

Médecins Sans Frontières

Medical protocol for sexual
violence care

2020



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Abbreviations

3TC	Lamivudine
ABC	Abacavir
ART	Antiretroviral Therapy for HIV
ATV/r	Atazanavir/ritonavir
AZT	Zidovudine
DTG	Dolutegravir
EC	Emergency contraception
ECP	Emergency contraception pills
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
HTIG	Human tetanus immune globulin
IM	Intramuscular
IU	International units
IV	Intravenous
LNG-ECP	Levonorgestrel Emergency Contraception Pill
PEP	Post-Exposure Prophylaxis
PrEP	Pre-exposure prophylaxis
SAC	Safe abortion care
STI	Sexually Transmitted infection
SV	Sexual Violence
Td	Tetanus toxoid-diphtheria
TDF	Tenofovir
TT	Tetanus toxoid
UPA-ECP	Ulipristal Acetate Emergency Contraception Pill
WHO	World Health Organization

1 Introduction

Sexual violence (SV) is defined as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person’s sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work” (Krug, 2002). Rape¹ is “forced, coerced or non-consensual penetration – even if slight – of the vagina, anus or mouth with a penis or other body part or penetration of the vagina or anus with any object” (IASC, 2015).

Sexual violence has immediate and long-term medical and psychological consequences. Survivors of SV should have access to quality, comprehensive care to support them to heal and recover.

Medical care for survivors of SV must be guided by key principles of respect, compassion, informed consent, privacy, confidentiality and non-discrimination. Medical care for survivors of SV involves:

- Assessing and treating pain, wounds and injuries
- Assessing the risk of HIV and, offering testing, information and HIV PEP or HIV PrEP
- Determining if a patient (women or girl of reproductive age) is pregnant and, preventing unwanted pregnancy through emergency contraception
- Providing safe abortion care if requested
- Providing prophylaxis or treatment of sexually transmitted infections (STIs)
- Administering vaccinations against hepatitis B and tetanus

Survivors of SV should be offered mental health care. Mental health care may include psychological first aid (PFA), psychosocial support, psychological care (or counselling) and psychiatric care. If there is no mental health professional available or the survivor declines support from the mental health care professional, then the health care worker should provide PFA and psychosocial support.

Psychological first aid and psychosocial support should always be available and health care workers should be trained to provide it. Psychological first aid describes a humane, supportive response to a fellow human being who is suffering and who may need support (WHO, 2011). Psychosocial support for survivors of SV includes communication skills with careful listening and a non-judgmental attitude, asking about needs, validating, re-assuring, strengthening coping skills and exploring social support, identifying needs and referring for further mental health care (if needed).

See the most recent MSF Mental health and psychosocial care guidelines for survivors of SV.

Survivors should be systematically offered a medical certificate (MC) which should include the patient’s story and examination findings. It is the survivor’s choice whether or not to take the MC, how to use it and whether or not to report to the police, legal and justice system. If the survivor chooses not to take the MC, it can be stored for later access.

See the most recent MSF medico-legal toolbox for further information.

Survivors of SV should be offered comprehensive, multidisciplinary care that responds to their needs and includes: medical and mental health care as well as referral to legal, justice, protection, safety, security², education, economic, skills and livelihood support services.

As survivors of SV may be at risk of ongoing harm, violence and even death, MSF teams must assess risk, be aware of local solutions to reduce risk and improve safety and offer referral to locally available support services.

¹ Throughout the document terms as “forced penetration” or “assault/incident” will be used instead of rape as these terms have a legal qualification.

² In most project protection, safety and security for survivors of SV is assured by referring to other actors offering safe houses, shelters or other.

1.1 Note on language

This medical protocol uses the terms survivor and patient interchangeably. The term “survivor” recognizes the agency, strength and resiliency of the person and focuses on empowering the person and their efforts, as well as their ability and capacity to cope, heal and recover. The term “patient” focuses on the provision of medical and mental health care after SV. However, the term victim is used in related documents, including the medical certificate. The term “victim” recognizes that harm, a crime and a violation of human rights has occurred. All language should be person-centered, show respect, and be based on the preference of the person seeking care.

While women and girls are vulnerable to SV, men and boys also experience SV and there is often less awareness, knowledge and support for men and boys. Lesbian, bisexual, gay, trans and intersex (LGBTI) persons face vulnerability and barriers to access care. This protocol uses the gender-neutral terms ‘survivor’, ‘patient’ and ‘they/them’ to include women, men, girls, boys and LGBTI persons.

1.2 Scope and purpose of the medical protocol

This ‘Medical Protocol for Sexual Violence Care’ is an updated, adapted version of, and replaces, the 2011 and 2014 editions of ‘Medical Protocol for Sexual Violence Care’ and includes medical care and psychosocial support. This medical protocol focuses on SV involving physical contact³. The protocol includes annexes with special considerations for survivors of SV who have delayed presentation to care or survivors of ongoing, repeated, recurrent, and chronic SV by intimate partner or another known person.

Further information on assessing, designing, implementing, monitoring and evaluating programs, creating access to care and designing models of care, awareness raising and community engagement, taking history, interviews, examination, documentation, document storage, further mental health support, medical certificates, referral and coordination with support services, data collection and analysis is available from: SV/Sexual and Reproductive Health (SRH) Referents or Advisors, MSF Operating Centre’s (OC) SV guidelines, *MSF Medico-legal toolbox*, and *MSF Mental health and psychosocial care guidelines for survivors of sexual violence*.

1.3 Acknowledgements

This protocol is based on the MSF Operational Centre Amsterdam (OCA) 2019 Medical protocol for survivors of sexual violence and Guidelines for creating access and providing care to survivors of sexual violence and intimate partner violence, developed by Meggy Verputten and Colleen Dockerty.

This intersectional protocol has been updated and developed by Colleen Dockerty, under the supervision of Patricia Lledo Weber, with valuable contributions from: Arantza Abril, Séverine Caluwaerts, De Plecker Eva, Nelly Staderini, Margaret Bell, Manisha Kumar, Angie Carrascal, Gilles van Cutsem, Cristina Carreño, Roberta Petrucci, Tanja Ducombe, Amin Lamrous, Lucy O’Connell, Jennifer Maria Marx, Arlene Chua, Carolina Jimenez and Cristian Casademont.

³ Including rape, attempted rape, coerced contact between the mouth and penis, vulva or anus, unwanted kissing, fondling, or touching of genitalia and buttocks and other forms of SV

2 Guiding principles

These principles guide how to engage with survivors of SV to support them from healing and recovery.

2.1 Respect

Treat survivors with respect, dignity, empathy, kindness and compassion. Respect a survivor's wishes and choices. Do not judge or blame. Sexual violence is never the fault of the survivor.

2.2 Informed consent

Ask survivors about their needs and wishes, provide information and options, and support them to make informed decisions about what is best for them. Informed consent can restore a sense of control and empowerment. Respect patients' right to decline any care or support – including providing information, undergoing an examination or receiving medication.

Give children and adolescents information and choices appropriate to their age. Ensure children and adolescents are involved and participate in decision-making, and express willingness to receive medical care. Parents or caregivers are usually responsible for giving informed consent for a child or adolescent. However, assess the child or adolescents' ability to understand the treatment, risks and benefits, their evolving capacity to meaningfully participate and make decisions and their best interests and safety – alone without the parents or caregivers. It may be appropriate to seek informed consent from a child or adolescent alone or in addition to their parents, depending on their age, developmental stage, maturity, evolving capacity, best interests and safety.

2.3 Privacy and confidentiality

Respect privacy and confidentiality. Provide care in a private room where others cannot see or hear. Only those directly involved in care should be present during care. Patients should have a choice with whom they will - or will not - share information. Information should only be disclosed with the consent of the patient. Documentation should be kept safely, securely stored.

Respect children and adolescents' privacy and confidentiality. Briefly interview children and adolescents alone to give the child or adolescent an opportunity to privately share information and express their fears or concerns without the caregiver present, and to assess their safety⁴. Ask children and adolescents whether they would like their parent or caregiver present during the interview, examination and medical care. A child or adolescent can have the interview, examination and medical care alone without a parent or caregiver – but a support person⁵ should be present.

Children or adolescents may request to withhold information from their parent or caregiver. Respect children or adolescents' confidentiality if they are old enough, have maturity and an evolving capacity to understand the implications of their decision, and if respecting confidentiality promotes their safety or best interest. Confidentiality may be breached if there is a threat to the child or adolescent's health, safety or best interest. In this case identify a safe, trusted parent or caregiver willing and capable of protecting the child or adolescent, or local protection services. Inform the child or adolescent that confidentiality will be breached and who will be informed.

2.4 Non-discrimination

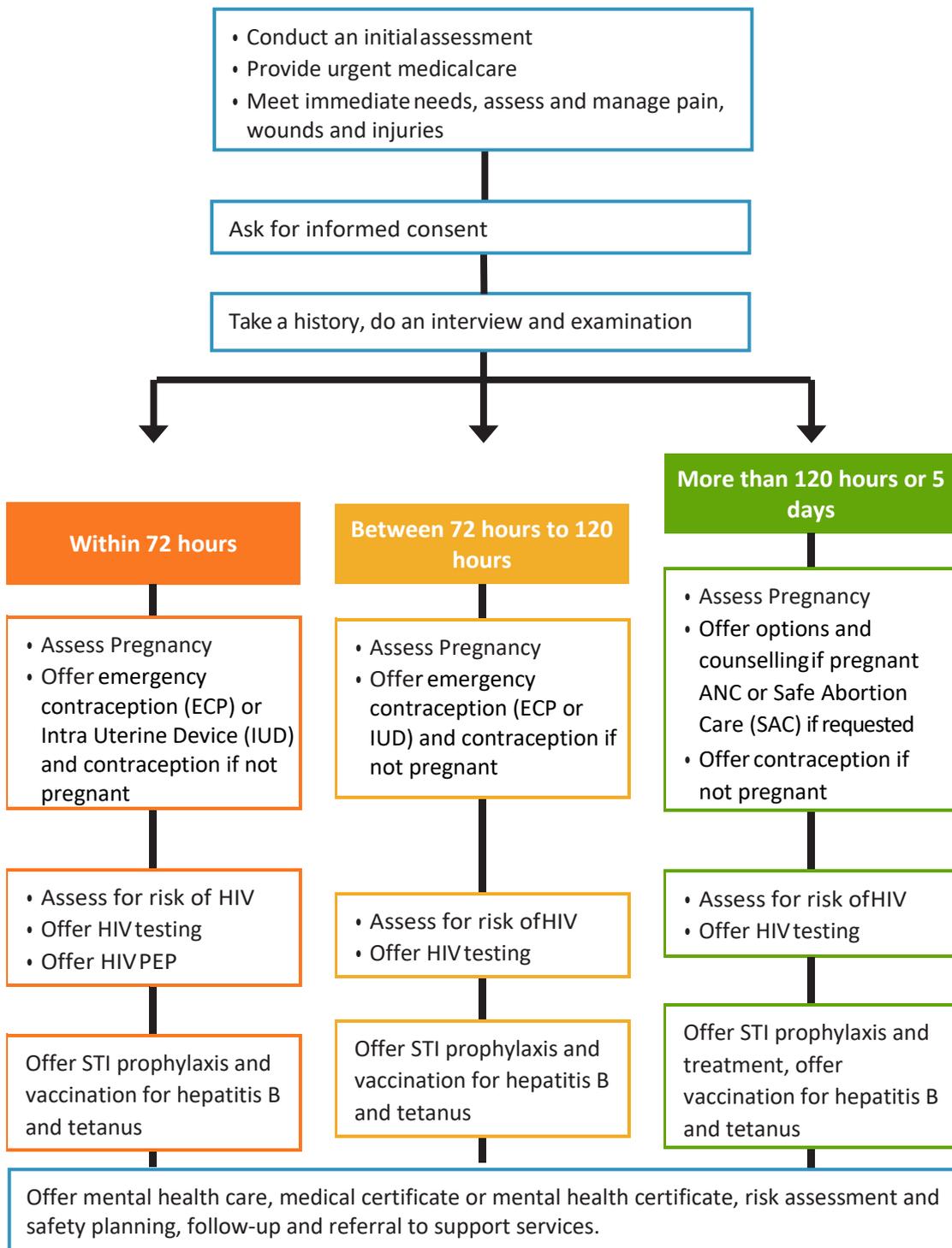
Offer health care to all regardless of age, gender, race, nationality, ethnicity, language, religion, political beliefs, socio-economic status, occupation, disability, marital status, sexual orientation,

⁴ If a child refuses to speak with the health care provider alone, is upset or agitated, use judgement to determine how to assess safety.

