World Health Organization

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Abbreviations and glossary

Abbreviations

CBO	community-based organization
CBT	cognitive behaviour therapy
CDC	Centers for Disease Control and Prevention
CEDAW	United Nations Committee on the Elimination of all Forms of Discrimination against Women
DSM	*Diagnostic and statistical manual of mental disorders*
EMDR	eye movement desensitization reprocessing
FIGO	International Federation of Gynaecology and Obstetrics
GDG	Guideline Development Group
GRADE	Grading of Recommendations Assessment, Development and Evaluation
ILO	International Labour Organization
IUD	intrauterine device
mhGAP	WHO Mental Health Gap Action Programme
NGO	nongovernmental organization
PICOT	Population, Intervention, Comparator, Outcome and Timeframe
PMTCT	prevention of mother-to-child transmission (of HIV)
PTSD	post-traumatic stress disorder
RHR	WHO Department of Reproductive Health and Research
SANE	sexual assault nurse examiner
STI	sexually transmitted infection
TF-CBT	trauma-focused CBT
UK	United Kingdom of Great Britain and Northern Ireland
UNHCR	Office of the United Nations High Commissioner for Refugees
UNFPA	United Nations Population Fund
USA	United States of America
WHO	World Health Organization

Glossary

Advocacy: In the context of services for intimate partner violence, the meaning of the term "advocacy" varies within and between countries, depending on institutional settings and historical developments of the role of advocates. Broadly speaking, "advocates" engage with individual clients who are being abused, with the aim of supporting and empowering them and linking them to community services. In some health-care settings, "advocates" may also have a role in bringing about systemic change, catalysing increased recognition by clinicians of women experiencing abuse. In these guidelines, we define the core activities of advocacy as support that includes: provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; informal counselling; ongoing support; and provision of safety planning advice. In our recommendations, we have made a distinction between advocacy and psychological interventions, which reflects a relatively clear distinction in the research evidence, with the latter being based on explicit psychological methods or theories.

Case-finding or clinical enquiry: In the context of intimate partner violence, this refers to the identification of women experiencing violence who present to health-care settings, through use of questions based on the presenting conditions, the history and, where appropriate, examination of the patient. These terms are used as distinct from "screening" or "routine enquiry".

Crisis intervention services: These are services that offer specialist support, advocacy, counselling and information in confidence, in a safe and non-threatening environment.

Cognitive behavioural therapy (CBT): CBT is based on the concept that thoughts, rather than external factors such as people or events, are what dictate one's feelings and behaviour. People may have unrealistic or distorted thoughts, which, if left unchecked,

could lead to unhelpful behaviour. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts), as well as a behavioural component. CBT varies, depending on the specific mental health problems.

Cognitive behavioural therapy with a trauma focus: Cognitive-behavioural interventions that involve a focus on the traumatic event (e.g. through imagined or in vivo exposure treatment and/or direct challenging of maladaptive cognitions related to the event and its sequelae).[1]

Empowerment: Helping women to feel more in control of their lives and able to take decisions about their future, as articulated in Dutton's empowerment theory.[2] Dutton notes that battered women are not "sick", rather they are in a "sick situation" and responses need to demonstrate an understanding, and take into account, their differing needs for support, advocacy and healing. Empowerment is a key feature of advocacy interventions and of some psychological (brief counselling) interventions.

Eye movement desensitization reprocessing (EMDR): This therapy entails standardized procedures that include focusing simultaneously on (a) spontaneous associations of traumatic images, thoughts, emotions and bodily sensations, and (b) bilateral stimulation, most commonly in the form of repetitive eye movements. Unlike CBT with a trauma focus, EMDR therapy involves treatment that is conducted without detailed descriptions of the event, without direct challenging of beliefs, and without extended exposure.

First-line support: This refers to the minimum level of (primarily psychological) support and validation of their experience that should be received by all women who disclose violence to a health-care (or other) provider. It shares many elements with what is being called "psychological first aid" in the context of emergency situations involving traumatic experiences.

Health-care provider: An individual or an organization that provides health-care services in a systematic way. An individual health-care provider may be a health-care professional, a community health worker, or any other person who is trained and knowledgeable in health. This can include lay health-care workers who have received some training to deliver care in their community. Organizations include hospitals, clinics, primary care centres and other service delivery points. In these guidelines, the term "health-care provider" usually refers to the primary care provider (nurse, midwife, doctor or other).

Intimate partner: A husband, cohabiting partner, boyfriend or lover, or ex-husband, ex-partner, ex-boyfriend or ex-lover.[3]

Intimate partner violence: Behaviour by an intimate partner that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse and controlling behaviours. This definition covers violence by both current and former spouses and other intimate partners. Other terms used to refer to this include domestic violence, wife or spouse abuse, wife/spouse battering. Dating violence is usually used to refer to intimate relationships among young people, which may be of varying duration and intensity, and do not involve cohabiting.

Mandatory reporting: Refers to legislation passed by some countries or states that requires individuals or designated individuals such as health-care providers to report (usually to the police or legal system) any incident of actual or suspected domestic violence or intimate partner violence. In many countries, mandatory reporting applies primarily to child abuse and maltreatment of minors, but in others it has been extended to the reporting of intimate partner violence.

Psychological interventions: Formal counselling, psychotherapy or a range of different psychological techniques provided by a person trained in these interventions, These approaches are provided in sex- or non-sex-specific groups or couples, or on an individual

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[1] This term is synonymous to the term "trauma-focused CBT" (TF-CBT) as used in the National Institute for Clinical Evidence Guidelines (NCCMH, 2005) and in Cochrane reviews (e.g. Bisson and Andrew 2005). It is noted that in the literature on traumatic stress, the latter term also has a more narrow definition for a very specific and widely disseminated multi-component CBT protocol for children and adolescents developed by Cohen and colleagues (2000).

[2] Dutton MA. *Empowering and healing the battered woman. A model for assessment and intervention*. New York, Springer Publishing Company, 1992.

[3] The definition of intimate partner varies between settings and studies and includes formal partnerships, such as marriage, as well as informal partnerships, including co-habiting, dating relationships and unmarried sexual relationships. In some settings, intimate partners tend to be married, while in others more informal partnerships are more common.

basis. This can take many forms, one of the most common being therapies that are loosely catalogued as cognitive behavioural therapies or CBT. See also "Cognitive behavioural therapy" and "Eye movement desensitization processing".

Sexual violence: Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed against a person's sexuality, using coercion, by any person, regardless of their relationship to the victim, in any setting, including, but not limited to, home and work.[1]

Sexual assault: A subcategory of sexual violence, sexual assault usually includes the use of physical or other force to obtain or attempt sexual penetration. It includes rape, defined as the physically forced or otherwise coerced penetration of the vulva or anus with a penis, other body part, or object, although the legal definition of rape may vary and, in some cases, may also include oral penetration.[2]

Routine enquiry: Sometimes used to refer to investigating intimate partner violence without resorting to the public health criteria of a complete screening programme;[3] it can also be used to denote a low threshold for women being routinely asked about abuse in a health-care setting, but not necessarily all women.[4]

Screening (universal screening): Large-scale assessment of whole population groups, whereby no selection of population groups is made.[5]

Shared decision-making: When clinicians and patients make decisions together using the best available evidence. In partnership with their clinicians, patients are encouraged to consider available options and the likely beneifts and harms of each, to communicate their preferences, and help select the course of action that best fits these.[6]

Shelter: Also known as a safe house or refuge, this is usually a place, often at a secret location, where women can flee from abusive partners. Usually run by a nongovernmental organization (NGO), it was the first social and political response to partner violence from the feminist movement in high-income countries in the 1970s. However, it can also refer to a church, community group, or other setting that provides a safe haven for women.

Support: For the purposes of these guidelines, "support" includes any or a combination of the following: the provision of legal, housing and financial advice; facilitation of access to and use of community resources such as refuges or shelters; emergency housing; and psychological interventions and provision of safety planning advice, as detailed in recommendation 1, p. 16.

Vicarious trauma: Defined as the transformation of the health-care provider's inner experiences as a result of empathetic and/or repeated engagement with (sexual) violence survivors and their trauma material (see http://www.svri.org/trauma.htm).

