Department of Health

Medical and Psychosocial Care for Survivors of Sexual and Gender-Based Violence

National Clinical Practice Guidelines

Papua New Guinea 2021

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Medical *and* Psychosocial Care *for* Survivors of Sexual and Gender-Based Violence

National Clinical Practice Guidelines

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FOREWORD

Literature[1] suggests that levels of sexual and gender-based violence (SGBV) are extremely high in Papua New Guinea (PNG). SGBV is a public health issue, as well as a human rights issue that impacts the rights of the affected individuals, and the statistics in PNG are alarming. The various studies mentioned in these Guidelines demonstrate that PNG experiences high levels of gang rape and partner rape. SGBV primarily affects women and girls, although men and boys can also be survivors of sexual violence (SV).

The Department of Health has increased its focus on SGBV in the Public Health's Strategic Directions 3 and 4 (Safe Motherhood and Control of HIV/AIDS and Sexually Transmitted Infections) as a major factor affecting the health of women, children and men in PNG.

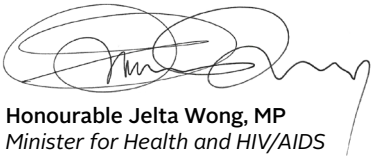
SGBV impacts the health of the affected individuals and increases the risks of unwanted pregnancy, sexually transmitted infections and HIV. Therefore, the health sector plays a critical role in ensuring that survivors receive the best treatment, care and support available. Healthcare workers also play a role in case prevention and seeking justice for survivors in the multi-sectorial approach to addressing SGBV.

These Clinical Guidelines provide information for health workers to gain a better understanding of their roles and responsibilities when responding to SGBV. Healthcare workers must be familiar with the laws of PNG that protect its citizens from SV, as well as the international conventions that protect individuals worldwide from SGBV, as outlined in these Guidelines.

1 See Chapter 1: Introduction to sexual and gender-based violence in the Papua New Guinea Context.

Additionally, the National Health Plan 2011–2020 outlines the strategies that healthcare professionals must follow when addressing SV, including rolling out family support centres (FSCs) to provide treatment, care and support for survivors of SGBV. These FSCs have provided a clear referral pathway for other services depending on the needs of each SV survivor.

These Clinical Guidelines were developed for healthcare workers and FSCs to facilitate the provision of treatment, care, support and assistance to legal, justice and other services for SGBV survivors. The future of this nation depends on the individuals who have committed to contributing meaningfully at all levels of the healthcare system. SV affects individuals physically, psychologically and socially and hinders the development of this nation. There must be a collective approach by all to mitigate the effects of SGBV.



Honourable Jelta Wong, MP
Minister for Health and HIV/AIDS

ACKNOWLEDGEMENT

It takes more than dedication, commitment and honesty to address the complexity of human behaviour and social interactions. Few dedicated individuals can provide the necessary effort and time to ensure that the communities of PNG are safe, free and educated on issues that influence the livelihoods of their citizens. The sensitivity, passion and determination of those very individuals who have provided the leadership, expert advice and technical support to address gender — specifically gender-based violence — and its health and economic impacts cannot be left unacknowledged.

The Medical and Psychosocial Care for Survivors of SGBV National Clinical Practice Guidelines are possible thanks to the support and commitment of partners and the National Department of Health staff. These Guidelines are the result of several consultations and the collaborative and supportive efforts of the Technical Working Group and its partners, provincial health facilities, public hospitals and the provincial health authorities. We would like to thank the many organisations and individuals involved in the development of these Guidelines for assisting health professionals in providing clinical care and treatment and supporting the case management of those affected by SGBV.

I am humbled to acknowledge and thank our partners, including the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, Médecins Sans Frontières (Doctors Without Borders), the Family and Sexual Violence Action Committee of the Consultative Implementation and Monitoring Council, FHI 360 and the Provincial Health Authorities, that have contributed in many ways to make this document possible. We cannot offer enough thanks to the individual members of the Working Committee, who have offered their dedication since the initial development of these Guidelines.

I extend a special thank you to Professor Glen Mola for his expert input and critique on the finalisation of these Guidelines.

I would also like to acknowledge the key partners that have facilitated funding for this document: the World Health Organization, the United Nations Children's Fund, the United Nations Population Fund, the Australian Department of Foreign Affairs and Trade, the United States Agency for International Development, International Committee of the Red Cross and several others. Thank you also to FHI 360 for facilitating the graphic design and layout of this document.

I look forward to the effective implementation of the *Sexual Clinical Guidelines on Medical and Psychosocial Care for Survivors of SGBV* by all health professionals throughout the health systems in PNG to benefit and protect the welfare of all our people.

Dr. Osborne Liko
Secretary

ACRONYMS

3TC	Lamivudine
ABC	Abacavir
AIDS	Acquired Immune Deficiency Syndrome
A&E	Accident and Emergency
ANC	Ante Natal Care
ANGAU	Australian New Guinea Administrative Unit
ART	Antiretroviral Therapy
AZT	Zidovudine
CA	Child Abuse
CEO	Chief Executive Officer
CIMC	Consultative Implementation and Monitoring Council
CPG	Clinical Practice Guidelines
CSA	Child Sexual Abuse
DMS	Director of Medical Services
DTG	Dolutegravir
DV	Domestic Violence
EC	Emergency Contraception
FSC	Family Support Centre
FSV	Family and Sexual Violence
FSVAC	Family and Sexual Violence Action Committee
FSVU	Family and Sexual Violence Unit (police)
FV	Family Violence
GBV	Gender-Based Violence

HC	Health Centre
HCT	HIV Counselling and Testing
HEP B	Hepatitis B Virus
HEO	Health Extension Officer
HIV	Human Immunodeficiency Virus
IASC	Inter-Agency Standing Committee
IM	Intramuscular
IPV	Intimate Partner Violence
IU	International Units
LPA	Lukautim Pikinini Act
LPV/r	Lopinavir/Ritonavir
MSF	Médecins Sans Frontières (Doctors Without Borders)
NGO	Non Government Organization
NDOH	National Department of Health
O&G	Obstetrics and Gynaecology
OCP	Oral Contraceptive Pill
OIC	Officer In Charge
PEP	Post-Exposure Prophylaxis
PFA	Psychological First Aid
PICT	Provider Initiated Counselling and Testing
PNG	Papua New Guinea
PTSD	Post-Traumatic Stress Disorder
SGBV	Sexual and Gender-Based Violence
SMO	Senior Medical Officer
STI	Sexual Transmitted infections
SV	Sexual Violence
TDF	Tenofovir

TIG	Tetanus Immunoglobulin
TT	Tetanus Toxoid
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VPA	Violence Prevention Alliance
WHO	World Health Organization

DEFINITIONS

CHILD

In accordance with the Convention on the Rights of the Child, Papua New Guinea (PNG) laws define a child as a person below the age of 18 years.

CHILD MALTREATMENT

Child maltreatment (sometimes referred to as 'child abuse' [CA] or 'neglect') includes all forms of physical and emotional ill-treatment, sexual abuse, neglect and exploitation that result in actual or potential harm to the child's health, development or dignity. This broad definition includes five subtypes of maltreatment: physical abuse, sexual abuse, neglect and negligent treatment, emotional abuse, and exploitation (World Health Organization [WHO]).

In PNG, it is common for children to witness violence within their families or households, which is a form of emotional abuse that health professionals must address.

CHILD SEXUAL ABUSE

WHO defines child sexual abuse (CSA) as:
'The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. CSA is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person.

This may include but is not limited to:

- The inducement or coercion of a child to engage in any unlawful sexual activity,
- The exploitative use of a child in prostitution or other unlawful sexual practices,
- The exploitative use of children in pornographic performances and materials.'[2]

2 WHO, 'Chapter 7 – Child sexual abuse', in WHO Guidelines for medico-legal care for victims of sexual violence, 2013, p. 75 <https://www.who.int/violence_injury_prevention/resources/publications/en/guidelines_chap7.pdf>, accessed 26 Oct. 2020.

ELDER ABUSE

Elder abuse is defined as 'a single or repeated act, or lack of appropriate action, occurring within any relationship where there is an expectation of trust which causes harm or distress to an older person'. Elder abuse can take various forms, such as physical, psychological or emotional, sexual, or financial abuse, and can result from intentional or unintentional neglect (WHO). There is currently no United Nations standard numerical criterion, but the generally accepted age to refer to the elderly population is 60 years or older.

GENDER

Gender denotes the social characteristics assigned to men and women. These social characteristics are constructed based on various factors, such as age, religion, nationality, ethnicity and social origin. They differ both within and between cultures and define the identities, status, roles, responsibilities and power relations among the members of any given society or culture. Gender is learned through socialisation and is not static or innate; rather, it evolves to respond to changes in the social, political and cultural environment.[3]

GENDER-BASED VIOLENCE

Gender-based violence (GBV) refers to any harmful act perpetrated against a person's will and based on socially ascribed (gender) differences between males and females. GBV encompasses a wide range of human rights violations, including the sexual abuse of children, rape, domestic violence (DV), sexual assault and harassment, the trafficking of women and girls, and several harmful traditional practices such as forced or early marriage.[4] Power, control and inequality are the key contributors to GBV.

GENDER EQUALITY

Gender equality refers to the equal rights, responsibilities and opportunities of women and men and girls and boys. Equality means that women's and men's rights, responsibilities and opportunities will not depend on whether they were born male or female.[5]

3 United Nations High Commissioner for Refugees (UNHCR), 'Sexual and gender-based violence against refugees, returnees and internally displaced persons: Guidelines for prevention and response', UNHCR, May 2003, p. 11, <https://www.unhcr.org/protection/women/3f696bcc4/sexual-gender-based-violence-against-refugees-returnees-internally-displaced.html>, accessed 26 Oct. 2020.

4 Inter-Agency Standing Committee (IASC), 'Guidelines for GBV interventions in humanitarian settings: Focusing on prevention of and response to sexual violence in emergencies', IASC, September 2005, p. 1, <https://interagencystandingcommittee.org/system/files/2020-09/Guidelines%20for%20Gender-based%20Violence%20Interventions%20in%20Humanitarian%20Settings.pdf>, accessed 26 Oct. 2020.

5 UN Women, 'United Nations Entity for Gender Equality and the Empowerment of Women | UN Women – Headquarters', UN Women [website], 2020, para. 3, <https://www.unwomen.org/en>, accessed 26 Oct. 2020.

INFORMED CONSENT/ASSENT

To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give their consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 16 years of age.

Informed assent is the expressed willingness to participate in services. For children under 16 years of age who are deemed too young to give informed consent but old enough to understand and agree to participate in services, service providers should seek the child's informed assent.[6]

INTERPERSONAL VIOLENCE

Interpersonal violence refers to violence between individuals and is subdivided into family and intimate partner violence (IPV) and community violence. The former category includes child maltreatment, IPV and elder abuse; the latter includes acquaintance and stranger violence, such as youth violence, assault by strangers, violence related to property crimes and violence in the workplace and other institutions.[7]

INTIMATE PARTNER

An intimate partner may refer to a husband or wife, cohabiting partner, boyfriend or girlfriend, lover, ex-husband or ex-wife, ex-partner, ex-boyfriend or ex-girlfriend, or ex-lover. This definition includes those in same-sex relationships.[8]

Note: an ex-partner is not necessarily considered an intimate partner in the context of PNG; however, in the interest of inclusion of this vulnerable category, 'ex-partner' is included in the definition, as per WHO guidelines.

6 . Erikson, 'Guidelines for health and psychosocial service providers in humanitarian settings: Caring for child survivors of sexual abuse', International Rescue Committee, August 2012, p. 19, <http://www.unicef.org/protection/files/IRC_CCSGuide_FullGuide_lowres.pdf>, accessed 26 Oct. 2020.

7 WHO-Violence Prevention Alliance (VPA), 'Building global commitment to violence prevention', WHO-VPA [website], 2020, para. 1, <https://www.who.int/violenceprevention/en/>, accessed 26 Oct. 2020.

8 Adapted from WHO, 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', WHO, 2013, p. vii, <https://apps.who.int/iris/bitstream/handle/10665/85240/9789241548595_eng.pdf;jsessionid=280C9871C2106ODE85726CEA2482F195?sequence=1>, accessed 26 Oct. 2020.

INTIMATE PARTNER VIOLENCE

IPV includes any behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviour. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to IPV include DV, spousal abuse and spousal battering. The term 'dating violence' can be used to refer to intimate relationships among young people, which may be of varying duration and intensity and do not involve cohabitation.[9]

PHYSICAL ASSAULT

Physical assault occurs when a person strikes, touches, moves or otherwise applies or threatens to apply force of any kind to another person, either directly or indirectly, to the extent that the person making the attempt or threat has presented the ability to affect the other person's purpose. A physical assault can occur without the other person's consent or with the other person's consent if the assailant obtained the consent through fraud.[10]

REGISTERED MEDICAL PRACTITIONER

A registered medical practitioner is anyone whose name appears on the PNG Medical Board or the PNG Nursing Council (as per the Medical Evidence Act).

RAPE/ATTEMPTED RAPE

Rape is an act of non-consensual sexual intercourse using force or the threat of force or punishment. It refers to the penetration of the vagina or anus with the penis of the perpetrator or other object or the penetration of the mouth with the penis of the perpetrator. Efforts to rape someone that do not result in penetration are considered attempted rape.

9 Ibid.

10 FindLaw Australia, 'Assault Laws in Australia: Definitions and Defenses', FindLaw Australia [website], 2020, para. 3, <https://www.findlaw.com.au/articles/4274/assault-laws-in-australia-definitions-and-defences.aspx>, accessed 26 Oct. 2020.

Any penetration without consent is considered rape, including:

- Rape of an adult female
- Rape of a minor (male or female), including incest. Even if the minor has agreed to the act, he or she cannot legally consent due to his or her age.
- Gang rape (if there is more than one assailant)
- Marital rape (between a husband and wife)
- Male rape by another man (sometimes known as 'sodomy') or male rape by a female perpetrator[11]

SEXUAL VIOLENCE

Sexual violence (SV) includes any sexual act or attempt to obtain a sexual act in which the perpetrator uses coercion. This definition can include unwanted sexual comments or advances, acts to sexually traffic a victim or acts otherwise directed against a person's sexuality. Any person can commit SV, regardless of their relationship to the victim and in any setting, including but not limited to home and work.[12]

SEXUAL ASSAULT

Sexual assault is a subcategory of SV and usually includes the use of physical or other force to obtain or attempt to obtain sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vagina or anus with a penis, another body part or object.

VIOLENCE

Violence is the intentional use of physical force or power (threatened or actual) against oneself, another person or a group or community. An act considered to be violence either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. [13]

11 Adapted from IASC, GBV Guidelines, loc. cit., 2005

12 WHO, 'Responding to intimate partner violence', loc. cit., 2013.

13 WHO, 'Global status report on violence prevention', WHO, 2014, p. 2, <http://apps.who.int/iris/bitstream/10665/145086/1/9789241564793_eng.pdf?ua=1&ua=1>, accessed 26 Oct. 2020.

1 | Introduction to sexual and gender-based violence, the PNG context

1 | Introduction; sexual and gender-based violence, the PNG context

Sexual and gender-based violence (SGBV) can occur in every culture and setting, including the home, the workplace, schools, prisons and communities, and cases exist at all levels of society and in every country. The root causes of SGBV include power, control and inequality, and studies from various countries, including PNG, have revealed that SV can affect adults, children and adolescents.

In PNG, SGBV is a common issue that affects many communities. DV (also referred to as IPV) occurs more frequently than other forms of SGBV; however, survivors of such violence often do not seek justice or healthcare, despite the serious risks the victims face. Health consequences of IPV, including physical injuries and psychological trauma, can be severe, and SV perpetrated by an intimate partner, another known perpetrator or a stranger is the most severe form of SGBV, with many cases reporting serious health consequences.

SV can result in unwanted pregnancy, the unsafe termination of a pregnancy, gynaecological and fertility problems and an increased risk of sexually transmitted infections (STIs), such as the human immunodeficiency virus (HIV) and acquired immune deficiency syndrome (AIDS). SV can also lead to an increased risk of dangerous and unhealthy sexual behaviours, such as early and increased sexual involvement and exposure to older or multiple partners. Moreover, violence during pregnancy can affect both the mother and the baby, creating additional risks for the victim.

SGBV also affects mental health, and the consequences can be serious and long-lasting. Survivors are more likely than their non-abused counterparts to experience post-traumatic stress disorder (PTSD), depression, anxiety, sleeping and eating disorders, low self-esteem, a decreased ability to function due to fear, substance abuse and an increased risk of suicide later in life.

In addition to high rates of general SV, PNG has extremely high levels of rape and gang rape. A 2013 United Nations study of community members from the Autonomous Region of Bougainville revealed that 62.4 per cent of male respondents reported having perpetrated some form of rape against a woman or girl, and 14 per cent reported having committed gang rape. [14]

14 E. Fulu, et al., 'Why do some men use violence against women and how can we prevent it? Summary report of quantitative findings from the United Nations multi-country study on men and violence in Asia and the Pacific', UNDP, United Nations Population Fund (UNFPA), UN Women and UNV, September 2013, p. 7, <http://www.partners4prevention.org/sites/default/files/resources/p4p-report-summary.pdf>, accessed 26 Oct. 2020.

Moreover, 33 per cent of women experienced sexual abuse as a child, with 12 per cent having been forced into sex as a child. Additionally, one in five women reported their first experience with sex to be rape.

Several other PNG studies highlight the scope of SGBV in the country:

- The Sade study at the Australian New Guinea Administrative Unit (ANGAU) Hospital conducted in 2002 surveyed 239 SV survivors (98 per cent female and 2 per cent male).[15] The results revealed that 29 per cent of the survivors were raped by more than one man, 57 per cent were under 20 years old, 12 per cent were under 10 years old and 50 per cent were assaulted in the daylight hours. Additionally, 89 per cent had no signs of sexual assault, 55 per cent had genital injuries and 55 per cent had no semen detected. Moreover, 52 per cent of the victims knew their perpetrators.
- According to Dr Seginami's study from 2004–2007 of 445 rape survivors at the Port Moresby General Hospital, 53 per cent were raped at home, 29 per cent were raped by more than one man, 62 per cent had no visible injuries and 69 per cent had no evidence of semen.[16] Moreover, 53 per cent were under 16 years old, 23 per cent were under 10 years old and the youngest was 1 year old.
- The 2007 Lewis et al. study of 400 women at health clinics revealed that the main trigger for violence against women was refusing to have sex or asking their partner to use a condom (80 per cent of DV cases).[17] Half of the women interviewed also expressed they cannot refuse to have sex with their partners without being punished.
- FHI 360 conducted a study on populations vulnerable to HIV and discovered high rates of STIs and HIV within the target populations.[18] According to the data, 58 per cent of men who have sex with men experienced anal sexual assault in the previous year, while 78 per cent of female sex workers reported sexual assault in the previous year. Additionally, 73 per cent of men who have sex with men and 66 per cent of female sex workers reported a non-sexual physical assault in the previous year.
- In the Family Support Centre (FSC) in Lae, data collected by Médecins Sans Frontières (MSF, Doctors Without Borders) from August 2010 to April 2013 illustrated that 5,652 individuals of 6,856 presentations for healthcare services received care. Of the surveyed individuals, 96 per cent were female, indicating that an estimated 4.9 per cent (with a confidence interval of 4.8–5.0 per cent) of females residing in the catchment area participated in the MSF program at least once during the analysis period. Additionally,

15 K. Sade, Study at ANGAU Hospital, 2002.

16 A. Seginami. 'Rape victims at Port Moresby General Hospital Gynaecology Clinic', 2004–2007.

17 B. Lewis et al., 'Final Report on Links Between Violence Against Women and the Transmission of HIV in PNG', National Aids Council Secretariat, November 2007.

18 FHI 360, 'Behaviors, Knowledge, and Exposure to Interventions: Report from a Behavioral Surveillance Survey, Port Moresby, PNG', the United States Agency for International Development/FHI 360, May 2011, p. 1, <https://www.fhi360.org/sites/default/files/media/documents/BSSPNGReportFinal2011.pdf>, accessed 26 Oct. 2020.

10 per cent of the presentations were children under 16 years of age. Of all presentations, 62 per cent reported specific events of IPV (sexual or physical), with 14 per cent reporting specific events of SV outside an intimate partner relationship, 3 per cent reporting other forms of violence and 21 per cent seeking counselling for experiences of past violence. Of the presentations cases for SV outside an intimate partner relationship, 79 per cent reported knowing the perpetrator, and 49 per cent were children under 16 years of age. Overall, 74 per cent of the presentations received medical treatment for physical injuries, while 71 per cent received at least one counselling session.

As these statistics demonstrate, the majority of SGBV survivors in PNG are women, though men and children of both sexes can also be victims. SGBV is a human rights issue as well as a public health issue and causes significant negative effects on the health and the rights of the people affected.

Several international laws and conventions protect the rights of individuals against SV, including the United Nations Universal Declaration on Human Rights, the Convention on the Elimination of All Forms of Discrimination Against Women and the Convention on the Rights of the Child.

The following PNG laws also protect the rights of individuals again SGBV: the PNG Constitution, the Criminal Code and Evidence Act (Sexual Offences and Crimes Against Children) 2002, the Lukautim Pikinini Act 2009 (LPA) and the Family Protection Act 2013 (criminalising DV). The repealed Sorcery Act 2013 and the enacted Trafficking and Smuggling in Humans Act 2013 are also relevant laws concerning SGBV.

The National Department of Health (NDOH) has increased its focus on SGBV within the Public Health's Strategic Directions 3 and 4 (Safe Motherhood and Control of HIV/AIDS and STIs), considering it a major factor affecting the health of women, children and men in PNG. In 2009, the NDOH Secretary instructed health facilities to include SGBV activities in all annual activity plans, including the operation costs of FSCs.[19]
When interacting with survivors of sexual and physical violence, health workers must provide non-discriminatory healthcare and remain inclusive of people with special needs. These National Clinical Practice Guidelines (CPG) were developed to support PNG health workers in achieving the NDOH's objective to provide adequate treatment and care to all survivors of SGBV.

These Guidelines aim to support key target populations, including survivors of all forms of family and partner violence, as well as all forms of SV, as illustrated in the table below. Sorcery accusation violence, as well as trafficking, are two forms of violence that frequently occur in PNG and are included under interpersonal violence.

19 Circular information. November 17, 2009.

TARGET POPULATIONS AND INTERPERSONAL VIOLENCE INCLUDED IN THE GUIDELINES

	FAMILY / PARTNER VIOLENCE			COMMUNITY VIOLENCE	
	CHILD	PARTNER	ELDER	ACQUAINTANCE	STRANGER
PHYSICAL	yes	yes	yes	no	no
SEXUAL	yes	yes	yes	yes	yes
PSYCHOLOGICAL	yes	yes	yes	no	no
DEPRIVATION OR NEGLECT	yes	yes	yes	no	no

2 | Aim and objectives of the guidelines

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THE AIM

These Guidelines aim to assist health professionals in improving health services and providing medical and psychosocial care to SGBV survivors, including women, men and children.

OBJECTIVES

The key objectives of these Guidelines are to provide healthcare workers with:

- Necessary skills, knowledge and information to provide treatment, care and support for survivors of SGBV
- Improved understanding of the importance of providing timely access to medical and psychosocial care
- Skills, knowledge and information required for medico-legal interaction to facilitate the documentation and management of SV cases for medical and legal purposes
- Standards for the provision of both integrated medical and psychosocial services for survivors of SV
- Guidance on safe, confidential and consented referral pathways between multi-sectoral services for survivors of SGBV

3 | Ensuring survivors have access to health services

3 | Ensuring survivors have access to health services[20]

From the first moment of contact and throughout the entire interaction with survivors of SGBV, healthcare providers must apply a survivor-centred approach to every encounter. Such an approach involves prioritising the rights, wishes and needs of the survivors (see Chapters 3.3 and 4) and providing psychological first aid (PFA) from the first moment of contact (see Chapter 7.2).

3.1 | RAISING AWARENESS

Many people are unaware of the potential health consequences of SGBV and thus minimise the necessity of obtaining timely and essential healthcare, as well as psychosocial support, to prevent possible health consequences. This lack of awareness and the potential stigma and social consequences that survivors of SGBV may face often form barriers that prevent survivors from accessing timely healthcare services.
Survivors of SGBV must understand the importance of presenting for medical care as soon as possible, preferably within 72 hours of the incident. Raising awareness, building trust and strengthening linkages within the community and with all relevant sectors will reduce the access barriers that many survivors face.