⁵ Support person can be a person working at project level or medical structure as medical (nurse, midwife), psychological (psychologist) or social (social worker) staff.

gender identity or expression, or any other characteristic.
 See the most recent MSF Medico-legal toolbox for further information.

3 Care flowchart for survivors of sexual violence



4 Assessment and management of pain

Survivors of SV may be in pain and therefore must be assessed and offered pain management if needed.

4.1 Pain assessment

Carefully assess pain and, identify the type and pattern of pain to guide treatment. Ask all patients about pain. Believe and listen to the patient (and caregiver), do not underestimate reports of pain, and listen to their story and language used. Only the individual is able to assess their level of pain. Ask about the cause, type, pattern, aggravating and relieving factors, locations(s) and intensity of pain. There may be more than one location of pain, a body map may be helpful. Use a pain assessment tool. Use an appropriate visual numeric/ analogue scale or a facial expression scale adapted to children based on developmental stage. Assess for chronic pain or neuropathic conditions that may develop even after the healing of injuries.

4.2 Pain management

The correct use of analgesia will relieve pain in most patients and should be based on the type, cause, and intensity of pain. A combination of analgesia is beneficial. Start with an analgesic from the level most effective for the type and intensity of the pain. Relieve the pain as quickly as possible. Prevent the return of pain by treating underlying cause(s) when possible. Use oral medication whenever possible. Do not use a placebo. Regularly assess and re-evaluate the patient's pain and response to treatment.

Dosages

Analgesics for children and adults				
Drug and route of administration	Dosage		Side effects	Note
	Children > 1 month	Adults		
Paracetamol PO	15 mg/kg every 6 to 8 hours (max. 60 mg/kg daily)	500 mg to 1 g every 4 to 6 hours (max. 4 g/day)	Acute overdose: hepatic necrosis Chronic overdose: liver toxicity, nephrotoxicity, thrombocytopenia	Lacks anti-inflammatory effects of NSAIDs, but no adverse effects on gastric mucosa or platelets
Ibuprofen PO	> 3 months: 5 to 10 mg/kg every 6 to 8 hours (max. 30 mg/kg daily) > 12 years: as for adults	200 to 400 mg every 6 to 8 hours (max. 1200 mg daily)	Allergic reactions, epigastric pain, peptic ulcer, haemorrhage, renal impairment.	Taken on full stomach or after meals. Fewer Gastro Intestinal (GI) effects than other non-selective NSAIDs
Tramadol PO	Dose: 1–2 mg/kg every 4–6 hours (max: 400mg/day) > 12 years: 50 to 100 mg every 4 to 6 hours (max. 400 mg daily)	50 to 100 mg every 4 to 6 hours (max. 400 mg/day)	Constipation, nausea, somnolence, myoclonus, seizures, respiratory depression, hypogonadism, and sleep-related breathing disorder	Given 25 to 50 mg every 12 hours to elderly patients and patients with severe renal or hepatic impairment. Lowers seizure threshold, should be used with caution with other drugs that lower seizure threshold and in patients with epilepsy

See MSF Clinical Guidelines Diagnosis and Treatment Manual, MSF Essential drugs for analgesia, MSF

5 Assessment and care of wounds and injuries

Often survivors of SV often have no visible wounds or injuries. However, some may have life threatening injuries or superficial vaginal, anal or genital injuries or wounds, including fistulas. Patients should receive assessment and care of wounds and injuries.

5.1 Life threatening wounds and injuries

- Assess airway, breathing, circulation and disability, life threatening wounds and injuries.
- If severe haemorrhage with hypovolemia is present, stabilize the patient by controlling bleeding, inserting an IV, restoring blood volume and giving a blood transfusion if necessary.
- Ask about head injury, symptoms of head injury, conduct a neurological assessment, examine the head, neck, eyes, ears and nose.
- Ask about strangulation⁶, assess for signs and symptoms of strangulation.
- If patients have concerning signs and symptoms of head injury or strangulation, provide or refer to immediate medical care and/or follow up if needed.

5.2 General wound care

Assess wounds and injuries. The goal of wound care is to promote healing and to avoid infection, scar formation and complications.

- Maintain aseptic technique
- Clean open wounds with red granulation with 0.9% sodium chloride or sterile water to remove any organic residue. Work from the cleanest to the dirtiest area
- Clean necrotic or infected open wounds with povidone iodine
- Clean, explore and excise the wound to decide if wounds require closure or suturing.
 - Suture simple wounds that are no more than 6 hours old with no devitalised or contused tissue or 24 hours old if on the face, scalp, upper limbs or hands
 - Delay suturing of a wound with devitalised, contused, infected or necrotic tissue. Clean and remove necrotic tissue with daily dressing changes and if after 72 hours there are no signs of local infection, the wound may be sutured.
- Assess if wounds require dressings and apply dressings. Change dressings every 1-5 days, depending on the wound.
- Use antibiotics only if indicated.

See MSF's 2019 Clinical guidelines *Diagnosis and treatment manual for curative programmes in hospitals and dispensaries: Guidance for prescribing'* for further information on wound care.

5.3 Mouth wounds

- Clean superficial wounds with sodium chloride 0.9%
- Suture deeper wounds with reabsorbable suture and provide antibiotic treatment.

5.4 Vaginal wounds

An external genital examination may be indicated to assess and treat injuries. Never conduct a genital examination for "virginity" testing or to determine history of sexual intercourse⁷.

Vaginal speculum examinations are **not** indicated for most survivors of forced penetration. Vaginal

⁶ external force applied to the neck obstructing airflow and blood vessels

⁷ See MSF OCA 2019 Guidelines for creating access and providing care to survivors of sexual violence and intimate partner violence, Pg 138 Do not conduct "virginity" testing; International Rescue Committee (2018) Myths surrounding virginity A guide for service providers

speculum examinations are:

- Indicated if there is vaginal bleeding, foul-smelling vaginal discharge, significant vaginal or uterine pain, penetrating injuries or suspicion of a foreign body.
- Contraindicated for a prepubescent girl⁸ or any patient who declines⁹.
- In cases of moderate or severe bleeding or injury, assessment and care should be done by a skilled health care worker. It may be preferable to refer the patient to another health care worker or transfer the patient to an appropriate health facility.

If there are vaginal wounds:

- Clean, but do not debride, superficial, non-penetrating vaginal wounds
- Clean the surrounding normal skin or mucosa with povidone iodine and clean the wound with normal saline 0.9%

Forced penetration with physical violence, force or insertion of objects into the vagina or anus can create a vesico-vaginal fistula¹⁰ or recto-vaginal fistula¹¹. Any patient with leaking faeces or urine should be referred for surgical care. This should be also part of the information provided to the patient before discharge. If a surgeon trained in fistula care is not available, the patient should be referred to a health facility for:

- Insertion of an indwelling catheter for 14 days
- Treatment anaemia, any concurrent infection and poor nutritional status.
- Facilitation of oral fluid intake of at least 4-6 litres per day.

See WHO (2006) *Obstetric Fistula: Guiding principles for clinical management and programme development*. http://whqlibdoc.who.int/publications/2006/9241593679_eng.pdf?ua=1

5.5 Ano-rectal wounds

Most rectal injuries are superficial and heal without treatment. Possible rectal injuries include anal sphincter tears, fistulas, or other genital mutilation.

- Clean superficial ano-rectal wounds with sodium chloride 0.9%. Antibiotics are not required.
- Clean deep wounds with involvement of the anal sphincter, and refer the patient to a surgeon. Antibiotics are not required.
- Rectal perforations can lead to sepsis and be life threatening. Stabilise the patient with IV fluids, give antibiotics (cefazolin, metronidazole and gentamicin) and refer to emergency medical care.

Vaginal and ano-rectal wounds can be difficult to assess. Survivors with heavy rectal bleeding, suspected presence of a foreign object or loss of control should be referred to a surgeon and offered an examination under anaesthesia.

⁸ Do not perform a vaginal speculum examination on a pre-pubertal girl without sedation. A vaginal speculum examination can be painful and traumatizing. If vaginal bleeding, foul-smelling vaginal discharge, significant vaginal or uterine pain, penetrating injuries, suspicion of a foreign body is suspected, a vaginal speculum examination should be done with sedation.

⁹ Any patient who is capable of consent and declines a vaginal speculum examination – even if otherwise indicated.

¹⁰ a hole between the vagina and bladder that leaks urine

¹¹ a hole between the vagina and anus that leaks stool

6 HIV post-exposure prophylaxis (PEP)¹²

Sexual violence, compared to consensual sexual intercourse, presents a higher risk of HIV transmission because violence can cause trauma, injury and abrasions of the vaginal, anal and/or oral mucous membranes. The 4 steps of care for survivors of SV to prevent HIV are to:

1. assess the risks of HIV and eligibility for HIV PEP and provide HIV testing
2. provide information and support
3. offer HIV PEP within 72 hours of the SV, and
4. offer adherence support, education and counselling.

6.1 Assess exposure to HIV, eligibility for HIV PEP and provide HIV testing

Assess risk for HIV exposure

Assess the risk of HIV transmission to decide whether or not to test for HIV and offer HIV PEP.

No risk of transmission ➡ **Do not offer HIV PEP**

- Kissing, unwanted touching
- Digital penetration or penetration of vagina, anus or mouth with foreign object
- Ejaculation on intact skin

Risk of transmission¹³ ➡ **Offer HIV PEP**

- Vaginal or anal penetration with or without ejaculation
- Oral penetration with ejaculation
- Blood or ejaculation onto non-intact skin, mucosa or external vaginal opening
- Human bite involving bleeding (the patient has bitten the perpetrator or was bitten by perpetrator)
- Unknown details due to intoxication, substance use, lack of consciousness, head injury, amnesia or other reasons but events suggest forced penetration occurred
- Survivor is a child or person with a disability who cannot provide details, but history, change in behavior, signs and symptoms and/or examination suggest forced penetration occurred

When in doubt ➡ **offer HIV PEP.**

Certain factors increase the risk of HIV transmission.

- Anal penetration
- Repeated, multiple episodes of SV, gang – forced penetration/multiple perpetrators
- Degree of trauma, abrasions, injuries and wounds
- High or unsuppressed viral load of the perpetrator (if the perpetrator is known)
- If the perpetrator(s) or survivor has an STI, genital lesions or ulcers
- Pre-pubescent or adolescent girls¹⁴, post-menopausal females, pregnant survivor

If any of these risk factors are present and known, provide information on the increased risk of HIV transmission to the patient.

The estimated risk of acquiring HIV infection from a single episode of consensual receptive condomless vaginal intercourse is 0.08% (8 in 10,000) and from a single episode of consensual receptive condomless anal sex is 1.4% (between 1 to 2 in 100) (Patel, 2014). The risk of HIV transmission is reduced to zero if a person with HIV is on effective anti-retroviral therapy (ART) and

¹² MSF HIV/TB Clinical Guide for Primary Care, 2018 (<https://samumfsf.org/en/resources/msf-hivtb-clinical-guide-2018#>) page 110

¹³ There is substantial risk of HIV acquisition if there is contact of the vagina, rectum, eye, mouth, other mucous membrane, non-intact skin, or percutaneous with blood, semen, vaginal secretions, rectal secretions, breast milk, or any body fluid that is visibly contaminated with blood and the source is known to be HIV-positive or the HIV status is unknown

¹⁴ due to immaturity of vaginal and cervical cell

HIV is virologically suppressed (Bavinton, 2018; Rodger, 2019). The HIV status and viral suppression of the perpetrator may be unknown. Assume the perpetrator is HIV positive and not virally suppressed.

Offer HIV testing

Rapid HIV testing¹⁵ should be offered if there is a risk of transmission of HIV, unless the patient is not at risk for HIV or already knows they are HIV positive. Patients may be too traumatized, distressed or overwhelmed to do HIV testing immediately after SV.

A baseline HIV test is recommended, but not required to start HIV PEP.