Violence against women: A broad umbrella term, defined by the United Nations as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life".[7] It includes many different forms of violence against women and girls, such as intimate partner violence, non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.

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1 Jewkes, Sen & Garcia-Moreno, Sexual violence, in Krug E et al. *World report on violence and health*. Geneva, World Health Organization, 2002.

2 Idem

3 The criteria are listed in Wilson JMG, Jungner G. *Principles and practice of screening for disease*. Geneva, World Health Organization, 1968 (http://whqlibdoc.who.int/php/WHO_PHP_34.pdf). The UK screening criteria are listed on http://www.screening.nhs.uk/criteria#fileid9287.

4 Taket A et al. Routinely asking women about domestic violence in health settings. *BMJ*, 2003, 327(7416):673–676.

5 The criteria are listed in JMG Wilson, Jungner G. Principles and Practice of Screening for Disease (italics). Geneva, World Health Organization, 1968. (http://whqlibdoc.who.int/php/WHO_PHP_34.pdf. The UK screening criteria are listed on http://www.screening.nhs.uk/criteria#fileid9287

6 Elwyn G et al. Implementing shared decision making in the NHS. *BMJ*, 2010, 341:c5146.

7 United Nations. Declaration on the elimination of violence against women. New York, United Nations, 1993.

Executive summary

Introduction

Women who have been subjected to violence often seek health care, including for their injuries, even if they do not disclose the associated abuse or violence. A health-care provider is likely to be the first professional contact for survivors of intimate partner violence or sexual assault. Statistics show that abused women use health-care services more than non-abused women do. They also identify health-care providers as the professionals they would most trust with disclosure of abuse.

These guidelines aim to provide evidence-based guidance to health-care providers on the appropriate responses to intimate partner violence and sexual violence against women, including clinical interventions and emotional support. They also seek to raise awareness, among health-care providers and policy-makers, of violence against women, to better understand the need for an appropriate health-sector response to violence against women.

The guidelines are based on systematic reviews of the evidence on identification and clinical care for intimate partner violence, clinical care for sexual assault, and training relating to intimate partner violence and sexual assault against women, as well as policy and programmatic approaches to delivering services and mandatory reporting of intimate partner violence. They provide standards that can act as the basis for national guidelines, and for integrating these issues into health-care provider education, as well as helping health-care providers to be better informed about the care of women experiencing sexual assault and intimate partner violence.

Although men are also victims of partner violence and sexual assault, these guidelines focus on women, because they experience more sexual violence, more severe physical violence, and more coercive control from male partners. However, much of the advice given will be relevant in respect of violence against women by family members other than intimate partners and may be relevant for partner abuse of men. Some of the advice will also be relevant to sexual assault of men.

Target audience

The guidelines are aimed at health-care providers because they are in a unique position to address the health and psychosocial needs of women who have experienced violence. Health professionals can provide assistance by facilitating disclosure; offering support and referral; providing the appropriate medical services and follow-up care; or gathering forensic evidence, particularly in cases of sexual violence.

The guidelines offer health-care providers evidence-based guidance on appropriate care, including clinical interventions and emotional support, for women suffering from intimate partner violence and sexual violence. They also seek to make health-care providers and policy-makers more aware of violence against women, to encourage an evidence-informed health-sector response, and improve capacity-building of health-care providers and other members of multidisciplinary teams. They should also prove useful to those responsible for developing training curricula in medicine, nursing and public health.

The guidelines also include a service-delivery and programme-guidance component aimed at those responsible for developing, funding and implementing programmes to address violence against women. The level of resources available, including other support services, will need to be taken into account when implementing the recommendations. The World Health Organization (WHO) will partner with ministries of health, nongovernmental organizations (NGOs) and sister United Nations agencies to disseminate these guidelines, and support their adaptation and implementation in Member States.

Guideline development methods

The process used in the development of these guidelines, which is outlined in the *WHO handbook for guideline development*,[1] involved: (i) identification of questions related to clinical practice and health policy; (ii) retrieval of up-to-date evidence; (iii) assessment and synthesis of the evidence; (iv) formulation of recommendations with inputs from a wide range of stakeholders; and (v) formulation of plans for dissemination, implementation and updating.

The scientific evidence for the recommendations was synthesized using the Grading of Recommendations Assessment, Development and Evaluation (GRADE) methodology for the clinical interventions. For each preselected critical question, evidence profiles were prepared from existing or commissioned systematic reviews. For the questions on policy and health-care delivery, the descriptive evidence was summarized, with the strengths and weaknesses of different approaches identified.

The Guideline Development Group (GDG) included academics, clinicians/service providers and policy-makers, working on women's health and violence against women in low- and middle- income countries, as well as women's health and rights advocates, thereby ensuring the representation of a wide range of user opinion. The recommendations were developed by WHO in association with the GDG, during a meeting at the WHO office in Geneva between 12 and 14 September 2011. The recommendations take into account the evidence, as well as considerations of the balance between benefits and harms, women's preferences and their human rights, and the cost implications in different countries and communities worldwide. Where there was a need for guidance, but no relevant research evidence, recommendations were agreed using the expertise of the GDG.

For clinical interventions, the quality of the supporting evidence was graded as very low, low, moderate, or high, using GRADE methodology. For some recommendations, existing guidelines were relied on in part, and the quality of the evidence in those guidelines was assessed. Where existing guidelines provided only indirect evidence, in other words evidence not directly applicable to these populations and settings, the quality of the evidence was labelled as such. Recommendations on health-care policy and provision, and on mandatory reporting, were considered to be best practices or to address human rights. For those recommendations, we also systematically searched for relevant literature and summarized it qualitatively, but did not use GRADE to assess the evidence and best practices. When no evidence was identified for either a clinical or a health policy recommendation, this was indicated in the summary of the evidence.

Recommendations were considered as strong or conditional, on the basis of the generalizability of benefit across different settings, and the needs and preferences of women to access services, as well as taking into consideration the level of human and other resources that would be required. In order to ensure each recommendation could be understood and used in accordance with its intended meaning, the GDG offered further clarifications, which are noted below the recommendations as remarks.

Input from peer reviewers and a range of stakeholders, including colleagues working directly with women survivors of violence, was also sought and helped to further clarify the wording of the recommendations. Important knowledge gaps that need to be addressed through primary research were identified, which allowed a list of critical research questions to be developed.

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[1] *WHO handbook for guideline development. Geneva*, World Health Organization, 2010.

Summary of recommendations

Recommendations		Quality of evidence	Recommendation
1. Women-centred care			
1	Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support.[a] Health-care providers should, as a minimum, offer first-line support when women disclose violence. First-line support includes: • being non-judgemental and supportive and validating what the woman is saying • providing practical care and support that responds to her concerns, but does not intrude • asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved) • helping her access information about resources, including legal and other services that she might think helpful • assisting her to increase safety for herself and her children, where needed • providing or mobilizing social support. Providers should ensure: • that the consultation is conducted in private • confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting) If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.	Indirect evidence[b]	Strong
2. Identification and care for survivors of intimate partner violence			
2.1 IDENTIFICATION OF INTIMATE PARTNER VIOLENCE			
2	"Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) should not be implemented.	Low–moderate	Conditional
3	Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence (see Box 1: Examples of clinical conditions associated with intimate partner violence, p. 19), in order to improve diagnosis/identification and subsequent care (see recommendation 30).	Indirect evidence	Strong
4	Written information on intimate partner violence should be available in health-care settings in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms (with appropriate warnings about taking them home if an abusive partner is there).	No relevant evidence was identified	Conditional

[a] This recommendation is adapted from *Psychological first aid*. Geneva, World Health Organization, 2011, aimed at individuals in community crisis situations (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf).

[b] The strength of the evidence is labelled "Indirect evidence" when no direct evidence was identified for this population and the recommendation was therefore based on evidence extrapolated from another appropriate population.

