan="2">Date and time of examination
______ / ______ / _____ ; _________
DD MM YY</td><td colspan="2">In the presence of</td></tr>
</table>

2. GENERAL MEDICAL INFORMATION

Existing health problems

Do you have any ongoing health problems? ☐ Yes ☐ No

If "yes", what health problems?

Do you have any allergies? If so, to what?

Are you taking any medicines, herbs or potions?

Vaccination status

Have you been vaccinated for…

…tetanus? ☐ Yes When? ______ / ______ / _____ (DD / MM / YY)

☐ No ☐ Does not know

…hepatitis B? ☐ Yes ☐ No ☐ Does not know

HIV/AIDS status

Have you had an HIV test? ☐ Yes When? _____ / ______ / _____ (DD / MM / YY)

☐ No

If "yes", may I ask the result? ☐ Negative

☐ Positive

☐ Not disclosed

3. DESCRIPTION OF INCIDENT

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

Time of incident:

Could you tell me what happened, please?

Has something like this happened before? ☐ Yes ☐ No

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

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

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

In cases of sexual assault	**Penetration**	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal)**
	Penis	☐	☐	☐	
	Finger	☐	☐	☐	
	Other (describe)	☐	☐	☐	
	Ejaculation	☐	☐	☐	
	Condom used	☐	☐	☐	

Actions after assault

After this happened, did you …

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

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method?

☐ IUD ☐ Sterilization
☐ Pill ☐ Condom
☐ Injectable ☐ Other ______________________

Were you using this method when the incident happened?

☐ Yes ☐ No

Menstruation and pregnancy

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

Were you menstruating at the time of event?

☐ Yes ☐ No

Do you think you might be pregnant? ☐ Yes ☐ No If "yes", number of weeks pregnant: ____ weeks
Have you ever been pregnant? ☐ Yes ☐ No If "yes", how many times? ______ times
History of consenting intercourse (only if samples taken for DNA analysis in assault case)
When was the last time you had sex willingly? ____ / ____ / ____ DD MM YY Who was it? (for example, husband, boyfriend, stranger)

5. HEAD-TO-TOE PHYSICAL EXAMINATION

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

Physical findings Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruises, petechiae (signs of bleeding under the skin), marks, etc. Document type, size, colour, form and other particulars. Describe as completely and accurately as possible. Do not interpret the findings.	
Head and face	Mouth and nose

Eyes and ears	Neck
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

6. GENITAL AND ANAL EXAMINATION

<table>
<tr><td colspan="2">Vulva/scrotum</td><td colspan="2">Introitus and hymen</td><td colspan="2">Anus</td></tr>
<tr><td>Vagina / penis</td><td colspan="2">Cervix</td><td colspan="2">Bimanual / rectovaginal examination</td><td>Evidence of female genital mutilation? (where relevant)
☐ Yes ☐ No</td></tr>
<tr><td colspan="6">Position of patient (supine, prone, knee–chest, lateral)</td></tr>
<tr><td colspan="3">For genital examination</td><td colspan="3">For anal examination</td></tr>
</table>

7. MENTAL STATE

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

Mood

Ask: *How have you been feeling?*

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

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

Thoughts

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

☐ Yes ☐ No

Are there bad thoughts or memories that keep coming back?

☐ Yes ☐ No

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

☐ Yes ☐ No

8. INVESTIGATIONS DONE

Type and location	Examined / sent to laboratory	Result

9.EVIDENCE TAKEN

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

10. TREATMENTS PRESCRIBED

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

11. COUNSELLING, REFERRALS, FOLLOW-UP

<table>
<tr><td colspan="2">Client plans to report to police *OR* has already made report?
☐ Yes ☐ No</td></tr>
<tr><td>Client has a safe place to go?
☐ Yes ☐ No</td><td>Has someone to accompany her/him? ☐ Yes ☐ No</td></tr>
<tr><td colspan="2">Counselling provided:</td></tr>
<tr><td colspan="2">Referrals made (for example, housing, mental health care, support group):</td></tr>
<tr><td>To:</td><td>Purpose:</td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td></td><td></td></tr>
<tr><td colspan="2">Follow-up agreed with client? ☐ Yes ☐ No

Date of next visit:: _______ / _______ / ________
DD MM YY</td></tr>
</table>

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

Title: ____________________________________

Printed name: ____________________________

Signature: _______________________________

Date: _______ / _______ / ________
DD MM YY

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

Signs of immediate risk

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

Asking about violence

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

You might ask:

- “Are you afraid of your husband (or partner)?”
- “Has he or someone else at home threatened to hurt you? If so, when?”
- “Has he threatened to kill you?”
- “Does he bully you or insult you?
- “Does he try to control you – for example, not letting you have money or go out of the house?”
- “Has forced you into sex when you didn’t want it?”

Listen	Listen closely, with empathy,not judging.
Inquire about needs and concerns	Assess and respond to her needs and concerns – emotional, physical, social and practical.
Validate	Show that you believe and understand her.
Enhance safety	Discuss how to protect her from further harm.
Support	Help her connect to services, social support.

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