See the following guidelines for HIV testing:

MSF Laboratory working group (2017) HIV diagnosis and monitoring Policy on HIV testing

MSF (2018) Patient Support, Education, Counselling Guideline: For adults living with HIV and/or TB

MSF (2018) Patient Support, Education, Counselling Guideline: For children and adolescents living with HIV

MSF OCBA (2019) Patient Support, Education, Counselling HIV/TB Toolkit

Interpreting HIV test results

Time to presentation	HIV testing	Recommendation
Patient presents < 72 hours since incident	HIV testing is done	HIV test is positive <ul style="list-style-type: none"> Do not offer HIV PEP If HIV PEP was started prior to test results, do not discontinue HIV PEP and refer for HIV care Discuss HIV test outcome, provide education, support and counselling, provide or refer for HIV care Ask if ART regimen has already been prescribed and ask about adherence, refer for HIV care
		HIV test is negative <ul style="list-style-type: none"> Offer HIV PEP for 28 days.
		HIV test is indeterminate <ul style="list-style-type: none"> Provide HIV PEP until a positive result is confirmed
	HIV testing is not done	Offer HIV PEP and offer HIV testing at follow-up
Patient presents > 72 hours since incident	Offer HIV testing Do not offer HIV PEP	HIV test is positive <ul style="list-style-type: none"> Discuss HIV test outcome, provide education, support and counselling, ask about ART regimen and adherence (if the patient is on ART), provide or refer for HIV care If HIV PEP was started before testing within 72 hours of the incident, discontinue HIV PEP
		HIV test is negative <ul style="list-style-type: none"> Communicate test results and offer repeat testing at 1 and 3 months after the SV

Assess eligibility for HIV PEP

If the patient presents **within 72 hours of SV** → Offer HIV PEP.

If a patient presents **after 72 hours of SV** → Do not offer HIV PEP.

¹⁵ If a patient less than 18 months old presents for testing, rapid HIV testing is not reliable and a HIV DNA PCR must be done. The mother's antibodies to HIV cross the placenta and remain in the baby after birth for up to 18 months of age so a positive rapid HIV test could be reflecting the presence of HIV antibodies from the mother.

Carefully explain that HIV PEP will not be provided as it is not effective after 72 hours, could cause unnecessary side effects and the risks outweigh the benefits.

If the patient presents more than 72 hours after SV, but there is repeated, ongoing SV at substantial risk of acquiring HIV due to increased vulnerability see [HIV PrEP for further guidance](#).

HIV PEP in case of repeated assault/incident

Patient history and time to presentation	Medication history	Recommendation
Patient presents < 72 hours after incident	Currently taking HIV PEP	Continue HIV PEP for 28 days from the date of the most recent incident.
	Finished HIV PEP after incident, not currently taking HIV PEP	Offer HIV testing Offer another 28 days of HIV PEP.
Patient presents < 72 hours after incident – repeated, ongoing SV at substantial risk of acquiring HIV due to increased vulnerability	Not currently taking HIV PEP or pre-exposure prophylaxis (PrEP)	Offer HIV testing, offer HIV PEP for 28 days and discuss HIV PrEP.
	Currently taking HIV PrEP with good adherence	Do not offer HIV PEP

See Annexes [Ongoing sexual violence](#) and [HIV PrEP](#) for further guidance.

6.2 Provide information and support

Provide information to support a decision about HIV PEP. Provide information about risks of HIV transmission, risks and benefits of HIV PEP, duration and frequency of treatment, potential side effects and how to manage side effects. Provide information to pregnant women about the risk of HIV and prevention of mother to child transmission.

See MSF (2017) *Prevention of mother-to-child transmission (PMTCT) of HIV Protocol*.

6.3 Offer HIV PEP

- Offer the first dose of HIV PEP as soon as possible, ideally within 4 hours
- HIV PEP can be given without food. However give atazanavir (ATV), lopinavir and ritonavir (LPV/r) with food.
- If the patient is uncertain about taking HIV PEP, they can start the first dose immediately and discuss continuing HIV PEP within the next 24 hours.
- If the patient vomits within 30 minutes of taking HIV PEP, give a new dose of HIV PEP.
- If the patient is taking HIV PEP, ECP and STI prophylaxis and is worried about taking too many pills, nausea or vomiting, provide HIV PEP first, then ECP and then STI prophylaxis.
- Provide the full 28-day supply of HIV PEP.

Baseline testing

Baseline laboratory tests are **not** required for HIV PEP. If available, it can be helpful to determine:

- haemoglobin to detect anaemia if zidovudine (AZT) is offered
- creatinine clearance if tenofovir (TDF) is offered
- Hepatitis B surface antigen¹⁶ if tenofovir (TDF)/lamivudine (3TC) are offered¹⁷

¹⁶ Only offer Hepatitis B surface antigen testing if referral is available and feasible. Refer patients who test positive for Hepatitis B surface antigen for further assessment, testing, care and treatment. Patients with a positive hepatitis B surface antigen test, may have self-limiting acute hepatitis B, spontaneously clear and not progress to chronic hepatitis B.

¹⁷ to detect active infection, need for ongoing Hepatitis B virus therapy after discontinuing HIV PEP and avoid the potential risk of hepatic flares. Be aware that if tested positive, the patient will need further management/referral.

HIV PEP dosages for adults, children and adolescents > 30 kg ¹⁸					
Preferred regimen			Alternative regimens		
Drug	Dose	Frequency	Drug	Dose	Frequency
Tenofovir (TDF)/ lamivudine (3TC) ¹⁹	300 mg/ 300 mg	1 tablet once a day	Zidovudine (AZT) ²⁰ / lamivudine (3TC)	300 mg/ 150 mg	1 tablet twice a day
<i>And</i>			<i>and</i>		
Dolutegravir (DTG)	50 mg	1 tablet once a day	Atazanavir (ATV)/ ritonavir (r)	300 mg/ 100 mg	1 tablet once a day
			<i>or</i>		
			Lopinavir (LPV)/ ritonavir(r)	200 mg/ 50 mg	2 tablets twice a day
			<i>or</i>		
			Darunavir (DRV)/ ritonavir (r)	DRV 400 mg + RTV 100 mg	(2 tablets of DRV + 1 tablet of RTV) once a day
			<i>or</i>		
			Raltegravir (RAL)	400 mg	1 tablet twice a day

¹⁸ Children >30kg should be given **TLD: Tenofovir (TDF), Lamivudine (3TC) and Dolutegravir (DTG)**

¹⁹ Tenofovir (TDF)/lamivudine (3TC)/dolutegravir (DTG) can be offered in a fixed dose combination or separate tablets. Fixed dose combinations are preferable for improved adherence.

²⁰ AZT is contra-indicated in children with Anemia. In that case, consider individualized management of the regimen (options could include for example: DTG-3TC).

HIV PEP dosages for children 20 to 30 kg														
Preferred regimen					Alternative regimens									
Drug	20-24.9 kg		25-30 kg		Drug	20-24.9 kg		25-30 kg						
	Dose	Frequency	Dose	Frequency		Dose	Frequency	Dose	Frequency					
Zidovudine (AZT)/ lamivudine (3TC)	Dispersible tablet 60 mg/30 mg	3 tablets twice a day	300 mg/150 mg	1 tablet twice a day	Abacavir (ABC)/ lamivudine (3TC) ²¹	Dispersible tablet 120 mg/60 mg	1.5 tablets twice a day	600 mg/300 mg	0.5 tablet twice a day					
						Dispersible tablet 60 mg/30 mg	3 tablets twice a day							
<i>And</i>					<i>and</i>									
Dolutegravir (DTG)	50 mg	1 tablet once a day	50 mg	1 tablet once a day	Atazanavir (ATV)/ ritonavir (r)	ATV capsules 100 mg + r tablets 50 mg	2 ATV tablets + 2 r tablets once a day	Tablet 300 mg/100 mg	1 tablet once a day					
						ATV capsules 200 mg + r tablets 50 mg	1 ATV tablet + 2 r tablets once a day	-	-					
					<i>or</i>					Lopinavir (LPV)/ ritonavir (r)	Tablet 100 mg/25 mg	2 tablets twice a day	Tablet 100 mg/25 mg	3 tablets twice a day
						Tablet 200 mg/50 mg	1 tablet twice a day	Tablet 200 mg/50 mg	2 tablets in the morning, 1 tablet at night					

²¹ There is no experience on ABC use in HIV negative children and Abacavir can cause life-threatening hypersensitivity reactions in people with the HLA-B*5701 allele gene. While hypersensitivity can affect 3–4% of Caucasian and Asian children, it is very rare among African children. The potential use of ABC in the PEP regimen while contraindicated in Asian and Caucasian descent, it could be considered in children of African origin. It should be discussed with your HIV/TB advisor.

						Pellets or granules 40 mg/10 mg	6 pellets or granules twice a day	-	-	
						Syrup 80/20 mg/ml	3 mL twice a day	-	-	
<i>or</i>										
						Darunavir (DRV)/ ritonavir (r)	75 mg/25 mg	5 DRV tablets and 2 r tablets twice a day	400 mg/100 mg	(1 DRV tablet + 1 r tablet) twice a day
<i>or</i>										
						Raltegravir (RAL)	Chewable tablets 25 mg	6 tablets twice a day	400 mg tablets	1 tablet twice a day

HIV PEP dosages for children < 20 kg

Preferred regimen										Alternative regimens									
Drug	Dose	Number of tablets and frequency by weight								Drug	Dose	Number of tablets and frequency by weight							
		3-5.9 kg		6-9.9 kg		10-13.9 kg		14-19.9 kg				3-5.9 kg		6-9.9 kg		10-13.9 kg		14-19.9 kg	
		☀	☾	☀	☾	☀	☾	☀	☾			☀	☾	☀	☾	☀	☾	☀	☾
Zidovudine (AZT)/ lamivudine (3TC) ^{Error!} Bookmark not	Dispersible tablet 60 mg/30 mg	1	1	1.5	1.5	2	2	2.5	2.5	Abacavir (ABC)/ lamivudine (3TC) ^{22 23}	Dispersible tablet 120 mg/60	0.5	0.5	0.5	1	1	1	1	1.5

²² Lamivudine (3TC) and emtricitabine (FTC) are interchangeable

²³ There is no experience on ABC use in HIV negative children and therefore not recommended in principle. In addition, Abacavir can cause life-threatening hypersensitivity reactions in people with the HLA-B*5701 allele gene. While hypersensitivity can affect 3–4% of Caucasian and Asian children, it is very rare among African children. The potential use of ABC in the PEP regimen while contraindicated in Asian and Caucasian descent, it could be considered in children of African origin. It should be discussed with your HIV/TB advisor.

defined.											Dispersible tablet 60 mg/30 mg	1	1	1.5	1.5	2	2	2.5	2.5
<i>And</i>										<i>and</i>									
Lopinavir (LPV)/ritonavir (r) ²⁴	Pellets or granules 40 mg/10 mg	2	2	3	3	4	4	5	5	Atazanavir (ATV)/ritonavir (r) ²⁵	ATV capsules 100 mg + r Tablet 25 mg ²⁶	-	-	-	-	2 ATV + 4 r	-	2 ATV + 4 r	-
	Tablet 100 mg/25 mg	-	-	-	-	2	1	2	2		ATV capsules 200 mg+ r Tablet 50 mg	-	-	-	-	1 ATV + 2 r	-	1 ATV + 2 r	-
	Tablet 200 mg/50 mg	-	-	-	-	-	-	1	1	Raltegravir (RAL)	10 mg/ml (oral granules 100 mg/sachet)	3 ml	3 ml	5 ml	5 ml	8 ml	8 ml	10 ml	10 ml

²⁴ Lopinavir (LPV)/ritonavir (r), Atazanavir (ATV)/ritonavir (r) or Raltegravir (RAL) should be changed to Dolutegravir (DTG) as soon as Dolutegravir (DTG) is validated for this age and weight group.

²⁵ Atazanavir (ATV) is only approved for use in children 3 months and older. Atazanavir (ATV) single strength capsules should be administered with RTV 100 mg for all weight bands. Atazanavir (ATV) powder formulation has limited availability in low and middle income countries but enables administration of Atazanavir (ATV) to infants and children as young as 3 months. Infants and children 5-15 kg should be administered 200 mg of Atazanavir (ATV) powder (4 packets, 50 mg/ packet) with 80 mg of ritonavir (RTV) oral solution (1 ml). (WHO, December 2018. Interim guidelines. Updated recommendations on first-line and second-line antiretroviral regimens and post-exposure prophylaxis and recommendations on early infant diagnosis of HIV)

²⁶ Atazanavir (ATV)/ritonavir (r) can be given in multiple combinations of Atazanavir (ATV) 100 mg, Atazanavir (ATV) 200 mg, Ritonavir (RTV) 25 mg and, Ritonavir (RTV) 50 mg, as long as the correct dosages are given.