Intervention strategies:

FSC staff (nurses, community health workers or dedicated health promotion teams) must provide:

- Awareness-raising messages in the waiting areas of hospitals and health centres (HCs). Installing television screens in waiting areas is a common method of addressing SGBV and presenting services offered at FSCs.
- Written information on SGBV in healthcare settings in the form of posters, pamphlets or leaflets. Staff should provide such information in private areas, such as women's washrooms, and include appropriate warnings on taking them home where an abusive partner may see them.
- A dedicated health promotion team, as well as a plan to raise awareness in community areas such as marketplaces, schools, churches or public events

20 For more information, see Chapter 5 (Enabling environment for service provision) of the NDOH of PNG, 'Guidelines for PHA/Hospital Management establishing hospital-based family support centers', Doc Player, 2013, p. 23, <https://docplayer.net/9914862-Guidelines-for-pha-hospital-management-establishing-hospital-based-family-support-centres.html>, accessed 26 Oct. 2020.

Key Advocacy Messages:

Key advocacy messages should reference the five essential services offered to SGBV survivors:

1. Treatment of Injuries
2. PFA
3. Prevention of HIV and STIs, pregnancy, the hepatitis B virus (HEP B) and tetanus
4. Safe referrals, including internal referrals to other specialist medical care providers and external referrals to other service providers (welfare, legal, safe house, police, child protection, counselling and repatriation)
5. Supportive Follow-Up
    - SGBV, including rape, is a medical emergency and must be managed as such.
    - Staff should ensure that the victim understands that SGBV is never the survivor's fault and can happen to anyone, including women, men and children.
    - Staff should provide the location and phone number of free and confidential health services, as well as the phone number of the National Free Hotline (71508000).
    - Staff should provide a free medical report upon the victim's request to report to the police.
    - As per the directive from the Police Commissioner in the circular No. 04/2009, staff must attend to the issue of rape and sexual assault as a criminal offence.
    - To provide the complete continuum of care, staff should encourage survivors to visit an FSC or health facility as soon as possible following an SGBV incident, preferably within 72 hours (three days); however, survivors may seek care at any time.

3.2 | IDENTIFICATION OF SURVIVORS

Providing access to an FSC facilitates the identification of SGBV survivors; however, most survivors do not have access to an FSC and must present to other departments. These departments are often unable to identify survivors and thus do not provide the target patients with the care they require.

Referral pathways for survivors of SGBV include:

- Self-referrals in which the survivor voluntarily presents directly to the clinic or FSC
- Referrals from within the hospital or HC, including accident and emergency (A&E), obstetrics and gynaecology (O&G), antenatal care (ANC) or the Paediatric Ward
- Referrals from outside the hospital, including other health facilities, nongovernmental organisations (NGOs), police, welfare, church organisations, schools or community leaders

Intervention strategies:

Healthcare providers should implement the following strategies when interacting with potential SGBV survivors:

- Healthcare providers must screen survivors on their potential exposure to SGBV when assessing conditions that such violence may cause or complicate; however, providers should not implement universal screening or routine enquiry at this point, such as asking all women of possible exposure in every healthcare encounter.[21] Health workers must be trained to recognise possible 'silent signs and symptoms' of SGBV and be comfortable with asking questions when necessary. Additionally, providers must know how to respond correctly if a survivor discloses an SGBV incident.
- Early and confidential identification of survivors of SGBV at possible referral entry points is essential for ensuring direct referrals to FSCs for medical care and psychosocial support. All staff working at these departments or organisations must be trained and sensitised to provide confidential and appropriate referrals.
- Healthcare staff who are unable to provide appropriate services should refer all identified survivors to an FSC or other department where the survivor can receive the complete continuum of care.

21 WHO, 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', loc. cit., 2013.

Clinical conditions associated with intimate partner violence / SGBV

Symptoms of depression, anxiety, PTSD and sleep disorders include: [22]

- Suicidal or self-harm tendencies
- Alcohol and other substance use
- Unexplained chronic pain
- Unexplained chronic gastrointestinal symptoms
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections
- Adverse reproductive outcomes, including multiple unintended pregnancies or terminations, delayed pregnancy care or adverse birth outcomes
- Unexplained reproductive symptoms, including pelvic pain or sexual dysfunction
- Repeated vaginal bleeding and STIs
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system, including headaches, cognitive problems or hearing loss
- Repeated health consultations with no clear diagnosis
- Involvement of an intrusive partner or husband during consultations

3.3 | RECEPTION OF THE SURVIVOR

Healthcare providers should offer immediate, confidential and survivor-centred support to women, men and children who disclose any form of violence by an intimate partner or other family member or a sexual assault by any perpetrator. First-line, survivor-centred support (at a minimum)[23] includes:

- Offering non-judgemental support and validating what the survivor says
- Providing practical, non-intrusive care and support that responds to the survivor's concerns
- Asking about the survivor's history of violence. The provider should listen carefully but refrain from pressuring the victim to talk. Staff should take care when discussing sensitive topics with survivors who require an interpreter
- Providing survivors with access to information on relevant resources, including legal and social
- Ensuring the safety of the survivor, as well as their children, when necessary
- Providing or referring for social support

22 Ibid.
23 Ibid.

Intervention strategies:

Healthcare workers should implement the following strategies when interacting with potential SGBV survivors:

- Providers should apply a survivor-centred approach and refrain from moving survivors between departments unless necessary. Providers should instead consult relevant experts to visit the survivor in one location, preferably the FSC.
- Providers should maintain confidentiality while also informing the survivors or their guardians (in the case of a minor) of the limits of confidentiality, such as the mandatory reporting of CSA.
- When a child is involved, healthcare providers must consider the best interest of the child at all times.
- Providers should conduct all consultations in private.
- Healthcare providers should refer survivors for any special needs they may have that the health worker is unable to provide.

First-line support[24]

Healthcare workers should offer immediate support to survivors who disclose any form of violence by an intimate partner or other family member or a sexual assault by any perpetrator.

Such support includes:

- Conducting the consultation in private
- Ensuring confidentiality while also informing the survivor of the limits of confidentiality, such as cases of mandatory reporting
- Remaining non-judgemental and supportive and validating what the survivor says
- Providing practical, non-intrusive care and support that responds to the survivor's concerns
- Asking the survivor about their history of violence, listening carefully and refraining from pressuring them to talk. Health workers should take care when using interpreters to discuss sensitive topics.
- Providing the survivor with access to information on relevant resources, including legal and social support
- Ensuring the safety of the survivor and their children, when necessary
- Providing or referring social support

24 WHO. 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', 2013.

4 | Establishing the initial interaction with Survivor of SGBV

4 | Establishing the initial interaction with Survivor of SGBV

To support survivors of SGBV, healthcare providers must provide accurate and appropriate information to enable survivors to make informed decisions and give informed consent. Such support allows the survivor to regain a sense of control and is an essential aspect of the survivor-centred approach.

Health workers should provide survivors with:

- Assurance of confidential care
- Information on the services offered by the FSC or point of service
- Information on the value of full treatment and follow-up visits
- Information on the survivor's rights
- Assurance of safety
- Options available to the survivor
- Assurance that the survivor's best interests will be at the centre of the care and treatment provided, though the survivor may reject any offered service
- Options of referrals to other agencies with the informed consent of the survivor
- Options of referrals to other agencies with the informed consent of the survivor[25,26]

Consenting process

Healthcare workers should implement the following process when obtaining informed consent:

- Informed consent requires the healthcare providers to present the survivor or legal guardian (in the case of a minor) with relevant and accurate information and discuss their available choices. The survivor or legal guardian must understand the presented information.
- Healthcare providers should ask survivors to give their consent for every aspect of the continuum of care, including obtaining their history, conducting physical examinations, conducting investigations, providing physical and mental health treatment, providing referrals to other agencies, conducting follow-up visits and preparing medical reports. Healthcare providers must also inform survivors that they are free to withdraw their consent to any or all components of the continuum of care at any time.

25 Within the limitation of the law or best interest of the survivor and community (public health).

26 For detailed guidance on the consenting process for children, see Chapter 11.

- Healthcare providers must obtain the express consent of the survivor for any report released to other agencies, such as welfare organisations, police (see Annex 3), faith-based organisations and NGOs.

When interacting with survivors of SGBV, healthcare providers must remember to:

- Conduct an initial assessment of the survivor's vital needs.
- Prioritise immediate treatment to meet the survivor's physical needs, such as first aid; however, healthcare providers must also initiate psychological support as soon as possible. If there are no urgent physical medical needs, health providers should provide PFA immediately.
- Provide appropriate and non-judgemental emotional support to the survivor and practice active listening.
- Remain sensitive to the emotional reactions of the survivor, as every person reacts differently to emotional trauma. Health providers should assure survivors that their reaction to the trauma they experienced is normal and understandable.
- Ensure the survivor's autonomy and right to make his or her own decisions. The initial point of care is a crucial time to begin the healing process, and healthcare providers must ensure that the survivors feel in control throughout the entire continuum of care.
- Invite the survivor to ask questions at any time and regularly check how he or she is feeling.
- The person who makes first contact with the survivor should not pressure them to speak; however, they should remain physically present if he or she wishes to talk until the primary healthcare provider arrives.

The person who makes first contact with the survivor should not pressure them to speak; however, they should remain physically present if he or she wishes to talk until the primary healthcare provider arrives.

FLOW CHART OF CARE FOR SEXUAL VIOLENCE SURVIVORS

1

- Receive the SGBV survivor
- Conduct triage and assess the survivor's urgent medical needs
- Immediately begin conducting PFA

2 **Take history**

3

Within 72 hours (up to three days) after the incident:

- Conduct a physical examination
- Provide care for physical injuries
- Conduct a pregnancy test and checklist for a pre-existing pregnancy
- Provide emergency contraception (EC)
- Prescribe STI treatment and prophylaxis
- Offer HIV counselling and testing (HCT) and provide post-exposure prophylaxis (PEP) to prevent HIV
- Provide vaccinations for HEP B and tetanus

Between 72 and 120 hours (three to five days) after the incident:

- Conduct a physical examination
- Conduct a pregnancy test and checklist for a pre-existing pregnancy
- Provide EC
- Prescribe STI treatment and prophylaxis
- Offer HCT
- Provide vaccinations for HEP B and tetanus

More than 120 hours (five days) after the incident:

- Conduct a physical examination
- Ascertain if the survivor is pregnant by rape (after two weeks)
- Provide counselling when necessary
- Prescribe STI treatment and prophylaxis
- Offer HCT
- Provide vaccinations for HEP B and tetanus

4

- Identify red flags and offer counselling if necessary
- Apply watchful waiting if no red flags are identified (see Chapter 7.7)
- Offer a medical report
- Develop a follow-up plan
- Ensure that all medical files are completed and remain confidential

5 **Refer the survivor to other services as appropriate**

5 | Medical interview

5 | Medical interview

Obtaining the medical history of the SGBV survivor is necessary to understand the context of the situation and provide timely and appropriate medical care. The healthcare provider should look for symptoms resulting from the event, such as bleeding or vaginal or anal discharge, and note the location of bruises or any other symptoms resulting from the attack.

For SV survivors, the patient's medical history is needed to determine if there has been penetration and, if so, where, how and under what circumstances. The healthcare provider should also obtain insight on additional symptoms, depending on the patient's history, such as trauma to any part of the body, particularly the head or abdomen.

If the attack occurred in the past, the survivor might exhibit sequelae, or long-term effects, such as a traumatic fistula with uncontrollable loss of urine or faeces, irregular menstrual cycles, pregnancy or abortion, or vaginal haemorrhage.

Survivors (male or female) may also suffer from sexual disorders, such as pain during intercourse, impotence or anal pain. Constipation or encopresis (faecal incontinence in children) can also result from rape.

Case clerking format method:

- Presenting complaint
- History of presenting complaint
- Past medical history
- Medical examination
- Management:
  - Investigation
  - Treatment
  - Referral
- Follow-up

During the medical interview, the healthcare provider should:

- Ensure that the survivor stays in control.
- Explain to the survivor the purpose of the interview and examination (e.g., to understand the circumstances of the rape or assault in order to provide quality medical care).
- Obtain informed consent from the survivor.
- Ask about previous incidents of violence.
- Ask if there are children in the family who witnessed the violence and determine if the event affected them.
- As this may be the only encounter the healthcare provider has with the survivor, maintain a compassionate and respectful approach to establish trust, including practising active listening and informing, supporting, examining and treating the survivor at his or her own pace.

It is preferable that the healthcare provider is of the same sex as the survivor (gender-specific service); at the very least, healthcare providers should offer this choice to the survivor. If the care provider is of the opposite sex, another healthcare provider (or a relative if another healthcare provider is unavailable) of the same sex as the survivor should be present throughout the care process to provide support to the patient.

If the survivor is alone, the healthcare provider should ask if there is someone the survivor would like to have present during the examination. All health professionals should be cautious if the survivor is a child, as the perpetrator may be the person accompanying the patient. If the survivor arrives with another person, the healthcare provider should take the patient aside to check whether he or she wishes for the companion to be present during the consultation.

6 | Physical examination

6 | Physical examination

The physical examination aims to identify the medical care each survivor requires.

During the physical examination, the collection of forensic evidence is not recommended, as there is no laboratory capacity in PNG to process forensic samples. Furthermore, the collection of spermatozoa does not provide significant evidence of rape, nor does the absence of spermatozoa prove a lack of sexual activity. If spermatozoa collection is indicated and the institution has laboratory capacity, then proceed to collection of spermatozoa (see Chapter 9).

During each physical examination, health providers should maintain the following general considerations:

- Ensure ready access to all necessary supplies; however, do not unpack any medical instruments prior to the consented examination. Health providers may store all supplies, including documentation, in a designated box in each consultation room.
- Wear gloves during the genital examination and when attending to wounds.
- Inform the survivor of every step of the examination and ask permission before proceeding (e.g., 'I will now touch your leg. Is that all right?').
- Respect the patient's modesty by covering their body appropriately so as to expose only the area being examined.
- Be conscious of and sensitive to the response of the survivor during the examination.
- Start with a general physical examination (vital signs and top-to-toe examination).
- Assess and document the survivor's general appearance and mental status.
- Include a detailed examination of the scalp, mouth, ears, forearms, wrists and ankles.
- Check for bite marks or finger and fingernail bruises on the neck, nipples and breasts.
- Conduct the genital exam last, only when indicated and after obtaining informed consent
- Document the findings on the Medical Examination Form and indicate necessary information on the drawings. This can be shown to the survivor.

Physical signs of rape are less likely to exist on the survivor's body (genital region) if the attack occurred more than one week prior to the examination. During the physical examination, the healthcare provider should note the size and colours of any bruises and scars. As comfort and reassurance for the survivor play an important role in his or her well being, it may be appropriate to conduct a full physical examination.

EXAMINATION OF THE GENITAL AREA (ONE WEEK AFTER THE ASSAULT AND ONLY IF MEDICALLY INDICATED): FEMALE EXAMINATION

Only conduct a genital examination if the survivor's history and the circumstances surrounding the event indicate the need to do so. Additionally, the provider must ask for and obtain consent from the survivor (or guardian of the survivor in the case of a minor) before conducting a genital examination.

The medical provider should conduct the genital examination last to allow for time to establish a rapport and encourage trust with the survivor.

The service provider should systematically inspect the genital area, following the outlined order:
Avoid conducting a speculum exam unless there are indications of internal

- Mons pubis
- Inside of the thighs
- Perineum
- Labia majora and minora
- Clitoris
- Urethra
- Introitus
- Hymenal remnants

Note: there is often no identifiable damage to the perineal area.
During the examination, use the accompanied pictogram in the Medical

Examination Forms (see Annex 2) to note:

- Scars from female genital mutilation or childbirth
- Injuries, such as lacerations, bruises, abrasions or tears (especially on the posterior fourchette)
- Signs of infection (ulcers, discharge or warts)
- Injuries to the introitus and hymen (hold the labia majora between the thumb and index finger at the posterior edge and gently pull them outwards and downwards)

gynaecological trauma that requires further investigation and possibly medical intervention. If the survivor is experiencing bleeding or pain, or if there is the suspected presence of a foreign object, the healthcare provider should treat the situation accordingly, referring the patient to a hospital or O&G division when necessary.

If indicated by the survivor's history or the circumstances of the event, the healthcare provider should examine the anus, noting the dilation, shape and crevices of the anus and the presence of faecal matter in the perineal area, bleeding or rectal injuries.

SPECIAL CONSIDERATIONS

Children and prepubertal girls

For children and prepubertal girls, healthcare providers should consider the following points:

- Never conduct a speculum examination on a prepubertal girl.
- If a penetrating vaginal injury or internal bleeding is suspected, refer the patient to O&G division for the examination, preferably under anaesthesia.
- For anal examinations, always ask the child to lie on one side.
- Hymenal tears are more common in children and adolescent girls.

Elderly (post-menopausal) women

For elderly (post-menopausal) women, healthcare providers should consider the following points:

- Elderly women who have been raped are at increased risk of experiencing vaginal injuries and STIs, including HIV.
- Due to the oestrogen deficiency in post-menopausal women, there will likely be vaginal dryness, reduced elasticity and vaginal atrophy, causing the greater potential for trauma. If there is a medical indication to conduct a speculum exam, use a thin, well-lubricated speculum.

Men:

For men, healthcare providers should consider the following points:

- If the survivor's history and circumstances of the event indicate (as per the female survivor's guideline), examinations should include checking the scrotum, testicles, penis, foreskin, frenulum, peri-urethral tissue, urethral meatus, hips, buttocks, thighs, neck and mouth.

- Note all instances of hyperaemia, swelling, torsion of testicles, bruising, tears and bites.
- Note any blood in the urine and check for penile or urethral trauma.
- If the survivor's history or circumstances of the event indicate anal penetration (by a penis or foreign object), conduct an anal examination and check the rectum for signs of trauma and infection.
- Note the dilation, shape and crevices of the anus and the presence of faecal matter in the perineal area, bleeding or rectal injuries.

Potential difficulties

Parents or guardians of the survivor may request a physical examination for an underaged (younger than 18 years old) girl who they claim has been raped. Still, if she claims that sex was consensual with a partner within her own age range then, the healthcare providers are advised not to proceed with the examination.

Health professionals cannot examine clients (both adults and children) without their consent (medical ethics). If the survivor is a minor, his or her guardians have the legal right to give consent; however, the best interest of the child is more important than the wishes of their guardian, as the guardian's wishes may create harmful consequences for the survivor. An examination is only necessary to identify health concerns and provide the best medical care for the survivor.

It is not the healthcare providers' role to make conclusions about the circumstances of the incident, nor to establish through a medical examination whether a person has had sexual intercourse. Take the time to talk with the survivor and his or her parents or guardians about their rights and the role of the healthcare provider.

In some instances, parents or guardians may request a physical examination and use the report for compensation purposes without the survivor's consent. Healthcare providers must not allow such practices to interfere with their primary role of providing the best treatment, care and support for the survivors.

Healthcare providers should only conduct a physical examination if required and only with the informed consent/assent of the survivor for the purposes of providing care and support.

7 | Forensic Evidence

7 | Forensic Evidence

Healthcare providers should not collect semen or conduct speculum examinations solely for the sake of finding forensic evidence, as it may be traumatic for survivors to undergo such examinations after having been raped. Additionally, there is no evidence that such examinations have ever led to significant legal outcomes in PNG.

When conducting forensic investigations, WHO recommends that healthcare providers consider the following points:

- » Forensic evidence may support the survivor's story, confirm recent sexual contact, indicate that the perpetrator used force or coercion and possibly identify the attacker.
- The proper collection and storage of forensic evidence may be essential to a survivor's success in pursuing legal redress.
- Healthcare providers should consider the existing mechanisms of legal redress and the local capacity to analyse specimens when determining whether to offer a forensic examination to a survivor. Providers should also consider the requirements and capacity of the local criminal justice system and the capacity of local laboratories to analyse evidence. ***Do not collect evidence that cannot be processed or that will not be used.***[27]

The collection of semen as forensic evidence does not completely prove that rape occurred, as other scientific advancements may not be able to prove beyond reasonable doubt that the semen belongs to the perpetrator.

Forensic evidence collection is only relevant if laboratories can conduct DNA testing (which is currently not available in PNG) and if the country's legal system can interpret the meaning of the presence or absence of forensic evidence appropriately.

27 WHO, UNFPA, UNHCR, 'Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons, revised edition', WHO/UNHCR, 2004, p. 1, <https://apps.who.int/iris/handle/10665/43117>, accessed 26 Oct. 2020.

8 | Provision of medical care

8 | Provision of medical care
(See flowchart in Annex 6)

All survivors of SGBV require medical first aid to treat physical injuries, vaccinations for HEP B and tetanus, if required, as well as PFA. Survivors of rape require additional interventions to prevent STIs, including HIV, and unwanted pregnancies.

Intervention	Survivors presenting within 72 Hours (<3 days)	
	Women/girls	Men/boys
Physical injuries	Clean and repair the wounds (for traumatic fistulas, refer to specialist care)	Clean and repair the wounds
Psychological First Aid	Yes	Yes
Determination of pregnancy	Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A
Emergency contraceptives	Give within 120 hours of the rape if the survivor is of reproductive age (menstruating)	N/A
Termination of unwanted Pregnancy	N/A	N/A
Prophylaxis of STI	Yes	Yes
Prevention of HIV	Yes	Yes
HIV testing	Recommended	Recommended
TT Vaccination	Vaccinate according to the risk and pre-exposure vaccination status	Vaccinate according to the risk and pre-exposure vaccination status
Hepatitis B Vaccination	Vaccinate according to protocol	Vaccinate according to protocol

There is a crucial difference in the provision of medical care for rape survivors who present for healthcare services within 72 hours (three days) of the incident, those who present between 72 hours and 120 hours (three to five days) of the incident, and those who present more than 120 hours (five days) after the incident. For all survivors, document the examination findings on the Medical Examination Form, including the drawings. The information on the form can be shown to the survivor.

Survivors presenting 72 – 120 Hours (3 – 5 days)		Survivors presenting after 120 Hours (>5days)	
Women/girls	**Men/boys**	**Women/girls**	**Men/boys**
Clean and repair the wounds (for traumatic fistulas, refer to specialist care)	Clean and repair the wounds	Clean and repair the wounds (for traumatic fistulas, refer to specialist care)	Clean and repair the wounds
Yes	Yes	Offer basic counselling	Offer basic counselling
Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A	Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A
Give within 120 hours of the rape if the survivor is of reproductive age (menstruating)	N/A	No	N/A
Offer termination of pregnancy options	N/A	Offer termination of pregnancy options	N/A
Yes	Yes	Yes	Yes
No	No	No	No
Recommended	Recommended	Recommended	Recommended
Vaccinate according to the risk and pre-exposure vaccination status	Vaccinate according to the risk and pre-exposure vaccination status	Vaccinate according to the risk and pre-exposure vaccination status	Vaccinate according to the risk and pre-exposure vaccination status
Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol

8.1 | TREATMENT OF WOUNDS AND OTHER INJURIES

(See flowchart in Annex 6)

For all patients, the healthcare professional should treat injuries according to the standard National Treatment Guidelines. Use the medical interview and history of the patient and event to guide the examination and check the survivor for injures such as wounds, fractures or internal trauma.

Healthcare professionals should be aware of:

- Possible infections from wounds; symptoms include fever, purulent discharge and pain.
- Severe abdominal trauma; symptoms include a perforated recto-sigmoid, posterior fornix and anterior bladder damage.
- Possible traumatic fistula. The physical effects of rape may be aggravated if the perpetrator has inserted foreign objects into the vagina, which can create a hole between a woman's vagina and bladder or rectum (or both), leading to uncontrollable loss of urine or faeces. Healthcare workers should refer to O&G if they suspect a fistula. Additionally, health providers should involve the partner in the referral process and offer counselling to both the survivor and the partner, as social implications of such a condition, though rare, can be serious.
- Possible pain the survivor may be experiencing. Pain is a subjective sensation that only the patient can assess, not the healthcare provider.

8.2 | PROVIDING PFA

(See flowchart in Annex 6)

PFA is an essential component of providing care for an SGBV survivor and should begin the moment he or she presents at the healthcare facility. PFA requires a compassionate, non-judgemental and supportive approach.

The principles of PFA[28]

The three basic action principles of PFA are look, listen and link. These action principles will help guide how you approach SGBV survivors and understand their needs, and link them with practical support and information.

Look

- Check the safety of the survivor.
- Check for obvious urgent basic needs.
- Check for serious distress reactions.

