REPUBLIC OF NAMIBIA
Ministry of Health and Social Services

Clinical Handbook on the Health Care of Survivors Subjected to Intimate Partner Violence and/or Sexual Violence, Namibia

World Health Organization

UN WOMEN
United Nations Entity for Gender Equality and the Empowerment of Women

UNFPA

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This is the Namibian adaptation of the global WHO clinical handbook http://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/

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Acronyms

ART	Anti-retroviral therapy
3TC	Lamivudine
ATVr	Atazanavir/ritonavir
CBT-T	Cognitive Behavarial Therapy
CEDAW	Convention on the Ellumination of all forms of discriminations against women
CRC	Convention on the Rights of the Child
DD	Date
DMPA-SC	Depot Medroxyprogesterone acetate
EC	Emergency Contraceptives
EMDR	Eye Movement Desensitization and Reprocessing
EN	English
FTC	Emtricitabine
GBV	Gender Based Violence
HAART/ARV	Higly Active Antiretroviral Therapy/ Antiretroviral
HBsAb	Hepatitis B Surface Antibody
HIV	Human Immunodeficiency Virus
HPV	Human Papillomavirus
ILO	International Labour Organization
IUCD	Intra Uterine Contraceptive Device
J88	Form generated by the Police and serves as a crucial medial evidence in cases of rape, assault or attempted murder.
LAC	Legal Assistance Centre
LIVES	Listen, Inquire about safety needs, Validate, Enhance Safety and Support
LNG	Levonorgestrel
mg	Miligram
MGECW	Ministry of Gender Equality and Child Welfare
mhGAP	Mental Health Gap Action Programme
miu	Million units
MM	Month
NGP	National Gender Policy
NVP	Nevirapine
PEP	Post-exposure prophylaxis
PID:	Pelvic inflammatory
PTSD	Post-traumatic stress disorder
SADC	Southern African Development Community
STI	Sexually transmitted infection
TDF	Tenofovir Disoproxil Fumarate
UN Women	United Nations Women
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VAW	Violence Against Women
WHO	World Health Organization
YY	Year

Preface

Despite many interventions, the unfortunate phenomena of domestic- and gender-based violence, in their manifold manifestations, have become regular realities here in Namibia and elsewhere. The danger of these phenomena has also been recognised internationally. It is for this reason that the United Nations System, through the World Health Organisation (WHO), UN Women and UNFPA has developed a Clinical Handbook on *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence.*

As part of our interventions, the Ministry of Health and Social Services together with other stakeholders have adopted the WHO Clinical Handbook as a guide for Namibian health care professionals in providing care to survivors of intimate partner violence or sexual violence. It provides straightforward and simple steps and suggestions to help survivors to start a path towards recovery in order to rebuild their lives after traumatic and life changing experiences. It helps the health care professional to help and provide appropriate support to persons who have experienced or currently experiencing domestic or sexual violence, regardless of age, gender or social status.

The Handbook guides health care service providers to relevant Namibian laws and policies that need to be taken into account when dealing with situation of domestic and sexual violence. It also guides health professionals with respect to relevant stakeholders for referral purposes. The purpose is to ensure that relevant authorities are informed timeously in order act and ensure that those affected by violence receive speedy service as required.

The Handbook consists of 5 parts, namely:

1. Awareness about Gender based Violence
2. First-line support for intimate partner violence and sexual assault
3. Additional Clinical care after sexual assault
4. Additional support for mental health, and
5. Intimate partner violence and family planning.

The Ministry of Health and Social Services strongly recommends that the Handbook becomes reference material for all health care providers in providing care to survivors of domestic- and gender based violence, sexual assault and other forms of abuse.

Mr. Ben Nangombe
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MINISTRY OF HEALTH AND SOCIAL SERVICES
REPUBLIC OF NAMIBIA

Part 1 Awareness about gender-based violence

What is gender-based violence?

Definitions of gender-based violence in the Namibian legal and policy frameworks

a) Gender-based violence:

Namibia's National Gender Policy (NGP) 2010-2020 draws on the GBV definition of the SADC Protocol on Gender and Development and defines GBV as:

"all acts perpetrated against women, men, girls and boys on the basis of their sex, which causes or could cause them physical, sexual, psychological, emotional or economic harm, including the threat to take such acts, or to undertake the imposition of arbitrary restrictions on or deprivation of fundamental freedoms in private or public life, in peace-time and during situations of armed or other forms of conflict, or in situations of natural disasters, that cause displacement of people."

The National Gender Policy (2010 - 2020) further defines GBV as follows:

"Gender-Based Violence refers to all forms of violence that happen to women, girls, men and boys because of the unequal power relations between them."

The Policy also provides the following examples of GBV in Namibia: domestic violence, rape and other forms of sexual abuse, sexual harassment at work and school, some forms of human trafficking, forced prostitution and early marriages. GBV also encompasses certain harmful traditional practices, such as when a widow is deprived of the property she shared with her husband.

b) Domestic violence.

The Combating of Domestic Violence Act 4 of 2003 defines different forms of violence as part of domestic violence:

- Physical violence
- Sexual abuse

- Economic abuse
- Intimidation
- Harassment
- Trespassing
- Emotional, verbal or psychological abuse

Threats or attempts to carry out any of these acts are also forms of domestic violence.

c) Rape

The Combating of Rape Act 8 of 2000 defines rape as the "intentional commission of a sexual act under coercive circumstances".
A "sexual act" covers the most intimate kinds of sexual contact, including the insertion of the penis, any other body part, or object into the vagina or anus of another person (excluding objects consistent with sound medical practices for medical purposes), the insertion of the penis into the mouth of another person, cunnilingus, or any form of genital stimulation.

"Coercive circumstances" includes force, threats of force, and other situations which enable one person to take unfair advantage of another.

Internationally accepted working definitions

Sexual assault

This refers to forced sex or rape. It can be by someone a survivor 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.

A person may suffer several types of violence from an intimate 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/object.

Emotional/psychological abuse

This can include many types of behaviours such as:
- criticizing her/him repeatedly
- calling her/him names or telling her/him, she/he is ugly or stupid
- threatening to hurt her/his or the children
- threatening to destroy things she/he cares about
- belittling or humiliating her/him in public.

Controlling behaviours

This includes, for example:
- not allowing the partner to go out of the home, or to see family or friends
- insisting on knowing where she/he is at all times
- often being suspicious that she/he is unfaithful
- not allowing her/him to seek health care without permission
- leaving her without money to run the home.

Sexual violence

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

Men and sexual violence

Men also may be victims of partner violence and sexual assault. However, in general, women are more likely to experience partner and 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.

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.

Relevant laws that you should be familiar with

Here are the main Namibian policies, Constitution and laws relevant to GBV

- The Constitution of the Republic of Namibia
- Combating of Rape Act 8 of 2000
- Combating of Domestic Violence Act 4 of 2003
- Child Care and Protection Act of 2015
- Abortion and Sterilisation Act 2 of 1975

Job aid

Relevant laws		
Name of law/ policy	**Relevant Provisions for health care providers**	**What it means for you**
The Constitution of the Republic of Namibia	N/A	As the supreme legal instrument, the Constitution provides a comprehensive set of fundamental rights and freedoms for all Namibia's citizens. It protects life, human dignity and personal liberty; prohibits torture and cruel, inhuman or degrading treatment or punishment; guarantees equality

The Constitution of the Republic of Namibia	N/A	before the law; and prohibits discrimination based on gender, race or colour. Thus women and girls accessing health care services have the right to quality care even in cases of gender based violence.
Combating of Rape Act 8 of 2000	All aspects of the law	• The survivor should be seen within all public health facilities. • A medical doctor, where possible, a senior doctor should examine and treat the rape/ sexual abuse survivor. This is especially necessary to ensure that the doctor is seen as a reliable expert witness. • In cases where the survivor wishes to report the case fill out the J-88 form • If no doctor is available, organize a referral to a health facility where a doctor is available . This is important because medical doctors are ordinarily called as expert witness in a criminal trial. • When referring the survivor, contact the receiving unit to ensure the survivor receives priority care • It is advisable, if a survivor comes to a health facility without reporting to the police and wishes to do so, the police should be called to the health centre to take a statement.