Precautions

- Avoid zidovudine (AZT) if haemoglobin is <9 g/dl or if there are clinical signs of anaemia
- Avoid tenofovir (TDF) for patients with pre-existing renal impairment where known or creatinine clearance < 50 mL/min if laboratory testing is available. However, creatinine clearance is not required and administration over 28 days is unlikely to cause significant renal toxicity.
- Check for drug interactions and monitor side effects.
- Rifampicin significantly reduces the levels of lopinavir/ritonavir (LPV/r), atazanavir (ATV), and dolutegravir (DTG). If the patient is on rifampicin: increase the dose of lopinavir/ritonavir (LPV/r)²⁷, do not use atazanavir (ATV), double the dose of dolutegravir (DTG) to 50 mg twice daily (from dolutegravir (DTG) to 50 mg once daily).

See MSF (2018) HIV/TB clinical guide for primary care, chapter 7 drug interactions.

Special considerations during pregnancy

- HIV PEP should be offered and is not contra-indicated during pregnancy.
- Provide information to women who are in the first 8 weeks of pregnancy or want to become pregnant about the potential small risk of neural tube defects in the infants of women taking dolutegravir (DTG) at the time of conception until 8 weeks of pregnancy. Women who do not currently want to become pregnant should be advised to use reliable contraception when taking dolutegravir (DTG) for HIV PEP. Dolutegravir (DTG) appears to be safe after 8 weeks of pregnancy.

Special considerations for children

- Dolutegravir (DTG) 50 mg is the first choice for children >20 kg, dolutegravir (DTG) 50 mg should not be given to children <20 kg
- Zidovudine 60 mg/lamivudine 30 mg (AZT/3TC) tablets for children are dispersible in a small volume of water or can be split, crushed and mixed with food.
- Lopinavir/ritonavir (LPV/r) 100 mg/25 mg tablets **cannot** be crushed or split and can be difficult to swallow.
- Lopinavir/ritonavir (LPV/r) 80/20 mg/mL syrup requires cold chain for storage, but once opened can stay stable for 42 days at 25°C.
- Lopinavir/ritonavir (LPV/r) 40mg/10 mg pellets or granules are preferred; are easier to give, and do not require a cold chain. Lopinavir/ritonavir (LPV/r) 40mg/10 mg pellets or granules must **not** be stirred, crushed or dissolved in liquid. They should be opened and poured over a small amount of soft food (like porridge).
- Lopinavir/ritonavir (LPV/r) syrup, pellets and granules have a bitter taste. Bitter taste can be masked by mixing with foods like bread, fruit, or sweets.

Side effects

- Nausea, vomiting, diarrhoea, headache, fatigue, insomnia, and weakness.

Managing side effects

- Can be taken at night to limit side effects
- Take medicine with foods, before bed or with anti-emetics or anti-motility drugs.
- If jaundice occurs in a patient taking atazanavir (ATV), advise the patient that jaundice is common and to continue HIV PEP until completion of 28 days. If the patient feels uncomfortable with jaundice, stop atazanavir (ATV)/ritonavir(r) without replacement and continue with the two remaining ARVs (TDF/3TC, AZT/3TC or ABC/3TC) until completion of PEP
- If jaundice occurs in a patient taking atazanavir (ATV), advise the patient that jaundice is common and to continue HIV PEP until completion of 28 days. If patient is feels uncomfortable with the jaundice, stop atazanavir (ATV)/ritonavir(r) and continue with tenofovir (TDF)/lamivudine (3TC).

²⁷ If >5 years old, double the dose of lopinavir/ritonavir. If <5 years, the double-dose LPV/r is not effective; either add additional ritonavir at 3/4 of the volume of LPV/r (e.g. if giving 2 ml LPV/r, add extra 1.5 ml ritonavir) or use an alternative.

6.4 HIV PEP adherence and follow-up

HIV PEP adherence is poor globally, especially for survivors of SV.

- Provide HIV PEP adherence support, education and counselling to help patients to increase adherence to HIV PEP.
- Provide support, education and counselling about side effects and how to manage side effects
- Understand the patient's challenges and constraints to adherence, provide individual strategies to help the patient adhere to HIV PEP for the full 28 days, or to help a caregiver supporting a child to adhere to HIV PEP for the full 28 days
- The main challenge to completing HIV PEP is tolerating side effects, however they are usually mild.
- Other challenges include lack of knowledge, poor social support, trauma, stigma, fear of disclosing taking HIV PEP to partners or family, fear of having HIV PEP at home, forgetting to take HIV PEP, not having enough food to take with HIV PEP among other reasons. Explore specific strategies to improve HIV PEP adherence.
- If feasible, organize follow-up visits for HIV PEP adherence support, education and counselling for the survivor to monitor and manage side effects and support adherence.

Follow-up HIV testing

- Repeat HIV testing at 1 month and the final HIV confirmatory test at 3 months.
- If the patient is HIV positive, provide support, education and counselling and link to HIV care.

7 Preventing unwanted pregnancy

7.1 Determining pregnancy

Sexual violence may result in an unwanted pregnancy. A survivor of SV (women and girls of reproductive age) may want to know whether she was pregnant at the time of the assault or whether she became pregnant as a result of the assault. Urine pregnancy tests can provide limited information based on the timing of the test:

Pregnancy test result	Timing of test	Information for patient
Positive	< 2 weeks after the assault	<ul style="list-style-type: none"> Is she pregnant? YES Is the pregnancy the result of the assault? NO. The pregnancy is most likely not the result of assault.
	> 2 weeks after the assault	<ul style="list-style-type: none"> Is she pregnant? YES Is the pregnancy the result of the assault? UNKNOWN If the patient is sexually active, it is not possible to determine if the pregnancy is the result of the assault. If the patient is not sexually active, she is most likely pregnant as a result of the assault.
Negative	2 weeks after the assault	<ul style="list-style-type: none"> Is she pregnant? UNKNOWN Repeat the test 2 weeks and 6 weeks later.

Determining whether a pregnancy is a result of the assault is not a pre-requisite for:

- Safe abortion care (SAC). MSF provides SAC whether or not the pregnancy is a result of the assault.
- Using oral ECP. Oral ECP will not harm a pre-existing pregnancy.

Offer support, education and counselling

Offer options, support, education and counselling if the patient is pregnant. Discuss the patients' thoughts, feelings, situation, needs and concerns. Ask thoughtful, open-ended questions. Show empathy and respect.

- If patient does not wish to continue the pregnancy, provide information about SAC, provide SAC or refer to appropriate quality provider. *See MSF (2019) Essential obstetric and newborn care guideline, Chapter 12 Termination of pregnancy.*
- If the patient wishes to continue the pregnancy and parent, provide or refer to antenatal and obstetrical care, and parenting support.
- If the patient wishes to continue the pregnancy and does not wish to, or cannot, keep the infant and parent, provide or refer to antenatal and obstetrical care, and discuss options for adoption, including adoption within family or community or referral to an organisation for adoption including government ministries, a child protection NGO, UN agency, faith groups or a women's group.

Most women or girls have already thought about their options and made the decision to have an abortion before seeking care. Do not persuade, pressure or convince the patient to choose an option she/they do not want.

7.2 Emergency contraception (EC)

Prevention of unwanted pregnancy should be discussed with all women and girl survivors of SV of reproductive age (from the first signs of puberty or onset of first menstrual period²⁸ onwards until menopause²⁹) presenting for care within 120 hours (5 days) and who are not already pregnant.

When in doubt, offer emergency contraception.

Prior to a decision about the EC method, it is useful to determine whether the patient was already pregnant. If it is not possible to determine a pregnancy:

- Emergency Contraception Pill (ECP) is not contraindicated, can still be given, ECP will **not** harm an established pregnancy.
- IUD is contraindicated, as it can harm an established pregnancy.

There are 4 types of EC, from most effective to least:

1. Copper intrauterine contraceptive device (CIUD)
2. Ulipristal acetate emergency contraception pill (UPA-ECP)
3. Levonorgestrel emergency contraception pill (LNG-ECP)
4. Oral contraception pills for emergency contraception.

Effectiveness is impacted by the timeframe between the assault and taking EC, day of the patient's menstrual cycle, and the patient's weight. EC is more effective the sooner it is taken after the assault.

Copper IUD to prevent unwanted pregnancy

The copper intra-uterine device (C-IUD) method is highly effective in preventing pregnancy within 120 hours or 5 days after the assault or within 120 hours or 5 days after ovulation (if the timing of ovulation can be estimated) – whichever is later.

The copper IUD is safe for any women without contraindications to an IUD – including adolescent girls, women and girls who have never been pregnant and those who have never given birth.

While the IUD is the most effective method of EC, invasive intra-vaginal procedures, such as IUD insertion, may be painful, uncomfortable, distressing or re-traumatising after SV and oral ECP may be preferred.

Insertion of the IUD requires a skilled provider, a health facility with a private setting and hygienic environment for a sterile procedure and the patient to complete STI treatment due to risk of pelvic inflammatory disease. IUD insertion may not be feasible in some settings.

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

Effectiveness

- Copper IUD may be a better choice for women > 70 kg. See Considerations with weight.
- Copper IUD is more effective than UPA-ECP and is more effective than LNG-ECP, especially between 72 to 120 hours after the assault.
- Copper IUD is also an effective long-acting reversible contraception.

Precautions

- Known or suspected pregnancy prior to the assault
- Active genital infection including postpartum endometritis, purulent cervicitis, chlamydia, gonorrhoea, STI or pelvic inflammatory disease

²⁸ Prevention of unwanted pregnancy should be discussed with girls who menstruated and/or who are in the beginning stages of puberty with breast development because they may ovulate even prior to the onset of menstruation (WHO, 2017).

²⁹ Women over 50 who have not menstruated for over 1 year or women aged 45 to 50 who have not menstruated for 2 years (FSRH, 2017)

- Post-abortion sepsis
- Unexplained vaginal bleeding
- Gynaecologic malignancy: untreated cervical cancer, endometrial cancer, etc.
- Distorted uterine cavity, congenital uterine abnormalities, fibroids or any abnormality
- Current malignant gestational trophoblastic disease
- Known pelvic tuberculosis
- Wilson disease

Adverse effects

- Uterine cramping, vaginal bleeding
- Changes in bleeding patterns (especially during the first 3 to 6 months) including prolonged heavy monthly bleeding, irregular bleeding, increased cramping and pain during monthly menstruation
- Miscarriage, preterm birth or infection if pregnancy occurs with the IUD in place (rare)
- Perforation risk during insertion (rare)
- Pelvic Inflammatory Disease

See MSF's Essential obstetric and newborn care guidelines for information on IUD insertion.

Ulipristal acetate emergency contraception pill

Ulipristal acetate (UPA-ECP) is an emergency contraception pill that is effective within 5 days or 120 hours after the assault.

Effectiveness

- UPA-ECP is the most effective oral ECP.
- UPA-ECP is more effective than LNG-ECP, especially between 72 to 120 hours after the assault.
- UPA-ECP should not be given after 120 hours post-incidence.
- UPA-ECP is less effective for people who weigh more than 85 kg, but can be given. Do not offer a double dose of UPA-ECP for women over 85 kg. It is not known whether LNG-ECP or UPA-ECP is more effective in women over 85 kg. No woman should be discouraged from taking ECP, denied access or refused ECP due to weight. Provide information about reduced effectiveness for higher weight to support an informed choice.

Dosage

Emergency contraception pill					
Drug	Brand names	Strength	Dosage	Route of administration	Duration
Ulipristal acetate	Ella, ellaOne	30 mg	30 mg	PO	Single dose

Precautions

- Severe asthma controlled by oral glucocorticoids, hepatic impairment, severe lactose problems³⁰
- Taking progestogen is a relative contraindication for UPA-ECP³¹. LNG-ECP is preferred to UPA-ECP if the patient is taking contraception (containing progestogen) and may be preferred to UPA-ECP if the patient wants to start contraception (containing progestogen) immediately. If only UPA-ECP is available, offer UPA-ECP and advise the patient to stop progestogen or progesterone for 5 days after UPA-ECP, use a back-up method of contraception and restart contraception after 6 days.
- Breastfeeding is not recommended 1 week after UPA-ECP, breast milk should be expressed and discarded

³⁰ Galactose intolerance, Lapp lactase deficiency, glucose-galactose malabsorption

³¹ Progestogen can decrease the effectiveness of UPA-ECP and UPA-ECP can decrease the effectiveness of progestogen as contraception.

- Using LNG-ECP and UPA-ECP within 120 hours of each other may compromise effectiveness. If used twice in a 120 hour or 5-day period, the same method should be used.

Side effects

- Headache, nausea, abdominal cramping, fatigue, dizziness, delayed menstrual period for up to 7 days.