Recommendations		Quality of evidence	Recommendation
2.2 CARE FOR SURVIVORS OF INTIMATE PARTNER VIOLENCE			
5	Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depressive disorder or alcohol use disorder) who are experiencing intimate partner violence should receive mental health care for the disorder (in accordance with the WHO Mental Health Gap Action Programme (mhGAP) intervention guide, 2010),[a] delivered by health-care professionals with a good understanding of violence against women.	Indirect evidence,[b] variable (varies with intervention, see http://www.who.int/mental_health/mhgap/evidence/en/)	Strong
6	Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR)[c] interventions, delivered by health-care professionals with a good understanding of violence against women, are recommended for women who are no longer experiencing violence but are suffering from post-traumatic stress disorder (PTSD).	Low–moderate	Strong
7	Women who have spent at least one night in a shelter, refuge or safe house should be offered a structured programme of advocacy, support and/or empowerment.[c]	Low	Conditional
8	Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health-care systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries, is uncertain.	Low	Conditional
9	Where children are exposed to intimate partner violence at home, a psychotherapeutic intervention, including sessions where they are with, and sessions where they are without their mother, should be offered, although the extent to which this would apply in low- and middle-income settings is unclear.	Moderate	Conditional
3. Clinical care for survivors of sexual assault			
3.1 INTERVENTIONS DURING THE FIRST 5 DAYS AFTER THE ASSAULT			
3.1.1 First-line support			
10	Offer first-line support to women survivors of sexual assault by any perpetrator (see also recommendation 1), which includes: • providing practical care and support, which responds to her concerns, but does not intrude on her autonomy • listening without pressuring her to respond or disclose information • offering comfort and help to alleviate or reduce her anxiety • offering information, and helping her to connect to services and social supports.	Indirect evidence[d]	Strong

[a] *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf)

[b] The strength of the evidence is labelled "Indirect evidence" when no direct evidence was identified for this population and the recommendation was therefore based on evidence extrapolated from another appropriate population.

[c] See Glossary.

[d] This recommendation is adapted from *Psychological first aid*. Geneva, World Health Organization, 2011, aimed at individuals in community crisis situations (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf).

	Recommendations	Quality of evidence	Recommendation
11	Take a complete history, recording events to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe including genitalia).[a] The history should include: • the time since assault and type of assault • risk of pregnancy • risk of HIV and other sexually transmitted infections (STIs) • mental health status.	Indirect evidence	Strong
3.1.2 Emergency contraception			
12	Offer emergency contraception to survivors of sexual assault presenting within 5 days of sexual assault, ideally as soon as possible after the assault, to maximize effectiveness.	Moderate	Strong
13	Health-care providers should offer levonorgestrel, if available. A single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart. If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available. If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking ongoing pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (see the *WHO medical eligibility criteria*, 2010).[b]	Moderate	Strong
14	If a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman is pregnant as a result of rape, she should be offered safe abortion, in accordance with national law.	No relevant evidence was identified	Strong
3.1.3 HIV post-exposure prophylaxis			
15	Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making[c] with the survivor, to determine whether HIV PEP is appropriate.	Indirect evidence (see joint International Labour Organization (ILO)/WHO guidelines, 2008)[d]	Strong

[a] See *Guidelines for medico-legal care of sexual violence survivors*. Geneva, World Health Organization, 2003; *Clinical management of rape survivors*. Geneva, WHO/Office of the United Nations High Commissioner for Refugees (UNHCR), 2004 and *E-learning programme on Clinical management of rape survivors*. Geneva, WHO/UNHCR/ United Nations Population Fund (UNFPA), 2009.

[b] *WHO medical eligibility criteria*. Geneva, World Health Organization, 2010.

[c] See Glossary.

[d] *Joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection*. Geneva, World Health Organization, 2008

Recommendations		Quality of evidence	Recommendation
16	Discuss HIV risk to determine use of PEP with the survivor, including: • HIV prevalence in the geographic area • limitations of PEP[b] • the HIV status and characteristics of the perpetrator if known • assault characteristics, including the number of perpetrators • side-effects of the antiretroviral drugs used in the PEP regimen • the likelihood of HIV transmission.	Indirect evidence[a]	Strong
17	If HIV PEP is used: • start the regimen as soon as possible and before 72 hours • provide HIV testing and counselling at the initial consultation • ensure patient follow-up at regular intervals • two-drug regimens (using a fixed dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side-effects • the choice of drug and regimens should follow national guidance.	Indirect evidence[c]	Strong
18	Adherence counselling should be an important element in PEP provision.	Very low	Strong
3.1.4 Post-exposure prophylaxis for sexually transmitted infections			
19	Women survivors of sexual assault should be offered prophylaxis for: • chlamydia • gonorrhoea • trichomonas • syphilis, depending on the prevalence. The choice of drug and regimens should follow national guidance.	Low–very low, based on indirect evidence	Strong
20	Hepatitis B vaccination without hepatitis B immune globulin should be offered as per national guidelines. • Take blood for hepatitis B status prior to administering the first vaccine dose. • If immune, no further course of vaccination is required.	Very low, based on indirect evidence	Strong
3.1.5 Psychological interventions			
21	Offer support and care as described in recommendation 10.	Indirect evidence[d]	Strong
22	Provide written information on coping strategies for dealing with severe stress (with appropriate warnings about taking printed material home if an abusive partner is there).	No relevant evidence was identified	Strong
23	Psychological debriefing should not be used.	Very low–low[d]	Strong

[a] *Joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection*. Geneva, World Health Organization, 2008

[b] In two cohort studies of HIV PEP, seroconversion rates ranged from 0% to 3.7%.

[c] *Joint ILO/WHO guidelines on post-exposure prophylaxis to prevent HIV infection*. Geneva, World Health Organization, 2008.

[d] This recommendation is adapted from *Psychological first aid*. Geneva, World Health Organization, 2011, aimed at individuals in community crisis situations (**whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf**).

Recommendations		Quality of evidence	Recommendation
3.2 PSYCHOLOGICAL/MENTAL HEALTH INTERVENTIONS AFTER 5 DAYS			
3.2.1 Interventions up to 3 months post-trauma			
24	Continue to offer support and care as described in recommendation 10.	Indirect evidence[a]	Strong
25	Unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming, or has difficulties functioning in day-to-day tasks, apply "watchful waiting" for 1–3 months after the event. Watchful waiting involves explaining to the woman that she is likely to improve over time, and offering the option to come back for further support by making regular follow-up appointments.	Very low–low	Strong
26	If the person is incapacitated by the post-rape symptoms (i.e. she cannot function in day-to-day tasks), arrange for cognitive behaviour therapy (CBT) or eye movement desensitization and reprocessing (EMDR), by a health-care provider with a good understanding of sexual violence.	Low–moderate	Strong
27	If the person has any other mental health problems (symptoms of depression, alcohol or drug use problems, suicide or self-harm), provide care in accordance with the WHO mhGAP intervention guide, 2010.[b]	Indirect evidence, variable (varies with intervention, see http://www.who.int/mental_health/mhgap/evidence/en/)	Strong
3.2.2 Interventions from 3 months post-trauma			
28	Assess for mental health problems (symptoms of acute stress/PTSD, depression, alcohol and drug use problems, suicidality or self harm) and treat depression, alcohol use disorder and other mental health disorders using the mhGAP intervention guide,[b] which covers WHO evidence-based clinical protocols for mental health problems.	Indirect evidence, variable (varies with intervention, see http://www.who.int/mental_health/mhgap/evidence/en/)	Strong
29	If the person has been assessed as experiencing post traumatic stress disorder (PTSD), arrange for PTSD treatment with cognitive behaviour therapy (CBT) or eye movement desensitization and reprocessing (EMDR).	Low–moderate	Strong
4. Training of health-care providers on intimate partner violence and sexual assault			
30	Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault (see recommendation 1) should be given to health-care providers (in particular doctors, nurses and midwives).	Very low	Strong

[a] This recommendation is adapted from *Psychological first aid*. Geneva, World Health Organization, 2011, aimed at individuals in community crisis situations (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf).