		• Rape is a statutory crime and the prosecution of the perpetrator can proceed even if the survivor decides to withdraw the charges after reporting the crime.
Combatting of Domestic Violence 4 Act, 2003	All aspects of the law	• Know what is domestic violence (see definition provided earlier) • Document the details of the incident(s). • Record any injuries and treatment provided • If a survivor wants protection, inform them that they can obtain a protection order and refer them to the nearest Magistrate Court or Gender Based Violence Protection Unit for further referral
Child Care and Protection Act of 2015	Article 224 (3) (c)	• Allow the child to be accompanied by a support person of their choice, unless they are of sufficient maturity and mental capacity to understand the reasons for the assessment or examination and express a wish not to be accompanied by any support person. • Only allow the necessary staff and caregivers to be present during assessment or examination. • To the extent possible, address the child in a language which she/he understands • Reporting of child abuse is mandatory for all professionals working with children between 0 -17 years of age.

Abortion and Sterilisation Act 2 of 1975	Abortion in Namibia is allowed under the following condition: 3.1 (d) Where the foetus is alleged to have been conceived in consequence of unlawful carnal intercourse, alleged rape or incest	If a survivor of sexual assault is pregnant due to the alleged assault and wishes to have an abortion you can perform it if: • 2 other medical practitioners from different partnerships and employers have certified in writing that in their opinion the pregnancy is due to the alleged rape or incest • At least one of the two practitioners: • must have practiced as a medical practitioner for over 4 years since the date of registration;
		• shall be the district surgeon concerned where the foetus is alleged to have been conceived in consequence of rape or incest • the gestational age of the pregnancy is within 28 weeks • You have an affidavit submitted to the magistrate or in a statement under oath to the magistrate, that the pregnancy is the result of a rape

Guiding principles for providing survivor-centred care

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

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

Survivor-centred care is guided by two fundamental principles: i) Respect for women's human rights and ii) Promotion of gender equality.

What does this mean in practical terms?

1. A rights-based approach. Human rights, in particular women's rights are set forth in international human rights agreements/instruments. Namibia 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, 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 survivor.

- **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 survivors in a fair and respectful way and do not discriminate. Recognize that women may face gender-based discrimination as well as other forms of discrimination because of their race, ethnicity, sexual orientation, religion, disability, or other characteristics, or because they have been subjected to violence. According to the principles in the Namibian National Gender Policy you should advocate for zero-tolerance for Gender-Based Violence. Customary, cultural and religious beliefs should not discriminate against women and should not contradict the interpretation, promotion and protection of women's rights and gender equality.

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 Gender-Based Violence 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 ashamed and have low self-esteem.

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

- being aware of the power dynamics and norms that perpetuate Gender-Based Violence
- 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.

Identifying a person who may be subjected to intimate partner violence

It is important for Health Care Providers to be aware that a person's health problems may be caused or made worse by intimate partner 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.

Persons subjected to intimate partner violence 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 drugs,
- thoughts, plans or acts of self-harm or (attempted) suicide,
- injuries that are repeated or not well explained,
- repeated sexually transmitted infections,
- unwanted pregnancies,
- unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, headaches),
- repeated health consultations with no clear diagnosis.
- You may also suspect a problem of intimate partner 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 the person is alone. Even if s/he is with another person, that person could be a relative of the suspected abuser.

If you do ask 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 survivors 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 words that survivors themselves use.

The Job Aid on the next page provides examples of the types of statements and questions you can use to ask about intimate partner violence.

Job aid

Asking about violence

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

- "Please be assured that I am here to help you. Anything you say to me will be kept confidential, unless you tell me you would like it to be disclosed."
- "Many survivors experience problems with their partner, or someone else they live with."
- "I have seen people 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/his problems. Depending on her/his answers, continue to ask questions and listen to her/his story. If s/he answers "yes" to any of these questions, offer her/his first-line support (see page 13).

- "Are you afraid of your husband/wife (or partner)?" If yes, "Could you tell me why you are afraid?"
- "Has your husband/wife (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 and what happened?"
- "Does your husband/wife (or partner) or someone at home bully you or insult you?"
- "Does your husband/wife (or partner) try to control you, for example not letting you have money or go out of the house?"
- "Has your husband/wife (or partner) forced you into sex or forced you to have any sexual contact you did not want?"
- "Has your husband/wife (or partner) ever 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 survivor decides to go to the police.

- Tell him/her what you would like to write down and why. Askhim/ her if this is okay with him/her. Follow his/her wishes. If there is anything s/he does not want, like an alleged rape or incest written down, do not record it.
- Enter in the medical record any health complaints, symptoms, and signs, as you would for any other person, including a description of his/her injuries. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured him/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 pressurise the person, and give him/her time to decide what s/he wants to tell you.
- Inform the person about services that are available if s/he chooses to use them.
- Offer information on the effects of violence on survivor's health and their children's health.
- Offer the person 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 survivor's emotional, physical, safety and support needs, without intruding on her/his privacy.

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

Remember: This may be your only opportunity to help this survivor.

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

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

Please go to pages 16-30 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 survivors' needs and concerns
- listening and validating survivors' concerns and experiences
- helping survivor to feel connected to others, calm and hopeful
- empowering survivor to feel able to help him/herself and to ask for help
- exploring what survivor options are
- respecting survivors' wishes
- helping survivor to find social, physical and emotional support
- enhancing safety.

Remember: When you help a survivor deal with practical needs, it helps with his/her emotional needs.

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

You should:

- NOT solve the survivor's problems
- NOT convince the survivor to leave a violent relationship
- NOT convince the survivor to go to any other services, such as police or the courts
- NOT ask detailed questions that force the survivor to relive painful events
- NOT ask the survivor to analyse what happened or why
- NOT pressure the survivor to tell you his/ 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 your conversation (but not a place that indicates to others why you are there).
- Assure her that your conversation will be private and confidential. If the survivor is a child between 0-17 years of age, you are required to report the situation, explain what you must report and to which authority and what procedures you will follow.
- First, encourage her to talk and show that you are listening.
- Encourage the survivor to continue talking if s/he wishes, but do not force him/her to talk. Use phrases such as "Do you want to say more about that?"
- Allow silences. If s/he cries, give him/her time to recover.

Remember: Always respect the survivor's wishes.

LISTEN

Purpose

To give the survivor a chance to say what the survivor wants to say in a safe and private place to a caring person who wants to help. This is important for 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 survivors' words. It means:

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

Active listening dos and don'ts	
Dos	**Don'ts**
How you act	
Be patient and calm.	Don't pressure the survivor to tell his/her story.
Let the survivor 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, don't look at a computer or write, unless you explain the need to take notes.
Your attitude	
Acknowledge how s/he is feeling.	Don't judge what the survivor has or has not done, or how s/he is feeling. Don't say: "You shouldn't feel that way," or "You should feel lucky you survived", or "Poor you".
Let him/her tell the survivors story at their own pace.	Don't rush the survivor.
What you say	
Give the survivor the opportunity to say what s/he wants. Ask, "How can we help you?"	Don't assume that you know what is best for the survivor.

Active listening dos and don'ts	
Dos	**Don'ts**
Encourage the survivor to keep talking if s/he wishes. Ask, "Would you like to tell me more?"	Don't interrupt. Wait until the survivore has finished before asking questions.
Allow for silence. Give the survivor time to think.	Don't try to finish the survivor's sentence .
Stay focused on the survivor's experience and on offering support.	Don't tell the survivor someone else's story or talk about your own troubles.
Acknowledge what the survivor wants and respect his/her wishes.	Don't think and act as if you must solve the survivor's problems for him/her. .

Learn to listen with your

Eyes – giving your undivided attention

Ears – truly hearing the survivor's concerns

Heart – with caring and respect

Purpose

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

As you listen to the survivor's story, pay particular attention to what s/he says about his/her needs and concerns – and what s/he doesn't say but implies with words or body language. S/he may let you know about **physical needs, emotional needs,** or **economic needs,** her **safety** concerns or **social support** s/he needs. You can use the techniques below to help the survivor express what s/he 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 the survivor to talk instead of saying yes or no.	"How do you feel about that?"
Repeat or restate what the person says to check your understanding.	"You mentioned that you feel very frustrated."
Reflect the survivor's feelings.	"It sounds as if you are feeling angry/upset about that…"
Explore as needed.	"Could you tell me more about that?"

Ask for clarification if you do not understand.	"Can you explain that again, please?"
Help the survivor to identify and express him/her needs and concerns.	"Is there anything that you need or are concerned about?" "It sounds like you may need a place to stay". "It sounds like you are worried about your children."
Sum up what s/he has expressed.	"You seem to be saying that...."
Some things to avoid	
Do not ask leading questions, such as "I would imagine that made you feel upset, didn't it?"	
Do not ask "why" questions, such as "Why did you do that…?" They may sound accusative.	