Managing side effects

- Eat before taking the pills to reduce the risk of nausea.
- If the patient vomits within 3 hours of taking UPA-ECP, repeat the dose and consider an anti-emetic.
- If vomiting occurs more than 3 hours of taking the UPA-ECP, do not give another dose.
- If the patient is taking HIV PEP, ECP and STI prophylaxis and is worried about taking too many pills, nausea or vomiting, provide HIV PEP first, then ECP and then STI prophylaxis.

Levonorgestrel emergency contraception pill

Levonorgestrel emergency contraception pill (LNG-ECP) is effective within 5 days or 120 hours after the assault.

Effectiveness

- LNG-ECP is more effective in preventing pregnancy the earlier after the assault it is taken, prior to 72 hours after the assault. LNG-ECP has decreased effectiveness after 72 hours compared to UPA-ECP but can still be given. LNG-ECP should not be given more than 120 hours after the assault.
- LNG-ECP is less effective for people with a weight >70 kg, but can be given as a double-dose of LNG-ECP (3 mg). UPA-ECP is more effective than LNG-ECP for women between 70 to 85 kg and is preferred. It is not known whether LNG-ECP or UPA-ECP is more effective over 85 kg. No women should be discouraged from taking ECP, denied access or refused ECP due to weight. Provide information about reduced effectiveness for higher weight to support an informed choice.

Dosage

Emergency contraception pill					
Drug	Brand names	Strength	Dosage	Route of administration	Duration
Levonorgestrel	Levonelle, Norlevo, Plan-B, Postinor-2, Vikela, Pregnon, Postpill	0.75 mg or 1.5 mg	1.5 mg	PO	Single dose

Precautions

- There are no contraindications to the use of LNG-ECP, except for pregnancy³²
- LNG-ECP is safe for all women and girls of reproductive age, including women and girls advised not to use oral contraceptives for ongoing contraception due to a history of cardiovascular disease or migraine headaches. Taking contraception is not a contraindication for LNG-ECP and contraception can be started immediately after LNG-ECP.
- A double dose of 3 mg LNG-ECP is recommended for patients taking enzyme-inducing drugs (efavirenz, ritonavir, rifampicin, phenytoin, carbamazepine) for > 2 weeks³³.
- A dose of 1.5 mg LNG-ECP should be given to patients starting HIV PEP. A double dose of LNG-ECP is not required³⁴.
- Using LNG-ECP and UPA-ECP within 120 hours of each other may compromise effectiveness. If used twice in a 120 hour or 5-day period, the same method should be used.

³² It will not be effective, but will not harm the confirmed pregnancy.

³³ Cytochrome enzyme inducing drugs taken for over 2 weeks consistently may interfere with the metabolism and effectiveness of LNG-ECP

³⁴ The effect of enzyme-inducing drugs takes approximately 2 weeks to reach the maximum

Side effects

- Nausea, vomiting, vaginal bleeding or spotting, breast tenderness, headache, dizziness, and fatigue. Side effects usually do not last more than 24 hours.
- Early or delayed menstrual period by up to 1 week.

Managing side effects

- Eat before taking the pills to reduce risk of nausea
- If the patient vomits within 2 hours after taking LNG-ECP, repeat the dose and consider adding an anti-emetic.
- If vomiting occurs more than 2 hours after taking the LNG-ECP, do not give another dose.
- If the patient is taking HIV PEP, ECP and STI prophylaxis and is worried about taking too many pills, nausea or vomiting, provide HIV PEP first, then ECP and then STI prophylaxis.

Oral contraception pills for emergency contraception

Emergency contraception can be provided using regular oral contraception pills: levonorgestrel only or combined oestrogen-progestogen pills.

- Levonorgestrel-only is more effective, has fewer adverse effects but has a high pill burden
- Combined oestrogen-progestogen has a lower pill burden.

Effectiveness

Oral contraceptive pills are significantly less effective than other oral ECP and the IUD. Offer oral contraceptive pills as ECP **only** if no other options are available.

Dosage

Oral contraception pills for emergency contraception							
Drugs	Brand names	Strength	# of tablets in 1 st dose	# of tablets in 2 nd dose	Total dosage	Route of administration	Duration
Levonorgestrel only	Microlut, Microval, Norgeston	30 mcg/0.03 mg	50	0	1.5 mg	PO	Single dose
	Ovrette	37.5 mcg	40	0	1.5 mg	PO	Single dose
Combined estrogen-progestogen	Eugynon 50, Fertilan, Neogynon, Noral, Neo-primovlar 4 Nodiol, Ovidon, Ovral, Ovran, Tetragynon/ PC-4, Preven, E-Gen-C, Neo-primovlar 4	Ethinylestradiol 50 mcg and Levonorgestrel 250 mcg or Ethinylestradiol 50 mcg and Norgestrel 500 mcg	2	2	Ethinylestradiol 0.2 mg and Levonorgestrel 1 mg Or Ethinylestradiol 0.2 mg and Norgestrel 2 mg	PO	2 doses, 12 hours apart

	Lo/FemenaL, Microgynon, Nordete, Ovral L, Rigevidon	Ethinylestradiol 30 mcg and Levonorgestrel 150 mcg or Ethinylestradiol 30 mcg and Norgestrel 300 mcg	4	4	Ethinylestradiol 0.24 mg and Levonorgestrel 1.2 mg or Ethinylestradiol 0.24 mcg and Norgestrel 2.4 mg	PO	2 doses, 12 hours apart
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7.3 Contraception

After discussing pregnancy status and emergency contraception, provide support, education and counselling on contraception for ongoing prevention of unwanted pregnancy.

(For information or guidance on contraception counseling contact your SRH advisor).

7.4 Safe abortion care

Survivors of SV may have an unwanted pregnancy and seek an abortion. MSF responds to girls' and women's needs for safe abortion care (SAC) to reduce suffering and maternal mortality and prevent unsafe abortion (MSF, 2019; MSF 2012; MSF, 2004). Safe abortion care should be available for all women and girls, not only for survivors of SV.

Provide information, support decisions and respect choices

Health care workers should provide information and options, support patients to make a decision, respect their choice without judgement, ensure privacy and confidentiality and provide safe medical care. *(For guidance on SAC support and counseling consult the MSF medication abortion counseling guide and flipbook, contact your SRH advisor to consult these documents).*

Information should include: methods of SAC, what to expect (bleeding, cramping and expulsion), duration of abortion care, potential side effects and complications, when, where and how to seek help in case of complications and follow-up care.

Methods of safe abortion

There are two methods of safe abortion:

1. **Medication abortion** – one or two medications are taken to induce a process that is similar to a miscarriage.
2. **Abortion procedure (Manual vacuum aspiration or MVA)** – an outpatient procedure that involves inserting a thin plastic tube into the uterus and removing the pregnancy using suction. Dilation and curettage is an outdated method that should **not** be used.

	Medical abortion	Aspiration
Advantages	<ul style="list-style-type: none"> • Non-invasive method. • Can be done at home. • No antibiotic prophylaxis required. 	<ul style="list-style-type: none"> • Immediate result. • No absolute contra-indications. • IUD can be inserted at the end of the procedure.
Disadvantages	<ul style="list-style-type: none"> • No immediate result (take hours to days). • Heavy bleeding and cramping as the pregnancy is expelled. • Aspiration required in the event of failure 	<ul style="list-style-type: none"> • Invasive method. • (Low) risk of uterine perforation or cervical laceration. • Antibiotic prophylaxis required.

Whenever possible, both methods should be available and discussed with the patient so she can

decide which one is best for her. Both methods can be offered up to 13 weeks gestational age. Only medication abortion can be offered up to 22 weeks gestational age.

See MSF's Essential obstetric and newborn care guidelines Chapter 12 for further guidance on safe abortion care.

8 Prevention and treatment of sexually transmitted infections

As soon as possible, survivors of SV should be assessed for risk of sexually transmitted infections (STIs) transmission and offered prophylactic treatment for STIs including chlamydia, gonorrhoea, syphilis, chancroid and trichomoniasis (if there is risk of transmission). The prophylactic treatment in a delayed presentation (>3 months) will still be indicated for certain STIs (see delayed presentation to care, Annex 1, page 37).

8.1 Assess risk of STI transmission

Assess the risk of STI transmission to decide whether or not to offer STI prophylactic treatment.

No risk of transmission ➡ Do not offer STI prophylactic treatment
<ul style="list-style-type: none"> SV with no genital contact

Risk of transmission ➡ Offer STI prophylactic treatment up to 3 months after assault³⁵.
<ul style="list-style-type: none"> Vaginal, anal and oral penetration by penis with or without ejaculation Vaginal, anal or oral contact with the perpetrators genitals Ejaculation onto genital area or mouth Unknown details due to intoxication, substance use, lack of consciousness, head injury, amnesia or other reasons but events are highly suggestive of STI risk Survivor is a child or person with a disability who cannot provide details, but history, change in behaviour, signs and symptoms and/or examination is highly suggestive of STI risk

8.2 Baseline testing

- STI testing is **not** required before giving STI prophylactic treatment.
- If the patient presents > 3 months since the SV and syphilis testing is available - syphilis testing can be offered.

8.3 Dosage

Prophylactic treatment for STIs for adults and children > 45 kg				
STI	Drug	Dosage	Route of administration	Duration
Gonorrhoea	Ceftriaxone ³⁶	250 mg	IM	Single dose
	<i>or</i>			
	Cefixime	400 mg	PO	Single dose
<i>and</i>				

³⁵ If > 3 months see Annex 1, page 37.

³⁶ Ceftriaxone is preferred over Cefixime, because some strains of *Neisseria gonorrhoeae* have decreased susceptibility to Cefixime. There are challenges with IM administration. PO medication may be preferred, especially with young children.

Chlamydia, Syphilis and Chancroid	Azithromycin ³⁷	2 g	PO	Single dose
	<i>and</i>			
Trichomoniasis	Tinidazole ³⁸	2 g	PO	Single dose
	<i>or</i>			
	Metronidazole	2 g	PO	Single dose

Prophylactic treatment for STIs for children <45 kg				
STI	Drug	Dosage	Route of administration	Duration
Gonorrhoea	Ceftriaxone	125 mg	IM	Single dose
	<i>or</i>			
	Cefixime	8 mg/kg (Maximum of 400 mg)	PO	Single dose
<i>and</i>				
Chlamydia, Syphilis and Chancroid	Azithromycin	20 mg/kg (Maximum of 1 g)	PO	Single dose
<i>and</i>				
Trichomoniasis	Tinidazole	50 mg/kg (Maximum of 2 g)	PO	Single dose
	<i>or</i>			
	Metronidazole (child 1 month and over)	10 mg/kg (max 1500mg/day) 3 times per day for 7 days	PO	3 times per day for 7 days

³⁷ Azithromycin 2 g PO single dose provides prophylaxis or treatment for primary, secondary and early latent syphilis < 1 years' duration. Syphilis testing is not required. If the patient presents 3 months or more since the SV and syphilis testing is available - syphilis testing can be offered. If the patient presents with signs and symptoms of active primary or secondary syphilis (solitary, painless lesion, papule, vesicle or ulcer or generalized mucocutaneous lesions on both skin and mucous membranes) or tests positive for syphilis within 1 year since SV, offer Azithromycin 2 g PO single dose (or benzathine benzylpenicillin 2.4 MIU (1.8 g) IM single dose, half the dose 1.2 MIU (900 mg) in each buttock). If the patient presents over 1 year since the SV and tests positive for syphilis, offer Benzathine benzylpenicillin 2.4 MIU (1.8 g) IM for 3 weeks.

³⁸ If Tinidazole is available, it is preferred as the first option because it is a single dose. However, if it is not available Metronidazole can be provided.

8.4 Precautions

- Cefixime and other cephalosporins should not be administered in known cases of allergy to cephalosporins or penicillin. As an alternative, spectinomycin IM 2 g as a single dose can be given.
- If there is an azithromycin allergy, benzathine benzylpenicillin 2.4 MIU (1.8 g) IM single dose³⁹ or doxycycline PO 100 mg twice a day for 7 days can be given.

8.5 Special considerations in pregnancy and breastfeeding

- Cefixime, ceftriaxone, and azithromycin are not contraindicated during pregnancy or breastfeeding.
- Doxycycline is contraindicated in pregnancy. If a patient is allergic to azithromycin and pregnant, offer 2.4 MIU (1.8 g) dose (administer 1.2 MIU (900 mg) in each buttock).
- Metronidazole is not contraindicated in pregnancy, but is contraindicated in breastfeeding. As an alternative tinidazole can be given divided into smaller doses.
- Tinidazole is not contraindicated in pregnancy or breastfeeding, but must be divided into smaller doses.