[b] *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf)

Recommendations		Quality of evidence	Recommendation
31	Health-care providers offering care to women should receive in-service training, ensuring it: • enables them to provide first-line support (see recommendations 1 and 10) • teaches them appropriate skills, including: – when and how to enquire – the best way to respond to women (refer to sections 2 Identification and care for survivors of intimate partner violence and 3, Clinical care for survivors of sexual assault) – how to conduct forensic evidence collection where appropriate[a] • addresses: – basic knowledge about violence, including laws that are relevant to victims of intimate partner violence and sexual violence – knowledge of existing services that may offer support to survivors of intimate partner violence and sexual violence (this could be in the form of a directory of community services) – inappropriate attitudes among health-care providers (e.g. blaming women for the violence, expecting them to leave, etc.), as well as their own experiences of partner and sexual violence.	Low–moderate	Strong
32	Training for health-care providers on intimate partner violence and sexual assault should include different aspects of the response to intimate partner violence and sexual assault (e.g. identification, safety assessment and planning, communication and clinical skills, documentation, and provision of referral pathways).	Low	Strong
33	Training for both intimate partner violence and sexual assault should be integrated in the same programme, given the overlap between the two issues and the limited resources available for training health-care providers on these issues.	No relevant evidence was identified	Strong
5. Health-care policy and provision[b]			
34	Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service (see minimum level of requirements, box 3, p. 39).	Very low	Strong
35	A country needs multiple models of care for survivors of intimate partner violence and sexual assault, for different levels of the health system. However, priority should be given to providing training and service delivery at the primary level of care.	Very low	Strong
36	A health-care provider (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (on location or on-call) at a district/area level.	Very low	Conditional

[a] See *Guidelines for medico-legal care of sexual violence survivors*. Geneva, World Health Organization, 2003; *Clinical management of rape survivors*. Geneva, WHO/UNHCR, 2004; and **E-learning programme on Clinical management of rape survivors**. Geneva, WHO/UNHCR/ UNFPA, 2009.

[b] Existing evidence was reviewed but GRADE was not used, owing to largely descriptive and qualitative data.

Recommendations		Quality of evidence	Recommendation
6. Mandatory reporting of intimate partner violence[a]			
37	Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended. However, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this and is aware of her rights.	Very low	Strong
38	Child maltreatment and life-threatening incidents must be reported to the relevant authorities by the health-care provider, where there is a legal requirement to do so.	Very low	Strong

[a] Existing evidence was reviewed but GRADE was not used, owing to largely descriptive and qualitative data.

Background

Violence against women[1] is a major public health and human rights concern, with intimate partner violence and sexual violence among the most pervasive forms of violence against women. Research, initially from North America and Europe, but increasingly from other regions, has demonstrated the high prevalence of violence against women globally and its adverse physical and mental health outcomes, in both the short and long term (Campbell, 2004; García-Moreno et al., 2005; Ellsberg et al., 2008; Bott et al., 2012). Health-care providers frequently, and often unknowingly, come into contact with women affected by violence, since abused women make extensive use of health-care resources (Ansara and Hindin, 2010; Black, 2011). Health-care providers are in a unique position to create a safe and confidential environment for facilitating disclosure of violence, while offering appropriate support and referral to other resources and services.

As detailed in the report of the *WHO multi-country study on women's health and domestic violence against women* (García-Moreno et al., 2005), the global statistics show:

- between 13% and 61% of women 15–49 years old report that an intimate partner has physically abused them at least once in their lifetime
- between 6% and 59% of women report forced sexual intercourse, or an attempt at it, by an intimate partner in their lifetime
- from 1% to 28% of women report they were physically abused during pregnancy, by an intimate partner.

However, although violence against women has been accepted as a critical public health and clinical care issue, it is still not included in the health-care policies of many countries. The critical role that the health system and health-care providers can play in terms of identification, assessment, treatment, crisis intervention, documentation, referral, and follow-up, is poorly understood or accepted within the national health programmes and policies of various countries. Health-care professionals tend to regard violence against women as a criminal justice issue, and view partner violence in particular as a domestic matter. They are also ill-equipped to deal with the issues, since medical and nursing education in many countries does not address this problem. In order for health-care providers to assume their roles in mitigating the effects of violence and fulfil their responsibility, it is necessary to sensitize them towards the issue and provide them with the information and tools necessary to respond sensitively and effectively to survivors. These guidelines are a first step in this direction.

Studies of the relationships between intimate partner violence, health status and use of health care by women have shown that women who have experienced violence are more likely than non-abused women to seek health care (Ansara and Hindin, 2010; Black, 2011), even if they do not disclose the violence. A health-care provider is often the first contact for survivors of intimate partner violence and sexual assault, and women living with partner violence identify health-care providers as the professionals they would most trust with disclosure of abuse (Feder et al., 2006).

Irrespective of the circumstances, health-care providers who come into contact with women facing violence need to be able to recognize signs of it, and respond appropriately and safely. Individuals who have been exposed to violence require comprehensive, gender-sensitive health-care services that address the physical and mental health consequences of their experience and aid their recovery from what is a traumatic event. They may also require crisis intervention services (see Glossary) in order to prevent further harm, although

[1] Women here is taken to also include young girls.

more often than not, a supportive response is needed. In addition to providing immediate health care, the health sector is potentially a crucial gateway (via referral pathways) to specific services for violence against women (where they exist), or to other services that the woman may require at a later date, such as social welfare and legal aid.

Documentation of injuries, health complaints and other problems resulting from violence can be used by the abused woman in a court of law as evidence, should she choose to take legal action. In addition to addressing the health consequences of violence, health-care providers, are also well placed to collect and document the evidence necessary for corroborating the circumstances of the reported abuse, and to help identify the perpetrator. Such evidence is often crucial to the prosecution in cases of violence, although these guidelines will not cover a full forensic examination. (For further information on this, see World Health Organization [WHO] *Guidelines for medico-legal care of victims of sexual violence* [WHO, 2003], the WHO/Office of the United Nations High Commissioner for Refugees [UNHCR] *Clinical management of rape survivors* [WHO/UNHCR,2004] and the WHO/UNHCR/United Nations Population Fund [UNFPA] *E-learning programme on clinical management of rape survivors*, 2009.)

Member States themselves have requested clearer guidance on what constitutes an appropriate health-service response to violence against women. Thus, the guidelines focus on intimate partner violence and sexual violence against women and present health-care providers with evidence-based guidance on how best to identify and respond to women who report experiencing violence. The guidelines also, for the first time, provide guidance on in-service training on intimate partner and sexual violence against women, for health-care providers and other members of multidisciplinary teams. While these guidelines focus on the health-sector response, we recognize that an appropriate response to violence against women requires multisectoral collaboration.

The guidelines also provide guidance for policy-makers and others in charge of planning, funding and implementing health services and professional training within health ministries, as well as policy-makers with responsibility for developing guidelines for curricula in the areas of medicine, nursing and public health. This is the first time WHO has issued guidance in this area. Policy-makers are in a position to ensure not only that the different services for women who experience violence are provided in a coordinated fashion and are adequately funded, but also that the issue is given the appropriate priority within relevant training programmes. The guidelines can also be used as a blueprint for the design of suitable health-care delivery systems for national, regional and local authorities, and to guide the content of educational curricula on service provision for women who experience violence.

These guidelines have been developed with particular regard for health-care providers working in settings where there may be severe constraints on the capacity to provide comprehensive health services. These guidelines will need to be adapted to specific local and/or national circumstances, taking into account the availability of resources, as well as national policies and procedures.

The level of resources available, including other support services, will also need to be taken into account in the implementation of the recommendations. WHO will partner with ministries of health, nongovernmental organizations (NGOs) and sister United Nations agencies to disseminate these guidelines, and support their adaptation and implementation in the countries involved.

Scope of the guidelines

The guidelines focus on violence (physical, sexual and emotional) by an intimate –usually male- partner, and sexual assault of women by men, because they are the most common forms of violence against women that occur in all settings. Our recommendations do not cover female genital mutilation, trafficking or other forms of violence against women.

Similarly, although men are also victims of partner violence and sexual assault, these guidelines focus exclusively on women because they experience more sexual violence, more severe physical violence, and more coercive control from male partners. In addition, we have very limited evidence on interventions for men (Tjaden and Thoennes, 2000; Walby and Allen, 2004; AuCoin, 2005).

While the focus is on male partner violence against women, much of the advice will be relevant in respect of violence against women by family members other than intimate partners and may be relevant for partner abuse of men. Some of the advice will also be relevant to sexual assault of men.

The recommendations on women-centred care (section 1, pp. 16 and 17) apply to both intimate partner violence and sexual assault, and the recommendations for survivors of sexual assault (section 3, pp. 25–34) are relevant for survivors/victims of sexual assault, irrespective of the perpetrator.