Purpose

To let the survivor know that his/her feelings are normal, that it is safe to express them and that s/he 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 s/he is saying, and that you believe what s/he 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 survivors 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 employ to help survivors deal with various emotions and reactions.

Job aid

Helping survivors cope with negative feelings	
The feeling	**Some ways to respond**
Hopelessness	"Many survivors do manage to improve their situation. Over time you will likely see that there is hope."
Despair	Focus on the survivor's strengths and how s/he 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/her 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."

Purpose

To help survivors assess their situation and make a plan for their future safety.

Many survivors who have been subjected to violence have fears about their safety. Some survivors 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 survivors by discussing their particular needs and situation and exploring their options and resources each time you see them, as the situation changes.

Assessing safety after sexual assault

A survivor who is assaulted often knows the person who assaulted him/her, and it often happens at home. If it was someone s/he knows, discuss whether it is safe for him/her to return home.

Assessing immediate risk of partner violence

Some survivors will know when they are in immediate danger and are afraid to go home. If s/he is worried about his/her safety, take him/her seriously.

Some survivors may need help thinking about their immediate risk. There are specific questions you can ask to see if it is safe for him/her to return to his/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 the survivor to stay that night away from home.

Job aid

Questions to assess immediate risk of violence

A survivor who answers "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/she ever used a weapon or threatened you with a weapon?
- Has he/she ever tried to strangle you?
- Do you believe he/she could kill you?
- Has he/she ever beaten you when you were pregnant?
- Is he/she violently and constantly jealous of you?

Adapted from Snider, 2009.

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

Making a safety plan

Even survivors who are not facing immediate serious risk could benefit from having a safety plan. If he/she has a plan, he/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 him/her to help him/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 the survivor cannot avoid discussions that may escalate with the partner, advise him/her to try to have the discussions in a room or an area that s/he can leave easily.

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

If s/he has decided that leaving is the best option, advise him/her to make his/her plans and leave for a safe place BEFORE letting the partner know. Otherwise, s/he may put him/herself and his/her children at more risk of violence.

Avoid putting her at risk

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

Remember to maintain the confidentiality of the survivor 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 survivor how s/he will explain where s/he has been. If s/he must take paperwork with him/her (for the police, for example), discuss what s/he will do with the documents.

Purpose

To connect survivors with resources for their health, safety, and social support.

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

How to help

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

Possible resources

Find out what support and resources are available to the survivor in the community. It can help if you have a personal contact to send his/her any of these services.

- helpline
- support groups
- Gender Based Violence Protection Units
- legal support
- health extension worker
- social worker
- psychologist
- spiritual leader.

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

Do not expect the survivor to make decisions immediately.

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

Referrals

Often survivors do not follow up on referrals from Health Care Providers. You can help make it more likely that s/he gets the help that you have recommended.

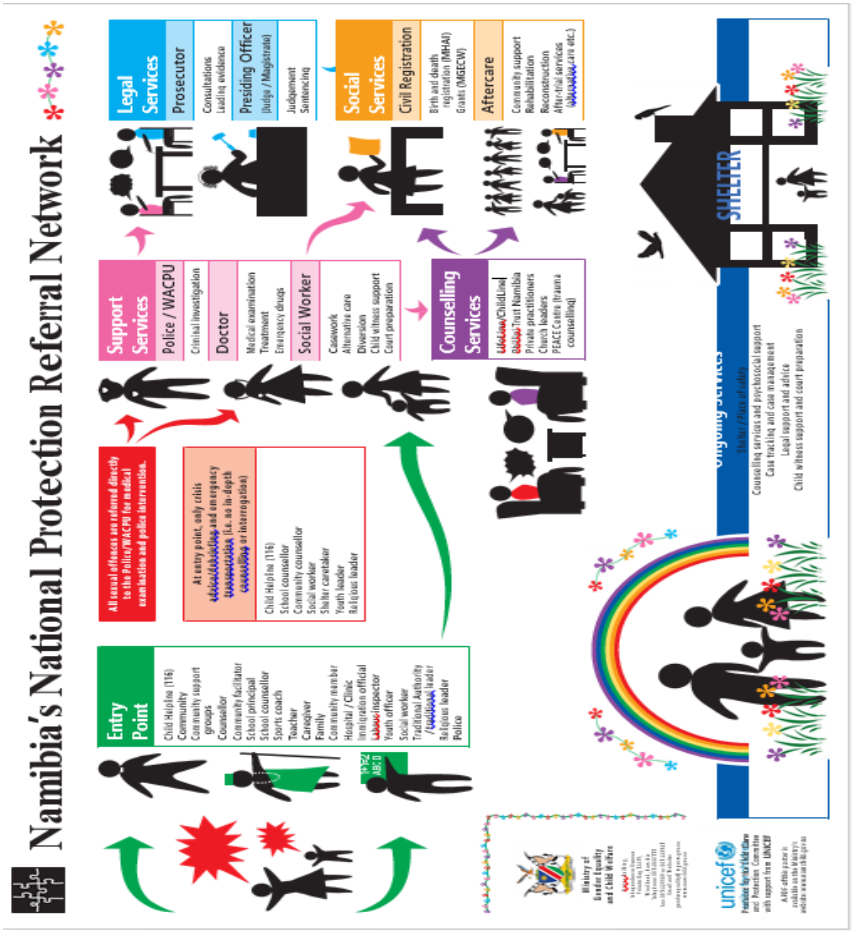
Tips on giving referrals

- Be sure that the referral addresses the most important needs or concerns of the survivor.
- If the survivor expresses problems with going to a referral for any reason, think creatively with him/her about solutions.
- Problems you might discuss:
  - No one to leave the children with.
  - The survivor's partner might find out and try to prevent it.
  - S/he doesn't have transport.
- If s/he accepts a referral, here are some things you can do to make it easier for the survivor:
  - Tell him/her about the service (location, how to get there, who he/she will see).
  - Offer to telephone to make an appointment for the survivor if this would be of help (for example, s/he does not have a phone or a safe place to make a call).
  - If s/he wants it, provide written information that s/he needs – time, location, how to get there, name of person he/she will see. Ask the survivor to think how s/he will make sure that no one else sees the paper.
  - If possible, arrange for a trusted person to accompany the survivor on the first appointment.

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

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

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



Job aid

Referral chart template			
What to refer for	**Where / who to refer to**	**Contact info**	**Responsibility for follow-up**

Taking care of your own needs

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

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

Questions and answers

Here are answers to some questions that Health Care Providers often ask about working with persons subjected to violence.

"Why not offer advice?"

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

"Why doesn't she just leave him?"

There are many reasons why survivors remain in violent relationships. It is important not to judge survivors and not to urge them to leave.
A survivor has to make that decision him/herself in his/her own time. Reasons for not leaving include:

- Survivor depends on the partner's income. In some societies, it is difficult for a woman to earn her own living.

- Survivor believes that children should be raised with both parents and thinks that his/her own welfare is less important than this ideal.
- Survivor thinks that violence is normal in relationships and that all partners will be violent and controlling.
- Survivor fears an extreme and violent reaction to leaving.
- Survivor self-esteem is low and believes that s/he cannot manage on his/her own.
- Survivor feels s/he has no place to go or no one to turn to for support.
- Survivor still loves the partner and thinks s/he will change.
- Survivor thinks that the partner needs him/her
- Survivor does not want to be alone.
- Survivor is afraid of being abandoned by the community for having left the partner.

"How did the survivor get into this situation?"

It is important to avoid blaming the survivor for what happened. Blaming the survivor will get in the way of your giving him/her good care. Violence is never appropriate in any situation. There is no excuse or justification for violence or abuse. Just because a survivor did something that made the partner angry does not mean that s/he 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 him/her (See page 31). 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 their needs and concerns, strengthening their social support and enhancing their safety. Also, you can help them see and consider options and help them feel they have the strength to make and carry out important decisions.

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

Respect the survivor's decision. Let them know that they can change their mind. However, evidence of sexual assault must be collected within 3 days. Let the survivor know if there is someone s/he can talk to further about options and help him/her make the report if s/he chooses to.

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

In cases where the survivor has a mental disability or is a child between 0-17 years of age , the law requires you to report to the police. In such cases, 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 when you, the survivor, happen to be a minor or have a mental disability, then the law expects me to report the case to the police and I will do this with your involvement and knowledge.

As a health-care provider, learn about the specifics of the law and conditions in which you are required to report as mentioned on pages 4-7. Assure the survivor that, outside of this required reporting, you will not tell anyone else without their permission.

"What if the survivor starts to cry?"