8.6 Side effects

- Gastrointestinal symptoms, nausea, vomiting, headaches, dizziness, allergic reactions including rash, pruritus and fever.
- If the person vomits within 2 hours of taking medication, repeat the dose.

8.7 Managing side effects

- Take STI prophylactic treatment with food to avoid nausea and vomiting.
- If the patient is taking HIV PEP, ECP and STI prophylaxis and is worried about taking too many pills, nausea or vomiting, provide HIV PEP first, then ECP and then STI prophylaxis.
- STI prophylaxis can always be given to the patient to take at home with clear instructions.

Due to the increased risk for transmission of human papilloma virus (HPV) and cervical cancer, HPV vaccination and cancer screening, diagnosis, prevention⁴⁰ and treatment may be offered depending on the context.

³⁹ Administer half the dose 1.2 MIU (900 mg) in each buttock

⁴⁰ Cryotherapy for cervical intraepithelial neoplasia or Loop Electrosurgical Excision Procedure (LEEP)

9 Hepatitis B vaccination

The risk of transmission of hepatitis B virus is 50 to 100 times higher than that of HIV (CDC, 2013; WHO, 2015). Offer post-exposure vaccination prophylaxis for hepatitis B as soon as possible after the SV. The risk of hepatitis B infection following exposure can be significantly reduced through rapid post-exposure vaccination with hepatitis B antigen containing vaccines.

9.1 Indication

Hepatitis B vaccination is indicated if a patient is at risk of exposure to hepatitis B through:

- Bite or mucosal exposures to blood or semen
- Receptive or insertive oral, vaginal and anal sexual contact

Post-exposure hepatitis B vaccination should be initiated (1st dose) for all patients at risk of exposure **regardless** of hepatitis B vaccination history⁴¹, and should not be delayed while waiting for hepatitis B serology results (if available). In the absence of serological results showing an effective protection against Hepatitis (anti-HBs ≥ 10 mIU/mL), the series of 3 doses should be completed **unless** the patient can provide documentation of **two**⁴² full series of hepatitis B vaccine.

9.2 Timing

Provide hepatitis B vaccination as soon as possible after the incident. The post-exposure protection of hepatitis B vaccination diminishes over time and probably has little effect after more than 14 days (or 2 weeks) of exposure. If the patient however presents more than 2 weeks after SV, still offer vaccination to protect in the case of possible future exposure.

9.3 Baseline testing

Pre- and post-vaccination serological testing is **not** required. Where available, serological screening may provide an opportunity to refer people with chronic hepatitis B for further care.

9.4 Type and dosage of vaccine

Administer monovalent hepatitis B vaccination formulation. The following dosages are advised:

- Adult presentation for adolescents and adults above 15 years: 10 to 20 μg
- Paediatric presentation for children from birth to 15 years: 5 to 10 μg
- As dosages vary according to the type of vaccine, always check the manufacturer's instructions.

For children younger than 7 years old, the combined vaccine can be considered⁴³.

A double dose of hepatitis B vaccine is **not** required for people living with HIV.

9.5 Method

- Administer by intra-muscular (IM) injection into the deltoid muscle in adults and children aged ≥ 2 years.
- Administer by IM injection to the upper-exterior (anterolateral) thigh in neonates, infants and young children aged < 2 years.
- Do not administer in the buttock muscle.

⁴¹ A completed 3 dose hepatitis B vaccine series or completed primary series (3 doses) of a pentavalent vaccination (Diphtheria, Pertussis, Tetanus, Hepatitis B and Hib) received in childhood.

⁴² An estimated 5-15% of persons may not respond to an initial 3-dose vaccine series. These people have a 30%--50% chance of responding to a second 3-dose series. A person who does not develop protective surface antibodies after completing two full series of the hepatitis B vaccine is considered non-respondent to vaccination.

⁴³ Diphtheria-Pertussis-Tetanus-Hepatitis B, *Haemophilus influenzae* type b (and inactivated polio vaccine) can be considered (depending on age, previous doses received and intervals between doses). The combined vaccines should not be used in children aged 7 years old or older.

- Can be co-administered with other vaccines (e.g tetanus containing vaccine) during the same visit. If administered simultaneously with other vaccines, give vaccines at different injection sites and use different syringes.

9.6 Vaccination schedule

Dose	Schedule
Hepatitis B vaccine dose 1	Day 0
Hepatitis B vaccine dose 2	Day 7 (7 days after dose 1)
Hepatitis B vaccine dose 3	Day 21-28 (14-21 days after HBs2)
Hepatitis B vaccine dose 4	12 months after the first dose of Hepatitis B vaccine

- The accelerated schedule above is recommended for survivors of SV, not the usual vaccination schedule.
- If the patient has started the vaccination schedule, do not start the vaccination series from the beginning, continue and complete the vaccination schedule as normal.
- Vaccination should be initiated even if the completion of the series cannot be ensured.⁴⁴
- If someone has started, but not completed the vaccination schedule, hepatitis B vaccination should be continued as scheduled

9.7 Precautions

- Do not administer in the event of allergic reactions to a previous dose of hepatitis B vaccine.
- No contraindication in pregnancy and while breast-feeding.
- No contraindication for people infected with HIV and who are immune compromised
- Febrile illness is not a contraindication for post exposure vaccination.

9.8 Side effects

- May cause: minor local reactions (pain or redness at injection site), fever, headache, myalgia; rarely: anaphylactic reaction.

9.9 Storage

Hepatitis B vaccine should be stored:

- Between 2 and 8°C
- Cannot be frozen

Depending on manufacturers notice, opened vials may be kept for use in subsequent immunization sessions (up to a maximum of 28 days) provided the vaccine is not expired, the vaccine has been stored with appropriate cold chain, and the vaccine vial monitor has not passed its discard point.

See MSF 2019 Essential drugs for further information.

⁴⁴ In healthy adults < 40 years hepatitis B vaccine induces a protective antibody response in approximately 30 to 55% after the first dose, in 75% after the second dose, and in more than 90% after the third dose.

10 Tetanus vaccination

Survivors of SV with wounds and who are not fully immunized may be at risk of tetanus. Tetanus is preventable through immunization with tetanus toxoid containing vaccines alone or in combination with human tetanus immune globulin (HTIG). HTIG may not be available in all settings due to supply constraints and cost.

10.1 Indication

All survivors of SV should be offered tetanus vaccination. Survivors of SV may have wounds, may have been exposed to and at risk of tetanus infection and will benefit from future protection from tetanus. Offer tetanus vaccination and HTIG (if available) according to the type of wound and vaccination status.

Type of wound	Complete vaccination (3 or more doses) Time since administration of last dose			Incomplete vaccination (less than 3 doses), no vaccination or unknown status
	<5 years	5-10 years	>10 years	
Minor clean wounds	None	None	1 Td booster dose	Initiate or complete tetanus vaccination
Other	None	1 Td booster dose	1 Td booster dose	Initiate or complete tetanus vaccination and administer HTIG (if available)

A total of 6 tetanus toxoid doses (3 doses primary series and 3 booster doses) during childhood or 5 doses during adolescence or adulthood provides lifelong protection.

10.2 Type and dosage

Tetanus toxoid containing vaccines available as:

- Tetanus toxoid diphtheria vaccine (Td)⁴⁵
- Monovalent tetanus toxoid vaccine (TT)⁴⁶

Provide tetanus toxoid containing vaccine type recommended by the national program.

The dosage is 0.5 mL IM (for both Td and TT and for children and adults)

For children under the age of 7, consider combination vaccines Diphtheria-Pertussis-Tetanus-Hepatitis B, *Haemophilus influenzae* type b (and inactivated polio vaccine).

Human tetanus immunoglobulin (HTIG) (if available)

- 250 international units (IU)⁴⁷
- If more than 24 hours have elapsed since the SV, increase the dose to 500 IU.

Children and adults receive the same dosage.

10.3 Method

Tetanus toxoid containing vaccine:

- Administer via the intramuscular (IM) route in the deltoid muscle in children above 2 years old and in adults and in the anterolateral thigh in children 2 years old and younger

Human Tetanus Immune Globulin (HTIG):

- Administer via IM route. Do not administer by IV route.
- Administer HTIG and tetanus vaccine in separate syringes and two different injection sites.

⁴⁵ The combined tetanus toxoid-diphtheria (Td) vaccine is most commonly used. If used in children less than 4 years old, protection against diphtheria won't be sufficient as Td contains reduced dose of diphtheria toxoid

⁴⁶ TT is being replaced by Td in most countries and is being withdrawn from the market.

⁴⁷ The quantity of human tetanus immunoglobulin is expressed in international units – IU

- Administer HTIG as soon as possible after injury.

10.4 Vaccination schedule

Offer tetanus vaccination as soon as possible after the SV incident. The first 2 doses are the priority as they provide protection from potential infection related to injuries from SV. However, 2 doses only provide a short duration of protection against future tetanus infection.

Tetanus vaccination schedule (children and adults)			
Dose	Schedule	Effectiveness of protection	Duration of protection
Dose 1	Day 0	0%	None
Dose 2	Day 28 (at least 28 days after dose 1)	80%	1 to 3 years
Dose 3	6 months after dose 2	95%	5 years
Dose 4	1 year after dose 3	99%	10 years
Dose 5	1 year after dose 4	99%	10 years

- If the patient has started the vaccination schedule, do not start the vaccination series from the beginning, continue and complete the vaccination schedule as normal.
- Vaccination should be initiated even if the completion of the series cannot be ensured.

10.5 Precautions

Tetanus toxoid containing vaccine:

- Do not administer in the event of allergic reactions after a previous dose of tetanus vaccine or any other antigen contained in the vaccine (depending on type of vaccine used).
- Febrile illness is not a contraindication for post exposure tetanus vaccination.
- If administered simultaneously with other vaccines, use different syringes and injection sites.
- Not contraindicated in pregnancy and while breast-feeding.

Human Tetanus Immune Globulin (HTIG):

- Do not administer to patients with known allergy to HTIG.
- Ensure that HTIG does not enter a blood vessel due to the risk of shock. Aspirate prior to injection to confirm that the needle is not in a vein.
- Not contraindicated in pregnancy and while breast-feeding.

10.6 Side events

Tetanus toxoid containing vaccine may cause: mild local reactions (redness, pain at the injection site), fever, malaise; rarely anaphylactic reactions.

Human Tetanus Immune Globulin (HTIG) may cause (very rarely): allergic reactions.

10.7 Storage

Tetanus toxoid containing vaccines

- Between 2 and 8°C
- Never freeze
- Depending on manufacturers notice, opened vials of this vaccine may be kept for use in subsequent immunization sessions (up to a maximum of 28 days) provided the vaccine is not expired, the vaccine has been stored with appropriate cold chain, and the vaccine vial monitor has not passed its discard point.

Human Tetanus Immunoglobulin (HTIG)

- Between 2 and 8°C
- Never freeze

See MSF 2019 Essential drugs for further information.

11 Psychosocial support

Psychosocial support is essential for healing and should be provided by all care providers. Mental health care should be offered to all survivors of SV. If there is no mental health professional available or the survivor declines support from the mental health care professional, then the health care worker should provide psychosocial support - listening, asking about needs, validating and re-assuring, strengthening coping skills and exploring social support. Psychosocial support, language and communications skills should be adapted to the age and developmental stage of the child. *See the most recent MSF Mental health and psychosocial care guidelines for survivors of sexual violence.*

11.1 Listen

- Listen attentively to the patient with empathy and compassion
- Let the patient tell their story at their own pace, don't rush, force or pressure them to talk
- Allow and respect silence
- Allow the person to cry or show emotions
- Be non-judgmental toward the person, their story and their emotional reactions
- Be aware of body language, eye contact, facial expressions, and gestures
- Show empathy, compassion and understanding by nodding, paraphrasing or summarizing

11.2 Ask

- Ask about the person's needs and concerns and help them to identify their priorities
- Give preference to open questions to invite the patient to express themselves

11.3 Validate and re-assure

Address feelings of shame, guilt, self-blame and isolation and challenge harmful beliefs, myths and misconceptions about SV. Acknowledge that it may be difficult for the survivor to share what happened.

"I believe you." "It's not your fault." "You are not to blame."
"You are not alone." "Help and support is available." "I am here to help you."
"There is no justification or excuse for what happened to you."
"No one deserves this."
"Everybody deserves to feel safe at home, at school, at work, while walking on the street."
"You are not dirty or ruined. You can have a normal life and do the things you wanted to do."
"You are not alone. Help and support is available." "I am here to help you."

Inform and re-assure the survivor that their reactions are normal after the abnormal traumatic event they went through.