28 Adapted from WHO, 'Psychological first aid: Guide for field workers', WHO, 2011, p. 18, <http://apps.who.int/iris/bitstream/10665/145086/1/9789241564793_eng.pdf?ua=1&ua=1>, accessed 26 Oct. 2020.

Ask questions to ensure that the survivor has a safe place to which they can return after their visit to the health facility. If they do not have such a safe space, organise an alternative to provide them with some safety measures. Organising a safe space may involve liaising (with the individual's consent) with community workers or protection agencies, such as safe houses, a Case Management Centre, child welfare or LPA officers. If the individual has dependents and is unable to care for them due to the current situation, assist the survivor in devising a plan for their short-term care and protection.

Listen

Listening properly to survivors is essential for understanding their situation and needs, helping them feel calm, and offering appropriate help and support.

Healthcare providers must learn to listen with their:

- **Eyes** by giving the person their undivided attention
- **Ears** by truly hearing their concerns
- **Heart** by showing respect and proving they care

When a survivor seeks support, healthcare providers should:

- Be respectful
- Introduce themselves
- Ask how they can help
- Ensure a private, safe and confidential space to talk
- Help the survivor feel comfortable (e.g., by offering a glass of water)

The health worker should ask the survivor about their needs and concerns. Although some needs may be obvious, always ask in order to establish trust and give the survivor a sense of control. Find out what is most important to them at that moment and help them determine what their priorities are.

Restoring control

SGBV is an extremely disempowering experience. The health provider should focus on empowering the survivor wherever possible and restoring a feeling of control over his or her body by asking for consent before each step of the medical exam. To avoid further victimization, the provider should not diminish the survivor's control over the situation by talking about the case without his or her consent or making decisions for the survivor.

Listen to the survivor and help him or her to feel calm by:

- Staying close to the survivor, but maintaining the right distance as staying too close may feel physically threatening
- Not pressuring the survivor to talk
- Listening if the survivor wants to talk about what happened

Help survivors feel calm

Some survivors may feel anxious, upset, confused or overwhelmed and may have some physical reactions to the trauma they have experienced, such as shaking or trembling, difficulty breathing or a rapid heartbeat. Healthcare workers should employ the following techniques to help distressed patients feel calm in their mind and body:

- Speak in a calm and soft voice.
- Remind the survivor that he or she is safe and that you are there to help.
- If the patient feels 'unreal' or disconnected from their surroundings, help them connect with their current environment and themselves. Ask the survivor to:
  - Place their feet on the floor and feel the ground on their feet
  - Tap their fingers or hands on their lap
  - Focus on non-distressing elements in their surroundings using their senses
  - Tell you what they see and hear
  - Focus on their breathing and take deep, slow breaths

Link

Survivors may feel vulnerable, isolated or powerless after a distressing event such as SGBV. Linking the patient to practical support is an essential element of PFA. It is important to remember that PFA is often a one-time intervention, and healthcare workers may only be available to help the survivor for a short time. The patient will need to use personal coping skills to recover in the long term; however, linking the survivor to relevant and practical support services may help them following the initial visit to the health facility.

Help survivors to help themselves and regain control of their situation by:

- Addressing basic needs and accessing multi-sectorial services. Immediately after a crisis event, help the survivor meet his or her basic needs. Learn what specific needs the survivor requires, such as social support, a safe house, justice services or transportation, and link them to available services that may meet those needs.help available.
- Coping with problems and trauma. Following a traumatic event, the survivor may feel overwhelmed with worries and fears. Healthcare workers should support the survivor in considering his or her most urgent needs and developing a plan to prioritise and address those

needs. For example, ask the patient to think about what they need to address now and what can wait until later. Being able to manage a few issues immediately will give the survivor a greater sense of control over the situation and strengthen their ability to cope in the long term.

When supporting the survivor, the healthcare professional must remember to:

- Support survivors in identifying a support circle, such as friends or family, who can help them through the current situation. Give practical suggestions for survivors to meet their own needs, such as explaining how to report the assault to the police.
- Ask the survivor to consider how they coped with difficult situations in the past and affirm their ability to cope with the current situation.
- Ask the survivor what helps him or her feel better during difficult situations. Encourage them to use positive coping strategies and avoid negative coping strategies without being judgemental about the survivor's process.

Providing accurate information is essential to help the survivor find relevant and supportive services. This information includes legal options, necessary immediate medical care, possible social and psychological reactions, and supportive networks. Do not overwhelm the patient with information; rather, encourage them to ask questions. Healthcare workers should always differentiate information from advice; it is important that survivors feel empowered to make their own decisions based on the available information rather than being advised on what they should do.

Studies have proven that people with access to adequate social support following a crisis cope better than those who do not feel well supported. In addition to connecting survivors with relevant services, PFA includes connecting patients with loved ones and social support.

Reassurance

It is important for survivors to understand that they experienced abnormal events and that their emotional reaction to those events is normal. Many cultures blame the victim, and there are several myths, false beliefs and misconceptions surrounding SGBV. Health providers may address those cultural misconceptions during the consultation to reassure the survivor. If the individual expresses feelings of shame or guilt, be sure to address them directly. Healthcare workers should communicate explicitly that SGBV is not the survivor's fault but rather the fault of the perpetrator. The survivor's behaviour or style of dress or any other action on their part did not provoke the violence.

Stimulation of structure

While it is understandable that a survivor of SGBV becomes inactive, re-starting normal daily activities and structure should be encouraged.

Medication

Should be reserved for situations of extreme distress and should be used only on a short-term basis. In situations where the survivor is in extreme distress, it is important to refer to a specialist or an MD for further evaluation.

Watchful waiting

Watchful waiting involves explaining to the survivor that he or she is likely to improve over time and offering regular follow-up appointments to provide further support.

Unless the survivor is depressed, suicidal or self-harming, shows signs of alcohol or drug use problems, reveals psychotic symptoms, or expresses difficulties in functioning in daily tasks, the healthcare provider should apply watchful waiting for one to three months following the SGBV event.[29]

Identification of red flags

During the initial consultation, the health worker must identify 'red flags' that indicate the need for a referral for further mental health support. The red flags include:

1. Thoughts or plans to hurt themselves, including **self- harm**, such as cutting fingers, or thoughts or plans to commit suicide. Healthcare workers should also be watchful for patients who want or plan to hurt other people.
2. Being so upset that the survivor is **careless** and cannot care for themselves. This behaviour can include not eating, drinking or sleeping or being unable to work or take care of the household. Healthcare workers should also be watchful for survivors who are unable to take care of their children, including the inability to provide for the child's basic needs (food, drink, sleep and safety), a lack of emotional attachment to the child and the inability to practice parenting.
3. **Disorientation**, including an inability to give informed consent. This behaviour can manifest in survivors who are in shock, as well as children or mentally disabled individuals who lack a sustainable network.
4. Signs of psychiatric problems, such as depression, PTSD, anxiety or schizophrenia.
5. Signs of distress (behavioural, emotional, physical or cognitive). Such survivors may request help.

29 WHO, 'Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines', loc. cit., 2013.

Examples of distress:

Behavioural	Emotional	Physical	Cognitive
» Extreme disorientation » Excessive drug, alcohol or prescription drug use » Isolation or withdrawal » High-risk behaviour » Regressive behaviour (feelings of revenge) » Separation » Violent behaviour » Being alert, 'on guard' or jumpy » Not responding to others or not talking » Chronic agitation or irritability	» Crying » Feelings of depression » Acute stress reactions » Acute grief reactions » Feelings of sadness » Feelings of fear or anxiety » Feelings of anger » Feelings of hopelessness » Feelings of guilt or shame » Feeling emotionally numb or being unable to identify what they feel	» Shaking » Loss of appetite » Headaches » Stomach aches » Difficulty with sleeping » Difficulty with eating » Fatigue, exhaustion or extreme tiredness » Physical complaints without medical reasons	» Thinking that something bad will happen » Confusion or disorientation (not knowing basic information about themselves) » Nightmares » Intrusive thoughts or images » Difficulty with concentrating » Difficulty with remembering » Difficulty with making decisions » Suicidal thoughts » Negative thoughts about themselves

Healthcare workers should provide information on counselling to each survivor after implementing PFA (see Annex 4).

8.3 | PEP OR HCT WITHIN 72 HOURS OF EXPOSURE

(See flowchart in Annex 6 and follow-up table on page 110)

According to WHO guidelines (2007), PEP refers to 'the set of services that are provided to manage the specific aspects of exposure to HIV and to help prevent HIV infection in a person exposed to the risk of getting infected by HIV. These services might comprise first aid, counselling including the assessment of risk of exposure to the infection, HIV testing, and depending on the outcome of the exposure assessment, the prescription of a course of antiretroviral drugs, with appropriate support and follow-up.'

- Potential exposure to HIV during rape is a medical emergency, and health providers should offer and begin PEP for survivors who present within 72 hours after rape with proven or possible exposure to infection (with negative HIV result if counselling and testing were completed).
- Administering PEP within four hours of the incident is ideal; however, PEP may be started up to 72 hours after the incident. Health providers should not provide PEP more than 72 hours post-exposure, as there is no evidence of its effectiveness after this time.
- Health providers must administer the first dose during the consultation to assist the survivor in taking the drugs and identify any side effects that may occur.

If the health facility does not have access to PEP, the healthcare worker should provide other relevant services and refer the patient as soon as possible (within 72 hours) to the closest facility that can provide PEP (preferably an FSC).

Risk assessment:

The healthcare provider must assess the risk of HIV transmission based on the information provided by the survivor. The risk levels are as follow:

Proven risk: vaginal and anal penetration[30]

Possible Risk: oral penetration with ejaculation; presence of the perpetrator's blood in the mouth or an open wound (if the survivor has bitten the perpetrator or been bitten by the perpetrator)

No Risk: kissing; digital penetration or penetration by a foreign object in the vagina, anus or mouth; ejaculation onto intact skin

30 Risk after a single (and non-violent) receptive vaginal sex act is 0.1 to 0.3 %; insertive vaginal sex 0.03 to 0.09 %; receptive anal sex 0.1 to 0.3 %, and insertive anal sex 0.03 %; J. Bamberger and Al. Am. J. Med 1999; 106323-326. However, a rape typically involves a level of violence and trauma (and consequently blood and genital secretions contact) much higher than that for normal sexual intercourse.

The risk of HIV transmission increases if:

- Blood is present
- The perpetrator is suspected of having an STI or HIV
- The survivor has an STI
- The survivor is an adolescent girl, as the immaturity of the vaginal and cervical cells increases the susceptibility to HIV infection
- The survivor experienced vaginal, anal or oral lesions or injuries, specifically if the individual is a child, virgin or older person
- Ejaculation occurred
- Gang rape or multiple penetrations occurred
- The survivor is menstruating

In the case of possible exposure (based on the above risk assessment), healthcare providers should offer PEP to the survivor. The healthcare worker should base the risk assessment primarily on the events that occurred during the attack; however, to maintain caution, treat each case as though the assailant is HIV positive.

Whenever possible, health workers should begin PEP at the earliest opportunity within 72 hours of the incident. If necessary, the provider should begin PEP without conducting the HIV test, as the provider can offer and discuss HCT during the next follow-up visit. However, before initiating PEP, HCT is recommended (but not required).

If the survivor presents shortly after the incident and is too traumatised to undergo HIV provider-initiated counselling and testing (PICT), the health worker should not initiate HIV PICT during the first encounter.

N.B.: The healthcare provider should document clearly why HIV testing was not conducted (e.g., the survivor declined HIV testing or was incapable of providing proper informed consent due to psychological trauma). For issues related to obtaining child consent, refer to page 79 on minor consent.

Healthcare workers should provide the following information to the survivor, taking into account the person's age, literacy skills and level of education:

- Risks of HIV transmission and the potential benefits of PEP
- Treatment regimens, including the duration and possible side effects. Inform the patient that side effects often subside after a few days.

Additionally, most side effects are mild, and survivors rarely require an interruption in their medication regimen.

- Description of adverse events that require immediate medical attention
- Benefits and importance of adhering to the treatment, even if the patient experiences side effects. Patients should report side effects to clinic staff rather than stopping treatment before the regimen is complete. Health providers may recommend symptomatic treatment for side effects with anti-emetics or anti-motility drugs. Additionally, patients may reduce side effects on their own by taking the medicine with food.
- Benefits and importance of attending scheduled follow-up visits

Healthcare providers should also obtain consent for PEP treatment from the survivor and ensure that the patient undergoes adherence counselling.

Ensuring Adherence to PEP

It is crucial for the survivor to complete the full 28-day PEP regimen, and healthcare professionals should implement strategies to support the survivor in remaining on treatment. The use of community engagements, comprehensive survivor education and other methods may facilitate adherence.

If the survivor experiences repeated rape or a second rape while undergoing PEP, continue the treatment for 28 days from the date of the most recent episode. If the survivor finished PEP before experiencing a second SGBV event, begin another 28-day course.

If the survivor is a pregnant woman, the healthcare provider should consider additional risks. If there is HIV transmission during pregnancy, the consequent acute HIV infection carries a high risk of transmission to the foetus or newborn, as recent infections usually experience high viral loads. Healthcare workers should include this information in the health education component of the consultation and inform the survivor of how best to complete the 28-day PEP regimen.

Routine laboratory testing

Routine testing with a full blood count and liver enzymes for survivors on PEP is not required.

PEP for adults, adolescents and children ≥30 kg

Category	First choice	Alternate choice
Adult & adolesents	tenofovir (TDF) + lamivudine (3TC) + dolutegravir (DTG)	TDF + 3TC + lopinavir (LPV/r)
Children ≥30 kg body weight	tenofovir (TDF) + lamivudine (3TC) + dolutegravir (DTG)	TDF + 3TC + lopinavir (LPV/r)

- Generally, the first choice (TDF + 3TC + DTG) regimen should be selected.
- As part of comprehensive PEP services, all adolescent girls and women should be offered pregnancy testing at baseline and during follow-up. EC should be offered to girls and women as soon as possible within five days of the sexual exposure and information provided on the risks (including the potential risks of neural tube defects) and benefits of DTG.
- For women and adolescent girls who do not want to take EC or DTG, an alternative antiretroviral drug (LPV/r) should be provided.
- If a TDF-containing regimen (TDF + 3TC) is not possible for clinical reasons (e.g., renal failure, glomerular filtration rate <50 ml/min), a zidovudine (AZT)-containing nucleoside/nucleotide reverse transcriptase inhibitors (NRTI) backbone (AZT + 3TC) can be considered. Assess for anaemia with hemocue if available. If hemocue is not available, please use clinical assessment for anaemia and avoid AZT only if anaemia is strongly suspected. If baseline anaemia, repeat the haemoglobin at two weeks for those patients on AZT as AZT can cause life-threatening anaemia if given forfour weeks.
- Tenofovir is not recommended in children weighing less than 30 kg. Nevirapine should not be used for PEP among children over 2 years old, adolescents and adults.

PEP for children ≥20 kg to <30 kg

Category	First choice	Alternate choice
Children ≥20 kg to <30 kg body weight	AZT + 3TC + DTG	Abacavir (ABC) + 3TC + DTG

PEP for children 20 kg or less

Category	First choice	Alternate choice
Children <20 kg body weight	AZT + 3TC + LPV/r	ABC + 3TC + LPV/r

*LPV/r should not be used for premature babies and babies less than two weeks old

PEP side effect management

For detailed information on PEP side effect management, refer to the NDOH PNG National Guidelines for HIV Care and Treatment (pages 37 - 42). The main side effects healthcare providers should consider are:

1. Nausea
2. Neuro-psychiatric symptoms
3. Headache

Provider-initiated counselling and testing

(See flowchart in Annex 6 and follow-up table on page 110)

Rape is a traumatic event, and healthcare providers must practice sensitivity when exploring the implications of HIV, either as a pre-existing condition or as a result of the sexual assault. Providers should always consider HCT as part of the continuum of care; however, if HCT is unavailable, providers can and should offer PEP (if indicated).

The benefits of knowing the survivor's HIV status prior to starting PEP include:

- Not requiring PEP if the survivor is already HIV positive
- Not attributing HIV acquisition to the rape and unnecessarily exacerbating the trauma from the event if the survivor is already HIV positive
- Providing reassurance and possible motivation to begin and complete the PEP regimen if the survivor is HIV negative
- Mitigating the risk of developing a resistance to antiretroviral therapy (ART) if the survivor is already HIV positive

According to the NDOH guidelines, healthcare providers should remain sensitive and careful when offering HCT for rape survivors. Providers should ensure privacy and confidentiality, offer testing, and ensure the provision of pre-test information.

For HCT of minors, refer to the section on consent for patients under 16 years of age.

Training and clinical supervision are essential requirements for all practising HCT staff that enable proper monitoring, quality improvement and professional development.[31] For staff working with rape survivors, improving dialogue skills and undergoing training is a continuous process; however, it is necessary to support the patient. A healthcare worker's capacity to open a dialogue with the survivor to discuss their ability and motivation to adhere to the regimen is essential for maintaining adherence and providing pre- and post-HIV counselling, if necessary.

Healthcare workers should administer rapid HIV testing according to the PNG NDOH Guidelines and Algorithm. Conduct the HIV determination test first and, if the patient is positive, confirm the results with the Stat Pack (see Annex 6).

If the survivor is determined to be HIV positive, do not offer PEP to the patient; the healthcare worker should instead refer the survivor to an Integrated Management of Adult and Adolescent Illness trained care provider to manage HIV care and treatment.

In the event of discordant results, health workers should follow the NDOH HIV testing interpretation algorithms. While the staff interpret the results, the primary healthcare provider should administer PEP immediately and repeat the tests in one week. After one week, if both tests are positive, refer the patient to an ART prescriber. If the results remain discordant or are negative, continue PEP. Note that most discordant results are revealed to be negative, and seroconversion linked to the sexual assault will not be evident at 72 hours. [32]

If the survivor has not undergone an HIV test prior to initiating PEP, the healthcare provider should conduct the test while administering PEP.

- If the HIV test is negative, continue PEP for 28 days.
- If the HIV and confirmation tests are positive, continue PEP and refer the patient to the nearest health facility with an Integrated Management of Adult and Adolescent Illness trained ART prescriber. The prescriber will discuss the outcome of the HIV test with the survivor and provide medical care, including any necessary complementary examinations and continued ART, if the survivor is eligible. While awaiting a referral to the nearest ART facility, the healthcare worker should provide co-trimoxazole prophylaxis and information, education and communication

31 If PEP is to be provided to a survivor of SGBV it must be done by an NDOH certified PEP prescriber. HCT must be done by an NDOH certified counselor/tester.

32 D. I. Boeras et al. 'Indeterminate and discrepant rapid HIV test results in couples' HIV testing and counselling centres in Africa', Journal of the International AIDS Society, vol. 14, no. 1, Apr. 2011, p. 1, National Center for Biotechnology Information [online database], doi:10.1186/1758-2652-14-18, accessed 26 Oct. 2020.

8.4 | PREVENTION AND TREATMENT OF STIs

Following an SGBV incident, all survivors should receive prophylactic treatment for chlamydia, gonorrhoea, syphilis and trichomoniasis as soon as possible.

Whenever a survivor of rape seeks help, the healthcare worker should provide the full prophylactic treatment for STIs. Note that infections, especially chlamydia, are characteristically asymptomatic in more than 60 per cent of female cases.

A person who reports having been raped should receive presumptive treatment of STIs (gonorrhoea, chlamydia and trichomonas infections using the standard treatment).

Presumptive treatment for Gonorrhoea and Chlamydia:

- Ceftriaxone 250 mg intramuscular (IM) as a single dose PLUS azithromycin 1 g orally as a single dose

OR

- Cefixime 400 mg orally as a single dose PLUS azithromycin 1 g orally as a single dose

Refer to the most current PNG Standard Management of STI and Genital Conditions Manual when managing STIs (page 56).

Treatment for Children

Give one dose of azithromycin plus amoxicillin and augmentine, (amoxicillin and clavulanic acid) and probenecid tablets.[33]

Weight	Azithromycin	Amoxicillin	Augmentin	Probenecid
Less than 10 kg	250 mg (1/2 tablet)	1 g (4x250 mg)	½ tablet	½ tablet
More than 10 kg	500 mg (1 tablet)	1 ½ g (6x250 mg)	1 tablet	1 tablet

Confirmed gonococcal disease in a young child almost always means that the child has been or is being sexually abused. In response:

- Discuss the problem with a medical officer if possible.
- Check the child for evidence of other sexually transmitted diseases (e.g., syphilis, HIV infection) and treat if present.
- Discuss the problem with the child's family if you feel this is the right thing to do.
- Check the adult members of the family for evidence of sexually transmitted disease and treat if present.

33 Paediatric dosage: Standard Treatment of Common Illnesses of Children in PNG, 10th Edition, 2016, p. 128

8.5 | PREVENTION OF PREGNANCY AND MANAGEMENT OF UNWANTED PREGNANCY

(See flowchart in annex 6)

A. Prevention of pregnancy

EC can prevent unwanted pregnancy, such as in the case of rape, and is most effective when taken as soon as possible after the incident. Healthcare providers should offer EC to all women and girls of reproductive age (from the first signs of puberty or the onset of the first menstrual period), unless it is certain that she was pregnant prior to the incident.

- If possible, perform a pregnancy test. If negative, offer EC. If positive, do not offer EC and refer the patient for ANC services.
- If a pregnancy test is not available, take the patient's history to determine the possibility of pregnancy. If pregnancy is not confirmed, administer EC. Even if there is the possibility of a pregnancy, it is acceptable and safe to provide EC, as it will not harm any unknown pre-existing pregnancy.

The healthcare provider should administer progesterone-only pills (Levonorgestrel) as soon as possible. An oral regimen is highly effective if taken within 72 hours of the incident, though the regimen can be administered up to 120 hours (five days) after sexual intercourse. However, it is important to administer EC as soon as possible as the effectiveness of EC reduces to less than 50 per cent between 72 hours and 120 hours after the incident.

The healthcare provider should employ special considerations for survivors taking PEP or ART:

- For a survivor who is given PEP or ART for any reason, provide a double dose of EC (3 mg Levonorgestrel) immediately.
- If the survivor has not received PEP or ART for any reason, provide a single dose of EC (1.5 mg 5 mcg Levonorgestrel) immediately.

Doses are identical, regardless of the age of the survivor.

If Levonorgestrel is unavailable, there are three alternatives:[34]

- Two tablets of Postinor (levonorgestrel 0.75 mg) taken immediately
- Triple dose of the combined oral contraceptive pill (OCP) (i.e., three tabs of Lo femenal or Microgynon 30ED) taken as soon as available after sexual intercourse, and repeat the dose 12 hours later
- 20 tabs of Microlut taken all at once

34 Manual of Standard Managements in Obstetrics and Gynaecology for Doctors, HEOs and nurses in Papua New Guinea; 7th Edition, 2016, p. 84.

There are no contraindications concerning EC. The provision of Levonorgestrel may suppress ovulation and prevent the implantation of a fertilised ovum in the uterus, but it cannot harm pre-existing pregnancies. Healthcare providers should reassure the survivor that the pill will have no effect on any existing pregnancies of which the survivor is unaware, nor on any future pregnancies.

Possible side effects of EC include:

- Nausea: to reduce the risk of nausea, the survivor may eat before taking the pills.
- Vomiting: if the survivor vomits within two hours of taking the pills, she must repeat the dose. After two hours, she should not take extra pills, as these will not increase the effectiveness of the protocol and may aggravate the vomiting. If vomiting persists after two hours, offer Metoclopramide (20 mg).

The healthcare worker should provide counselling for EC to discuss the following topics:

- Changes in the menstrual cycle: inform the survivor that her next period may start several days earlier or later than expected. If her next period is very different from her normal menstrual cycle, she should return to the health facility for a consultation.
- Pregnancy assessment: advise the survivor to follow up for a pregnancy assessment after 21 days, as EC is not 100 per cent effective.
- Side effects: instruct the survivor to return if she experiences side effects, such as a headache, dizziness or abdominal pain, that continue for more than one week after taking the EC pill(s).
- Family planning counselling: discuss methods of family planning during the survivor's first follow-up visit. This topic may not be appropriate during the first visit, as the healthcare provider has already covered many aspects, and too much information may overwhelm the survivor.

Following the provision of EC, carry out a pregnancy test if there is no menstruation within 21 days or within five to seven days after the expected date (if the date is known). If the follow-up pregnancy test is positive within 21 days of the incident, the pregnancy is likely not a result of the incident.

B. Management of unwanted pregnancy after rape

A rape survivor may present to seek termination after becoming pregnant from the rape. If she does not have access to a safe pregnancy termination service, she may turn to unsafe methods of termination. It is important for healthcare providers to prevent such methods whenever possible.