Give the survivor 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 survivor doesn't acknowledge it?"

Do not try to force the survivor to disclose. (Your suspicions could be wrong.) You can still provide care and offer further help. See page 11 for more details.

"What if the survivor wants me to talk to the spouse/partner?"

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

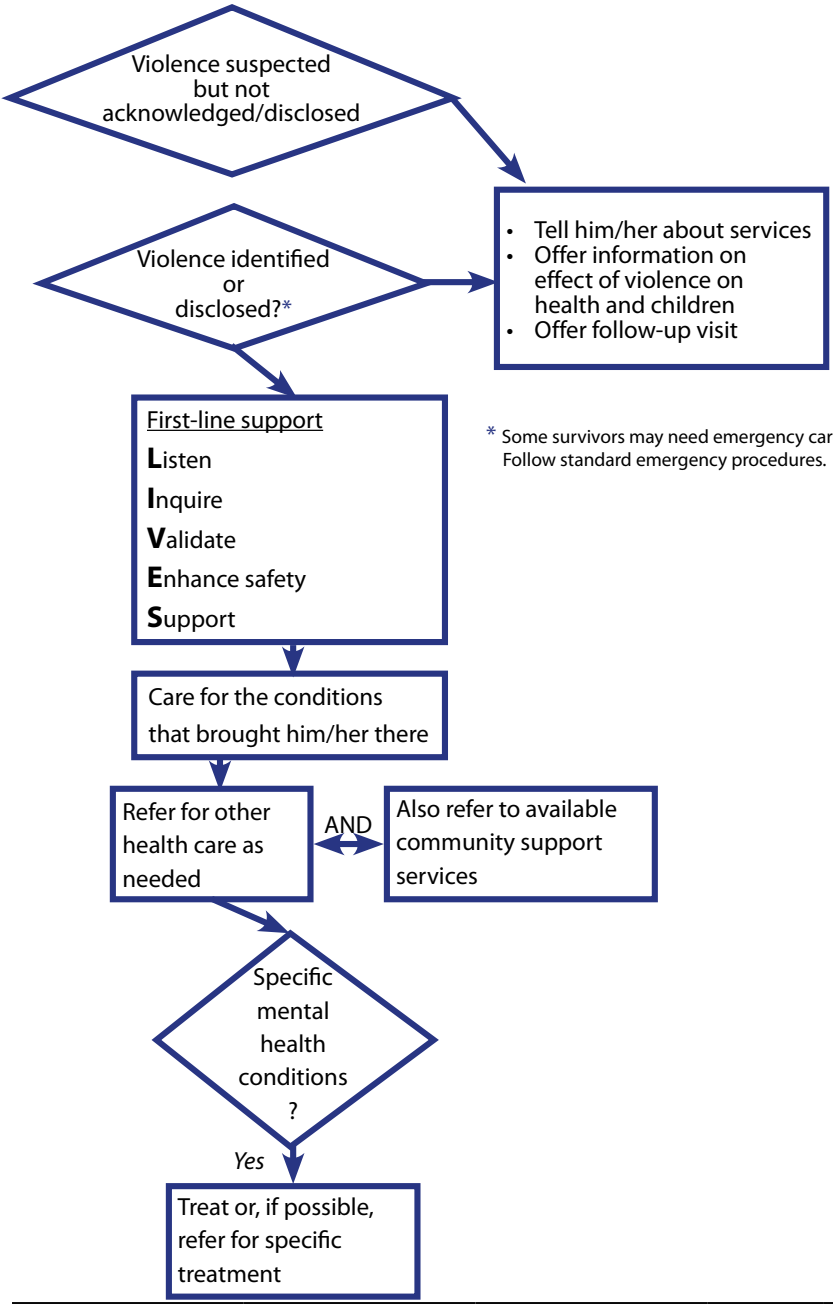
“What if the partner is one of my clients, too?”

It is very difficult 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 survivor’s disclosure is protected. Do not offer couple counselling.

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

- Share your concerns honestly with the survivor, explaining why you think s/he might be at grave risk and explain that you want to discuss with his/her the possible options for making him/her safe. In this situation, identifying and offering secure alternatives where s/he can go is particularly important.
- 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 caring for violence by intimate partner



* Some survivors may need emergency care for injuries. Follow standard emergency procedures.

Part 3 Additional care for physical health after sexual assault

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

The rape/sexual assault survivor must be treated as a priority case by all staff, from the intake staff to the nurses and doctors (although life-threatening cases may be given priority over a rape survivor who is not in immediate danger).

A medical doctor should see and treat the rape/sexual abuse survivor. If no doctor is available at the clinic or hospital, organize a referral to a health facility where a doctor is available, and inform the health facility that the survivor is coming.

If a survivor 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, Listen, Inquire, Validate (first-line support). Then:

1. Take a history and conduct the examination (p.36 - 37).
2. Treat any physical injuries (p.43).
3. Provide emergency contraception (p.44).
4. Prevent sexually transmitted infections (STIs) (p.46).
5. Prevent HIV (p.48).
6. Plan for self-care (p.51).

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 34 shows the order of steps.

For follow-up actions after the first 5 days, see pages 52-55

"What can I do if a survivor 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 survivor comes too late for some of these steps, you can still always:

- Provide first-line support (p. 13)
- Offer STI prevention and treatment (p. 47)
- Offer hepatitis B immunization (p. 48)
- Test for pregnancy and HIV.
- Assess mental health and provide care as needed (see Part 4, page 57).

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 (p. 79-85).
- Prepare for the examination and obtain informed consent (p. 79-85).
- Do a head-to-toe physical examination (p. 79-85).

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? what was used to penetrate?), (3) a

gynaecological history, (4) an assessment of mental state (see Part 4), (5) what was used for the assault (any weapons)
The history and exam form on pages 79-85 as well as the Police J-88 form on suggest questions.

General tips

- First, review any documents that the survivor has. Avoid asking questions she/he 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 survivor is taking. See the history and exam form on pages 79-85 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 the risk of pregnancy, STIs and HIV;
- guide specimen collection and documentation.

Communicate

- Politely ask the survivor to briefly describe the events.

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

- Explain that learning from what happened will help you give the survivor the best care. Assure her/him that you will keep what s/he says private unless s/he wants the police to take up the case.
- Explain that s/he does not have to tell you anything that s/he does not want to talk about.
- Let them tell their story in the way that they want and at their own pace. Do not interrupt. If it is essential to clarify any details, ask after they have finished.
- Ask questions 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 survivor may omit or avoid describing painful, frightening or horrific details. Do not force her/him to describe them. If you really need specific information in order to treat her/him properly, explain why you need to know.

(3) Take a gynaecological history

The examination forms on pages 79-85 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/he is feeling and what her/his emotions are while taking the history.
If you see signs of severe emotional distress, ask specific questions. See Part 4, p. 57.

B. Prepare for the exam and obtain informed consent

Communicate

- Ask the survivor's permission to do a physical exam and obtain informed consent for each step.

- Ask if they want a specific person to be present for support, such as a family member or friend.
- If you are a male provider examining a female survivor, ask if she is comfortable with you examining her. If not, find a female provider to do the exam.

Have an observer there

- For a female survivor, 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 survivor that she/he will be examined and treated only if she/he wants. Explain that she/he 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/he wants legal redress.
- For each aspect of the exam, invite questions, and answer fully. Make sure that s/he understands. Then, ask her/him to decide yes or no. Tick the box on the form.
- Once you are sure that s/he has understood the examination and the form completely, ask her/him to sign.

Talking to a survivor about reporting to the police

- In cases where the survivor has a mental disability, the law requires you to report to the police. Inform the survivor about this.
- If the survivor wants to go to the police, tell her/him that they will need to have forensic evidence collected.
- Tell the survivor what evidence collection would involve.
- If the survivor has not decided whether or not to go to the police, the evidence can be collected and kept. If more than 7 days have passed since the assault, it is too late to collect evidence.
- If the survivor 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 examination should be done and well documented (see form pages 79-85 and physical examination from J-88 on pp. 86-91). TThe exam can be useful if the survivor 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/,

Guidelines for Medico-legal Care for the Victims of sexual violence, 2003 at http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/,

Strengthening the Medico-legal Response to Sexual Violence, 2014 at http://who.int/reproductivehealth/publications/violence/medico-legal-response/en/.

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

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 the survivor that she/he is in control. She/he can ask questions, can stop the exam at any time and can refuse any part of the exam.