"It's alright to talk about this." "It's okay to talk." "It can be hard to talk about this."
"This space is safe for you to talk and express your emotions."
"It's ok if you don't want to talk."
"It's okay to not be okay." "It's alright to cry."
"It's alright to be angry." "It's alright to be sad."
"It can be common to feel numb, to feel nothing."
"All the feelings you have—whether anger, guilt, fear, hopelessness, sadness, shame, confusion—are common and okay for you to feel."
"You may have many different feelings." These feelings can be confusing."

11.4 Strengthen positive coping methods

Positive coping strategies can help survivors be present, decrease distress, and increase resilience. They can find different small, simple ways of coping.

- Build on and reflect on their strengths and abilities
- Explore how they coped with difficult situations in the past, when they felt sad or distressed.
- Discuss engaging in activities that are interesting, pleasurable or relaxing
- Discourage negative coping strategies (such as misusing drugs or alcohol, smoking, oversleeping, overworking).

11.5 Explore social support

Survivors may feel isolated, marginalised and stigmatised. Stigma and isolation can worsen recovery. Explore possible stigma within the family or community. Discuss existing social supports – family, friends, neighbours, community or religious supports. Ask:

“When you are not feeling well or sad, who do you like to be with?”
“Who do you go to for help or advice?” “Who do you share your problems with?”
“Who are the people that give you hope and strength?”

Encourage the patient to connect with and confide in someone they trust – if it is safe to do so. Do not pressure them.

Explore formal social supports in the community – women and girl’s safe spaces, support groups, community centres, informal or formal education, or income-generating activities. Spending time with safe, trusted, supportive people can reduce feelings of distress and isolation and can help in healing and recovery.

11.6 Assess needs and offer further mental health care

Some patients may need further mental health care. Signs and symptoms of the need for further mental health care including: persistent sadness, nightmares, flashbacks, difficulty sleeping, poor appetite, confusion, feeling suicidal, or not functioning in daily activities.

Assess patients for these signs and symptoms and provide support, education and counselling that if survivors develop these signs and symptoms, they can return and ask for support and further mental health care.

If there is no mental health care available in the project, MSF teams should be aware of and offer referral to local mental health care. If there is no locally available mental health care, MSF teams should advocate for mental health care to be available within the MSF project.

See MSF Mental health and psychosocial care guidelines for survivors of sexual violence and WHO mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings (2016) for further information.

12 Follow-up

Follow-up is an important part of care for survivors of SV. It can be very challenging and difficult for survivors to return for follow-up care and many do not return.

On follow-up visits, assess needs and provide care:

- Assess psychological, mental and emotional status and social support, provide mental health care and psychosocial support
- Assess physical health, wounds and injuries
- If taking HIV PEP, monitor HIV PEP side effects and adherence
- Offer HIV support, education and counselling and HIV testing if appropriate.
- Assess pregnancy status. If she is pregnant, provide information and counselling about available options (SAC, antenatal care, adoption).
- Assess STI symptoms and treat appropriately.
- Provide hepatitis B and tetanus vaccination and information on the next vaccination dose.
- Provide information and referrals to other support services where needed – including legal, justice, protection, safety, security, education, economic, skills and livelihood support services.
- Encourage the survivor to return for the next follow-up appointment.

Suggested follow-up schedules

The following is a suggested schedule, but follow-up care should be adapted and flexible depending on the patients' needs, preferences, best interest, ability to return and the context and coordinated together with other services. For example, if a patient returns 5 days after the initial visit and may not be able to return, offer to give the 2nd hepatitis B vaccination. Alternatively, patients can have reduced follow-up visits depending on their needs – such as at 1 week, 1 month, 3 months and 1 year.

All patients	In addition, for survivors taking HIV PEP
1 week Give 2 nd hepatitis B vaccination	1 week • Monitor HIV PEP side effects and adherence
2 weeks	2 weeks • Monitor HIV PEP side effects and adherence
3 weeks (21 days)	3 weeks • Monitor HIV PEP side effects and adherence
4 weeks (28 days) • Give 2 nd dose of tetanus vaccination and 3 rd dose of hepatitis B vaccination	4 weeks (28 days) • Ask about HIV PEP completion • Offer HIV testing
3 months • Repeat HIV testing	
7-13 months • Give 3 rd dose of tetanus vaccination	
1 year • Give 4 th dose of hepatitis B vaccination, 3 rd dose of tetanus vaccination can be given at the same time if not already given	

Annex 1: Delayed presentation to care

Survivors may seek care weeks, months or years after SV. Identify, address and respond to the patient's needs, offer medical care to prevent or treat medical consequences, and offer psychosocial support to reduce isolation, shame and suffering.

12.1 Ask

- Ask the survivor about their situation, needs and concerns, and desire for support. Listen empathetically.

12.2 Assess risk of HIV

- Assess the risk of HIV and if at risk offer HIV testing. See [Assess risk and provide HIV testing](#).
- If the patient presented for care ≤ 3 months since SV, advise the patient to return for HIV testing 3 months from the date of the SV.
- If the patient presents ≤ 3 months since the SV, HIV testing may determine if the survivor was exposed to HIV from the SV. Assess ongoing risk of HIV other than the SV.

12.3 Determine pregnancy, provide information and support

- Ask about the timing of SV and last menstrual period. If there was no menstrual period since the assault, offer pregnancy testing and determine whether a pregnancy is the result of the assault (if possible). See [Determining pregnancy](#).
- If the patient is pregnant, provide support, education and counselling on options – including safe abortion care, antenatal, obstetrical care, parenting support or adoption. See [Offer support, education and counselling](#). Provide safe abortion care if requested. See [Safe abortion care](#).
- If the patient has a baby born as a result of the assault, offer referral to psychosocial support, parenting support, social support and community reintegration (if available).
- If the patient is not pregnant, offer contraception to prevent future unwanted pregnancies.

12.4 STI prophylaxis and treatment

- Assess risk for STIs, see [Assess risk of STI transmission](#) (page27). If the patient is at risk of STIs and testing is available:
 - If survivor presents > 3 months offer rapid syphilis testing⁴⁸ - either Bioline treponemal testing or rapid plasma reagin (RPR) nontreponemal test and treat as appropriate.
 - If the patient presents < 3 months since the SV, advise to return for repeat syphilis testing 3 months after SV if available.
 - In both cases ($<$ or > 3 months presentation since SV incident) – if the patient tests positive for syphilis, treat as appropriate.
 - Offer testing for chlamydia and gonorrhoea and treat as appropriate.
- If the patient is at risk of STIs and **no testing is available**, and the patient is asymptomatic:
 - high or unknown prevalence of chlamydia ($\geq 5\%$)⁴⁹: give Azithromycin 1 g PO stat dose (plus appropriate treatment if syphilis test was positive)
 - Low prevalence setting for chlamydia ($< 5\%$): no prophylaxis

⁴⁸ If available, offer rapid chlamydia and gonorrhoea testing. Chlamydia and gonorrhoea testing is not available or feasible in many settings due to costs and complexity

⁴⁹ It is difficult to define the prevalence of Chlamydia in a given country, as there are huge variations by country and/or population age (e.g. adolescent compared to women/men of older age). It may be advised to consult the medical responsible at project level to gather information about the prevalence of Chlamydia in your context and adapt the SV protocol to project setting.

- Do not treat gonorrhoea presumptively as the prevalence is overall lower and there is an increasing risk of antibiotic resistance for *Neisseria gonorrhoea*

NB: For all patients ask about signs and symptoms of STIs and if symptomatic, offer syndromic treatment.

- See [Prevention and treatment of STIs](#) and *MSF 2019 Clinical Guidelines Diagnosis and Treatment Manual* for treatment.

12.5 Vaccination

- Hepatitis B vaccination is unlikely to be effective after 14 days of exposure (Plotkin). If the patient however presents more than 2 weeks after the SV, offer hepatitis B vaccination to prevent hepatitis B from possible future exposure. See [hepatitis B vaccination](#).
- Offer tetanus vaccination if indicated. See [Tetanus vaccination](#)

12.6 Pain assessment and wound care

Assess patients for pain, injuries, impairment and disability, chronic health conditions, chronic pain, genito-urinary symptoms (urinary frequency, dysuria, urinary incontinence, constipation, incontinence of stool, genital or anal pain, bleeding or discharge), sexual dysfunction (erectile dysfunction, vaginismus⁵⁰, dyspareunia⁵¹) – especially for those who experienced repeated, ongoing SV or SV within torture.

12.7 Mental health care and psychosocial support

Mental health care should be offered to all survivors of SV. If there is no mental health professional available or the survivor declines support from the mental health care professional, then the health care worker should provide psychosocial support - listening, asking about needs, validating and re-assuring, strengthening coping skills and exploring social support. See [Psychosocial support](#) and *MSF Mental health and psychosocial care guidelines for survivors of sexual violence*.

⁵⁰ involuntary muscle spasm prevents vaginal penetration and often results in painful sexual intercourse

⁵¹ painful sexual intercourse

Annex 2: Sexual violence by intimate partners or ongoing sexual violence

Patients may present after experiencing ongoing, repeated, recurrent, and chronic SV. Patients may be experiencing SV by an intimate partner, as a form of intimate partner violence⁵². Patients also may be experiencing ongoing, repeated SV by another known person⁵³. People may choose not to or be unable to leave the situation due to vulnerability, threats, fear, reliance on the perpetrator, lack of resources or safe options to leave. This section discusses ongoing SV experienced by adults, see [Ongoing child sexual abuse](#) for ongoing sexual abuse against children.

12.8 Ask and listen

- Ask the survivor about their situation, needs and concerns, desire for support and listen empathetically.

12.9 HIV PEP or PrEP

Assess risk of exposure to HIV, provide HIV testing, information and offer HIV PEP or PrEP (depending on time from incident to presentation) – including survivors who have experienced SV from their intimate partner or a known perpetrator.

Assess risk and provide HIV testing

- Assess the risk of HIV and offer HIV testing. See [Assess risk and provide HIV testing](#).
- Discuss the risk of transmission HIV with the survivor based on:
 - HIV prevalence in the region
 - Whether the perpetrator:
 - is known to be living with HIV or at substantial risk of HIV
 - has multiple partners, sex with sex workers or with men
 - has an STI, genital lesions or ulcers, or is not circumcised
 - stays overnight in other places, for days, weeks or months at a time
 - works in high risk jobs including the military, truck driving or mining
 - is a person who injects drugs or hormones
 - Characteristics of the SV - anal penetration, degree of trauma, abrasions, injuries and wounds
 - Characteristics of the survivor that may increase the risk of HIV transmission (current STIs, pre-pubescent or adolescent age)
- Provide support, education and counselling about future risks of HIV and advise repeat HIV testing every 3 months if there is an ongoing risk.

Provide information and offer HIV PEP or HIV PrEP

- **Discuss HIV PEP** - provide information about risks and benefits of HIV PEP, duration and frequency of treatment, potential side effects and how to manage side effects and limitations. HIV PEP only prevents acquiring HIV from exposure within the last 72 hours (or 3 days) and not from multiple exposures in the past or future. HIV PEP is not intended for multiple, repeated, ongoing exposure to HIV and prolonged use.
- **Discuss HIV PrEP (if available)** - if there is ongoing substantial risk of acquiring HIV, and/or the ongoing perpetrator has a high risk of HIV, see [HIV PrEP](#).

12.10 STI prevention and treatment

⁵² Intimate partner violence (IPV) is a behaviour by a current or former intimate partner (such as husband, boyfriend, wife or girlfriend) which causes physical, sexual or psychological harm, including physical aggression, forced intercourse and sexual coercion, psychological abuse, and controlling behaviour (WHO, 2013; Krug, 2002).

⁵³ A person in position of power, authority or trust – a neighbour, close family friend, employer, aid worker or peace keeper, gang leader, police, border guard, smuggler, detention guard.

At the first visit assess risk of STI transmission, see [Assess risk of STI transmission](#). If the patient is at risk of STIs:

- Ask about signs and symptoms of STIs. If symptomatic, offer appropriate syndromic treatment.
- Offer testing for STIs, when available. If tests are positive, offer appropriate treatment. Advise to return within 3 to 6 months for repeat STI testing.
 - Offer a rapid diagnostic test for syphilis if the survivor presents 3 months after SV and if available – either rapid syphilis treponemal testing or rapid plasma reagin (RPR) nontreponemal test.
 - If available, offer rapid chlamydia and gonorrhoea testing. Chlamydia and gonorrhoea testing is not available or feasible in most settings due to costs and complexity.
- If the patient is asymptomatic and testing is not available, offer and provide STI prophylactic treatment.