Unwanted pregnancy resulting from rape can be very traumatic for the survivor. The health worker must provide counselling to the survivor, as well as information about her options, including the termination of pregnancy to reduce maternal mortality and suffering.

Unsafe terminations of pregnancy are responsible for a significant proportion of serious morbidity and mortality for women in countries where access to safe termination services is limited.

According to WHO, it is estimated that 13% of global maternal mortality is a consequence of unsafe practices and that 38% of the 210 million pregnancies in the world are unplanned/unwanted; 57.5% choose to terminate their pregnancies of which almost 50% are obliged to resort to clandestine, unsafe terminations. Studies have shown that up to 50% of women presenting with incomplete abortion (miscarriage) in developing countries are actually miscarrying as the result of unsafe termination of pregnancy.

Methods of pregnancy termination:

Methods	Period	Remark	Advantages/Disadvantages
Medical (misoprostol, mifepristone)	< 12 weeks	Sensitivity of the uterine musculature to misoprostol progressively increases as pregnancy continues. The risk of excessive bleeding increases after nine weeks of gestation.	Advantages: non-invasive procedure, no anaesthesia, minimal pain Disadvantage: bleeding, cramps, nausea, uncertainty, repeated follow-up visits
Manual vacuum aspiration	< 12 weeks	Treatment of choice for incomplete spontaneous abortions	Advantages: faster, more certain results, uses regional anaesthesia Disadvantages: invasive
Dilatation and curettage	Up to 12 weeks	Implement only when other methods are not applicable	Advantages: faster, more certain results Disadvantages: invasive, uses general anaesthesia, need for skilled surgeon or obstetrician, risk of uterine or cervical perforation, risk of infection

Treatment regimens for medical termination of pregnancy for rape survivors (WHO) up to 12 weeks (84 days) into pregnancy[35]

	Up to 9 weeks (63 days)	9 to 12 weeks (63 – 84 days)
Misoprostol alone	- Misoprostol 800 µg - Vaginal or sublingual - Every three to 12 hours (up to three doses)	
Mifepristone & Misoprostol	- Mifepristone 200 mg - Oral - Immediate dose	
	- Misoprostol 800 µg - Vaginal, buccal or sublingual - Immediate dose OR If no more than seven weeks after the incident (49 days): - Misoprosotol 400 µ g - Oral - Immediate dose - Use 24-48 Hours after taking Mifepristone	- Misoprostol 800 µg, then 400 µg - First dose vaginal, second dose vaginal or sublingual - Provide every three hours (up to five doses) - Begin Misoprostol 36–48 hours after taking Mifepristone

35 WHO, 'Clinical practice handbook for safe abortion', WHO, 2014, p. 29, <https://apps.who.int/iris/bitstream/handle/10665/97415/9789241548717_eng.pdf?sequence=1>, accessed 26 Oct. 2020.

8.6 | PREVENTION OF HEP B

(See flowchart in Annex 6)

The transmission of HEP B is significantly higher than that of HIV, and transmission usually occurs via blood or through sexual intercourse. Every rape survivor should be offered prophylaxis for HEP B as soon as possible after the incident (similarly to the HIV risk assessment). As HEP B has an incubation period of two to three months, vaccination is also recommended for survivors who present later than others and who have not previously received vaccination.

Calendar of vaccination

Dose	Calendar
Hep B1	Day 0
Hep B2	7 days after Hep B1
Hep B3	21-28 days after Hep B2
Hep B4	12 months after Hep B3

N.B. This vaccination calendar is specifically designed for survivors of SV to allow for improved completion rates. The accelerated schedule can confer early protective immunity lasting up to one year. For life-long protection, health providers should administer the booster once every year.

Health providers must administer HEP B vaccinations by IM injection into the deltoid muscle in adults and the upper-exterior part of the thigh in children. Do not administer the vaccination in the buttock muscle, as the immune reaction is insufficient.

Possible side effects of the vaccinations include minor local or systematic reactions, such as pain or redness at the injection site, fever, headache or myalgia. In rare cases, survivors may experience an anaphylactic reaction, serum-disease-like reaction, lymphadenopathy or peripheral neuropathy.

Healthcare providers should consider the following contraindications for the vaccination:

- Assess the patient's history of hypersensitivity to any component of the vaccine.
- Assess the risks and benefits of patients with multiple sclerosis.
- There is no contraindication for pregnancy and breastfeeding.
- There is no contraindication in cases of symptomatic or asymptomatic HIV infection.

Healthcare providers may administer the HEP B vaccination at the same time as the anti-tetanus vaccinations; do not combine the vaccinations in the same syringe.

Storage guidelines for the HEP B vaccination are as follows:

- Store between 2 C and 8 C.
- Never freeze.
- After opening, a vial of 10 doses, it may be kept for 28 days.

8.7 | PREVENTION OF TETANUS

(See flowchart in Annex 6 and follow-up table on page 110)

Any individuals who present with breaks in the skin or mucosa, especially dirty wounds or injuries caused by implements, should be considered at risk for tetanus unless fully immunised.

Depending on the pre-exposure vaccination status, the tetanus toxoid (TT) and tetanus immunoglobulin (TIG) vaccinations should follow a predetermined schedule, as illustrated on the next page.

Schedule for Tetanus Toxoid (TT) and Tetanus Immunoglobulin (TIG)

Risk	Complete vaccination 4 or more doses; less < 5 years since the administration of the latest dose	Complete vaccination 4 or more doses; 5 – 10 years since the administration of the latest dose	Complete vaccination 4 or more doses; >10 years since the administration of the latest dose	Incomplete vaccination Less than four doses; no vaccination or unknown status
Minor wounds	None	None	TT: one booster dose	Initiate or complete TT
Major wounds (deep wounds, substantial tissue loss, foreign bodies or necrosis)	None	TT: one booster dose	TT: one booster dose	Initiate or complete TT and TIG

Tetanus incubation usually occurs between three and 21 days after the incident but can take much longer. Every rape survivor should receive immunisation for tetanus unless he or she can prove that they are fully immunised. Receiving the vaccinations at the point of entry will have a beneficial effect on the survivor's future health; for women, vaccinations will prevent the transmission of tetanus to children.

If there are indications of TIG (see schedule above), administer the vaccination. If there are clinical signs of a tetanus infection, the hospital staff should admit and manage the survivor.

Tetanus Toxoid Vaccination

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

For TT1, healthcare providers should administer 0.5 ml with an IM injection for children and adults.

If the survivor is a child under five years of age who is not vaccinated, the health worker should implement the primary series of three injections at a minimum of four-week intervals, following the schedule for the regular expanded program of immunisation with diphtheria, pertussis and tetanus.

Possible side effects include a rare and mild local reaction, such as redness and pain at the injection site, and allergic reactions.

Healthcare providers should consider the following contraindications for the vaccination:

- Assess for known allergies to the TT vaccine.
- There are no contraindications for pregnant and breastfeeding women.
- There are no contraindications for cases of symptomatic or asymptomatic HIV infection.

Storage guidelines for the TT vaccination are as follows:

- Store between 2 C and 8 C.
- Never freeze.
- After opening, a vial of 10 doses, the vaccine may be kept for 28 days.
- After opening, the bottle of 10 doses of vaccine may be kept for 1 month.

Tetanus Immunoglobulin (TIG)

Indications for the TIG vaccination include:

- Tetanus prophylaxis in wound management, according to the table in this section (Schedule for TT and TIG)
- Treatment of tetanus (see the NDOH clinical guidelines)

Healthcare providers should administer the following dosage and method of administration for prophylaxis:

- Administer 250 international units (IU) in 1 ml by IM injection into the deltoid or gluteal region for children and adults
- If more than 24 hours have elapsed between the event that caused the wound and the patient seeking medical care, double the dosage to 500 IU.
- Possible side effects include a rare and mild local reaction, such as redness and pain at the injection site, and allergic reactions.

Healthcare providers should consider the following contraindications for the vaccination:

- Assess for known allergies to the TIG vaccine.
- There are no contraindications for pregnant and breastfeeding women.

Storage guidelines for the TIG vaccination are as follows:

- Store between 2 C and 8 C.
- Never freeze.

9 | Individual case documentation and data collection

9 | Individual case documentation and data collection

General guidelines for all case documentation and data collection paperwork

When completing case documentation and paperwork, healthcare workers must:

- Write clearly and legibly
- Confirm that the information is accurate and complete
- Review any reports or referral notes paperwork brought in by the survivor to avoid repeating questions already documented in relation to the case
- Maintain respect, privacy and confidentiality at all times. Healthcare workers must not share survivor's files with third parties without the survivor's consent.

Medical Examination Forms

The healthcare provider should use the medical examination form to guide the process of taking the patient's medical history.

The examination form includes:

- General information
- Description of the incident
- Patient's medical history
- General physical examination
- Genital and anal examination
- Investigations performed, if available and required
- Treatment and care provision
- Referrals
- Follow-up consultations
- Follow up

Obtaining an accurate and relevant history from a child may be challenging, particularly for young children with limited language available to describe the incident. Developing trust with the child and conveying concern and care are the most important objectives during the initial consultation. If possible, involve the caregiver when taking the child's history to elicit accurate information. Healthcare workers must use a code to input the survivor identification on the examination forms.

Data collection

After the initial consultation, the medical examination form will provide relevant data to report valuable indicators. These indicators will measure the quality of care for the survivor and the effectiveness of the program, allowing the health worker to analyse the context, situation and needs of the survivor.

A data tool should be anonymous (without names) and typically includes:

- Patient identification number, date of consultation, date of the incident and the delay between the incident and the first consultation
- Age, sex, village, district, province and current address of the survivor
- Reasons for the presentation (SV, IPV, family violence [FV] or CA) and a description of the incident (rape, other SV, physical violence or emotional abuse)
- Type of medical care provided (PFA, EC, PEP, vaccines, dressing, suture, surgical intervention, etc.)
- Medical report offered and collected (yes/no)
- Counselling offered and follow-up sessions scheduled (as per the follow-up table, see Annex 3)
- Medical follow-up

10 | Medico-legal interaction

10 | Medico-legal interaction

A medical report is a confidential document that contains details of the event the survivor experienced and the medical examination findings. The objective of the medical report is to document that the survivor was examined in an FSC or other health facility and describe the medical findings of the examination. While it is a medical document and can assist survivors if they wish to pursue legal justice, it cannot be used as 'proof' of SGBV and should not be issued to verify that the survivor has experienced abuse. Only a court of law (never the village court) can determine whether a rape occurred. Ideally, the medical practitioner who performed the examination should prepare and sign the medical report and serve as a witness in court if subpoenaed.[36]

All SGBV survivors have the right to a free medical report, as per the Government's free health policy.[37]

Before the survivor leaves the healthcare facility, healthcare providers must complete the medical report (see Annex 3) and offer all survivors a 'notification for release of the survivor medical report'. If the survivor wishes to report the incident to the police and share the medical report with the officers, healthcare workers should include a signed written consent form that verifies the survivor's approval to share the sensitive and confidential document with the police.[38] To ensure true consent from the survivor, the FSVU of the police force should offer the survivor a 'notification for release of the survivor medical report' to collect the medical report from the FSC or health facility (released only through the chief executive officer [CEO] or director of medical services [DMS] office through a delegated officer in charge [OIC]). This process will safeguard the survivor's autonomy while respecting the PNG law.

36 NDOH of PNG, 'Guidelines for PHA/Hospital Management establishing hospital-based family support centers', loc. cit, 2013.

37 July 2016 (removal of fees for GBV, SV and CA cases at all hospitals, HCs, sub-HCs and health facilities).

38 Consent for sharing the medical report is separate from consent to conduct the medical examination.

If the survivor does not wish to report the case to the police, the health facility will store the medical report in a secure location for 10 years to allow future access, if needed (stored without the signed consent of the survivor). In all cases, healthcare providers should ensure that the survivor receives his or her individual survivor code in case he or she wishes to receive the medical report at a later date (see Annex 3 for the medical report format).

When completing the medical report, healthcare providers must remember to:

- Record findings of the examination clearly, completely and in neutral language
- Never speculate, make allegations or draw conclusions concerning the case or the perpetrator
- Use the patient's own words (using quotation marks) to describe the event whenever possible
- Use the pictograms (see Annex 3) to locate the anatomical site of the injury
- Always allow the survivor to decide whether to tell other entities or organisations about the incident. The medical team cannot make this decision for the patient.

In the event of CA, completing a medical report is mandatory, and the health worker must inform a child protection officer of the incident.

11 | Referral pathway

11 | Multi-sectoral referral

RATIONAL

The Referral Guide for the healthcare sector in SGBV presents one of the elements of the multi-sectorial coordination model: to generate a coherent set of relationships among agencies and organisations in order to provide the victims with the maximum level of assistance and protection while investing minimum resources.

This Guide aims to provide practical guidance for healthcare providers — including health facilities, FSCs and hospital coordinators and managers — to establish referral pathways within their respected areas. The Guide also seeks to provide a frame of referral pathways and present information on service provision by other service providers.

REFERRAL SYSTEMS DEFINITION

Referrals describe the processes a survivor connecting with an individual professional or institution concerning her or his case, as well as professionals and institutions communicating and collaborating to provide the survivor with comprehensive support.

Partners in a referral network generally include various government departments and agencies, women's organisations, community organisations, faith-based organisations and medical institutions. A necessary prerequisite for the design and implementation of effective referrals is the existence of an institutionalised referral mechanism.

Referral mechanisms require efficient lines of communication and clearly established referral pathways and procedures with clear and simple steps. To ensure sustainability and accountability, see the SGBV training curriculum module for more information on developing a referral pathway.

OBJECTIVES OF A REFERRAL SYSTEM

The objectives of a referral system include:

- Minimising trauma and secondary victimisation that survivors may experience
- Reducing negative health and social impacts of family and sexual violence (FSV) and GBV through consistent healthcare, counselling and practical support for survivors
- Supporting survivors in accessing relevant services, including access to justice, in the context of interagency cooperation and collaboration and using a coordinated service delivery system
- Increasing service providers' capacity to deliver services through improved systems and processes for sharing information and providing greater support from referral pathway stakeholders

TYPES OF REFERRALS

1. Internal referrals (hospitals) within hospital units

All provincial hospitals MUST have an established FSC or SGBV emergency unit to provide all essential services in one place. This unit is ideally a 'one-stop shop' that is operational on a 24/7 basis.

1.1 Entry through hospital-based FSCs

Initiate all procedures or processes necessary to stabilise survivors.

Trained officers at the FSC or health facility must provide all five essential services, including documentation. These essential services include:

- Medical first aid
- PFA
- Prevention of HIV/STIs
- Prevention of pregnancy
- Prevention of HEP B and tetanus

As much as possible, for sexual assault cases, healthcare providers must minimise movements of survivors — including physically referring them to HIV/STI clinics — to avoid stigma and discrimination, providing necessary prevention, care and support at the FSCs.

The physical movement of a survivor of rape to an STI/HIV clinic that needs PEP would put an STI/HIV tag on the survivor for known cases of rape. Hence, movement for that purpose would be considered unethical and professionally unjust unless absolutely necessary. The unnecessary movement of survivors is discouraged.

If indicated for specialists' attention, a Consultation Referral Note must be sent to the relevant SMO, senior clinician or trained health extension officer (HEO) to attend to survivors only at the FSC. As much as possible, survivors must not be physically moved to other units within the hospital unless absolutely necessary.

Movement of survivors from the FSC can only occur when necessary, including for surgery in an operating theatre (for major surgical procedures), X-rays, scans, and other medical or investigatory (laboratory) procedures that necessitate movements of survivors.

Inform other support service providers of the survivor, but only with the survivor's consent.

1.2 Entry through other hospital-based entry points: outpatient department (adult and children), A&E, antenatal clinics, HIV/STI clinics, labour ward, etc.

If the hospital or health facility has an established FSC, refer and accompany the survivor to the FSC and follow requirements as indicated in 1.1 above.

If NO FSC is established yet, initiate support, care and treatment at the convenience of the survivor, ensuring services are survivor-centred, gender-sensitive and on the basis of human-rights-based approaches.

1.3 Referrals from the FSC or primary healthcare centre to a higher-level health facility or structure

District or provincial hospitals require a robust referral pathway to offer the five essential services for specialised care, including mental health counselling. Section 1.1 above highlights these five services.

2. Internal referrals (health system) within levels of healthcare facilities

Aid posts, health posts and HCs to higher-level hospitals: referrals from the primary healthcare centre to other healthcare systems for further specialised health treatment, care and management.

3. External referrals

External referrals include those from the FSC or primary healthcare centre to other relevant sectoral service providers for support services, including social and legal support and assistance.

External referrals to other relevant support services (social and legal support and assistance): referrals from the primary healthcare centre to non-medical-related services for survivors with multiple and complex needs.

REFERRAL CRITERIA

Internal referrals (hospitals) within hospital units

Healthcare providers should take into account the following special considerations when referring survivors in need of further treatment from the FSC or primary healthcare centre to a higher-level health structure:

- **Medically unstable patient:** in hospitals with established FSCs, a patient in need of emergency medical care must be referred to the hospital's A&E department as soon as possible. Such patients include those who may require diagnostic or special services, such as emergency surgery, obstructed and gynaecological care, or specialist care (e.g., eye services). For patients with a potential fracture or orthopaedic injury, refer the patient for diagnostic imaging (X-rays). Open fractures are considered emergency referrals.
- **HIV services:** patients who test positive for HIV should be referred for confirmation tests and HIV counselling and treatment.
- **Pregnancy from rape:** patients with unwanted pregnancies resulting from rape should be referred as soon as possible to the SMO of O&G for accurate assessment and advice regarding the patients' options.

Note: for all cases within a hospital setting, the referring FSC or healthcare worker must provide a Consultation Referral Note (see 1.1 above) to the specialised unit, as currently practised (see Annex 1: Useful Contacts and Referrals).

Internal referrals (health system) within levels of healthcare facilities

For healthcare providers working in an aid post, health post or HC, all facility staff should issue referrals to the nearest district, provincial or regional hospital (preferably a hospital hosting an established FSC or GBV unit). If the nearest hospital does not have an established FS C, healthcare staff should issue the referral to designated focal points within the facility.

Healthcare providers working in a district or provincial hospital not hosting an FSC department should issue the referral to designated focal points within the facility, the nearest healthcare facility with an established FSC or the nearest facility with the capacity to receive and provide essential medical and psychosocial care for SGBV survivors. Healthcare providers working in HCs may also refer their patients to psychosocial counsellors serving as GBV focal points. Additionally, health staff should issue the referral for medical reports to the nearest FSC or district provincial hospital with trained SGBV medical staff.

The indicators for SGBV referrals can include one or more of the following:

- Absence of:
  - A medical officer, HEO or specialist nursing officer trained in GBV clinical care and management
  - Laboratory facilities
  - HIV and STI PEP kits
  - Emergency contraceptives for females of reproductive age (menstruating)
- Incidence of SV, assault or rape. Providers should refer all such cases within 72 hours of the incident.

Note:

- No genital or breast examinations may be performed for female victims of sexual assault or rape unless indicated or conducted at the hospital level by a medical officer, HEO or specialist nursing officer trained on GBV clinical care and management.
- It is the survivor's decision to seek social or legal support or assistance. The medical service provider should provide information on the availability of such services but NEVER advise the patient on what to do, including advising the survivor to report the incident to the police or local traditional court.
- When referring to other support services, healthcare providers do not need to provide a detailed referral letter (see Annex 2 for the referral form for non-medical services).

Referral pathway flow chart: hospital

Providing referrals to higher-level healthcare facilities is an important element of the essential package of health services for SGBV survivors. Such referrals allow patients with complicated health concerns to access more comprehensive and qualified medical assistance than they would receive at smaller, community-based healthcare facilities, such as health posts or sub-HCs. Additionally, such referrals provide survivors with additional access to external referrals, including social and legal services at the provincial, district or community levels.

Hospital Referral Pathway for Survivors of FSV and CA
(three days from the incident to prevent HIV and unwanted pregnancy)

Hospital Entry Points	FSC or SGBV Unit	Relevant Sectoral Support Services
• A&E • O&G • Adult OPD • Children's OPD • HCT sites	• Medical first aid • PFA • HIV and STI prevention (PEP) • Prevention of unwanted pregancy (EC) • HEP B and tetanus vaccines • Case documentations • Provision of medical reports	• Police (Family and Sexual Violence Unit [FSVU]) • Welfare • Safe house • Child protection • Mental health and counselling

If FSC or SGBV Emergency Unit established, immediately refer to that Unit

When providing referrals, healthcare staff should:

- Explain that the patient's health issues require further examination and more intensive treatment than the current healthcare facility is able to provide
- Encourage the patient and his or her family members to follow the referral pathway and visit the recommended healthcare facility, stressing the importance of prompt action and designating and confirming the date of the patient's visit to the hospital
- For referrals to an FSC, explain how the FSC services function

Follow-up of referrals

Conducting follow-ups for survivors who were referred to other services, including internal services, is a crucial aspect of the referral process. After establishing a referral pathway, healthcare providers, including entry point service providers and those who facilitated the referral, must maintain a close follow-up with each survivor. The follow-up should ensure the patient's access to quality care and services, determine whether their needs were met and assess the outcomes of the referrals.

Key elements of maintaining an effective follow-up include:

- Asking survivors about their referral consultation during the follow-up visit
- Determining the number of referrals from the health facility to the FSC or other health facility with SGBV services
- Conducting regular meetings to collect feedback from partners on referral pathways, including the Family and Sexual Violence Action Committee (FSVAC) meeting (if established) or a partner's meeting with hospital management support
- Advocating an SGBV response cluster meeting (if an FSVAC is not established) to reinforce the multi-sectorial response approach
- Requesting a social worker or triage nurse from an FSC to call various departments' GBV focal points to seek information on the outcomes of the referral visits
- Returning SGBV survivors who were internally referred from an FSC to the referring FSC to complete their treatment, with the SGBV committee and facility management issuing constant reminders
- Providing a medical report and referrals to other social and legal services (only through an FSC, if an FSC is established) to centralise the survivor flow
- Directing and facilitating the survivors' follow-up visits to the FSC as much as possible in order to complete full medical care (e.g., PEP, HIV and pregnancy tests, and vaccinations)
- Ensuring that each referral addresses the patient's most important needs or concerns
- Following up on the exit reports

12 | Follow-up care

12 | Follow-up care

Healthcare providers must encourage SGBV survivors to return to the clinic for follow-up visits and, if possible, ensure that the survivor sees the health worker who provided care during the initial consultation.

Healthcare providers must present a positive message about follow-up visits and explain the benefits of continued consultations — including follow-up vaccinations, medical check-ups and the opportunity to assess how the survivor is coping — to encourage the patient to return.

Healthcare workers must also determine if there are any barriers that may prevent the survivor from returning to the clinic, such as barriers in making the decision, barriers in reaching the clinic or even barriers within the clinic. Provide a phone number for the clinic that the survivor may call with any questions; however, avoid giving out personal phone numbers for security reasons.

The suggested follow-up schedules are as follows:

- For patients taking PEP, conduct follow-up visits at seven, 14, 21 and 28 days and after three months.
- For patients not taking PEP, conduct follow-up visits at seven days, 28 days and three months.

During each visit, the healthcare worker should conduct specific evaluations and assessments, including:

- Evaluation of the survivor's mental and emotional status using the 'bilum scale' (see Annex 5)
- Assessment of the general physical state of the patient (head-to-toe assessment) and assessment of how the previous injuries are healing
- Assessment of the patient's pregnancy status (if EC has failed), providing appropriate counsel to discuss available options in the event of pregnancy resulting from rape
- Evaluation of the patient's compliance with treatments, especially PEP, and side effect management

Many SGBV survivors choose not or may not be able to return for follow-up visits; during the initial consultation, healthcare workers should provide all relevant and necessary advice and explanations for the survivor to understand the importance of the follow-up visits. Such information includes a written list (or culturally appropriate pictograms) of follow-up instructions on what to do and what to expect. In locations with high rates of illiteracy, the healthcare provider should transmit the message orally to the survivor and a person he or she trusts, as the survivor will likely be stressed and unable to remember all the information given during the first consultation.

Additionally, healthcare workers should provide vaccinations, if required (according to the vaccination schedules).

- Information on relevant HCT. If the HIV test result is available by the time of the follow-up visit and the survivor is HIV positive, continue PEP and provide care and referrals to an ART service.
- Testing for HIV antibodies at the baseline and three months for all survivors exposed to HIV to determine whether HIV infection has occurred
- Information and referrals to other support services when necessary (NGO support and support groups for rape survivors, shelters and safe houses, social services, legal services, specific reproductive health services, etc.)