- Look at the survivor before you touch her/him and pay attention to her/his appearance and emotional state.
- At each step of the exam, tell her/him what you are going to do, and ask her/his permission first.
- Ask often if she/he has any questions and if you can proceed.

Examine

- Make sure equipment and supplies are prepared.
- Take the patient's vital signs and physical profile—pulse, blood pressure, respiratory rate, temperature, weight, and height. Work systematically.
- Be unhurried. Give time to the examination.
- Record all your findings and observations clearly and fully on a standard exam form (see page 79-85).
- Complete the J-88 form – See pages 86-91
- Document carefully and fully any injury or other mark as this can be important evidence.

Conduct a 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 survivor feel as comfortable as possible.
- Let her/him know when and where you will touch her/him.
- For vaginal exams help the woman to lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her/his body. It should be drawn up at the time of the examination.
- Work systematically. Have a good light source to view injuries. Follow the J-88 (see pages 86-91)
- In addition, please fill out additional details on the form provided on page 79-85.

Remember: Being sexually assaulted is a traumatic event. Survivors may be very sensitive to being examined or touched, particularly by a male provider. Proceed slowly. Ask often if she/he 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 the survivor's distress.

Job aid

Physical exam checklist

Look at all the following	Look for and record
• 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) • Female genitals (internal examination, using a speculum) • Anal region (external)	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

Record findings and treatment

Health Care Providers often must answer questions from police, lawyers or the courts about injuries to survivors they have treated. Careful documentation of findings and treatment on J-88 and the additional form provided on pages 86-91 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 (in line with National Standard Treatment guidelines)
- 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 on page 45). Offer pregnancy test to the woman.

Facts about emergency contraception pills

Progesterone only (89% effectiveness): levonorgestrel 1.5 mg within 12 hours but not later than 72 hours.
Note: If the patient is taking an anticonvulsant or TB treatment with rifampicin, a higher dose is needed.
If a sexual assault occured >72 hours ago, a copper IUCD is more effective than the above pills for preventing pregnancy. The IUCD can be inserted 0-120 hrs after the rape.
Clinical judgment is very important. Survivors who are offered emergency contraception (EC) to prevent pregnancy following sexual assault must be made aware of the following facts about EC:

1) The risk of pregnancy is significantly reduced if taken within 72 hours of the assault; EC is 97% effective, and the earlier it is taken the more effective it is.
2) EC does not cause an abortion but prevents ovulation, blocks fertilization and interferes with implantation; they will not affect an existing pregnancy.
3) The pills may cause vomiting and nausea. If vomiting occurs within 1 hour of taking the pills, the dose should be repeated
4) In most cases, the next menstrual period will occur around the expected time or earlier. If it is delayed, a pregnancy test should be performed.

[1] National Guidelines for Antiretroviral Therapy Fourth Edition January 2014

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, injectable, implants, IUCD (intra uterine contraceptive device), 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.** The National Standard Treatment Guidelines (2011) suggest taking the EC pills within 72 hours. While she can take them up to 5 days after the sexual assault, they become less effective with each day that passes and are most effective if taken within 72 hours.
- 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 Metoclopramide 10mg 3 times per day 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 up to the legal time limit, as specified in the laws and policies section above.

Emergency copper IUCD

- A copper- T IUCD can also be inserted 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 IUCD.
- It is a good choice for very effective long-acting contraception, if a woman is interested in the IUCD, then she could be referred for it immediately.

2.3 Prevent sexually transmitted infections

- Survivors who have been sexually assaulted should be given antibiotics to prevent and treat the following sexually transmitted infections (STIs)—chlamydia, gonorrhoea, trichomonas and syphilis.
- Offer STI treatment on your first meeting with the survivor.
- There is no need to test for STIs before treating.
- Give preventive treatment for STIs as per National Standard Treatment Guidelines (2011).
- Give the shortest courses available as per National Standard Treatment Guidelines (2011) in Namibia, as these are easiest to take.

The chart on the next page contains dosage information based on the National Standard Treatment Guidelines for your further reference.

Job aid

STI treatments [1]		
STI	**Medication**	**Dosage and schedule**
Chlamydia	Doxycycline 100mg	orally/twice per day for 5-7 days
Gonorrhoea	Ciprofloxacin 500mg	orally immediately once per week for 3 weeks
trichomonas	Metroniclazole 400mg	orally/twice per day for 7 days or 2g immediately
Syphilis	Benzathine Penicillin 2.4 MIU	Intramuscular immediately
Other locally common STIs		
Chancroid	Ceftriaxone 250mg	Intramuscular immediately
Herpes	Co-trimoxazole 2 single tablets	orally/twice per day for 7 days
HPV	No Treatment/ Abstinence from sex until warts disappear	No Treatment
Hepatitis,	High Care	High Care
Pelvic inflammatory disease (PID),	Ceftriaxone 250mg Cefixime 400mg Metronidazole 400mg	Intramuscular immediately immediately orally Every 12hours for 7 days
HIV-Aids.	HAART/ARV	Immediately or as soon as possible within one week

[1] Namibia Standard Treatment Guidelines

Hepatitis B

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

- Ask if she/he has received a vaccine against hepatitis B. Respond according to chart below.
- The National ART Guidelines recommend starting Hepatitis B immunoglobulin and Hepatitis B vaccination as soon as possible if the patient is not already immune, and no later than 21 days after the incident. If the result of the HBsAb test is nonreactive vaccinate at 1 to 2, and 4 to 6 months.

Has she/he been vaccinated for hepatitis B?

Immunization status	Treatment guidelines
No, never vaccinated for hepatitis B or if the results of the HBsAb test is non-reactive.	1st dose of vaccine: at first visit. 2nd dose: 1 - 2 months after the first dose. 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 as per the National ART Guidelines[1] 2014
- 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 survivor about whether HIV PEP is appropriate in her/his situation.

[1] National Guidelines for Antiretroviral Therapy Fourth Edition January 2014

When should PEP be considered?

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

Communicate

Taking PEP is the survivor's decision. Discuss the following points to help her/him decide.

- Does she/he 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.
- The earlier PEP is started, the lower the chances of getting HIV; however it is not 100% effective.
- She/he 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, and headaches. (For most people side-effects decrease in a few days.)

If the survivor takes HIV PEP

The National ART Guidelines (2014) recommend the following PEP regimen after rape:

PEP drugs	regimen
TDF+FTC (or 3TC) Or TDF+FTC+ ATV/r	Daily for 28 days

- 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.
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals.
- Offer HIV testing at the initial consultation.
- If the survivor cannot tolerate efavirenz, lopinavir may be substituted for efavirenz.
- Retest at 6 weeks, 3 months and 6 months.
- In the case of a positive test result, refer for HIV treatment and care.

PEP adherence counselling

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

- 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 the survivor forgets to take her/his medicine on time, she/he should still take it, if it is less than 12 hours late.
- If it is more than 12 hours late, she/he should wait and take the next dose at the regular time.
- She/he should not take 2 doses at the same time.
- She/he should return to the clinic if side-effects do not go away in a few

days, if she/he is unable to take the drugs as prescribed, or if she/he has any other problems.

2.5 Plan for self-care

Explain your examination findings and treatment
Discuss with the survivor the examination findings, what they may mean for her/his health, and any treatments provided. Invite her/him to voice questions and concerns. Respond in detail and check her/his understanding.

Care of injuries

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

Follow-up

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

3. Follow-up after sexual assault

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

Job aid

Follow-up after sexual assault		
2-week follow-up visit		
Injury	• Check that any injuries are healing properly.	☐
STIs	• Check that the survivor has completed the course of any medications given for STIs. • Check adherence to PEP, if she/he is taking it. • Discuss HIV test results.	☐
Pregnancy	• Revisit pregnancy test if the initial test for pregnancy was negative if she was at risk. If she is pregnant, tell her about the available options. Refer her for safe abortion if she decides she wants one and within the limits of the laws and policies. (refer to part one).	☐
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 57-70.	☐

Planning	• Remind her/him to return for further hepatitis B vaccinations in 1 month and 6 months and HIV testing at 6 weeks, 3 months and 6 months, or else to follow up with her/his usual health-care provider. • Ask her/him 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.	☐
4-6 weeks follow-up visit		
STIs	• Give second Hepatitis B vaccination, if needed. Remind her/his of the 6-month dose.	☐
Mental health	• Continue first-line support and care. • Assess her/his emotional state and mental status. Ask if she/he 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 57-70) 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.	☐
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 57-70) 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/ him of the 6-month dose of hepatitis B vaccine, if needed.	☐
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 57-70.	☐