Human rights underpinning of the guidelines

Intimate partner violence and sexual violence have been recognized as violations of women's human rights, including their rights to freedom from discrimination,[1] to life, to integrity and security of the person,[2] and to the highest attainable standard of health.[3] Marital rape, in particular, has been acknowledged to be a form of violence against women[4] and deemed contrary to respect for human dignity.[5]

Under human rights treaties that governments have signed, there is a responsibility to prevent, investigate and punish all forms of violence against women.[1] For instance, states that are party to the International Covenant on Civil and Political Rights are required to report on laws that address violence against women and specific prevention and response measures. The United Nations Human Rights Committee specifically requires information on "measures of protection, including legal remedies, for women whose rights under article 7 [freedom from torture and other cruel, inhuman or degrading treatment] have been violated".[6] Meeting this responsibility to prevent, investigate and punish all forms of violence against women requires specific and targeted government action through the health sector, as well as other sectors such as justice and education. International and regional human rights bodies have provided guidance on the contribution that health-care professionals can – and should – make towards ensuring women's freedom from gender-based violence, as well as providing an adequate response when such violence has occurred.

For instance, according to the United Nations Committee on the Elimination of all Forms of Discrimination against Women (CEDAW), States Parties to the CEDAW Convention should ensure the following (among other measures):

- women-centred care is offered in the form of acceptable health services – these are services that "are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives"[7]
- policies, including health-care protocols and hospital procedures, that address violence against women and sexual abuse of girls, and allow the provision of appropriate health services.[8] Health-care policy and provision should place "gender perspective at the centre of all policies and programmes affecting women's health and should involve women in the planning, implementation and monitoring of such policies and programmes and in the provision of health services to women"; all health-care services should be "consistent with the human rights of women, including the rights to autonomy, privacy, confidentiality, informed consent and choice"[9]
- gender-sensitive training to enable health-care workers to detect and manage the health consequences of gender-based violence,[10] by ensuring "that the training curricula of health-care workers include comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence".[11]

At the regional level, a good example of human rights guidance on intimate partner violence and sexual violence (among other forms of gender-based violence) is the Protocol to the African Charter on the Rights of Women in Africa. The Protocol commits States Parties to implementing "appropriate measures to ensure the protection of every woman's right to respect for her dignity and protection of women from all forms of violence, particularly sexual and verbal violence" and measures to combat all other behaviour, attitudes, or practices that negatively affect the fundamental rights of women and girls".[12]

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1 CEDAW General Recommendation 19.
2 Protocol to the African Charter on the Rights of Women in Africa Article.
3 CESCR General Comment 14, paras 10, 21, 35, 36.
4 Protocol to the African Charter on the Rights of Women in Africa article 4(2)(a).
5 ECHR (1995) C.R. v. the United Kingdom. Application Nos 20166/92 and 20190/92, decided on 22 November 1995. Strasbourg, European Court of Human Rights, 1995.
6 Human Rights Committee, General Comment 28: Equality of rights between men and women (article 3), para 11.
7 CEDAW General Recommendation 24, para 22.
8 CEDAW General Recommendation 24, para 15.
9 CEDAW General Recommendation 24, para 31, see also CEDAW General Recommendation 19 para 24.
10 CEDAW General Recommendation 24, para 15.
11 CEDAW General Recommendation 24, para 31.
12 Articles 3 and 5.

Methods

Identifying, appraising and synthesizing the available evidence

The scope of the guidelines and the questions were informed by the results of the *Expert meeting on health-sector responses to violence against women*, held between 17 and 19 March 2009, in Geneva, Switzerland (WHO, 2010a). A total of 16 PICOT questions (Population, Intervention, Comparator, Outcome and Time frame) were developed by the Steering Group, with input from external reviewers. The questions were reviewed by the Guideline Development Group (GDG) and by peer reviewers, who also provided input on the selection and rating of the outcomes to be considered. The full list of PICOT questions is available on request. The evidence was reviewed by different individuals and the strategies are detailed separately at Weblink. A list of each review and evidence table available can be found in the table in Annex III. The search strategy and methods of quality assessment and appraisal are provided in each review.

For recommendations on clinical interventions and on training, GRADE (Grading of Recommendations Assessment, Development and Evaluation) methodology (Schünemann et al., 2009), as defined in the WHO methods handbook (2010b), was used. The studies were double extracted and appraised. The different appraisals were then compared and discussed between the two reviewers and, where there was a difference, this was resolved by a third reviewer. Reviews on mental health interventions in populations experiencing intimate partner or sexual violence were complemented by the more general evidence in the WHO mental health guidelines (WHO, 2010c) (recommendations 5, 27 and 28). Where clinical recommendations were based on indirect evidence (in other words evidence that was not directly from the population of women suffering intimate partner violence or sexual assault), the assessment of the quality of the evidence was labelled accordingly. Indirect evidence was largely based on existing guidelines on emergency contraception, STIs prophylaxis and related mental health and other issues. Where no evidence was available, recommendations were made because they were considered to be best practices or they addressed human rights and equity issues, and the lack of relevant evidence was noted.

For questions related to health-care policy and provision and to mandatory reporting, the literature was systematically reviewed, the available data compiled in evidence tables, and these data qualitatively summarized. GRADE methodology was not used, however, to assess the quality of the body of evidence for these types of questions, because the individual studies were too heterogenous and most had serious methodological limitations. In addition, many of the questions and recommendations were based on best practices, human rights conventions, and issues of equity, which do not lend themselves to GRADE methodology. The GDG therefore reviewed the qualitative summary of the available data and formulated recommendations based on those data, as well as on best practices, and on human rights principles and conventions. The assessment of the quality of evidence for these recommendations was labelled as very low.

Recruitment of the Guideline Development Group

The GDG was made up of academics, clinicians, government officials and advisers on health-care policy, as well as people who worked directly with women experiencing violence and women's health and rights advocates from low- and middle-income countries. Consideration was given to geographic diversity and gender balance, although the latter was difficult as this field is dominated by women.

Potential members of the GDG were selected on the basis of their contribution to the area, as well as the need for regional and area of expertise diversity. The 25 attendees at the 2009 *Expert meeting on health-sector responses to violence against women* (WHO, 2010a) represented a wide variety of stakeholders within the field. As a respected researcher in the field, the chairman was selected for his extensive experience of guideline development methodology and of chairing guideline development groups. The potential GDG members were identified, in part from among the attendees of the 2009 meeting, who were asked to send in a personal statement and complete the WHO declaration of interest form. The personal statements were reviewed by the Steering Group.

Declaration of interest by Guideline Development Group members and peer reviewers

All GDG members and participants of the meeting completed a declaration of interests form prior to the meeting. These forms were reviewed by the responsible officer at WHO, the senior coordinator in the WHO Department of Reproductive Health and Research (RHR), and the project manager, before finalization of the group composition and invitation to attend the GDG meeting. Annex II contains a summary of the relevant declarations of interest. The peer reviewers, who were sent the guidelines for review, also submitted a declaration of interest form prior to reviewing the guidelines, and these were also similarly reviewed. Procedures for management of conflicts of interest were based on WHO *Guidelines for declaration of interest* (WHO experts). This is not a field with significant financial interests, but it does contain publicly stated opinions and research that are of interest. Because the GDG membership included many of the key researchers in the field, before each topic was discussed, members declared which studies they had been involved in, and in these cases they did not actively participate in the discussion but only responded in order to clarify any questions posed by other GDG members. Because of a stated public position, the chairman stood down during the discussion on 'screening' for intimate partner violence, allowing the session to be chaired by the WHO officer responsible for the guidelines.

Decision-making during the Guideline Development Group meeting

The GDG met at the WHO in Geneva for a three-day meeting between 12 and 14 September 2011. The review of evidence was sent out in advance so it could be summarized in a presentation during the meeting. The GDG members began by discussing the evidence, clarifying points of fact, and interpreting the findings. In terms of developing recommendations, the GDG recognized that there exists a very wide variation from region to region in the prevalence of violence against women, the laws to protect women, and the resources available to help them. It was therefore particularly necessary for the GDG to consider the relevance of the evidence in this context, using the following considerations:

- the balance of benefits versus the harms of an intervention;
- values and preferences of women, sensitivity to women's needs and concerns, and human rights standards such as the right to information, respect and dignity; and
- costs and resource use and other relevant feasibility issues of providers in low- and middle-income settings.