Appointment cards should include the survivor's registration number. All cards should include the addresses of other agencies and partners that can provide relevant assistance to meet the survivor's needs.
provide assistance suitable for survivors needs.

13 | Specific care for children

13 | Specific care for children[39]

Identifying children who have been emotionally, physically or sexually abused can be challenging, and caring for a survivor of CA requires specific considerations. Depending on the survivor's age, children may not be able to come forward or express themselves to describe the incident. Additionally, if the perpetrator is the survivor's caretaker (a relatively common occurrence), the child is likely economically and emotionally dependent on the perpetrator, which often contributes to the child's sense of loyalty and hesitancy to come forward. Furthermore, health staff may be apprehensive and unprepared to identify and care for CA and CSA victims, potentially further limiting the child's access to necessary health services.

General considerations

When caring for children that may be survivors of CA and CSA, healthcare providers should:

- Conduct a brief initial assessment to identify and prioritise any urgent medical needs, particularly convulsions, persistent vomiting, stridor (agitation and vomiting) in a normally calm child, lethargy or unconsciousness, or the inability to drink or breastfeed. In children under three months old, check for a bulging fontanel ('soft spot'), fever or low body temperature, or respiratory distress. Be alert for children who are not freely moving or protecting an injured limb.
- Create a safe environment, including allowing the child to identify an individual such as a trusted staff member that they would like to be present during the history taking and physical examination. If possible, ask the child while he or she is alone, as the perpetrator may be the person accompanying the child, and their presence may make it difficult for the survivor to be honest. However, health professionals must understand that child abusers are often close family members, and children may feel attached to and protective of their abuser.
- Introduce themselves and any unknown people who are present. If the child is small, bend down to his or her level and assure the child that he or she is not in any trouble. Begin by asking general, non-intrusive questions (about school or friends) to establish trust.
- Carefully evaluate whether the child has a safe place to return to following the visit and ensure their protection once they leave.

39 This section is adapted from: A. Erikson, 'Guidelines for health and psychosocial service providers in humanitarian settings: Caring for child survivors of sexual abuse', loc. cit., 2012.

Common silent signs and symptoms of CA[40]

Healthcare providers, as well as teachers, parents, caregivers and other individuals who regularly interact with children, must be aware of the common signs and symptoms of CA. Most children will remain silent, and it often takes time for children to disclose their experiences. Establishing trust with the child and explaining confidentiality will allow children to disclose any abuse they have experienced and give them a sense of control to make their own decisions. A single sign or symptom does not indicate that a child has been abused; however, the presence of several signs may suggest that a child is at risk.[41] It is important to believe reports of CA, no matter what the healthcare provider has observed. Some signs may emerge during periods of stress, such as the loss of a loved one or another traumatic event, even long after the abuse has occurred.

Boys and girls react differently to CA due to several factors, including their age, developmental stage and cultural context. While the majority of the signs and symptoms are behavioural and emotional in nature, physical changes can also indicate abuse. The most common physical signs of CSA (or other forms of CA) include:

- Pain, discolouration, sores, cuts, bleeding or discharge in the genitals, anus or mouth
- Persistent or recurring pain during urination or bowel movements
- Wetting and soiling accidents unrelated to bathroom training
- Weight loss or weight gain
- Lack of personal care

Infants and toddlers (ages 0–5)

It is common for toddlers who have experienced abuse to show regressive behaviours. Children may appear to lose certain skills or behaviours they had previously mastered (e.g., bladder control), or they may revert to behaviours they had previously outgrown (e.g., thumb-sucking). Similarly, young children often become 'clingy' or overly attached to familiar adults, such as caregivers and teachers to whom they feel close. They may also resist leaving places where they feel safe, such as their home or classroom, or be afraid to visit locations that may trigger memories of a frightening experience. Significant changes in eating or sleeping habits are common, and young children may complain of physical aches and pains that have no medical basis.

40 This section is adapted from: A. Erikson, 'Guidelines for health and psychosocial service providers in humanitarian settings: Caring for child survivors of sexual abuse', loc. cit., 2012.

41 For some children, behaviour and physical indications of abuse are not always apparent.

Summary of common signs (0 – 5 years):

- Crying, whimpering or screaming more than usual
- Clingy behaviour or unusual attachment to caregivers
- Refusing to leave safe places
- Difficulty with sleeping or sleeping constantly
- Losing the ability to converse, losing bladder control or exhibiting other developmental regression
- Displaying knowledge or interest in sexual acts that are inappropriate for their age
- Sexual behaviours with other children or adults, in play with dolls or with themselves

Younger Children (ages 6–9)
Children in this age range may also exhibit regressive behaviours, such as asking adults to feed or dress them, and may also report unexplained physical symptoms, similar to young children. However, older children have a better understanding of the meaning of SA and may exhibit more advanced thoughts and beliefs about what they experienced and perceive as negative consequences. Older children may also develop emotional reactions ranging from sadness, fear, anxiety or anger and may even experience feelings of shame or guilt. As a result of these feelings, older children may begin to withdraw from their friends and refuse to go to school, or they may begin to behave aggressively. They may also be unable to concentrate, resulting in a decline in school performance.

Summary of common signs (6 – 9 years):

- Similar reactions to children ages 0–5
- Fear of particular people, places or activities or of being attacked
- Exhibiting regressive behaviours (e.g., wetting the bed or wanting parents to dress them)
- Suddenly refusing to go to school
- Repeatedly touching their private parts
- Re-enacting sexual acts with other children or in play
- Sexualised behaviours with adults
- Avoiding family and friends or generally keeping to themselves
- Refusing to eat or wanting to eat all the time
- Feeling like a 'bad' boy or girl (feeling shame and guilt)

Adolescents (ages 10–19)
Adolescence is defined as the period between ages 10 and 19 years old. It is a continuum of development in a person's physical, cognitive, behavioural and psychosocial spheres that presents particular challenges specific to a person's developmental stage. Adolescence is often described as a time of transition into adulthood and can be a very difficult time for young people, as they are no longer viewed as a 'child 'but are not yet regarded as an 'adult'.

Early adolescence (ages 10–14) is marked by puberty and important physical changes to the body. Although individuals in early adolescence may be emotionally and cognitively closer to children than adults, they are beginning to define the identities they will carry into adulthood. As early adolescents become aware of their sexuality, they may begin to experiment with sex or be targeted for sex. However, adolescents in this age group, particularly girls, tend to be dependent on others, lack power within most of their relationships and are not given opportunities to participate in the decisions that affect them.

Late adolescence (ages 15–19) is marked by the end of puberty, though the body is still developing during this time. Adolescents in this age group tend to act more like adults but have yet to reach cognitive, behavioural or emotional maturity. Their capacity for analytical thought and reflection is enhanced but still developing. Peers are extremely important and influential during this time, particularly for girls with limited exposure to their peers and individuals outside of their immediate families. Girls who have reached physical maturity also have an increased chance of being targeted for SV and exploitation.

In general, adolescents tend to place more importance on peer groups and 'fitting in'. This focus can complicate their efforts to cope with sexual abuse, as there is a high level of stigma and shame surrounding sexual abuse within PNG communities. Adolescents may be reluctant to discuss their feelings or may even deny any emotional reactions to sexual abuse due in part to their desire to fit in and avoid the shame and stigma associated with sexual abuse. Additionally, survivors may feel that they are at fault as a result of wearing revealing clothing or engaging in other behaviours or thoughts that they believe caused the abuse. Adolescents, especially older adolescents, are more likely to demonstrate traumatic responses similar to those seen in adults, including:

- Flashbacks
- Nightmares
- Emotional numbing
- Avoidance of reminders of the trauma

- Depression or suicidal thoughts
- Difficulties with peer relationships
- Delinquent or self-destructive behaviour (changes in school performance, abandonment of friendships or acts of self-harm)
- Feelings of self-blame

Summary of common signs (10 – 19 y)

- Depression (chronic sadness), crying or emotional numbness
- Nightmares (bad dreams) or sleep disorders
- Problems in school or avoidance of school
- Displaying anger or expressing difficulties with peer relationships, fighting with others or disobeying or disrespecting authority
- Displaying avoidant behaviour, including withdrawing from family and friends
- Self-destructive behaviour (abusing drugs and alcohol or self-inflicting injuries)
- Sexual promiscuity
- Changes in school performance
- Exhibiting eating problems, such as eating all the time or not wanting to eat
- Suicidal thoughts or tendencies
- Talking about abuse or experiencing flashbacks of abuse

History taking

Obtaining an accurate and relevant history from a child may be challenging, particularly for young children with limited language available to describe the incident. Developing trust with the child and conveying concern and care are the most important objectives during the initial consultation.

When obtaining information, healthcare workers may employ the following suggestions:

- If a child does not want to talk, assure the child that this is okay and that he or she can return another time.
- Begin with an open-ended and general question, such as, 'Can you tell me why you are here today?' Assure the child that it is all right not to know the answer to any questions asked
- Avoid leading or suggestive questions; use open-ended questions to obtain information about the incident and use yes or no questions for clarification. Opening with, 'Tell me about...' can be a useful way to obtain information on the incident.
- Allow the child to talk at his or her own pace.

- Assure the child that it is good he or she has come. When the child presents with a caretaker, spend time with the child alone, if possible. Assure the child that you understand it is difficult for him or her to talk about what happened. The use of dolls (both male and female) or drawings can be helpful in allowing the child to express themselves. It is important to ask the child to explain the drawings or the doll play rather than offering an interpretation.
- Explain to the child (in non-explicit terms) that there are certain acts that people are not allowed to do to each other.
- For older girls, ask if she has started to menstruate (to determine if she may be pregnant) and obtain any obstetrical history.

After taking the child's history and the history of the event, healthcare workers should:

- Praise the child for disclosing what has happened and assure them that they did the right thing in coming forward.
- Reassure the child that he or she is not to blame for what happened.
- Normalise any feelings of anger or violation, as well as any other feelings the child may be experiencing.
- Explain the child's reactions to the parent or caretaker. Parents and caretakers often misunderstand developmental regressions or sexualised behaviours and may become angry with the child. By ensuring their understanding of the child's behaviour, the healthcare worker can help the caretakers to intervene with an empathic response. Additionally, caretakers often blame themselves for the abuse the child has experienced; healthcare workers must address these feelings and develop next steps to provide care for both the caretaker and the child.

CSA and other forms of CA are often repeated and perpetrated by a person the child knows.

If possible, healthcare workers should try to understand and clarify:

- The home situation (safety and security)
- How the abuse occurred (verbal, threats, weapons, etc.).
- Who perpetrated the abuse and whether this person is still a threat
- Whether the abuse has happened before, how often and how recently the last event occurred
- Whether the child has any specific physical complaints
- Whether any siblings are at risk of or are being abused

Physical Examination

During each physical examination of a child survivor, healthcare workers should:

- Ensure a trusted person remains with the child if he or she wishes. Ask the caretaker to wait outside during the consultation, depending on the child's age, as children sometimes feel more comfortable talking if the caretaker is not present.
- Never examine a child against his or her will, regardless of age, unless the examination is essential for his or her medical care.
- Explain every step of the process in simple terms and encourage the child to ask questions about elements he or she does not understand.
- If the child is in pain, administer adequate analgesia (painkillers) and allow the medication to become effective prior to starting the examination.
- Be gentle and never use any force or restraints; ensure that any other individuals in the room (an accompanying person trying to be helpful) does not use force or restraints.
- For younger children, use a doll to show the child what will occur during the examination, any procedures and positions.
- Allow the child to see and handle supplies, such as swabs and gloves, to give them a sense of control.
- Examine small children on the mother's lap and older children on a chair or an examination table, depending on the wish of the child.
- Have access to good lighting.

When conducting the examination, the healthcare worker should:

- Note the weight, height and pubertal stage of the child.
- Conduct a meticulous examination (head to toe), including the head, ears, mouth, wrists and ankles, and note all findings.
- Inspect the genital area carefully and note any injuries; to check the hymen, apply gentle lateral pressure to view the vaginal orifice (the amount of hymeneal tissue and the size of the vaginal orifice are not accurate indicators of penetration). Closely observe the appearance and shape and check for the presence of oedema or inflammation, irregularities, lacerations or adhesions and other evidence of trauma.
- Never conduct a digital examination or speculum examination on a prepubertal girl: if the health worker suspects a penetrating vaginal injury or internal bleeding, only an O&G specialist may conduct a speculum examination of prepubertal girls under general anaesthetic.

- For boys, check for injuries to the frenulum of the prepuce, as well as anal or urethral discharge; take swabs if indicated.
- Conduct an anal examination for all abuse survivors (in the supine or lateral position), noting any anal fissures or tears; reflex anal dilatation (opening of the anus on lateral traction on the buttock) can be indicative of penetration or constipation.
- Note all findings in the medical examination form, using the pictograms when possible.

Forensic investigations

If the required facilities are available, healthcare workers may conduct forensic investigations. However, there are several points to consider for such investigations:

- Collecting pathological (forensic) specimens is not necessary to provide emergency care for survivors of sexual assault. Survivor-centred care indicates providing care even without the capacity for forensic specimen processing. A lack of forensic specimens does not prove that rape or assault has not occurred.
- The absence of sperm does not prove that rape did not occur, as the assailant could have used a condom, may have had a vasectomy or may have azo- or oligospermia. The assault may also have involved external ejaculation, no ejaculation or retrograde ejaculation, or the rape may have occurred more than 48 hours before the examination. However, the presence of sperm does not prove that a rape did occur. Additionally, a lack of visible injuries is not an indication that rape has not occurred.
- Healthcare providers should not collect semen or conduct speculum exams solely for the sake of finding forensic evidence, as it may be traumatic for survivors to undergo such examinations after having been raped. Additionally, there is no evidence

When conducting forensic investigations, WHO recommends that healthcare providers consider the following points:

- Forensic evidence may be used to support the survivor's story, confirm recent sexual contact, indicate that the perpetrator used force or coercion and possibly identify the attacker.
- The proper collection and storage of forensic evidence may be essential to a survivor's success in pursuing legal redress.

» Healthcare providers should consider the existing mechanisms of legal redress and the local capacity to analyse specimens when determining whether to offer a forensic examination to a survivor. Providers should also consider the requirements and capacity of the local criminal justice system and the capacity of local laboratories to analyse evidence. ***Do not collect evidence that cannot be processed or that will not be used.***[42]

The collection of semen for the purpose of forensic evidence does not completely prove that rape occurred, as other scientific advancements may not be able to prove beyond a reasonable doubt that the semen belongs to the perpetrator.

Forensic evidence collection is only relevant if laboratories can conduct DNA testing (which is not available in PNG) and if the country's legal system can interpret the meaning of the presence or absence of forensic evidence appropriately.

Treatment and care

The treatment and prevention of STIs, HIV, HEP B and tetanus follow the same process in adults and children, with adjusted dosages and considerations for the vaccination schedules for children (see the paediatric doses in Annex 6). However, healthcare workers should apply additional considerations when treating children:

» Developing and improving skills related to psycho-emotional care is required when providing counselling for child trauma.

» Providing parents or guardians with education on supporting their child through treatment adherence and side effects is necessary to ensure successful treatment.

Follow-up

The follow-up process is medically the same for adults and children (a head-to-toe assessment is recommended). However, healthcare workers should apply additional considerations during follow-up consultations with children:

» Pay particular attention when assessing the risk of additional incidents and developing a child protection strategy.

» Persistent vaginal infections could be indicative of continued SA or the presence of a foreign body in the vagina. Conduct an additional investigation and manage the situation accordingly, offering referrals if concerns continue.

42 WHO, UNFPA, UNHCR, 'Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons, revised edition', loc. cit., 2004.

Referrals to legal and social protection services
Healthcare providers must refer all CA cases to legal and social protection services for child survivors:

- Legal: healthcare workers must refer all CSA cases to the sexual offence squad of the police department.
- Social protection services: healthcare workers must report all CA cases to the child protection officer of the Department of Community Development, as per LPA.

Obtaining consent from minors[43]
The age of consent for a child in PNG is 16 years of age. When the child is under the legal age of consent, in principle, the child's legal guardian must provide consent for all examinations and operations. However, in certain situations, the caregiver cannot or will not give consent (e.g., if the caregiver is the suspected perpetrator or if the child came unaccompanied to the FSC). In these situations, the health worker must act in the best interest of the child. Healthcare facilities must provide essential healthcare and support if the child gives assent (if under the legal age of consent) or consent (if over the legal age of consent).

Infants and Toddlers (ages O–5)
Very young children are not sufficiently capable of making decisions regarding care and treatment. Healthcare providers should seek informed consent for children in this age range from the child's caregiver or another trusted adult in the child's life, not from the child. If no such person is present, the health worker may need to provide consent for the child to implement actions that support his or her health and well-being.

Additionally, healthcare workers cannot seek informed assent for children in this age range. However, the service provider should explain to the child what is happening during each step in the process using basic and appropriate terms.

Younger Children (ages 6–11)
Children in this age range are neither legally able nor sufficiently mature enough to provide informed consent to participate in and receive services. However, they are able to provide their informed assent or 'willingness' to participate. Service providers should ask children in this age range for their permission to proceed with services and actions that affect them directly. The child can provide permission orally, and the healthcare worker can document this permission on the informed consent form.

43 This section is adapted from: A. Erikson, 'Guidelines for health and psychosocial service providers in humanitarian s ` ettings: Caring for child survivors of sexual abuse', loc. cit., 2012.

For children in this age range, written parental or caregiver informed consent is required, along with the child's informed assent. If it is not possible to obtain informed consent from a parent or caregiver, the healthcare provider should approach another trusted adult (identified by the child) who can safely participate in care and treatment decisions to consent for the child.

Younger Adolescents (ages 12–14)
Children in this age range have evolving capacities and advanced cognitive development and may be mature enough to make decisions and provide informed assent or consent to continue services. In standard practice, the health worker should seek the child's written informed assent to participate in services, as well as the parent or caregiver's written informed consent. However, if the service provider deems it unsafe or not in the child's best interest to involve the caregiver, the health worker should identify another trusted adult in the child's life to provide informed consent and seek the child's written assent. If this is not possible, a child's informed assent may carry due weight if the health worker determines the child to be mature enough;[44] in this case, the health worker should consult with his or her supervisor and may proceed with care and treatment with the supervisor's guidance and support.

Older Adolescents (ages 15–17)
Older adolescents are generally considered mature enough to make decisions, and adolescents aged 15 or older are often permitted to make decisions regarding their own care and treatment, especially for social and reproductive healthcare services. Older adolescents can give their informed consent or assent, though supportive and non-offending caregivers may be included in the care and treatment decision-making process and provide their informed consent if the child wishes. However, the healthcare provider should speak directly with the child to determine if the caregiver will participate in the care and treatment continuum. If the adolescent and caregiver agree to proceed, the health worker should document their verbal informed consent using a consent form before proceeding with the examination and treatment.

Special situations
While the healthcare worker should follow the guidelines, there are several situations in which the provider should consider the specific circumstances:

- If it is not in the best interest of the child to include a caregiver in the informed consent process, the health worker should identify a trusted adult in the child's life who can provide consent.
- If there is no trusted adult available to provide consent, the health worker should determine the child's capacity to make his or her own decisions based on his or her age and level of maturity.

44 Due weight refers to the proper consideration given to the child's views and opinions based on factors such as his or her age and maturity.

- If a child under 15 years of age does not assent, but the caregiver does, or if both the child and caregiver do not consent or if a child above 15 years of age does not consent, the health worker must decide whether it is appropriate to go against the wishes of the child and caregiver to proceed with the consultation. Such decisions should be made on a case-by-case basis and use the child's age and level of maturity, cultural and traditional factors, the presence of supportive caregivers, and the urgency of the situation to determine whether the patient requires urgent care and treatment services.
- If the children or caregivers are hesitant to proceed, health workers should ask additional questions to determine the cause of such hesitation. For example, the child and caregiver may be worried that the health worker will share the information with the police. In this situation, the provider can discuss the survivor's right to decide how to share information if warranted and present the risks and benefits of reporting.
- If the service provider identifies serious risks in the survivor's situation, it may not be in the child's best interest to report the incident to the police. The health worker can further explain and discuss these circumstances with the child and, subsequently, his or her supervisor. Health workers should take the time to discuss the child's and caregiver's concerns regarding proceeding with the consultation and provide clear and accurate answers to address the identified concerns.

Safety of the child

A safety plan is a tool that the child and health worker can use to keep the child safe from further harm. Health providers should work with the child to develop a safety plan based on his or her views, opinions and thoughts and ensure that he or she feels comfortable with carrying out whatever plan the healthcare worker and survivor have developed. A proper safety plan should include:

1. A safe environment away from the perpetrator to ensure that the abuse cannot continue. It is important to involve a child protection officer and the police in developing this aspect of the safety plan.
2. A trusted person who can remain with the child at all times to ensure that he or she is free from external harm and does not harm him- or herself (in the case of suicidal thoughts, which is more likely to occur in adolescents).
3. Strategies to assist the survivor in coping (preventing self-harm and negative ideation)

Supporting the family of an abused child
Families experience different emotions at different times in response to the discovery that a member of their family has been abused. Counsellors and healthcare providers must understand how families can respond and how that response can affect their ability to support the abused child. Such support includes:

- Providing practical support for the child
- Accompanying the child to the hospital
- Providing detailed information in an interview

Parents may feel aggressive, non-trusting, defensive, guilty, suspicious or frightened when dealing with healthcare providers. While it can be challenging to convince the caregiver to work with the healthcare staff rather than against them, it is an essential component of providing care for the child. Counsellors or healthcare providers must approach the family with a welcoming and understanding attitude to encourage trust and cooperation. A confrontational, accusatory or judgemental attitude will only increase the negative emotional responses of the family.

Offer PFA or counselling to the caregivers accompanying the abused child to ensure that they are able to support the child through treatment and care.

14 | Vicarious trauma

14 | Vicarious trauma

Vicarious trauma : an occupational hazard for people working and volunteering in the fields of victim services marked by the continuous exposure to victims of trauma and violence. Studies have found that exposure to the trauma of others may change the world view of these responders and can put people and organisations at risk for a range of negative consequences.

Compassion fatigue: a combination of physical, emotional and spiritual depletion associated with caring for others who are in significant emotional pain and physical distress

Burnout: a state of physical, emotional and mental exhaustion caused by the long-term involvement in emotionally demanding situations

Health providers must be able to recognise the symptoms of vicarious trauma in themselves and others. Vicarious trauma is the trauma a healthcare worker experiences as a result of empathic engagement with traumatised survivors, particularly after hearing their reports of traumatic experiences. Many overlapping and interrelated concepts are used to define the impact that working with trauma survivors can have on providers.

Prevalence

Evidence has demonstrated that vicarious trauma, compassion fatigue and burnout are interconnected, with vicarious trauma and compassion fatigue leading to burnout. Studies among victims' services professionals have found that:

- Fifty per cent experience traumatic stress symptoms in the severe range
- Fifty per cent experience high to very high levels of compassion fatigue
- Thirty-four per cent met the PTSD diagnostic criteria from secondary exposure to trauma
- Thirty-seven per cent experience clinical levels of emotional distress associated with compassion fatigue

Signs and symptoms

Vicarious trauma can impact health workers' personal and professional lives, and it is important that they recognise the signs and symptoms in themselves and among their colleagues.

What to do: Individual self-care

Individuals who have been successful in addressing vicarious trauma have shared traits that helped them to be more stress resistant. Such traits include:

- Having a sense of personal control and believing that they can take action to change the situation around them
- Remaining present, engaged and active rather than passive during challenging times
- Making healthy lifestyle choices, such as avoiding addictions, exercising regularly and finding time to relax
- Maintaining healthy relationships to help them deal with difficult times

Symptoms of vicarious trauma (personal)[45]

Physical	Rapid pulse and breathing; headaches, fatigue and physical aches; impaired immune system
Emotional	Feelings of powerlessness, numbness, anxiety, guilt, fear, anger, depletion, hypersensitivity, sadness or helplessness; severe emotional distress; physical reactions to reminders/triggers/ flashbacks
Behavioural	Irritability, impatience or mood swings; sleep and appetite changes; isolation from friends and family; self-destructive behaviour; nightmares; hypervigilance; being easily startled or frightened
Spiritual	Loss of purpose or meaning; questioning good versus evil or prior religious beliefs; disillusionment or pervasive hopelessness
Cognitive	Diminished concentration, inattention, racing thoughts or preoccupation with clients; traumatic imagery or recurrent and unwanted distressing thoughts; cynicism, pessimism or self-doubt
Relational	Withdrawing or isolating from friends and family; decreased interest in intimacy or sex; minimisation of others' concerns; intolerance or mistrust; projection of anger or blame

45 Office of Victims of Crime, U.S. Department of Justice, 'The Vicarious Trauma Toolkit', Office of Victims of Crime [website], 2020, para. 1, <https://ovc.ojp.gov/program/vtt/introduction>, accessed 26 Oct. 2020.