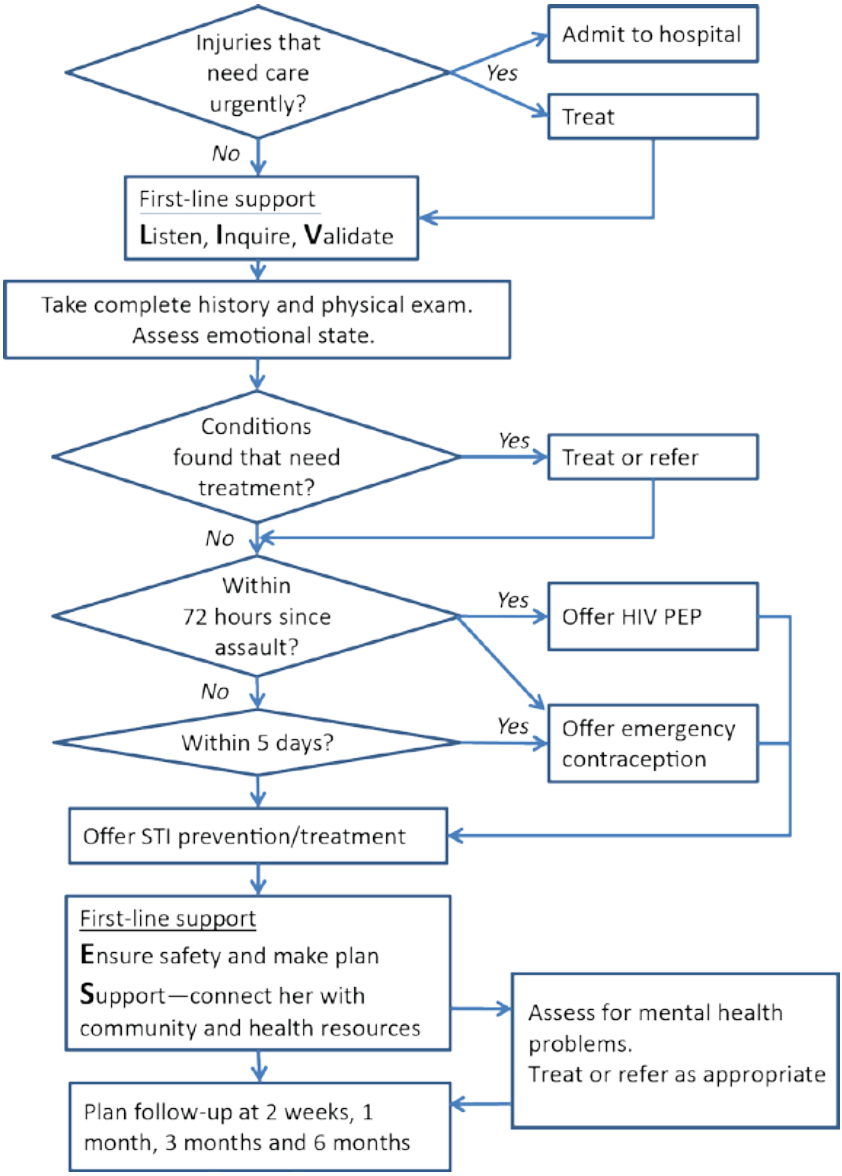
Testing schedule

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

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

** Test if the survivor is uncertain whether she/he 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 people 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 survivor's stress and help them heal.

Some survivors, however, will suffer more severely than others.
It is important to be able to recognize these survivors and to help them obtain care. If such help is not available, there are things that 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 13).
- Explain that she/he is likely to feel better with time.
- Help strengthen her/his positive coping methods (see next page).
- Explore the availability of social support (see next page).
- Teach and demonstrate stress reduction exercises. (See pages 59-61. 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 the survivor's positive coping methods

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

Encourage him/her to:

- Build on his/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.

Give the survivor details for calling in to the appropriate services, in case the suggestions are not helping, and encourage him/her to return if needed.

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 survivors that, even if there is no one with whom they wishes to share what has happened to her, they still can connect with family and friends. Spending time with people they enjoy can distract from the distress.

Help the survivor 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 the survivor 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.

Job aid

Exercises to help reduce stress

1. Slow breathing technique

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

2. Progressive muscle relaxation technique

- In this exercise you tighten and then relax muscles in your body. Begin with your toes.
- Curl your toes and hold the muscles tightly. This may hurt a little. Breathe deeply and count to 3 while holding your toe muscles tight. Then, relax your toes and let out your breath. Breathe normally and feel the relaxation in your toes.
- Do the same for each of these parts of your body in turn. Each time, breathe deeply in as you tighten the muscles, count to 3, and then relax and breathe out slowly.
- Hold your leg and thigh muscles tight…
- Hold your belly tight…
- Make fists with your hands…

- Bend your arms at the elbows and hold your arms tight…
- Squeeze your shoulder blades together…
- Shrug your shoulders as high as you can…
- Tighten all the muscles in your face….
- Now, drop your chin slowly toward your chest. As you breathe in, slowly and carefully move your head in a circle to the right, and then breathe out as you bring your head around to the left and back toward your chest. Do this 3 times. Now, go the other way…inhale to the left and back, exhale to the right and down. Do this 3 times.
- Now bring your head up to the centre. Notice how calm you feel.

Helping with more severe mental health problems

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 the survivor take care of their appearance? Are their clothing and hair cared for or in disarray? Is the survivor distracted or agitated? Is she/he restless, or is she/he calm? Are there any signs of intoxication or misuse of drugs?
Mood, both what you observe and what she reports	Is the survivor calm, crying, angry, anxious, very sad, without expression?
Speech	Is she/he silent? How does she/he speak (clearly or with difficulty)? Too fast/too slow? Is she/he confused?

Thoughts	Does the survivor have thoughts about hurting themselves? Are there bad thoughts or memories that keep coming back? Is she/he seeing the event over and over in her/his 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/he is unable to function in her/his daily life, she/he may have more severe mental health problems. See page 62-63 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 survivor's anxiety around suicidal thoughts and helps her/him feel understood.

If she/he has:

- current thoughts or plan to commit suicide or to harm her/himself,

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/he is now extremely agitated, violent, distressed or uncommunicative,

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

Refer the survivor immediately to a specialist or emergency health facility.

Moderate-severe depressive disorder

Survivors of 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 survivor is unable to find a way to cope and these symptoms persist, then she/he 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 survivor has suffered from such depressive disorder before experiencing violence, she/he 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 survivor has persistent symptoms over at least 2 weeks and cannot carry out their 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 survivor have moderate-severe depressive disorder?

Assess for the following:

A. The survivor has had any of the following core symptoms of depressive disorder for at least 2 weeks:

- 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 survivor 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 for at least 2 weeks:

- 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 survivor 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.

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/he 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 behaviors such as excessive gambling or spending, making important decisions without adequate planning
  - Unrealistically inflated self-esteem.

The survivor 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 her/himself or others. If so, then the depression is likely part of another disorder called **bipolar disorder** and she/he 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 survivor (and caregiver if appropriate):

- Depression is a very common condition that can happen to anybody.
- The occurrence of depression does not mean that she/he 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/he should try to do as many of the following as possible. They will all help to improve her/his 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 58 and 61.

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

- There is a need (i.e. steps 1-4 in management of moderate-severe depression are not working).

OR

- The survivor is at imminent risk of suicide/self-harm (see page 62).

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 the symptoms. Consider referral if there is no improvement.

Post-traumatic stress disorder

Immediately after a potentially traumatic experience such as sexual assault, most survivors experience psychological distress. For many survivors 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/he 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

Survivors with PTSD may be difficult to distinguish from survivors 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 survivor 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 survivor 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/he has any other medical conditions, moderate-severe depressive disorder, suicidal thinking or alcohol and drug use problems.

Management of PTSD

1. Educate her/him 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/him to:

- Continue normal daily routines as much as possible.
- Talk to people she/he trusts about what happened and how she/he feels, but only when she/he 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 57 and 59.

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 when there is a need

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

OR

- She/he is at imminent risk of suicide/self-harm (see page 62).

5. Follow-up

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

Part 5 Intimate partner violence & contraception: How family planning providers can help

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

If a client discloses violence to you, or you suspect violence, you can help. In general, follow the LIVES steps (see pages 13-34) to give her first-line care and support.

What is reproductive coercion?