At second and further visits assess risk of STI transmission, see [Assess risk of STI transmission](#). If the patient is at ongoing risk of recurrent STIs, provide support, education and counselling about the following options to reduce future re-infection, recurrent, persistent STIs and developing complications and support the patient to make a decision:

- Provide information on signs and symptoms of STIs and advise the patient to return for syndromic treatment if signs and symptoms develop. If symptomatic, offer appropriate syndromic treatment
- Repeat STI testing every 3 to 6 months (if available) and if positive, treat as appropriate
- Offer STI prophylaxis or treatment (periodic presumptive treatment) every 6 to 12 months (if testing is not available); and/or:
- Offer the patient STI treatment for the partner/perpetrator⁵⁴. It is the patient's choice if they take the treatment to give to partner/perpetrator. **MSF does not do contact tracing** of partners/perpetrators in cases of IPV or where the perpetrator is known. Contact tracing may put the survivor at risk of violence, rejection, isolation and marginalization. Respect the survivor's privacy, confidentiality and safety.
- Offer condoms⁵⁴

See [Prevention and treatment of STIs](#), *MSF 2019 Clinical Guidelines Diagnosis and Treatment Manual* and *MSF 2019 Essential drugs*.

12.11 Preventing unwanted pregnancy

- Offer a pregnancy test to determine if the patient (women and girls of reproductive age) is pregnant as a result of the assault. See [determine if the patient is pregnant](#)
- If she is pregnant, offer support, education and counselling and offer safe abortion care if requested. See [offer support, education and counselling](#) and [safe abortion care](#)
- If she is not pregnant:
 - Offer EC if the patient presents within 120 hours or 5 days of the incident. Inform the patient that she is welcome to return for EC if needed in the future. See [Offer emergency contraception](#)
 - Along with EC or if the patient presents after 120 hours or 5 days, offer contraception to prevent future unwanted pregnancies. Discuss covert methods of contraception that may not be detected by the intimate partner/perpetrator.

12.12 Vaccination

Offer hepatitis B vaccination. See [hepatitis B vaccination](#).

Offer tetanus vaccination if indicated. See [Tetanus vaccination](#).

⁵⁴ The survivor may not have the option to negotiate STI treatment or condom use with their partner and the request for condom use could trigger, escalate or worsen violence.

12.13 Pain management and wound care

Assess for pain, wounds and injuries and provide pain management and wound care. See [Pain assessment and management](#) and [Assessment and care of wounds and injuries](#)

12.14 Risk assessment, safety planning and referral

Listen non-judgmentally and respectfully. Do not tell the patient what to do, do not advise the patient to leave the situation of ongoing, recurrent or chronic violence. Discuss risks, harm and danger and explore strategies to improve safety. Offer referral to support services including advocacy, empowerment, safety, security and protection.

12.15 Mental health care and psychosocial support

Mental health care should be offered to all survivors of SV. If there is no mental health professional available or the survivor declines support from the mental health care professional, then the health care worker should provide psychosocial support - listening, asking about needs, validating and re-assuring, strengthening coping skills and exploring social support. See [Psychosocial support](#) and *MSF Mental health and psychosocial care guidelines for survivors of sexual violence*.

Ongoing child sexual abuse

Children may be experiencing ongoing, repeated sexual abuse – including by someone who is known, trusted and/or in a position of power or authority. Health care workers must ensure the child's best interest and protect the child's safety – including from further harm or abuse. Health care workers should assess the risk of harm, the child's vulnerabilities and strengths and the willingness and capacity of the parent or caregiver to protect the child's best interest and safety. Health care workers must act to protect a child if they are at risk of ongoing harm and the caregiver is not willing or able to protect the best interest and safety of the child. A safe, trusted parent or caregiver willing and capable of protecting the child or adolescent, or local protection services, may need to be found.

See MSF OCA (2019) Guidelines for creating access and providing care to survivors of sexual violence and intimate partner violence, Pg 174 Risk assessment and safety planning for child survivors of sexual abuse for further information.

Annex 3: HIV pre-exposure prophylaxis (PrEP)

HIV PrEP is the use of ongoing ART prior to and after potential exposure to HIV by uninfected persons at substantial risk to prevent acquiring HIV infection.

12.16 Indications

HIV PrEP is recommended for key populations or individuals at substantial risk of acquiring HIV – due to a higher risk behaviour or a situation of increased vulnerability.

Populations at substantial risk due to increased vulnerability may include:

- people forced to leave their home and on the move at risk of ongoing or multiple episodes of SV
- survivors of ongoing sexual and/or physical violence by an intimate partner or known perpetrator(s) living with HIV who are not on ART or who has not been on ART for more than 6 months, who is unknown to be adherent, whose viral load is unknown
- adolescent girls who have left school early
- people who have received money, housing, food or gifts in exchange for sex, or people who need to exchange sex for shelter, food or income

Key populations at substantial risk include:

- sex workers
- men who have sex with men, trans people and other LGBTI persons
- people who inject drugs or hormones and share injecting equipment
- people in detention and other closed settings (WHO, 2016; MSF, 2018)

12.17 Timing

HIV PrEP is taken daily during periods of substantial risk of acquiring HIV. Ideally, start PrEP a week prior to high risk sexual encounter and continue for 1 month after the last high risk encounter. HIV PrEP can be stopped when there is low or no risk of acquiring HIV.

If a patient had exposure to HIV in the last 72 hours, offer HIV PEP for 28 days and then start PrEP.

12.18 Baseline testing

- HIV test (required)
- Hepatitis B surface antigen test⁵⁵ (required if tenofovir (TDF) is offered). If negative, offer hepatitis B vaccination. If positive, tenofovir (TDF) and lamivudine (3TC) will effectively treat hepatitis B – but refer for further testing and care.
- Creatine clearance (recommended, not required)

12.19 Precautions

- Estimated creatinine clearance <50 ml/min
- Signs and symptoms of acute HIV infection, probable recent exposure to HIV, HIV-positive
- Allergy to any medicine in the PrEP regimen

12.20 Special considerations during pregnancy

- Pregnancy testing is not recommended. PrEP can be taken safely during pregnancy and should be recommended during pregnancy for women at substantial risk for HIV.

12.21 Dosage

⁵⁵ Patients who test positive for hepatitis B surface antigen should be referred for further assessment, testing, care and treatment. A patient may have positive hepatitis B surface antigen test, have self-limiting acute hepatitis B, spontaneously clear and not progress to chronic hepatitis B.

HIV Pre-exposure prophylaxis (PrEP)			
Drug	Dosage	Route of administration	Frequency
Tenofovir (TDF)	300 mg	PO	OD
<i>And</i>			
Lamivudine (3TC)	300 mg	PO	OD
<i>Or</i>			
Emtricitabine (FTC)	300 mg	PO	OD

12.22 Monitoring

- Offer patient support, education and counselling, offer STI screening and testing, monitor for side effects
- Offer HIV testing every 3 months to confirm negative status and continue HIV PrEP
- Check creatinine level should be checked at baseline, then every 3 months for the first year, then annually thereafter. Absence of creatinine level testing is not a reason not to offer PrEP.
- Provide support, education and counselling on effectiveness, adherence, information on lack of STI protection and contraceptive effect, suggested testing, safety, side effects, and linkage to other healthcare services

See MSF (2018) HIV/TB clinical guide for primary care [https://samumfsf.org/sites/default/files/2019-09/HIVTB%20Clinical%20Guide%20for%20Primary%20Care August2019 WEB.pdf](https://samumfsf.org/sites/default/files/2019-09/HIVTB%20Clinical%20Guide%20for%20Primary%20Care%20August2019%20WEB.pdf)

See WHO (2017) WHO Implementation Tool for Pre-exposure prophylaxis (PrEP) of HIV infection <https://www.who.int/hiv/pub/prep/prep-implementation-tool/en/>

Annex 4: Further resources

The following further MSF resources can accompany the medical protocol:

- MSF (2017) Medico-legal toolbox
- MSF (2019) Essential drugs: Practical guidelines intended for physicians, pharmacists, nurses and medical auxiliaries
- MSF (2019) Clinical Guidelines Diagnosis and Treatment Manual
- MSF (2019) Essential obstetric and newborn care guidelines
- MSF OCA (2019) Guidelines for creating access and providing care to survivors of sexual violence and intimate partner violence
- MSF International AIDS Working Group (2017) Prevention of mother-to-child transmission of HIV Protocol for prevention of mother to child transmission.
- MSF Laboratory working group (2017) HIV diagnosis and monitoring Policy on HIV testing
- MSF (2018) Patient Support, Education and Counselling Guideline: For adults living with HIV and/or TB, https://samumfsf.org/sites/default/files/2018-09/PSEC_Adults%20MSF%20Guideline.pdf
- MSF (2018) Patient Support, Education and Counselling Guideline: For children and adolescents living with HIV https://samumfsf.org/sites/default/files/2018-06/PSEC_Children%20and%20adolescents_0.pdf
- MSF OCBA (2019) Patient Support, Education and Counselling HIV/TB Toolkit
- MSF (2018) HIV/TB clinical guide for primary care https://samumfsf.org/sites/default/files/2019-09/HIVTB%20Clinical%20Guide%20for%20Primary%20Care_August2019_WEB.pdf
- MSF OCBA Guidance for the Clinical Management of Survivors of Torture with Persistent Pain
- MSF Mental health and psychosocial care guidelines for survivors of sexual violence.

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13.2 HIV Post-exposure prophylaxis

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- MSF (2012) Patient education and counselling handbook for HIV/TB infected adult patients
- MSF (2014) MSF HIV/TB Clinical Guide
- MSF (2015) Integrating HIV & TB care in basic health care package in MSF projects: A programmatic guide
- MSF Laboratory working group (2017) HIV diagnosis and monitoring Policy on HIV testing
- MSF (2018) Patient Support, Education and Counselling Guideline: For adults living with HIV and/or TB, https://samumfsf.org/sites/default/files/2018-09/PSEC_Adults%20MSF%20Guideline.pdf
- MSF (2018) Patient Support, Education and Counselling Guideline: For children and adolescents living with HIV https://samumfsf.org/sites/default/files/2018-06/PSEC_Children%20and%20adolescents_0.pdf
- MSF OCBA (2019) PSEC HIV/TB Toolkit
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<https://apps.who.int/iris/bitstream/handle/10665/325892/WHO-CDS-HIV-19.15-eng.pdf?ua=1>

13.3 Preventing unwanted pregnancy

- European Consortium for Emergency Contraception (ECEC) (2016) Emergency contraception methods: The EC wheel <http://www.ec-ec.org/ecmethod/>
- ECEC (2015) Efficacy of emergency contraception and body weight Current understanding and recommendations
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- WHO (2018) Family Planning: A global handbook for providers.

13.4 Safe abortion care

- Engender Health (2003) Counselling the post abortion client: A training curriculum.
- Ipas. (2018). *Clinical Updates in Reproductive Health*. L. Castleman & N. Kapp (Eds.). Chapel Hill, NC: Ipas.
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- MSF (2019) Essential obstetric and newborn care guidelines
- WHO (2012) Safe abortion: technical and policy guidance for health systems
- WHO (2014) Clinical practice handbook for Safe abortion
- WHO (2018) Medical management of abortion
- WHO (2019) WHO launches new guideline to help health-care workers ensure safe medical abortion care <https://www.who.int/reproductivehealth/guideline-medical-abortion-care/en/>

13.5 STI prophylaxis

- MSF (2019) Essential drugs: Practical guidelines intended for physicians, pharmacists, nurses and medical auxiliaries

13.6 Hepatitis B vaccination

- CDC (2013) Viral Hepatitis <https://www.cdc.gov/hepatitis/Populations/PDFs/HepGay-FactSheet.pdf>
- WHO (July 2015) Hepatitis B: How can I protect myself? <https://www.who.int/features/qa/11/en/>

13.7 Wound care

- WHO (2006) Obstetric Fistula: Guiding principles for clinical management and programme development. http://whqlibdoc.who.int/publications/2006/9241593679_eng.pdf?ua=1

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13.9 HIV Pre-exposure Prophylaxis

- MSF (2018) MSF HIV/TB clinical guide for primary care
- WHO (2016) Consolidated Guidelines on the Use of Antiretroviral Drugs for Treating and Preventing HIV Infection
- WHO (2017) WHO Implementation Tool for Pre-exposure prophylaxis (PrEP) of HIV infection <https://www.who.int/hiv/pub/prep/prep-implementation-tool/en/>
- WHO Oral PrEP Implementation Tool App <https://www.who.int/hiv/mediacentre/news/oral-prep-app/en/>