Symptoms of vicarious trauma (professional)

Physical	Rapid pulse and breathing; headaches, fatigue and physical aches; impaired immune system
Performance	Decrease in the quality or quantity of work; exhibiting low motivation or task avoidance; obsession with detail, working too hard or setting impossibly high standards, difficulty with inattention and forgetfulness
Morale	Decrease in confidence; decrease in interest or a sense of disconnectedness; negative attitude, apathy or reduced compassion; dissatisfaction, demoralisation or feeling undervalued and unappreciated
Relational	Detached or withdrawn from co-workers; poor communication or experiencing conflict; feelings of impatience or intolerance of others; sense of being the 'only one who can do the job'
Behavioural	Calling out sick, arriving late or exhibiting poor follow-through; overworking and experiencing exhaustion; irresponsibility

Preventing and mitigating vicarious trauma

There are several steps that healthcare workers can take to prevent or mitigate vicarious trauma.

Step 1: Be aware of your state of mind and body

Healthcare workers are more vulnerable to vicarious trauma and compassion fatigue when they fail to pay attention to their responses. They are often so focused on helping others that they ignore or simply cannot detect their own problems and pain. Take the time to assess your feelings by asking yourself:

- How you tend to show stress. Do you exhibit any of the common signs and symptoms?
- How your body reacts to stress. Assess your posture, facial expressions, muscle tensions and breathing.

Ask colleagues, family, friends, supervisors or other trusted individuals for feedback on instances in which they witnessed you reacting to stress. Pay attention to how you react when interacting with traumatised clients and determine if you are unconsciously mimicking their physical and emotional state.

Step 2: Learn how to manage your stress and commit to taking action
Healthcare workers should commit to practising self-care, which WHO (1998) defines as 'what people do for themselves to establish and maintain health, and to prevent and deal with illness. It is a broad concept encompassing hygiene (general and personal), nutrition (type and quality of food eaten), lifestyle (sporting activities, leisure, etc.), environmental factors (living conditions, social habits, etc.) socio-economic factors (income level, cultural beliefs, etc.) and self-medication.'[46] However, while it is important to understand the breadth of self-care, making the commitment to take action is essential for practising self-care.

Step 3: Make a personal plan of action
After identifying how you respond to vicarious trauma and committing to practising self-care, the next step is to make a plan. Determine which particular skills and strategies would be helpful to mitigating vicarious trauma, including daily and weekly tasks and activities. This can include listening to relaxing music, writing in a journal, going for a walk, engaging in positive self-talk, going fishing, attending a class or enjoying a night out every week. Ask family, friends and colleagues for ideas based on their observations concerning your interests. Consider ways to include actions across the continuum of self-care, including eating well, sleeping enough, building supportive and healthy relationships at home and at work, and engaging in creative and physical activities, such as art or sports. Regular prayer and meditation or attending religious services can be helpful for those who are religious. Write your plan down to hold yourself accountable. Whatever coping skills you include, studies have proven that writing down an action plan encourages individuals to actively and consistently complete tasks and carry through with activities.

Step 4: Act on the plan
Find a friend, colleague or family member who can help hold you accountable to your plan and encourage you to practise self-care. Engaging a colleague as a 'buddy', particularly someone in your field, may be helpful to encourage regular check-ins and support one another. Create a support system, and take the time to regain your balance by refocusing and realigning your priorities.

46 International Self-Care Foundation, 'What is health care?', International Self-Care Foundation [website], < https://isfglobal.org/what-is-self-care/>, accessed 25 Aug. 2021.

As you work through these four steps, remember to reflect on the positive aspects of your work. Do you find this work rewarding? Do you feel personal satisfaction from helping others? Does this work give you purpose? Reflecting on the positive aspects of the job can bring balance, especially when an experience feels overwhelming.

What to do: Peers

Successful peer support can create a caring environment with positive feedback and personal support in individual or group settings. It should be structured, and participants should meet regularly to identify, discuss and address the effects of vicarious trauma. Peer groups can be an effective venue for building knowledge and skills, promoting role modelling and sharing coping skills and providing feedback to leadership and supervisors. However, peer support is not a substitute for supervision and requires the support of clinic management and supervisors.

Careful planning and implementation are necessary to experience benefits from peer support. Healthcare workers who wish to begin a peer support system should:

- Discuss options with supervisors and facility management to ensure that the clinic leadership supports the idea.
- Develop a clear confidentiality protocol and ensure that everyone knows and follows it.
- Identify and train peer leader(s) within the facility. Ask supervisors for support in providing time to seek and participate in training to become an effective peer support leader.
- Outline the expectations, rights and responsibilities of participants, including attendance and confidentiality requirements.

What to do: Organisational and management responsibilities

Identifying and addressing vicarious trauma is not the responsibility of the individual provider alone, and self-care, while important, is insufficient for fully preventing and mitigating vicarious trauma. Clinical organisations have an ethical 'duty to train'; they must teach their staff about the potential negative effects (including vicarious trauma, compassion fatigue and burnout) of the work, as well as how to cope with the duties of the job. Supervisors and those in a position of responsibility in health facilities can advocate or implement several steps to support their staff:

Take leave

Employed survivors may receive sick leave based on their employer's human resource leave policies to allow the patient to recover from the traumatic event and manage potential side effects of medications (e.g., ART).

Create an enabling work environment with trauma recovery concepts of safety, empowerment, collaboration, choice and trust. Staff who perceive that their organisations are supportive experience lower levels of vicarious trauma.

Identify and address warning signs in employees and take action. Discuss these warning signs with the employee, telling them what you have noticed and asking them how you can support them. Hold the conversation in a private location and do not sit behind a desk; the employee should see you as a supportive peer rather than a supervisor. Focus on introducing effective coping strategies and help the employee to develop their plan. Meet with them each week to assess their progress and provide any necessary support.

Lead by example and practice what you preach. Seek support when necessary and take the time to assess how you are coping. Make a plan and be a leader in self-care. If staff see the management take their own health seriously, they will be more likely to focus on self-care and address the warning signs of vicarious trauma. Providing effective and high-quality services to traumatised clients (and staff) requires that all healthcare providers take care of themselves, including the management staff.

Educate the staff about the signs and symptoms of vicarious trauma, compassion fatigue and burnout. Hold regular individual supervisory meetings and larger staff meetings to communicate with staff members and assess their risk of experiencing vicarious trauma. Use these interactions to raise awareness of the signs and symptoms of vicarious trauma and monitor staff risk both individually and across the organisation. Develop resource materials on vicarious trauma and ensure that the resources are available to the staff.

Support staff members through individually or professionally facilitated peer support groups. Following critical or acute incidents, seek out and support the staff members and connect the affected staff to external counselling. Conduct formal debriefings and case reviews using a structured protocol and encourage collegial team reflection and support. Include discussions of vicarious trauma in performance evaluations.

Manage caseloads and work responsibilities to ensure that staff have a variety of cases and that no individual healthcare worker has a full caseload of complex trauma cases. Even if a particular staff member handles rape cases or cases of violence against children particularly well, giving a single healthcare worker the majority of such cases can lead to severe burnout and may result in their resignation. To utilise such staff members' skills, partner them with another staff member who can learn their skills and techniques for providing quality care to trauma survivors. Ensure that all staff have some cases with lower severity, some with moderate severity and some with more intense needs. Additionally, vary each staff member's work responsibilities and set realistic expectations for seeing clients, updating charts, attending meetings and participating in self-care activities. Finally, remind them of the importance of setting and maintaining boundaries between work and home.

Offer opportunities for professional development through participation at conferences, training sessions, committees, task forces and community meetings.

Implement and support opportunities for staff to convene. Such opportunities can include social interactions (such as celebrating birthdays or work anniversaries) and on-site wellness activities (such as fitness, yoga and mindfulness programs). Take advantage of each gathering to show appreciation for the staff, remind the team of the important services they provide to clients (despite limited resources) and encourage teamwork and collaboration.

Focus on the positive!

Individual staff, peers and supervisors should take the time to focus on the positive aspects of providing care to others. Practising self-care and participating in peer activities can increase resilience and improve adaptability to adversity, trauma, tragedy, threats and stress.

While the hazards of the healthcare field can incite vicarious trauma, compassion fatigue and burnout, healthcare workers can also experience vicarious resilience, compassion, satisfaction and transformation.

Just as health professionals can absorb trauma from their interactions with survivors, they can also experience vicarious resilience and the feeling of overcoming adversity through their interactions with trauma survivors. Vicarious resilience can lead to:

- Improved perspectives and appreciation of our own problems
- Increased optimism, motivation, efficiency and energy
- Increased sense of hope, understanding and belief in the possibility of recovery from trauma and other serious challenges
- Renewed commitment to helping patients and finding greater meaning in the work

While working with trauma patients can accumulate fatigue, healthcare workers can also accumulate satisfaction from compassionate interactions with others and derive pleasure from the work. By focusing on the positive aspects of the job, healthcare professionals are more likely to acknowledge the meaningfulness of their contribution to patients and even society.

By incorporating self-care and developing a peer support system, health workers can experience vicarious transformation and a deepened sense of connection with others, a greater appreciation of their lives and a greater sense of meaning and hope.

ANNEXES

Annex 1 | Useful contacts and referrals

FSVAC is the coordinating body for all matters related to the multi-sectoral approach to supporting survivors of SGBV and FSV in PNG. Contact the provincial FSVAC coordinator to facilitate referrals to other sectors upon the survivor's request. For medical referrals, contact the provincial hospital.

For more detailed contact information, see the Meri Toksave Directory of Emergency Services for those affected by FSV.

HOSPITAL-BASED FAMILY SUPPORT CENTRES (FSCS)

SOUTHERN REGION

1. Western Province

Daru General Hospital FSC
P.O. Box 1,
DARU,
Western Province.
Phone: +675 645 9166
Contact Person: Sr.Taita Saliki / Sr.Dore Peary
Position: FSC - OIC / GESI officer WPHA
Phone/Mobile:7473 0005 / +675 7138 3438
Email:

2. Gulf Province

Kerema General Hospital FSC
P.O. Box 28 ,
KEREMA,
Gulf Province.
Phone: +675 648 12 68/73
Contact Person: FSC OIC
Position: FSC OIC
Phone/Mobile:
Email:

3. Milne Bay Province

Alotau General Hospital FSC
P.O. Box 402,
ALOTAU,
Milne Bay Province.
Phone: +675 641 1200/05
Contact Person: Ms. Edna Tounokon
Position: FSC OIC
Phone/Mobile: +675 7126 1631
Email: tounokon003@gmail.com

4. National Capital District

Port Moresby General Hospital FSC
Free Mail Bag,
BOROKO,
National Capital District.
Phone: +675 324 8245/6
Contact Person: Ms. Tessie Soi
Position: FSC Coordinator
Phone/Mobile: +675 7126 1631
Email: tessiesoi2015@gmail.com / tsoi@pomgen.gov.pg

5. Oro Province

Popondetta General Hospital FSC
P.O. Box 93 ,
POPONDETTA,
Milne Bay Province.
Phone: +675 629 7741
Contact Person: FSC-OIC
Position: FSC OIC
Phone/Mobile: +675 629 7962/7178/7869
Email:

6. Central Province

Port Moresby General Hospital FSC
Free Mail Bag,
BOROKO,
National Capital District.
Phone: +675 324 8245/6
Contact Person: Ms. Tessie Soi
Position: FSC Coordinator
Phone/Mobile: +675 7126 1631
Email: tessiesoi2015@gmail.com / tsoi@pomgen.gov.pg

HIGHLANDS REGION

7. Enga Province

Wabag General Hospital FSC
P.O. Box 196,
WABAG,
Enga Province.
Phone: +675
Contact Person: Dr. Betty Koka
Position: Director Public Health
Phone/Mobile: +675
Email: kaulam495@gmail.com /
engapublichealth@gmail.com

8. Southern Highlands Province

Mendi General Hospital FSC
Free Mail Bag
MENDI,
Southern Highlands Province.
Phone: +675
Contact Person: Sr. Mary Balupa
Position: FSC OIC
Phone/Mobile: +675 7006 2475
Email: marybalupa2017@gmail.com

9. Hela Province

Tari Hospital FSC
P.O. Box ,
TARI,
Hela Province.
Phone: +675 7119 2333
Contact Person: Sr. Clare Lembo
Position: FSC OIC
Phone/Mobile: +675 7296 6532
Email: clarelembo80@gmail.com

10. Western Highlands Province

Mt. Hagen General Hospital FSC
P.O. Box 36,
MT. HAGEN,
Western Highlands Province.
Phone: +675 540 1841/ +675 542 1166
Contact Person: Sr. Iudith Namba/ Sr. Dolyn
Position: FSC Coordinator
Phone/Mobile: +675 7379 1422/ 7366 6783
Email: edith.namba@whhs.gov.pg

11. Jiwaka Province

Minj District HC FSC
P.O. Box ,
BANZ,
Jiwaka Province.
Phone: +675
Contact Person: Sr. Agnes Kerry
Position: FSC OIC
Phone/Mobile: +675 7319 2995
Email:

12. Simbu Province (a)

Kundiawa General Hospital FSC
P.O. Box 346,
KUNDIAWA,
Simbu Province.
Phone: +675 535 1066
Contact Person: Ms Jean Kupo
Position: FSC Clinical Social Worker/ Mental Health
Phone/Mobile: +675 7300 3320
Email: jean.garikikikupo.jgk@gmail.com

12. Simbu Province (b)

Kerowagi District HC FSC
P.O. Box 71 ,
KUNDIAWA,
Simbu Province.
Phone: +675
Contact Person: Ms Lina Gene
Position: FSC OIC
Phone/Mobile: +675
Email: lynagene@gmail.com

13. Eastern Highlands Province

Goroka General Hospital FSC
P.O. Box 392,
GOROKA,
Eastern Highlands Province.
Phone: +675
Contact Person: Sr. Koim Jonduo
Position: FSC Coordinator
Phone/Mobile: +675 7344 3817
Email: goimkumgi@gmail.com

MOMASE REGION

14. Morobe Province

Lae ANGAU Memorial Hospital FSC
P.O. Box 457,
LAE,
Morobe Province.
Phone: +675 473 2205/ 472 6070
Contact Person: Sr. Anasthasia Wakon/ Sr. Kasa
Position: FSC OIC
Phone/Mobile: +675 7390 0007/ 7580 3437
Email:

15. Madang Province

Madang General Hospital FSC
P.O. Box 2030,
MADANG,
Madang Province.
Phone: +675 422 2022
Contact Person: Catherine Bedford
Position: FSC Mental Health Nurse
Phone/Mobile: +675
Email:

16. East Sepik Province (a)

Wewak General Hospital FSC
P.O. Box 395,
WEWAK,
East Sepik Province.
Phone: +675 458 1387
Contact Person: Ms. Cynthia Huafolo
Position: FSC Social Worker
Phone/Mobile: +675 7362 1483
Email: chuafolo20@gmail.com

16. East Sepik Province (b)

Maprik District Hospital FSC
P.O. Box 395,
WEWAK,
East Sepik Province.
Phone: +675 641 1200
Contact Person: Mr. Raymond Pohonai
Position: Project Coordinator
Phone/Mobile: +675 7295 8633/ 7366 4666/ 76930368
Email:

17. West Sepik (Sandaon) Province

Vanimo General Hospital FSC
P.O. Box 331,
VANIMO,
West Sepik Province.
Phone: +675 857 1167/ 857 1080
Contact Person: Francis Petos
Position: FSC Health Officer
Phone/Mobile: +675 732 47 392
Email:

NEW GUINEA ISLANDS REGION

18. Manus Province

Lorengau Hospital FSC
P.O. Box ,
LORENGAU,
Manus Province.
Phone: +675
Contact Person:
Position: FSC OIC
Phone/Mobile: +675
Email:

19. New Ireland Province

Kavieng General Hospital FSC
PO Box 63,
KAVIENG
New Ireland Province
Phone: +675 984 2040
Contact Person: Sr. Mary Matua/ Dr.Maylin Kariko
Position: FSC-OIC / SMO Pediatrics
Phone/Mobile: +675 7430 8471 / +675 7102 2799
Email:

20. East New Britain Province	21. West New Britain Province
Nonga Base Hospital FSC Free Mail Bag, RABAUL, East New Britain Province. Phone: +675 982 7333/ 982 7421 Contact Person: Sr. Veronica Marfu Position: FSC OIC Phone/Mobile: +675 7111 8231 Email: vmmarfu@gmail.com	Kimbe General Hospital FSC P.O. Box 736, Hoskins Highway KIMBE, West New Britain Province. Phone: +675 983 5174 Contact Person: HEO Stella Robin / Mr. Jack Moite Position: FSC- OIC / GBV coordinator (PHA) Phone/Mobile: +675 7430 8471/ 7257 8598 Email: moitejj@gmail.com / stellarobin161@gmail.com
22. Autonomous Region of Bougainville (a)	**22. Autonomous Region of Bougainville (b)**
Buka General Hospital FSC P.O. Box 188, BUKA, ARoB. Phone: +675 973 9166 Contact Person: Sr. Michelle Kalabai Position: FSC Coordinator Phone/Mobile: 7230 92 93 Email:	Arawa District Hospital FSC P.O. Box 188, BUKA, ARoB. Phone: +675 Contact Person: Sr. Immaculate Keaito Position: FSC OIC Phone/Mobile: 7913 1388 Email: ikeaito16@gmail.com

Call TOLL-FREE 1-Tok Kaunselin Helpline on (+675) 7150 8000 for all other Updated Contacts and Services for IMMEDIATE HELP

NATIONAL COORDINATION & PARTNERSHIP SUPPORT FOR FAMILY SUPPORT CENTRES (FSCs)

NATIONAL DEPARTMENT OF HEALTH

Program Advisor – Gender & Men's Health	Technical Officer – Gender Health & Human Rights
National Department of Health P.O. Box 807, WAIGANI, National Capital District. Phone: +675 301 3720 Contact Person: Mr. Sebastian Robert Position: Technical Advisor – Gender & Men's Health Program Phone/Mobile: +675 7942 8012 Email: sebastian.robert@live.com / sebastian.robert35@gmail.com	National Department of Health P.O. Box 807, WAIGANI, National Capital District. Phone: +675 301 3720 Contact Person: Ms. Cathleen Alua Position: Technical Officer – Gender Health & Human Rights Phone/Mobile: +675 7223 3314 Email: cathleenalua@gmail.com

PNG WHO COUNTRY OFFICE

Program Technical Officer

WHO PNG Country Office
P.O. Box 5896,
BOROKO,
National Capital District.
Phone: +675
Contact Person: Ms. Jessica Yaipupu
Position: Program Technical Officer – Gender Health Program
Phone/Mobile: +675 7137 3332
Email: yaipupuj@who.int

OTHER DEVELOPMENT AND IMPLEMENTING PARTNERS

Family Health International (FHI 360)

Family Health International (FHI 360)
P.O. Box 447,
Waigani,
National Capital District.
Phone: +675 323 0966 / 72014401
Contact Person: Roselyn Nopa
Position: Gender Advisor
Phone/Mobile: +675 323 0966 / 72014401
Email: rnopa@fhi360.org

United Nations Population Fund (UNFPA)

UNFPA
PO Box 1041,
Port Moresby,
National Capital District
Phone: +675 321 2877
Contact Person: Lucy Stevens
Position: Programme Specialist (GBV/SRHR)
Phone/Mobile:+675 321 2877
Email: lstevens@unfpa.org

United Nations Children Fund (UNICEF)

UNICEF
PO Box 472
Port Moresby
National Capital District
Phone: +675 321 3000 / 7270 41 99
Contact Person: Hennie Kama
Position: Child Protection
Phone/Mobile: +675 321 3000/ 72704199
Email: hkama@unicef.com

Annex 2 | Consent/assent form

Name of Healthcare Facility: _____ Survivor Number: _____

Note to the Healthcare Provider:
After explaining consent and assent to the survivor (refer to CPG regarding consent), read this form to the survivor (or his/her parent/guardian), explaining that they can choose to refuse any (or none) of the items listed. Obtain a signature or a thumbprint with the signature of a witness.

First Name: _____ Last Name: _____
I, _____ *(print the name of the survivor or guardian, if the survivor is a child) authorise the above-named health facility to perform the following (check (tick the appropriate boxes):*

	Yes	No
Take a full history	☐	☐
Conduct a medical examination	☐	☐
Conduct pelvic examination (If relevant)	☐	☐
Collect relevant evidence and forensic specimens *(refer to the CPG)*	☐	☐
Provide medical treatment	☐	☐
Provide a medical report to the police and/or courts concerning the case *(this information will be limited to the results of the history and examination and any relevant follow-up care provided)*	☐	☐
If the survivor is a child above the age of 6 years: Verbal informed assent is given by the child	☐	☐

I understand that I can refuse any aspect of the examination I do not wish to undergo, even if I have already signed this form.

Signature/finger print: _____ Date of birth/age: _____ Sex: F M
Date: ___ /___ /___ Contact information: _____
Witness: _____ Residence: _____

Name /Title:_____ /_____
(Healthcare provider taking the history and conducting the examination)

Signature:_____ Date: ___ /___ /___

Annex 3 | Medical examination record

MEDICAL EXAMINATION | CONFIDENTIAL INFORMATION

REASON FOR PRESENTATION
☐ IPV only ☐ IPV(previous SV) ☐ IPV(current SV) ☐ SV ☐ FV
☐ GBV ☐ other

1 | GENERAL INFORMATION

Survivor number: _____ Home location: _____
☐ Male ☐ Female Age: _____ Date of birth ___ /___/___
Date/time of first visit ___ /___ /___ , ___ /___ a.m./p.m.
FSC/health facility: _____
Interview conducted by: _____ Title: _____

Knowledge of services:
☐ 1. Mass media
☐ 2. Primary healthcare
☐ 3. Secondary/tertiary care
☐ 4. Non-medical organisation
☐ 5. Hearsay
☐ 6. Community Activities
☐ 7. Other: _____

Referred by:
☐ 1. Health facility
☐ 2. Self
☐ 3. Outreach
☐ 4. Other organisation
☐ 5. Police
☐ 6. Village court
☐ 7. Protection Sector

In case of child, include name of school: _____
Accompanied by (no name): *(e.g., parent, sibling, aunt, teacher, etc.)* _____
Phone number (survivor): _____
Phone number (caretaker): _____
Permission to be contacted: YES/NO

PFA + Safety assessment	Yes	No
Is there any immediate need or concern (children, relatives, etc.)?	☐	☐
Is the survivor physically and emotionally safe (no people around who would harm or threaten the survivor)?	☐	☐
Presented safety, role of the nurse and counsellor, confidentiality and overview of services.	☐	☐
Explain what will happen in this consultation.	☐	☐

Notes _____

_____

_____

_____

_____

2 | INCIDENT

Date /time of incident: ___/___ /___ , ___ /___ a.m./p.m.