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

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

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

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

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

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

Job aid

Questions in family planning settings

Situation	Illustrative questions
Refusal of specific contraceptive methods or insistence on a particular type of method	Contraceptive methods are widely used and have been found to be beneficial to the health of women and children. Is there any problem at home that makes you refuse this method?
Resistance to contraceptive counselling	We routinely offer all women counselling. FP procedures have important health benefits for women and children. Is there any problem/ Do you have any worry which is preventing you from being counselled?
Insistence on tubal ligation	Although tubal ligation is routinely offered as one contraceptive method, is there any particular reason for your insistence on undergoing this procedure? Is there any problem which has made you take this decision?
Looking anxious or depressed	You look very sad and I am very concerned about you. Can you tell me how I can help you?
Disclosure of insomnia or anxiety	We all need to have good sleep to lead a healthy life. Is there any particular reason for the state you are in? Is there something or someone at home that might be worrying you?

In particular, explore issues of violence when counselling about method choice. Your skills as a family planning provider can especially help a woman deal with this aspect of her situation.
To explore how violence affects her reproductive and sexual life, you can ask these four questions:

- Has your partner ever told you not to use contraception, blocked you from getting a method, or hid or taken away your contraception?
- Has your partner ever tried to force you or pressure you to become pregnant?
- Has your partner ever refused to use a condom?
- Has your partner ever made you have sex without using contraception so that you would become pregnant?

Discuss her answers and how she can make the best choices in these circumstances. The following methods can be offered to a woman who does not wish to reveal her use of contraceptives to her partner or if she wants a method that would be difficult for her partner to interfere with:

- **Injectable contraceptives.** Intramuscular injectable contraceptives leave no signs on the skin. The 2- and 3-month injectables often stop menstrual periods after a time. This could be a concern if her partner monitors her periods. In contrast, monthly injectable usually make monthly cycles more regular. Let her know that injectable require regular follow up visits.

- **Subcutaneously-administered depot medroxyprogesterone acetate** (DMPA-SC, 104 mg/0.65 mL). This is a new method added by WHO in its 2015 eligibility criteria for contraceptive methods[4]. It is highly effective and follows the same profile as DMPA intra-muscular. It also requires regular follow up.

- **Implants**. Once inserted under the skin, implants work for several years. Sometimes they can be seen and felt under the skin, however. Many women will experience a change in their bleeding pattern, this can include no bleeding, intermittent and/or frequent spotting and bleeding, and rarely heavy/prolonged bleeding. Usually implants do not require regular follow up.

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

- **Copper and hormonal (LNG) IUCDs.** They remain out of sight in the uterus. Copper IUCDs are associated with increased menstrual flow, while hormonal IUCDs can make the periods lighter or cause periods to stop. It is important to assess the risk of STIs before placing an IUCD[5]. Since women subjected to intimate partner violence are at higher risk of STI and HIV infection, health care providers should take into account prevalence and individual risk to judiciously assess IUD insertion and continuation. Usually IUDs do not require regular follow up. If placed within 5 days after unprotected intercourse can be used as an emergency contraception method. In this case, IUD initiation should follow the same indications as when it is initiated as a regular contraceptive method.

- If she does not want to have any further children, you may offer her sterilisation.
  - If she chooses sterilization and does not wish for her partner to find out, it is important that she is supported in doing so. In such a situation, requiring the partner's consent may not be safe for her.
  - The Married Persons Equality Act No 1 (1996)and National Policy for Reproductive Health (2001) do not require the partner's consent to perform this procedure.

It is very important to make clear that the above contraceptive methods DO NOT protect against STI or HIV infection. Provide the woman with information and offer referral to support services for women's empowerment and skills building on condom use negotiation and safer sexual practices if available.

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

DUAL PROTECTION

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

Annexure 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

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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

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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/

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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/

Job aid

Sample form for history and additional examination

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 their dignity. Do not express negative judgments about them or others.
Be gentle. Encourage her/him to answer but do not insist.
Ask one question at a time. Speak simply and clearly. Ask for clarification or detail if needed.
Give time to answer and allow silences. Do not rush.

CONFIDENTIAL	**CODE:**

Medical History and Examination Form for Sexual Assault

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

1. GENERAL INFORMATION

Family name	Given name
Telephone number	
Date of birth _____ / _____ / _____ DD MM YY	Age
In the presence of	

2. GENERAL MEDICAL INFORMATION

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

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, or traditional medicines?

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": How many times has this happened before?	
When was the last time this happened?	_____ / _____ / _____ 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 involved	
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
Douche?	☐ Yes	☐ No

4. GYNAECOLOGICAL HISTORY

Are you using a contraceptive method?	
☐ IUCD	☐ 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 If within the last 24 hours, what time was this? Is the person traceable? (for example, husband, boyfriend, acquaintance)

5. 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

6. 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	☐	☐	

7. COUNSELLING, REFERRALS, FOLLOW-UP

Client plans to report to police OR has already made report?

☐ Yes ☐ No

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

Counselling provided:

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

To:	Purpose:

Follow-up agreed with client? ☐ Yes ☐ No

Date of next visit:: _____ / _____ / _____

DD MM YY

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

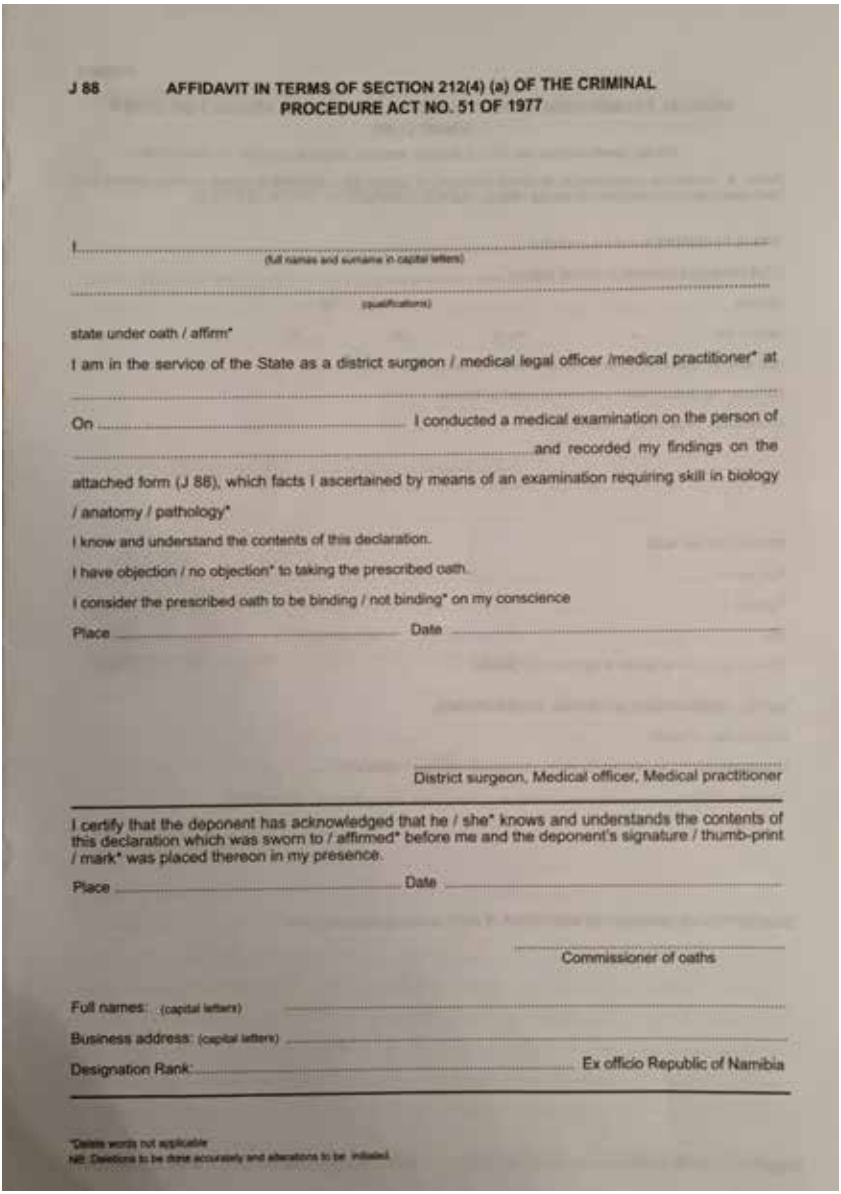
Title: _____

Printed name: _____

Signature: _____

Date: _____ / _____ / _____ DD MM YY

J 88 Form



J 88 AFFIDAVIT IN TERMS OF SECTION 212(4) (a) OF THE CRIMINAL PROCEDURE ACT NO. 51 OF 1977

I .....
(full names and surname in capital letters)

.....
(qualifications)

state under oath / affirm*

I am in the service of the State as a district surgeon / medical legal officer /medical practitioner* at

.....