The GDG set the evidence into context using the considerations above. Where there was a need for guidance, but no relevant research evidence was available, recommendations were developed using the expertise of the GDG and the considerations above.

Taking into account the above considerations, if it was agreed that the recommendation would be of near universal benefit, it would be rated as a strong recommendation. If however, there were caveats on its benefit in different contexts, it was rated as conditional. The recommendations on health-care policy and provision (section 5) were based on the systematic reviews that primarily found descriptive observational studies. The recommendations on training of health care providers (section 4) and on health-care policy and provision (section 5) recognized the dual objectives of equitable access and good quality care, and the importance of training providers to be competent in responding to women survivors of violence, so they can access services and do so in a way that protects and promotes their health and rights. The feasibility of implementing the recommendations in country settings with limited human and other resources was also taken into account.

The wording and strength of each recommendation was determined, in most cases, through consensus. Unanimous agreement was reached for all but two recommendations. (These were recommendation 2, regarding 'universal screening', and recommendation 7, regarding advocacy/support/empowerment for intimate partner violence.) Where the agreement was not unanimous, the outcome was decided upon by a vote. The reviewer of the topic, and WHO staff, were exempt from voting, but regional WHO staff who had been invited as advisers did vote. In these two cases, the minority opinion is written up in the discussion or remarks in the relevant section.

Document preparation and peer review

In addition to the GDG members, suitable peer reviewers were identified to allow input from a wider range of stakeholders.

Both GDG members and peer reviewers were invited to:

- rate the outcomes of the PICOT questions in advance of the evidence reviews
- comment on the reviews and draft recommendations of the clinical interventions for sexual assault and intimate partner violence prior, to the meeting
- comment on the other reviews, following the meeting but prior to revision
- comment on the final guidelines document after the meeting.

All comments were collated by the Steering Group, with each comment reviewed and responses added to the comments in a table (available on request). Relevant revisions were then made to the documents, before the revised version was sent back to the members of the GDG for a final review.

A total of 26 people commented on the PICOT questions and rated the outcomes (a table of ratings is available on request). The systematic reviews and GRADE or other tables were prepared and presented to the GDG to inform the recommendations. The following section contains the summaries of the evidence and the evidence-informed recommendations for each of the broad areas covered by the guidelines. Many people, including WHO staff, peer reviewers, stakeholders and GDG members, participated in the consultation on the review of evidence and in the preparation of the final guidelines.

Evidence and recommendations

1. Women-centred care

Women who experience intimate partner violence or sexual violence can have very different needs, depending on their circumstances and the severity of the violence and its consequences. Furthermore, women in similar circumstances may need different types of support over time. There are, however, a minimum set of actions and principles that should guide the health-care response to women suffering from violence (physical, sexual or emotional), whether by an intimate partner, relative, acquaintance or stranger, regardless of the circumstances. This minimum first-line supportive response is outlined in the recommendation below.

1.1 From evidence to recommendation

This recommendation is based on the experience of those working with survivors of intimate partner violence and sexual violence, and builds on the recommendations of the WHO publication, *Psychological first aid* (WHO, 2011), with the specific elements adapted by the GDG to deal with violence against women. Psychological first aid is aimed at individuals in community crisis situations; there is only indirect evidence for "psychological first aid" (see *Psychological first aid*. Geneva, World Health Organization, 2011, aimed at individuals in community crisis situations (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf).

1.2 Recommendation

1. **Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support.[a] Health-care providers should, as a minimum, offer first-line support when women disclose violence. First-line support includes:**

- **being non-judgemental and supportive and validating what the woman is saying**
- **providing practical care and support that responds to her concerns, but does not intrude**
- **asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken when discussing sensitive topics when interpreters are involved)**
- **helping her access information about resources, including legal and other services that she might think helpful**
- **assisting her to increase safety for herself and her children, where needed**
- **providing or mobilizing social support.**

Providers should ensure:

- **that the consultation is conducted in private**
- **confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)**

If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

Quality of evidence: Indirect evidence was identified
Strength of recommendation: Strong

Remarks:

(a) Any intervention must be guided by the principal to "do no harm", ensuring the balance between benefits and harms, and prioritizing the safety of women and their children as the uppermost concern.

(b) The privacy and confidentiality of the consultation, including discussing relevant documentation in the medical record and the limits of confidentiality with women, should be a priority. Therefore, good communication skills are essential.

(c) Health-care providers should discuss options and support women in their decision-making. The relationship should

be supportive and collaborative, while respecting women's autonomy. Health-care providers should work with the women, presenting options and possibilities, as well as providing information, with the aim to develop an effective plan and set realistic goals, but the woman should always be the one to make the decisions.

(d) In some settings, such as emergency care departments, as much as possible should be done during first contact, in case the woman does not return. Follow-up support, care, and the negotiation of safe and accessible means for follow-up consultation should be offered.

(e) Health-care providers need to have an understanding of the gender-based nature of violence against women, and of the human rights dimension of the problem.

(f) Women who have physical or mental disabilities are at an increased risk of intimate partner and sexual violence. Health-care providers should pay particular attention to their multiple needs. Women who are pregnant may also have special requirements (see recommendation 8).

2. Identification and care for survivors of intimate partner violence

This section covers identification of survivors of intimate partner violence and the clinical interventions that address it.

2.1 Identification of intimate partner violence

There has been much debate about the safe and effective identification in health-care settings of women experiencing intimate partner violence. Some individuals, particularly in the United States of America (USA), advocate asking all women consulting health-care providers about partner violence ("universal screening" or "routine enquiry"), while others argue the case for a more selective approach on the basis of clinical and diagnostic considerations ("clinical enquiry" or "case-finding") (see Glossary). In general, studies have shown that screening for intimate partner violence (i.e. systematically asking all women about violence) increases the identification of women with intimate partner violence, but have not shown a reduction in intimate partner violence, nor any notable benefit for women's health.

The evidence was assessed to identify "the effects of interventions aimed at identifying women survivors of intimate partner violence delivered at the health system level".

2.1.1 Evidence summary

An unpublished WHO review on screening and clinical interventions for intimate partner violence (available on request), an update of a previous systematic review (Feder et al., 2009), concluded there was insufficient evidence to support the idea that screening leads to a reduction in intimate partner violence or an improvement in quality of life or health outcomes, concluding that the connection between the two was complex. The current review therefore identified "screening" programmes that also offered post-screening action, in the hope that this would be more likely to go beyond increased detection rates and health-care provider acceptance, thus leading to improved outcomes for the women. In the screening programmes considered in this review, the most common type of "action" described was a prompt in the medical record of the screening test result provided to the health-care provider before the visit, or automatic referrals to social workers or professional advocates.

Of the four additional studies (Rhodes et al., 2006; Ahmad et al., 2009; MacMillan et al., 2009; Koziol-McLain et al., 2010) not reviewed in Feder et al. (2009), most were implemented in an emergency department setting (n = 4), two were conducted in family practice ambulatory settings (Ahmad et al., 2009; MacMillan et al., 2009), and two were conducted in obstetrics/gynaecology or antenatal clinic settings, or a family practice (MacMillan et al., 2009; Humphreys et al., 2011). In total, there were 1919 women in these studies; two studies were in Canada, one in New Zealand and one in the USA. MacMillan et al. (2009) did not report findings by study site.

No studies were found to have demonstrated an important or statistically significant reduction in recurrence of intimate partner violence. The MacMillan et al. (2009) and the Koziol-McLean et al. (2010) randomized-efficacy trials had similar findings of a small effect size (odds ratio of 0.82 and 0.86, respectively, not statistically significant) in family practice, obstetrics and gynaecology clinics and emergency departments in Ontario Canada, and the emergency department of an urban hospital in New Zealand respectively.