Delay: ☐ < 24 hours ☐ 24 - 72 hours ☐ 4 - 5 days
☐ 6 days - 1 month ☐ 1 - 3 months

Relationship to perpetrator(s): _____ Number of perpetrator(s): ____

Location of incident: _____

Context (activity at time of incident): _____

Description of incident (in survivor's own words):

_____

_____

_____

_____

Physical violence	**Yes**	**No**	**Comments** *(type of violence: beating, biting, etc.)*
Use of physical violence			
Threats of violence			
Death threats			
Use of restraints			
Abduction			
Use of weapons			
Drugs/ alcohol involved			

Penetration	**Yes**	**No**	**Unsure**	**Description** *(oral, vaginal, anal, type of object used)*
Penis				
Finger/Object				
Ejaculation				
Condom used				

Comments: (Note: Penetration is the introduction to any extent of any object into the vagina, anus or mouth) _____

_____

_____

_____

Type of violence: ☐ Physical ☐ Sexual ☐ Emotional ☐ Multiple

Type of sexual violence: ☐ Rape ☐ Assault ☐ Harassment ☐ Exploitation ☐ Other

3 | MEDICAL HISTORY

Current symptoms:

OBSTETRIC/GYNAECOLOGY HISTORY:

First day of last period: ___ /___ /___

Menstruation at time of event ☐ Yes ☐ No ☐ Unsure

Evidence of pregnancy ☐ Yes ☐ No ☐ Unsure

If yes, how many weeks? _____

Pregnancy prior to SV ☐ Yes ☐ No ☐ Unsure

Date of last consenting intercourse within a week prior to assault: __ /__ /__

Previous sexual assault or abuse: ☐ Yes ☐ No ☐ Unsure

Number of births: G____ P____ Last childbirth (date): ___ /___ /___

Currently breastfeeding: ☐ Yes ☐ No

Contraception use: ☐ None ☐ OCP ☐ Depo ☐ IUD
☐ Implant ☐ Condom ☐ Sterilization
☐ Other

Date of last contraceptive device: (if applicable) ___ /___ /___

Additional information: *(including history of miscarriages, abortions, ectopic pregnancies, pelvic surgery, pelvic trauma, etc.):*

PAST MEDICAL HISTORY:

Known allergies: _____

Current medication: _____

Vaccination status	Vaccinated	Not vaccinated	Unknown
Tetanus	Date: ___ /___ /___	☐	☐
HEP B	Date: ___ /___ /___	☐	☐

HIV Status: ☐ Known positive
☐ Known negative (date of last test: ___ /___ /___)
☐ Unknown

Hep B Status: ☐ Known positive
☐ Known negative (date of last test: ___ /___ /___)
☐ Unknown

History of previous STIs *(please give details of STI and treatment, if known):*

_____

_____

_____

_____

4 | GENERAL PHYSICAL EXAMINATION

Appearance (general observations with respect to stains, damage or missing items, including clothing and hair, and obvious physical or mental disability):

Mental state appearance (general observations with respect to behaviour, appearance and demeanor, such as calm, crying, anxious, cooperative, depressed, etc.):

Weight: _____ Height: _____

Pulse rate: _____ Blood pressure: _____

Temperature: _____ Respiratory rate: _____

PHYSICAL FINDINGS:

Be mindful that there may be no visible injuries present. Describe what is visible, including location, nature, size and colours of any injuries (e.g., abrasions, bruises, lacerations, etc.). Use the relevant pictogram to record locations of the findings. ***DO NOT INTERPRET THE FINDINGS.***

Scalp: ☐ No visible injuries

Ears: ☐ No visible injuries

Eyes: ☐ No visible injuries

Nose: ☐ No visible injuries

Mouth:	☐ No visible injuries
Face:	☐ No visible injuries
Neck:	☐ No visible injuries
Chest:	☐ No visible injuries
Breast:	☐ No visible injuries
Abdomen:	☐ No visible injuries
Back:	☐ No visible injuries
Buttocks:	☐ No visible injuries

Upper extremities: ☐ No visible injuries
(shoulders, hands, nails)

Lower extremities: ☐ No visible injuries
(hips, feet, nails)

Other:

GENITAL AND ANAL EXAMINATION:

Note that genital and anal examination can be re-traumatising for survivors and should only be carried out by trained health workers. Collection of forensic evidence should only be completed if laboratory facilities can process the specimen and if the legal system is functioning. Half of pre-menopausal women will have no visible genital injuries following rape.

Comment on any abrasions, lacerations, bruising, blood, faeces, vaginal discharge and debris (e.g., gravel, twigs, hair)

Observation of external genitalia

Vulva/scrotum:

Introitus/hymen:

Vaginal opening/penis:

Speculum (if done)

Vaginal walls:

Cervix:

Anal examination (if done)

Other:

INVESTIGATIONS DONE:

	Positive	Negative	Declined	Not indicated
Pregnancy Test:	☐	☐	☐	☐
1st PICT HIV:	☐	☐	☐	☐

X-ray: (findings): _____

Ultrasound: (findings): _____

Forensic evidence (findings), if facilities are available: _____

TREATMENT/CARE PROVISION PRESCRIBED AND ACCEPTED BY SURVIVOR (If survivor refuses treatment offered indicate under comments)

Treatment	Yes	No	Declined	Description/ comments
First aid (resuscitation, fracture care, wound care)				
EC pill				Date/time: ___ /___ /___
STI prophylaxis and treatment				
Tetanus vaccination				
HEP B vaccination				
HIV PEP				Date/time: ___ /___ /___
Family planning				
Other				
PFA				
Medical Report Written				
Medical report given to the survivor				

REFERRALS:

Referral arrangement	Yes	No	Declined
Referred for counseling			
Survivor plans to report to the police or has already reported			
Medical report to be ready on (date):			
In-hospital consulting services (e.g., children's OPD, gynaecology, psychiatry OPD, surgical outpatient department, orthopaedic or X-ray)			
Outside hospital referral to (name of facility):			
Assisted in ensuring the survivor has a safe place to go			

FOLLOW UP:

Follow up	Yes	No	Dates of f/u & comments		
Return to FSC					
HEP B vaccine			7 day:	28 days:	1 year:
Tetanus vaccine			28 days:	6 months:	1 year:
PEP			First: Third:	Second: Fourth:	
PICT for HIV			Initial PICT if not yet done (3 months):		
Suture removal					
Pregnancy test			21 days:		
Wound check					
Plaster of Paris and check removal					
Counselling			First: Third:	Second: Fourth:	
Others					

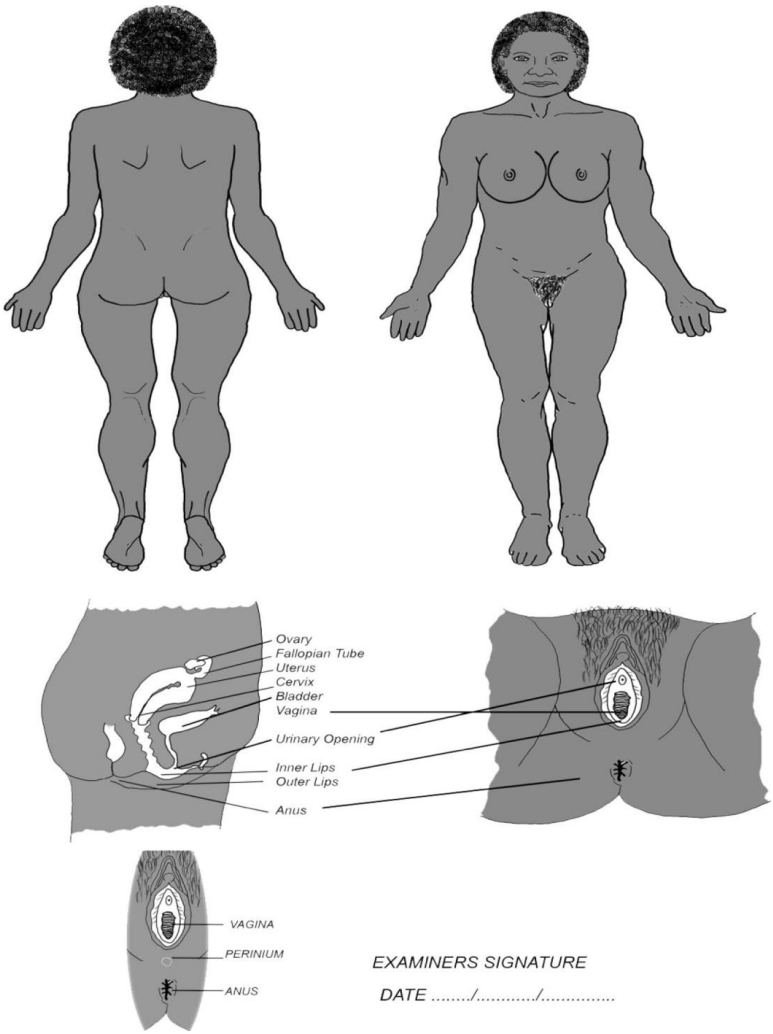
SCREENING FOR CHILD PHYSICAL OR SEXUAL ABUSE:

	Yes	No
Are there children living in the house?	☐	☐
Have they experienced violence from the perpetrator?	☐	☐
Have they witnessed the survivor being abused?	☐	☐
Has the survivor noticed any changes in their behaviour?	☐	☐

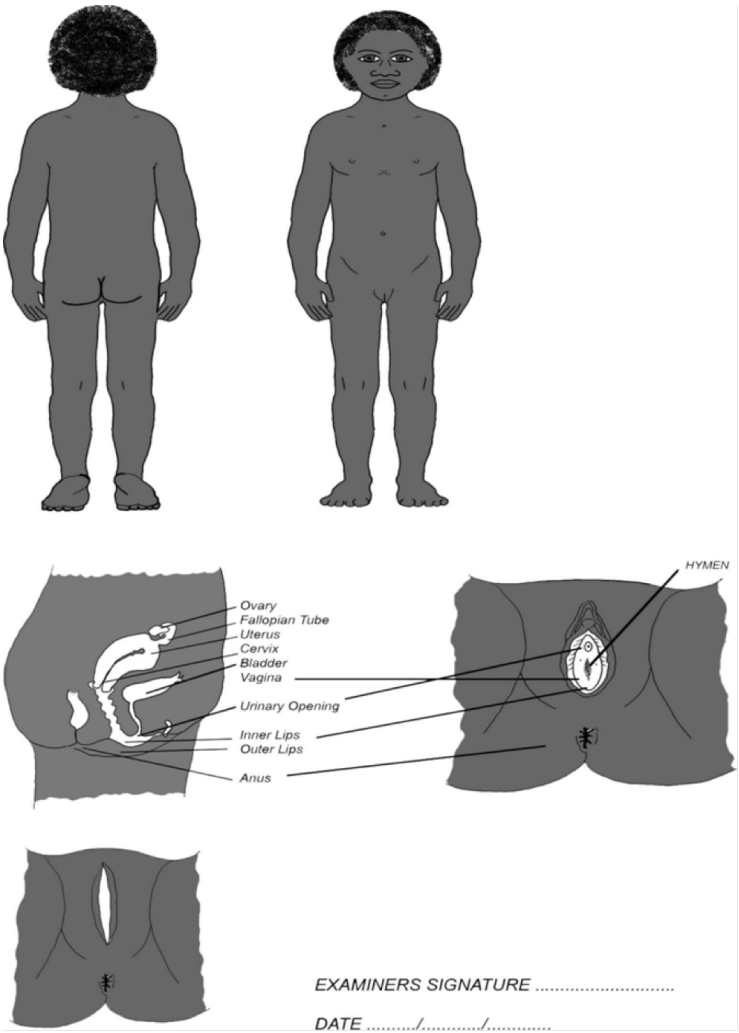
Note: if the child may have experienced or witnessed abuse, encourage the survivor to bring the child to the FSC for an assessment.

Make sure the survivor knows that he or she can come back at any time!

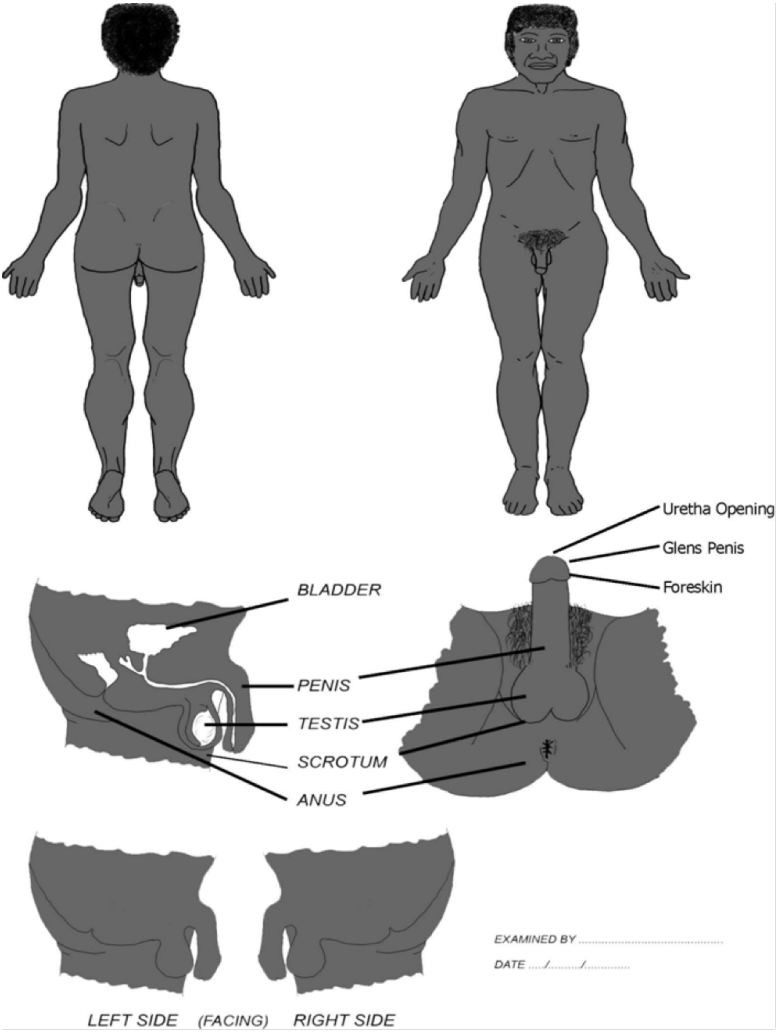
PICTOGRAM FEMALE ADULT:



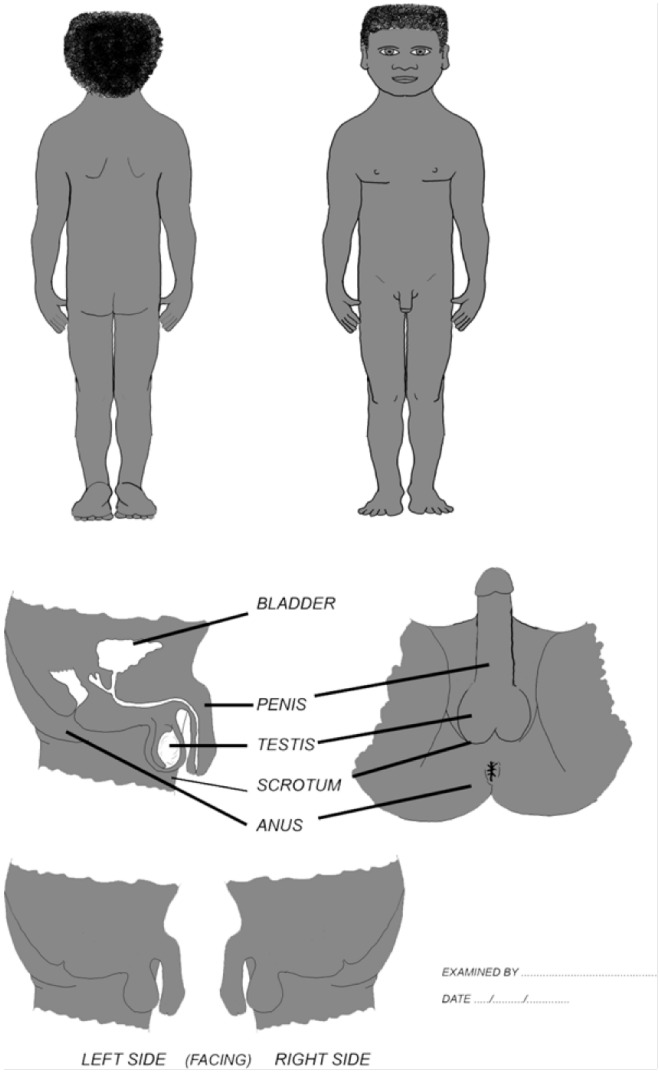
PICTOGRAM CHILD FEMALE:



PICTOGRAM MALE ADULT:



PICTOGRAM CHILD MALE:



Annex 4 | Medical report and notification for release of survivor medical report

Medical Report - Family Support Centre

The Medical Report is prepared by the person conducting the examination.
Complete the form in legible CAPITAL LETTERS.

I, the undersigned:		
First name	Family name	Title and hospital position
certify that I have examined and treated the survivor: Mr/Mrs/Ms/Miss		
First name	Family name	Title and hospital position
Address of the person examined		
On this date at this time (time/ date/month/year)	.....a.m./p.m./...../...../.....	
at the ..... Department of .....health facility/hospital		
aat his/her/the guardian's request (name and relationship of the guardian, if applicable)		
He/she has declared that he/she was the victim of a sexual assault/ intimate partner violence/child abuse on: (time/date/month/year)		.....a.m./p.m. ...../...../.....
at (place, if known)		
by (known/unknown person/s)		

During the consultation, he/she told me (quote as faithfully as possible the person's words without looking to interpret them. Do not exclude threatening elements, constraints or violence linked to the circumstances):

During the examination, Mr/Mrs/Ms/Miss ..... presented with the following signs *(detail the behaviour, such as prostration, agitation, calm, fright, muteness, tears, etc. Describe in detail all lesions observed on the entire body, including signs of abrasion, cuts, scratches, bites, strangulation, swelling, burns, etc. Indicate the location, extent, number and character [recent or old]. Include detectable traumatic lesions, genital infections, etc.):*

Note: The absence of physical injuries does not indicate that no sexual assault occurred.

Survivors consent: "I am informed about the content of this document, and I give my permission to the healthcare provider who examined me and signed this document to share this medical report with the investigating police officer within one week from the indicated date and upon presentation of the medical report request form.

Name:..... Signature/finger print: .....
Date:.....

Signature of Healthcare professional: .....
Date: ...../...../.....

NOTIFICATION FOR RELEASE OF SURVIVOR MEDICAL REPORT

I, ... (Name of survivor) authorise the Office of the DMS/OIC of ..... Hospital/Health Centre/Village Health Post to release my medical report to the Family and Sexual Violence Unit of ..... Police Station to use as evidence for proceedings against the perpetrator.

Signature: .....
Name of survivor: .....

Signature of attending Healthcare Provider (Witness): .....

NOTIFICATION FOR RELEASE OF CHILD SURVIVOR MEDICAL REPORT

I, ... (Name of legal guardian of the survivor), father/mother/legal guardian of ..... (Name of child survivor) authorise the Office of the DMS/OIC of .....Hospital/Health Centre/Village Health Post to release my medical report to the Family and Sexual Violence Unit of ..... Police Station to use as evidence for proceedings against the perpetrator.

Signature of guardian: .....
Name of guardian: .....
Name of child: .....

Signature of attending Healthcare Provider (Witness): .....

Annex 5 | Psychological support

All survivors should receive PFA and further counselling if indicated by red flags or upon the request of the survivor.

Providing psychological support to a survivor of SGBV may appear difficult to many healthcare providers who feel they do not have the necessary skills and knowledge to provide adequate care. However, many healthcare providers have a natural disposition towards helping and supporting people in need and require only practical tips on how to provide basic psychological support to become more confident counsellors.

1 | BASIC COUNSELLING TECHNIQUES

There are several basic counselling techniques that healthcare workers can use when interacting with individuals who have had a traumatic experience.

Be respectful

The survivor has already suffered from a painful event prior to seeking help. The healthcare provider must respect his or her ability to survive the experience and find the courage to seek medical attention. The patient is likely experiencing low self-confidence or feeling isolated or rejected by his or her peers. Demonstrating respect is a simple way to contribute to the healing process.

Be non-judgmental

The healthcare provider should exhibit a non-judgemental attitude concerning all aspects of the assault, including the survivor's actions during the attack (lack of resistance) or afterwards (failure to seek help or report the incident sooner). Listening with an open and accepting attitude will enable the survivor to speak more freely.

People often feel extremely guilty about their own behaviour during difficult situations and believe that they could have prevented the violence they experienced. It is important to emphasise that SV is a violation of a person's rights and is always the fault of the perpetrator, never the victim. When people 'freeze' or otherwise fail to escape SV, they are responding in the only way they can at that moment, and often, this lack of struggling preserves their lives. Healthcare workers should ensure that patients understand that their reaction is normal and understandable.

Maintain confidentiality

A breach of confidentiality could be extremely damaging for the survivor and may discourage other survivors from seeking help. Healthcare workers must observe absolute confidentiality and reassure the survivor that what they have revealed will remain confidential; however, the patient should understand that some limitations exist, such as the legal obligation to inform authorities of CSA. Despite these limitations, medical ethics always have primacy, and records of the interview should be stored safely in a locked drawer with extremely limited access.

Be consistent

The person to whom a survivor tells his or her story has been invested with a significant amount of trust. During follow-up care, health facilities should ensure (whenever possible) that patients see the same healthcare worker who provided care during the initial consultation. Maintaining consistency will provide the patient with a sense of control and promote trust.

Be patient-centred

Do not push or rush the survivor; let each patient express him- or herself at a comfortable pace by showing interest and engaging in active listening. Do not interrupt but try to keep the conversation focused. Allow silence, but do not allow it to become too long, as the patient may become uncomfortable. If the survivor does not want to talk, inform him or her that a trusted staff member will be available, should he or she want to talk at a later time. This reassurance can be especially important for children and teenagers. After an experience of disempowerment, it is essential that the survivor feels in control of the medical process. Without this sense of control, medical care can feel like another abusive experience and can be re-traumatic for the patient.

Be empathic

Trying to understand how a patient feels after a traumatic experience can be helpful in providing care. However, do not assume that he or she feels the way you would feel in a similar situation, as everyone experiences events differently. The healthcare provider should always check their understanding of the situation with the patient to ensure that the survivor feels heard and in control.

Allow the survivor to cry

Tending to someone who is crying can be upsetting. However, the healthcare provider should not become emotional with the patient (crying or expressing strong anger), as the survivor may then feel the need to help or protect the healthcare provider and may even feel responsible for the emotional upset. When a survivor cries, the healthcare provider should remain quiet, empathise and offer him or her a tissue. Telling him or her not to cry denies the patient the possibility of expressing him- or herself. Healthcare providers should also avoid physical touch, such as putting a hand on the patient's shoulder, as the survivor may find physical contact invasive or uncomfortable. It can be helpful for the healthcare provider to acknowledge that what has happened to the patient was wrong, should not have happened and is not his or her fault.

Pay attention to body language

Keep an open and relaxed posture and maintain a culturally appropriate distance with the patient (err on the side of caution). Eye contact can be an important means of communicating interest and respect, though this often varies across cultures. Try to understand the local cultural norms and avoid unwittingly offending the survivor.

Ask appropriate questions

When speaking with a survivor of SV, the healthcare provider should listen empathetically, direct the conversation and ask questions to help the patient tell his or her story. Different questions have different functions:

> *Directive or closed questions* are questions that leave the survivor few options, such as questions that require a 'yes' or 'no' answer or questions such as, 'What age are you?' These questions are easier to answer and can help a survivor to mention important facts and discuss issues that are emotionally charged. This type of questioning can enable someone to report on facts, though it limits the health providers ability to understand the patient's feelings and opinions about these facts.
>
> *Open questions* are questions that invite free expression and expansion and can elicit a wide range of answers. Such questions include, 'How do you feel?', 'What do you want to do now?' or 'Tell me what happened.' While these questions can be difficult to answer, they allow the survivor to talk about their experience. However, the patient may need to take some time to think before he or she is ready to answer, and many questions can lead to long answers.

Suggested replies to open questions provide the patient with possible answers. For example, when asking, 'How did you feel when this happened?' the survivor may have a difficult time expressing his or her feelings. The healthcare worker may instead say, 'When people experience these events, they often feel scared, angry or shocked. Did you have any of these feelings?' Providing possible answers can help the survivor express his or her emotions and normalise his or her reactions. However, healthcare workers must ensure that the survivor feels free to give an alternative answer and ask questions that are empathic rather than judgemental. By asking questions that 'drive' an answer rather than provide options, the survivors are likely to confirm the health worker's suggestions, regardless of how they really feel.

Statements ending in a question allow the healthcare worker to clarify what the survivor has said and provides the opportunity for the patient to correct the health worker's understanding. Such questions include, 'It sounds like you felt pretty angry about that, or have I misunderstood?'

'Why' questions are questions that often feel like an accusation; healthcare workers should avoid asking such questions whenever possible. Instead of asking, 'Why did you do this?' the health provider can ask, 'What were the reasons you did this?'

Leading questions imply an answer or give information for the survivor; healthcare workers should always avoid such questions, particularly when working with children or adults with learning difficulties.

Practice active listening

Interjecting little words and phrases ('Ah,' 'I see', etc.) can indicate active listening and encourage the survivor to continue. However, it is important to stop the patient and clarify what he or she means if a word or statement is vague or unfamiliar. It is better to admit uncertainty than to assume the wrong conclusion.

Summarize

Summarising what the patient has said can keep the consultation directed and organised. It is important to be tentative when presenting the summary (frequently checking with the survivor to ensure understanding), as the healthcare worker may not have understood everything clearly or the words used in the summary may not seem appropriate to the survivor. This exercise is particularly relevant when completing the 'history' section of the History and Examination Form.