On ..... I conducted a medical examination on the person of

.....and recorded my findings on the

attached form (J 88), which facts I ascertained by means of an examination requiring skill in biology / anatomy / pathology*

I know and understand the contents of this declaration.

I have objection / no objection* to taking the prescribed oath.

I consider the prescribed oath to be binding / not binding* on my conscience

Place ..... Date .....

.....
District surgeon, Medical officer, Medical practitioner

I certify that the deponent has acknowledged that he / she* knows and understands the contents of this declaration which was sworn to / affirmed* before me and the deponent's signature / thumb-print / mark* was placed thereon in my presence.

Place ..... Date .....

.....
Commissioner of oaths

Full names: (capital letters) .....

Business address: (capital letters) .....

Designation Rank: ..... Ex officio Republic of Namibia

---

*Delete words not applicable
NB: Deletions to be done accurately and alterations to be initialled

FORM A

MEDICAL EXAMINATION REPORT IN A CASE OF ALLEGED ASSAULT OR OTHER CRIME (J 88)

(TO BE COMPLETED BY DISTRICT SURGEON, MEDICAL OFFICER OR MEDICAL PRACTITIONER)

Form ' A ' should be completed in all cases and form 'B' should be completed in cases where a patient has been examined in connection with sexual offence, PLEASE COMPLETE IN CAPITAL LETTERS.

THIS IS TO CERTIFY that at the request of:.....

I (full name and surname in capital letters) .....

Address ..... Tel. no.....

have on this ..... day of ..... 20..... at ..... h.....

examined at: (place where examination was carried out).....

the under mentioned patient and have to report as follows:

Information regarding incident:.....

.....

.....

.....

DETAILS OF PATIENT:

Full name:.....

Address.....

Sex:..... Apparent age.....

Name of guardian or person in loco parentis present:.....

INITIAL OBSERVATIONS (EXTERNAL OBSERVATIONS)

General state of health:.....

Mental state:(calm / aggressive / hysterical /confused / shocked / crying etc).....

Condition of clothing: (changed since incident / describe tears, missing buttons, stains i.e blood, dirt, vomit, ejaculation).....

.....

.....

.....

DESCRIPTION OF BRUISES AND ABRASIONS, IF ANY:(note the exact nature and position).....

.....

.....

.....

.....

.....

.....

District surgeon, Medical officer, Medical practitioner

REPORT ON EXAMINATION IN A CASE OF ALLEGED RAPE OR OTHER SEXUAL OFFENCE (PLEASE COMPLETE IN BLOCK LETTERS)

Full name of patient:.....

GIVE DETAILED DESCRIPTION OF BRUISING, WOUNDS ETC TO THE FOLLOWING:

Breasts:.....

.....

.....

.....

Labia majora:.....

.....

.....

.....

Labia minora:.....

.....

.....

.....

Fourchette:.....

.....

.....

.....

Vestbule:.....

.....

.....

.....

Hymen:.....

.....

.....

.....

Vagina (1,2,3 fingers):.....

Discharge:.....

.....

Examination: (easy / painful).....

Page 3 District surgeon, Medical officer, Medical practitioner

Page 2 District surgeon, Medical officer, Medical practitioner

Haemorrhage:

Date of last menstruation:

Anus:

Perineum:

Penis:

Scrotum:

Inner thighs and/or buttocks: (give detailed description of bruising, redness and/or tenderness)

Other observations:

Conclusion: (Please state whether or not in your opinion, the injuries fit/do not fit with the time and circumstances of the alleged incident)

District surgeon, Medical officer, Medical practitioner

SPECIAL INVESTIGATIONS

Microscopical or other special examinations of stains, etc.....

Specimens taken for special examination:(i.e clothes/shoes/other objects and give a description thereof).....

RAPE KIT:

(a) Taken: Seal number:.....

(b) Not taken: (reasons):.....

BLOOD SAMPLE FOR HIV/ BLOOD-ALCOHOL ETC:

(a) Taken: Seal number:.....

(b) Not taken: (reasons):.....

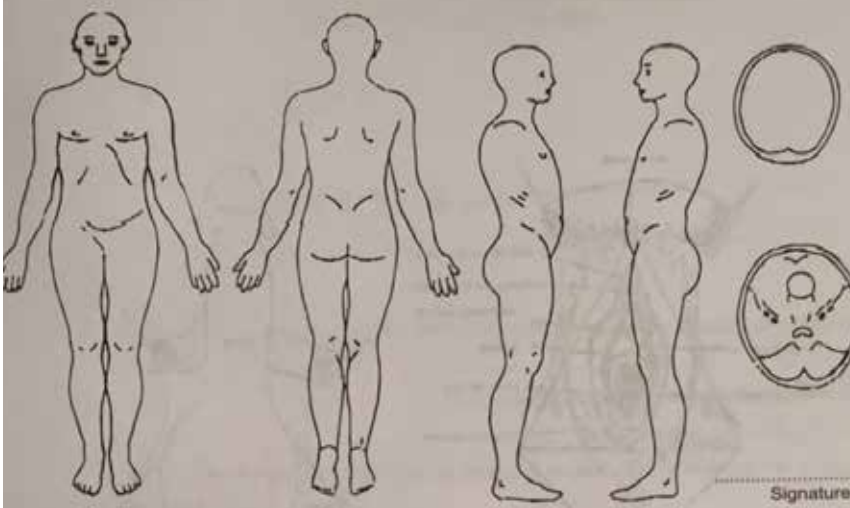
Specimens handed to: (full name and surname in capital letters).....

Address:.....

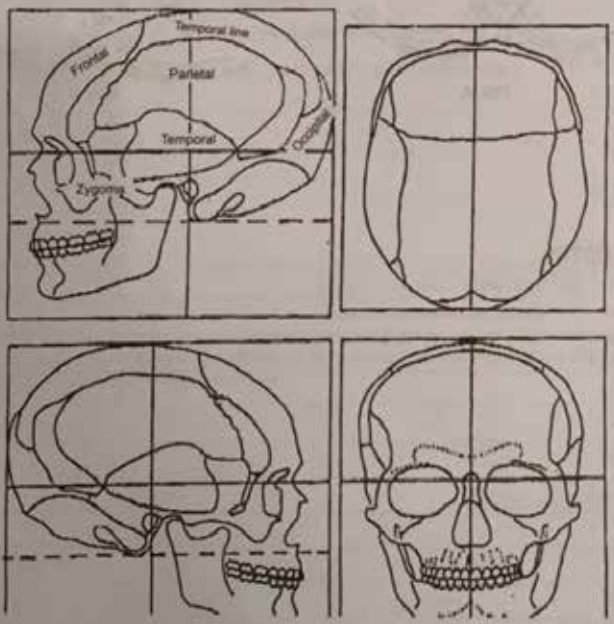
Signature:..... Date.....

EXPLANATORY NOTES:

District surgeon, Medical officer, Medical practitioner



Signature



District surgeon, Medical officer, Medical practitioner

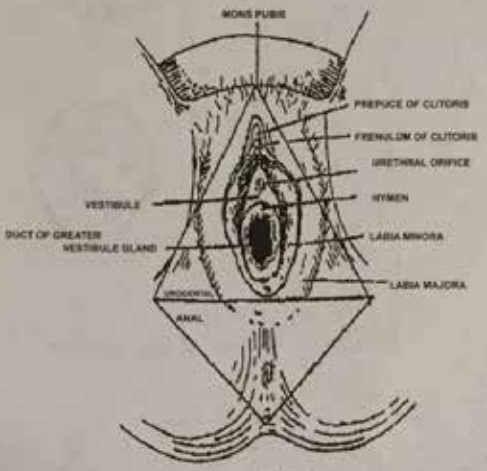


FIG. A

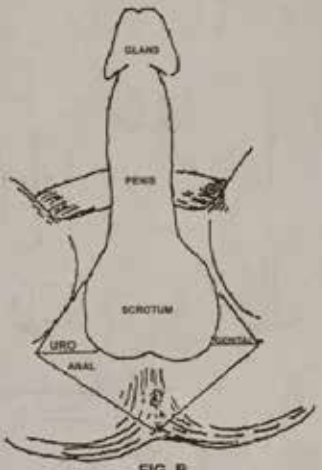


FIG. B

EXPLANATORY NOTES:

District surgeon, Medical officer, Medical practition

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

Signs of immediate risk	**Asking about violence**
• 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?"	*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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Notes

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