Only one study, a randomized controlled trial, was found to have assessed multiple health outcomes – quality of life, and symptoms of depression and post-traumatic stress disorder (PTSD) (MacMillan et al., 2009). At 18 months'

follow-up, there were no important differences in these health outcomes. Hence, similar to the findings of earlier reviews, there remains insufficient evidence that screening plus action leads to a reduction in recurrence of intimate partner violence, or an improvement in quality of life or health outcomes.

A more recent randomized clinical trial of intimate partner violence screening in the USA (Klevens et al., 2012) that measured recurrence of intimate partner violence and improvements in quality of life and other health outcomes, strengthened the evidence for recommendation 2, which recommends against the screening of all women in health-care settings for intimate partner violence. Overall, the quality of the available evidence for screening studies was graded low to moderate, and showed that screening women for intimate partner violence in health-care settings did not fulfil the public health criteria for implementation of a screening programme. There are no studies measuring outcomes for women comparing identification through screening versus case-finding or clinical enquiry. While there is one trial (MacMillan et al., 2009) showing no harm caused by screening, another study conducted in antenatal settings detected potential harm (Bachus et al., 2010).

2.1.2 From evidence to recommendations

One of the public health criteria for screening is the availability of an effective response. The review of screening studies summarized above considered quality of life, recurrence of intimate partner violence, and referral rates as outcomes. In addition to the evidence, issues considered by the GDG included the opportunity cost and usefulness of screening in settings with very high prevalence and limited referral options and sustainability, and potential risks and concerns for women's safety. Based on the experience of some members of the GDG, these considerations included:

- The high burden of universal screening where there is high prevalence, particularly in settings with limited referral options and overstretched resources/providers, which translates into opportunity costs of over-stretched health-care providers and a limited capacity for responding to women who may be identified through screening. In these settings, focusing on selective enquiry based on clinical considerations is more likely to benefit women.
- Women may find repeated enquiry difficult, particularly if no action is taken. This may potentially reduce their uptake of health services.
- While screening increased detection, it also tends to increase resistance from clinicians, and rates of screening tend to decrease rapidly. It can easily become a tick-box exercise carried out without due consideration, or undertaken in an ineffectual way.
- Training providers to ask all women about violence when there are limited options to offer them has an important opportunity cost. It is preferable to focus on enhancing providers' ability to respond adequately to those who do disclose violence, show signs and symptoms associated with violence, or are suffering from severe forms of abuse.

A minority of GDG members thought that the benefits of universal screening outweighed the disadvantages. Their reasons were:

- It increases detection, without which intervention cannot take place (even though options for this are limited).
- Screening programmes do not seem to harm individuals, and most women do not object to being asked.
- Health-care providers are not necessarily familiar with the signs and symptoms of intimate partner violence and may only ask women who they think may be at risk, increasing the potential for stereotyping.
- There is also a risk that if the enquiry is selective, it could mean that health-care providers will avoid asking if they feel uncomfortable (although this happens even when universal screening is the recommended approach).

2.1.3 Recommendations

2. "Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) should not be implemented.

Quality of evidence: Low–moderate
Strength of recommendation: Conditional

Remarks:

(a) There is strong evidence of an association between intimate partner violence and mental health disorders among women. Women with mental health symptoms or disorders (depression, anxiety, PTSD, self-harm/suicide attempts) could be asked about intimate partner violence as part of good clinical practice, particularly as this may affect their treatment and care.

(b) Intimate partner violence may affect disclosure of HIV status or jeopardize the safety of women who disclose, as well as their ability to implement risk-reduction strategies. Asking women about intimate partner violence could therefore be

considered in the context of HIV testing and counselling, although further research to evaluate this is needed.

(c) Antenatal care is an opportunity to enquire routinely about intimate partner violence, because of the dual vulnerability of pregnancy. There is some limited evidence from high-income settings to suggest that advocacy and empowerment interventions (e.g. multiple sessions of structured counselling) following identification through routine enquiry in antenatal care, may result in improved health outcomes for women, and there is also the possibility for follow-up during antenatal care. However, certain things need to be in place before this can be done (see Minimum requirements).

3 Health-care providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence (see Box 1, Examples of clinical conditions associated with intimate partner violence), in order to improve diagnosis/identification and subsequent care (see recommendation 30).

Quality of evidence: Indirect evidence
Strength of recommendation: Strong

Remarks:

(a) A minimum condition for health-care providers to ask women about violence is that it is safe to do so (i.e. the partner is not present); they must be trained on the correct way to ask and on how to respond to women who disclose violence (see Minimum requirements). This should at least include first-line support for intimate partner violence (see recommendation 1).

Minimum requirements for asking about partner violence

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

(b) Providers need to be aware and knowledgeable about resources available to refer women to when asking about intimate partner violence.

4 Written information on intimate partner violence should be available in health-care settings in the form of posters, and pamphlets or leaflets made available in private areas such as women's washrooms (with appropriate warnings about taking them home if an abusive partner is there).

Quality of evidence: No relevant evidence was identified
Strength of recommendation: Conditional

2.2 Care for survivors of intimate partner violence

Evidence was reviewed for the question: "What effects do health-care provider-initiated interventions have for women survivors of intimate partner violence?"

Eight new studies published since the WHO systematic review were identified, as well as an additional publication (Kiely et al., 2010) of a new outcome from a previously reviewed study.

Box 1 Examples of clinical conditions associated with intimate partner violence[a]

- Symptoms of depression, anxiety, PTSD, sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Unexplained chronic gastrointestinal symptoms
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Repeated vaginal bleeding and sexually transmitted infections
- Chronic pain (unexplained)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

[a] Adapted from Black MC. Intimate partner violence and adverse health consequences: implications for clinicians. *American Journal of Lifestyle Medicine*, 2011, 5:428–439.

The evidence for addressing the effectiveness of clinical interventions came from these new studies, as well as 14 prior studies that met the inclusion criteria from three previous systematic reviews (Sadowski and Casteel, 2010; Ramsay et al., 2006; and unpublished WHO 2009 update of Ramsay et al., 2006).

The evidence for the interventions in the following categories is summarized below:

- Psychological/mental health interventions
- advocacy/empowerment interventions (see Glossary for context-specific definitions)
- mother–child interventions
- other interventions (expressive writing and yogic breathing).

The 22 studies were all controlled trials; the majority were conducted in high-income countries: Australia (1), Hong Kong (3) and the USA (17), and one in a middle-income country: Peru. The settings varied and included community, health care, shelter/refuge or a hybrid of health-care and non-health-care settings. Challenges in interpreting studies of clinical interventions for intimate partner violence included lack of detail and the overlap between psychological and advocacy/empowerment interventions, in so far as the former often have components of non-psychological support and the latter may include psychological support such as counselling. In addition, in many studies, the interventions were not described in enough detail to distinguish between formal psychological interventions and psychological support.

The 20 studies of advocacy/empowerment and psychological interventions had both methodological strengths and limitations. The quality of evidence ranged from low (13) to moderate (7). All were randomized controlled trials using standardized assessment instruments and outcomes rated as "important" or "critically important". The limitations included the lack of blinding of the randomization process or outcome assessment, high attrition rate of the sample, and, frequently, very small sample size, which rendered the study underpowered. The heterogeneity of the studies precluded data pooling of underpowered studies and meta-analysis.

Since the last systematic review, the field has been active and has expanded the body of evidence considerably. Also, the newer studies have been conducted in health-care settings, demonstrating the feasibility of studying intimate partner violence in this setting, presumably gaining increased support from the health sector in the process.

2.2.1 Psychological/mental health interventions

Evidence summary

There were five studies that evaluated this type of intervention (Kubany et al., 2004; Gilbert et al., 2006; Lieberman et al., 2006; Kiely et al., 2010; Zlotnick et al., 2011). In a few of these, the intervention was tailored for women who had experienced intimate partner violence, and contained elements of advocacy or empowerment. As it was not possible to tease the components apart, their findings contribute to the body of evidence in both the advocacy/empowerment and psychological intervention categories. These studies show that some form of individual cognitive behavioural therapy (CBT) interventions for women who have experienced intimate partner violence may reduce PTSD and depression (during pregnancy), compared with no intervention, with one study reporting better birth outcomes. However, there is no evidence to suggest these interventions have a beneficial effect on quality of life as measured in the studies. From a previous systematic review, nine controlled studies of group psychological interventions were identified, including four randomized controlled trials (Wingood, Gilbert, Laverde, Melendez), one case control (Arinero), and four parallel group studies (Cox, Limandri, Rinfert-Raynor, Kim). They included studies based in Colombia and Korea and evaluated highly heterogeneous, psychologically based interventions and outcomes. Although the majority reported some positive outcomes, the quality of the overall study design and conduct was poor.