2 | DO'S AND DON'TS

There are some basic "Do's" and "Don'ts" that apply and that a health care provider can keep in the back of his/her mind when supporting a survivor of FSV in the immediate aftermath of the incident.

Do

- Ensure safety, stabilisation and protection from further threats by providing a safe, calm environment (ask distressed individuals to leave the room) and offering symbolic shelter, such as covering the patient with a blanket.
- Identify basic needs, including immediate medical attention.
- Listen patiently and display an accepting and non-judgemental attitude.
- Reinforce with the survivor where they are now (i.e., in the clinic) and that they are safe. Once the survivor feels safe and comfortable, provide an opportunity for him or her to talk about what happened; however, if they do not wish to speak, respect their decision and do not pressure them for information.
- Use accurate, clear and short sentences when speaking to the survivor. After a traumatic event, it can be difficult for an individual to concentrate and process information.
- Ask for the survivor's concerns and try to address each issue.
- Discuss coping strategies, if relevant and appropriate. Discourage negative coping strategies, such as drugs and alcohol use, and encourage participation in normal routines and positive coping strategies, such as culturally acceptable relaxation methods.

Do not

- Give false reassurances or make promises that may not or cannot be kept.
- Force people to talk if they do not want to share what has happened.
- Tell survivors how they should be feeling, behaving or thinking.
- Tell survivors that what has happened is a result of something they have done.
- Criticise services on which the person may depend for support.
- Suggest potential symptoms or signs of PTSD. The evidence indicates that survivors are open to 'suggestions' at this time of high stress.

3 | ASSESSING AND SUPPORT FOR SPECIFIC SYMPTOMS

The survivor may present many different feelings and reactions to the trauma he or she has experienced, such as anxiety, anger, sadness, guilt or a feeling of being contaminated or 'dirty'. The survivor may also exhibit problems with sleeping, eating or sexuality, as well as dissociation (being unable to stay in the present moment), flashbacks, nightmares, symptoms of PTSD, suicidal thoughts and ideation, or negative coping strategies (drugs and alcohol abuse). This list is by no means exhaustive, and there are many possible reactions a survivor may exhibit after experiencing a traumatic event. If a healthcare worker has concerns about the mental health of the survivor and their reactions to trauma, refer them to a counsellor (or a nurse or doctor if no counsellor is available).

4 | CONSIDERATION OF SPECIAL CASES

Ensuring appropriate care can be particularly challenging, notably when dealing with patients with special circumstances. Healthcare workers should employ specific strategies when working with the following cases:

Children who will not talk:

- Explain to the child that it is okay if he or she does not wish to talk right now.
- Tell the child that you are concerned and want to help.
- Reassure the child that it is normal to be feeling many different emotions and that it is understandable if he or she is having difficulty saying certain things.
- Use dolls and art materials to aid in working with the child. Children often feel more comfortable with expressing themselves through art and play rather than verbally.
- Invite the child to return to the clinic and see you again.
- If a caregiver is present, consider the age of the child and context of the situation when determining if he or she should be in the room with the survivor.

Adolescents:

- This age group is very vulnerable, and the survivor may be feeling guilty about what happened.
- Adolescent survivors often have difficulties in communicating what has happened to them because they are not comfortable with using certain expressions or do not have the words to explain what has happened.
- Discuss what happened to the survivor with an open, non-judgemental attitude and provide clear, accurate and appropriate information.

Mentally disabled individuals:

- Due to their limited ability to defend themselves and speak out against abuse, mentally disabled individuals can be particularly vulnerable to abuse, including sexual abuse.
- Survivors may have difficulty in articulating what they have experienced.
- The perpetrator may be someone close to the survivor and may allege that the survivor gave consent.
- If a caregiver is present, consider the degree of disability of the individual and context of the situation when determining if he or she should be in the room with the survivor.

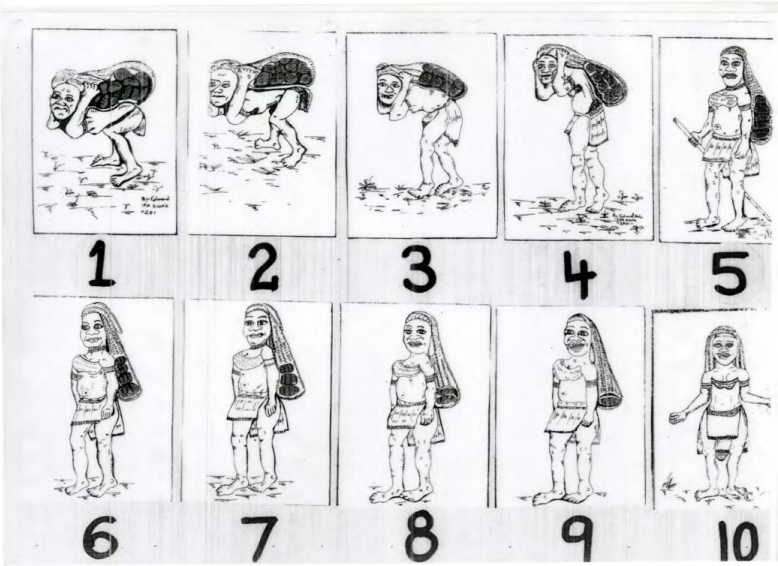
Male survivors:

- Men who have experienced SV should receive the same medical care as women.
- When appropriate, explain to the male survivor that having an erection and even ejaculating when being anally penetrated is a normal physiological reflex to prostatic stimulation. Additionally, anal pressure, pain, fear and high-stress arousal can trigger the ejaculatory function, which is not necessarily associated with pleasure, eroticism or homosexuality.

NB. Extreme arousal and a physiological fear response can result in a physiological orgasm for both female and male survivors. If not addressed, this reaction can continue the myth or false belief that the survivor wanted or enjoyed the experience. Healthcare providers should explain this to the survivor, saying that some victims can experience a non-erotic, non-pleasurable orgasm during rape and that this does not mean that they wanted or enjoyed the rape; it is a biological outcome of high-anxiety arousal and muscular tension. This information can greatly relieve survivors who may be feeling too guilty to even come forward about the event.

Assessing how the survivor feels:

The bilum scale is a tool that healthcare providers can use to discuss with the survivor how he or she feels before and after a counselling session. In the first picture, the person carries a very heavy bilum; this represents a heavy load or feeling psychologically burdened. In each of the following pictures, the bilum becomes lighter, representing a lighter psychological load. In the last picture, the bilum is empty, representing no psychological difficulties or worries. This tool can help survivors to rate his or her emotional status during each counselling session and note any improvements or setbacks.



Annex 6 | Flow charts for care provision

1 | MEDICAL FIRST AID

Assess if the client is STABLE or UNSTABLE:

If the client has any of the following conditions, refer him or her immediately to the A&E department for emergency medical care:

- Unconcious
- Confused state
- Faint or lightheaded
- Breathing difficulties due to trauma
- Hemorrhaging from trauma
- Unstable vital signs with associated symptoms (respiratory rate < 24, heartrate < 100, systolic blood pressure < 100)
- Signs of systemic infection (septicemia) from a wound (temperature < 38.5 °C) or shock

YES

If YES to any of the above conditions, refer to the A&E department immediately

- First dose of PEP and EC should be offered (if possible) prior to the referral

NO

If NO to all of the above conditions, assess the patient for physical injury and provide physical first aid as needed

- Suturing
- Wound care
- Dressings
- Pain medication, if indicated
- X-ray form

After initial stabilisation, refer survivor for PFA.

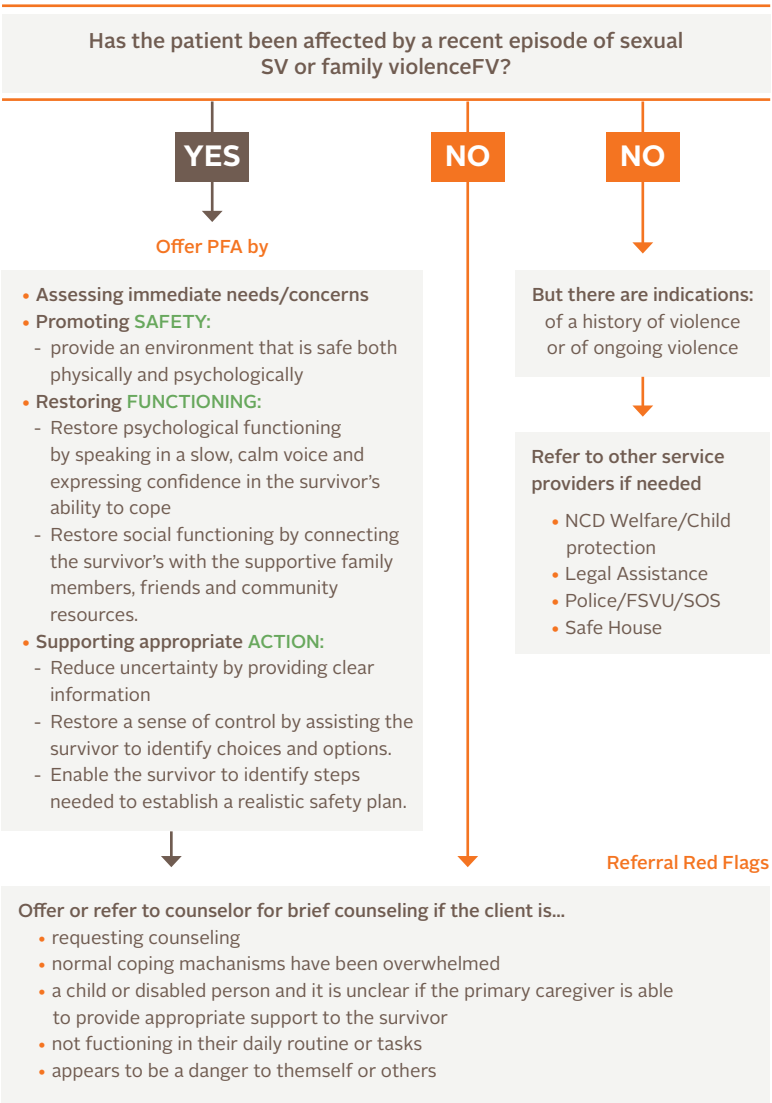
Schedule for providing medical care to SGBV survivors:

	Survivors presenting within 72 hours		Survivors presenting between 72 and 120 hours		Survivors presenting after 120 hours	
Intervention	Women/girls	Men/boys	Women/girls	Men/boys	Women/girls	Men/boys
PFA	Clean/repair wounds. For traumatic fistulas, refer to specialist care	Clean/repair wounds	Clean/repair wounds. For traumatic fistulas, refer to specialist care	Clean/repair wounds	Clean/repair wounds. For traumatic fistulas, refer to specialist care	Clean/repair wounds
Psychological First Aid	Yes	Yes	Yes	Yes	Offer basic counselling	Offer basic counselling
Determination of pregnancy	Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A	Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A	Determine if the survivor was pregnant before the rape (not a pre-requisite for treatment)	N/A
EC	Give within 120 hours after rape – if reproductive age (menstruating)	N/A	Give within 120 hours after rape if of reproductive age (menstruating)	N/A	No	N/A
Termination of unwanted pregnancy	N/A	N/A	Offer option termination of pregnancy	N/A	Offer option termination of pregnancy	N/A

Schedule for Providing Medical Care to SGBV Survivors:

	Survivors presenting within 72 hours		Survivors presenting between 72 and 120 hours		Survivors presenting after 120 hours	
Intervention	Women/girls	Men/boys	Women/girls	Men/boys	Women/girls	Men/boys
Prophylaxis of STI	Yes	Yes	Yes	Yes	Yes	Yes
Prevention of HIV	Yes	Yes	No	No	No	No
HIV testing	Recommended but not a pre-requisite	Recommended but not a pre-requisite	Recommended but not a pre-requisite	Recommended but not a pre-requisite	Recommended but not a pre-requisite	Recommended but not a pre-requisite
Tetanus prophylaxis	According to the risk and pre-exposure vaccination status	According to the risk and pre-exposure vaccination status	According to the risk and pre-exposure vaccination status	According to the risk and pre-exposure vaccination status	According to the risk and pre-exposure vaccination status	According to the risk and pre-exposure vaccination status
HEP B prophylaxis	Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol	Vaccinate according to protocol

PFA and referral 'red flags':



3 | PEP FOR PREVENTION OF HIV, STIs AND UNWANTED PREGNANCIES

PEP for HIV Prevention – within 72 hours or earlier)

PEP drug regimens

PEP for adults, adolescents and children ≥30 kg

Category	First choice	Alternate choice
Adult & adolesents	tenofovir (TDF) + lamivudine (3TC) + dolutegravir (DTG)	TDF + 3TC + lopinavir (LPV/r)
Children ≥30 kg body weight	tenofovir (TDF) + lamivudine (3TC) + dolutegravir (DTG)	TDF + 3TC + lopinavir (LPV/r)

Generally, the first choice (TDF + 3TC + DTG) regimen should be selected.

- As part of comprehensive PEP services, all adolescent girls and women should be offered pregnancy testing at baseline and during follow-up.
- EC should be offered to girls and women as soon as possible within five days of the sexual exposure and information provided on the risks (including the potential risks of neural tube defects) and benefits of DTG.
- For women and adolescent girls who do not want to take EC or DTG, an alternative antiretroviral drug (LPV/r) should be provided.
- If a TDF-containing regimen (TDF + 3TC) is not possible for clinical reasons (e.g., renal failure, GFR <50 ml/min), an AZT-containing NRTI backbone (AZT + 3TC) can be considered.
- Assess for anaemia with hemocue if available. If hemocue not available, please use clinical assessment for anaemia and avoid AZT only if anaemia strongly suspected. If baseline anaemia, repeat the haemoglobin at two weeks for those patients on AZT as AZT can cause life-threatening anaemia if given for four weeks.
- TDF is not recommended in children weighing less than 30 kg.
- Nevirapine should not be used for PEP among children over 2 years old, adolescents and adults.

PEP for children ≥20 kg to <30 kg

Category	First choice	Alternate choice
Children ≥20 kg to <30 kg body weight	AZT + 3TC + DTG	Abacavir (ABC) + 3TC + DTG

PEP for children 20 kg or less

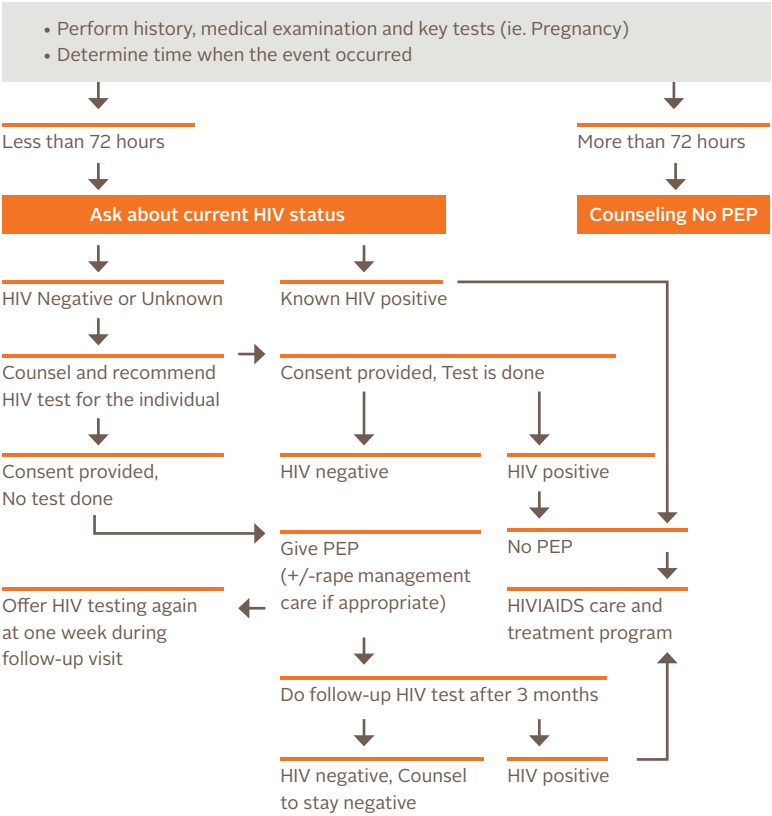
Category	First choice	Alternate choice
Children <20 kg body weight	AZT + 3TC + LPV/r	ABC + 3TC + LPV/r

*LPV/r should not be used for premature babies and babies under 2 weeks old.

See Annex 4 (Paediatric dosing for PEP) on page 135 of the PNG National Guidelines for HIV Care & Treatment.

4 | HIV TESTING AND COUNSELLING FOLLOWING SGBV INCIDENTS

All persons presenting to a health facility after allegedly being raped should be counselled by the attending healthcare provider about the potential risk of HIV transmission following rape. For HIV testing and counselling, refer to page 41 of the *National Guidelines for HIV Care and Treatment.*



The survivor should be offered HTC, but declining HTC should not cause delay in initiating PEP. If the survivor presents shortly after the incident and is too traumatised for HTC, the survivor may decline the test. Even though the survivor declines HTC, they are still eligible for PEP within 72 hours (3 days) of the sexual assault. The healthcare provider should clearly document the reason why HTC was not done.

PREVENTION AND TREATMENT OF STIs

Following an SGBV incident, all survivors should receive prophylactic treatment for chlamydia, gonorrhoea, syphilis and trichomoniasis as soon as possible.

Whenever a survivor of rape seeks help, the healthcare worker should provide the full prophylactic treatment for STIs. Note that infections, especially chlamydia, are characteristically asymptomatic in more than 60 per cent of female cases.

A person who reports having been raped should receive presumptive treatment of STIs (gonorrhoea, chlamydia and trichomonas infections using the standard treatment)

Presumptive treatment for Gonorrhoea and Chlamydia:

- Ceftriaxone 250 mg intramuscular (IM) as a single dose PLUS azithromycin 1 g orally as a single dose

OR

- Cefixime 400 mg orally as a single dose PLUS azithromycin 1 g orally as a single dose

Refer to the most current PNG Standard Management of STI and Genital Conditions Manual when managing STIs (page 56).

Treatment for Children

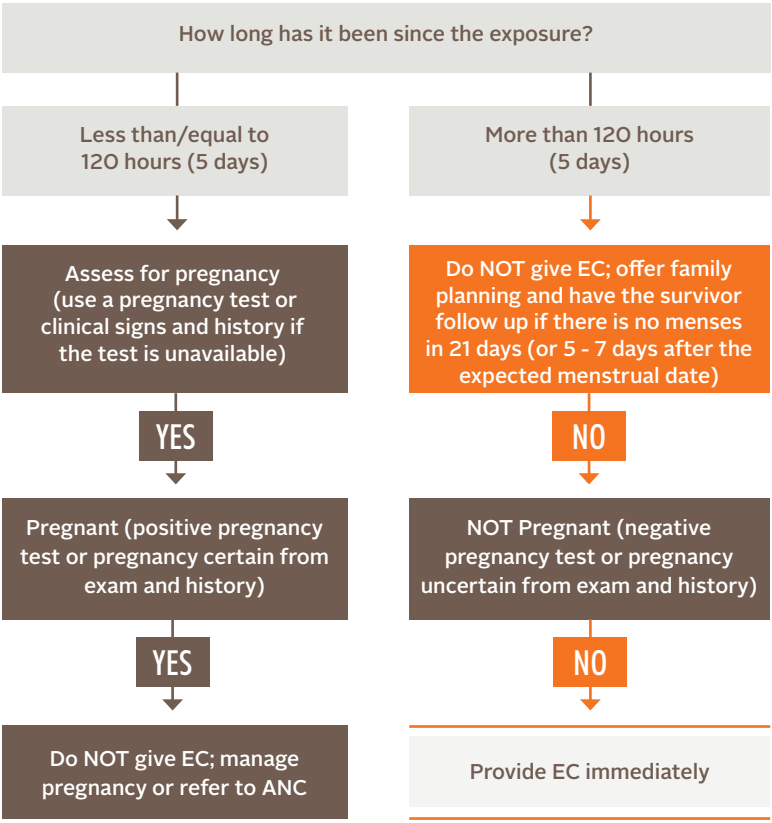
Give one dose of azithromycin plus amoxicillin and augmentine, (amoxicillin and clavulanic acid) and probenecid tablets.

Weight	Azithromycin	Amoxicillin	Augmentin	Probenecid
Less than 10 kg	250 mg (1/2 tablet)	1 g (4x250 mg)	½ tablet	½ tablet
More than 10 kg	500 mg (1 tablet)	1 ½ g (6x250 mg)	1 tablet	1 tablet

Confirmed gonococcal disease in a young child almost always means that the child has been or is being sexually abused. In response:

- Discuss the problem with a medical officer if possible.
- Check the child for evidence of other sexually transmitted diseases (syphilis, HIV infection) and treat if present.
- Discuss the problem with the child's family if you feel this is the right thing to do.
- Check the adult members of the family for evidence of sexually transmitted disease and treat if present.

5 | PREVENTION OF PREGNANCY FOLLOWING RAPE



- EC can be given up to 120 hours after sexual intercourse; however, its effectiveness decreases over time. Provide EC as soon as possible!
- EC prevents pregnancy but does not cause an abortion; it will not harm an existing pregnancy if the woman is already pregnant.
- Offer a follow-up pregnancy test if there is no menses in 21 days (or 7 days after the expected menses).
- EC pills (OCP): three tabs every 12 hours or Levonorgestrel 1.5 mg as soon as possible

6 | PREVENTION OF TETANUS AND HEP B

HEP B vaccine

Every rape survivor should be offered HEP B prophylaxis as soon as possible after the incident if they have not completed the HEP B vaccination series.

Administrator HEP B vaccine according to the following schedules

Dose	Calendar	Duration of protection
HEP B 1 HEP B 2 HEP B 3	Day O 7 Days after HEP B1 21 Days after HEP B 2	This accelerated schedule confers early protection immunity lasting up to 1 year
HEP B 4	1 year after HEP B 3	Lifelong protection following the fourth dose

DOSAGE

- 1.0 ml IM injection for adults (16 years and older)
- 0.5O ml IM injection for children (O–15 years of age)

Tetanus vaccine

Check for the following

- Any breaks in the skin or mucosa
- Dirty wounds or injuries caused by implements
- Incomplete vaccination (< 4 doses); confirm with the health record book

NO

If NO to all of the above questions

Patient is NOT eligible for the tetanus toxoid vaccine *(other treatment, counseling and referrals may be required)*

YES

If YES to any of the above questions

Dose	Calendar	Effectiveness of protection	Duration of protection
Tetox 1	Day 0	0%	None
Tetox 2	4 weeks after Tetox 1	80%	1-3 years
Tetox 3	6 months after Tetox 2	95%	5 years
Tetox 4	1 year after Tetox 3	99%	10 years

- *If the client has not received tetanus immunisation in the past and has deep and dirty wounds, immunoglobulin should be offered.*
- *Dosage: 250 IU in 1 ml injection into the deltoid or gluteal region (dosage should be doubled if more than 24 hours has elapsed between wounding and seeking medical care (500 IU)*

Annex 7 | SGBV Emergency Unit or FSCs

1. SGBV Emergency Unit or FSC
   a. New medical emergency units (to be) established in all hospitals specialising in the provision of SGBV treatment, care and services
   b. Provides five essential services:
      i. Medical first aid
      ii. PFA
      iii. Prevention of STI/HIV resulting from sexual assault (rape)
      iv. Prevention of pregnancies or management of unwanted pregnancies resulting from sexual assault (rape)
      v. Prevention of medical conditions including HEP B and tetanus related to SGBV
   c. Links to SGBV services, including referrals to and from other external support services such as police FSVU and safe houses/havens

2. Medical Reports
   a. To be written ONLY by the attending medical practitioner — medical officer, HEO or trained nursing officer (NO)
   b. Does NOT necessitate countersigning even by the OIC of the FSC SGBV Medical Emergency Clinic
   c. MUST be kept safe and confidential with the SGBV Emergency Unit under the protection of the unit's OIC
   d. Should NOT be written or countersigned by a social worker

3. Medical Social Workers
   a. Will no longer be included in the FSC/SGBV Emergency Unit organisational structure
   b. Will ONLY be requested to attend to survivors through hospital or health facility consultation processes where the Medical Social Works Department/Units are established

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WHAT CAN **HEALTH WORKERS** DO?

Provide timely care for physical, sexual, reproductive and mental health

Visit your nearest Hospital Family Support Centre (FSC) for these essential services

- **Medical First Aid**
- **Psychological First Aid**
- **Prevention of HIV/STI**
- **Prevention of Pregnancy**
- **Prevention of Hepatitis B and Tentanus**