From evidence to recommendations

For individual psychological interventions, CBT interventions are recommended for women who are no longer experiencing violence but are suffering from PTSD. The evidence for this specific population is low quality, but comes supported by a much larger body of evidence for CBT that is of moderate quality. There is insufficient evidence to recommend CBT for women who are still experiencing intimate partner violence.

There was insufficient evidence to recommend a group psychological intervention for women who have experienced intimate partner violence.

However, the GDG wished to remind health-care providers that women with diagnosed mental health disorders who suffered intimate partner violence should receive mental health care as advised in the WHO Mental Health Gap Action Programme (mhGAP) guidelines (WHO, 2010), provided

Box 2	Abridged recommendations for depression (DEP 1–6) and other significant emotional or medically unexplained complaints (OTH 1–7)
Role of antidepressants and benzodiazepines	DEP 1. Antidepressants should not be considered for the initial treatment of adults with mild depressive episode. Tricyclic antidepressants or fluoxetine should be considered in adults with moderate to severe depressive episode/disorder.
	OTH 2. Neither antidepressants nor benzodiazepines should be used for the initial treatment of individuals with complaints of depressive symptoms in the absence of current/prior depressive episode/disorder.
Duration of antidepressant treatment	DEP 2. Antidepressant treatment should not be stopped before 9–12 months after recovery.
Brief, structured, psychological treatment	DEP 3. Interpersonal therapy and cognitive behavioural therapy (CBT) (including behavioural activation, DEP 4), and problem-solving treatment should be considered as psychological treatment of depressive episode/disorder in non-specialized health-care settings if there are sufficient human resources (e.g. supervised community health workers). In moderate and severe depression, problem-solving treatment should be considered as adjunct treatment.
	OTH 3. A problem-solving approach should be considered in people with depressive symptoms (in the absence of depressive episode/ disorder) who are in distress or have some degree of impaired functioning.
	OTH 1. Psychological treatment based on CBT principles should be considered in repeat adult help seekers with medically unexplained somatic complaints who are in substantial distress and who do not meet criteria for depressive episode/disorder.
Relaxation training and physical activity	DEP 5, DEP 6. Relaxation training and advice on physical activity may be considered as treatment of adults with depressive episode/ disorder. In moderate and severe depression, these interventions should be considered as adjunct treatment.
Psychological support after recent traumatic event	OTH 4. Psychological debriefing should not be used for recent traumatic event to reduce the risk of post-traumatic stress, anxiety, or depressive symptoms.
	OTH 5. Providing access to support based on the principles of psychological first aid should be considered for people in acute distress exposed recently to a traumatic event.
Graded self-exposure based on CBT principles in adults with post-traumatic stress disorder (PTSD) symptoms	OTH 6. If it is possible to continue to follow up with the patient, graded self-exposure based on the principles of CBT should be considered in adults with PTSD symptoms.
Psychological treatment based on CBT principles in people concerned about prior panic attacks	OTH7. Psychological treatment based on CBT principles should be considered as treatment of people concerned about prior panic attacks.

Source: Dua et al, 2011.

by professionals with an understanding of the impact and management of violence against women (Howard et al., 2010).

There is a substantial existing body of literature on the treatment of a range of mental disorders, including depression and PTSD (Bisson et al., 2007). WHO already has guidelines on treatment of depression, psychosis and alcohol use disorders, among other conditions (WHO, 2010; Dua et al., 2011). WHO is currently working on mhGAP guidelines and clinical protocols for acute stress, bereavement and PTSD. The WHO mhGAP Guidelines Development Group has thus far approved the recommendations shown in Box 2 that are potentially relevant to victims/survivors of intimate partner violence.

Recommendations

5 **Women with a pre-existing diagnosed or partner violence-related mental disorder (such as depression, or alcohol use disorder) who are experiencing intimate partner violence should receive mental health care for the disorder in accordance with WHO mhGAP intervention guidelines (WHO, 2010), delivered by health-care professionals with a good understanding of violence against women.**

Quality of evidence: Indirect evidence; variable (varies with intervention, see http://www.who.int/mental_health/mhgap/evidence/en)
Strength of recommendation: Strong

Remark:

(a) Use of psychotropic medications in women who are either pregnant or breastfeeding requires specialist knowledge and is best provided in consultation with a specialist where available. For details on management of mental health issues in these two groups please see the mhGAP guidelines (WHO, 2010).

6 Cognitive behavioural therapy (CBT) or eye movement desensitization and reprocessing (EMDR) (see Glossary) interventions, delivered by health-care professionals with a good understanding of violence against women, are recommended for women who are no longer experiencing violence but are suffering from PTSD.

Quality of evidence: Low–moderate
Strength of recommendation: Strong

2.2.2 Advocacy/empowerment interventions

Evidence summary

Fifteen studies of interventions defined as advocacy or empowerment were identified (McFarlane et al., 2000, 2006; Sullivan et al., 2002; Constantino et al., 2005; Tiwari et al., 2005, 2010a, 2010b; Gillum et al., 2009; Cripe et al., 2010; Bair-Merrit et al., 2010; Kiely et al., 2010; Humphreys et al., 2011; Taft et al., 2011; Miller,). These interventions included multiple components such as linking women to services, empowering women, educating women on parenting, and safety behaviours. The implementation of the interventions was heterogeneous in terms of who delivered the services (lay to professional) and setting (i.e. home, community, telephone and health-care setting). There is evidence that intimate partner violence advocacy/empowerment interventions may reduce recurrence of intimate partner violence for some women, but there is insufficient evidence of an impact on quality of life or mental health outcomes. The strongest evidence came from three advocacy trials conducted in Hong Kong, which implemented similar empowerment-based interventions of brief duration to three (relatively small) samples of women – antenatal, community health centre based, and shelter based.[1] Of these three studies, the two evaluating the intervention in health-care settings reported benefit in some health and abuse outcomes. There remains uncertainty about the intensity required for advocacy/empowerment to have an effect outside of antenatal settings.

There are two important caveats, particularly in the context of developing an evidence base for international guidelines for health-care services. First, the strongest evidence for individual advocacy or support comes from trials of women in shelters, refuges, or safe houses with no direct connection to health-care settings, although there is more recent evidence from small-sample studies in antenatal care settings. Secondly, the evidence is based on studies in high-income countries, so other considerations need to be taken on board before making an extrapolation to the majority of the world's population.

Two studies investigated harm or distress caused by the topics of discussion, or breaches in confidentiality (McFarlane et al., 2006; Tiwari et al., 2005), and found none.

From evidence to recommendations

After reviewing the evidence, the GDG thought there was some uncertainty about (i) the effectiveness of advocacy for quality of life and mental health outcomes, and (ii) extrapolation of benefit to women not residing in shelters, or women who are not pregnant. A vote was taken on recommendation 8 and the caveats were represented in the remarks.

Recommendations

7 **Women who have spent at least one night in a shelter, refuge, or safe house should be offered a structured programme of advocacy, support, and/or empowerment (see Glossary).**

Quality of evidence: Low
Strength of recommendation: Conditional

Remarks

(a) The extent to which this may apply to women leaving the household in situations where shelters do not exist is not clear.

(b) This may be considered for women disclosing intimate partner violence to health-care providers, although the extent to which this may apply in circumstances outside of shelters is not clear and should be researched further.

(c) In populations where the prevalence of intimate partner violence is high, priority should be given to women experiencing the most severe abuse. (The GDG did not agree whether this should extend to severe psychological abuse.)

[1] The strength of the evidence is labeled as "indirect evidence" when no direct evidence was identified for this population and the recommendation was therefore based on evidence extrapolated from another appropriate population.

(d) Interventions should be delivered by trained health-care or social care providers or trained lay mentors, tailored to the woman's personal circumstances and designed to combine emotional support and empowerment with access to community resources.

8 Pregnant women who disclose intimate partner violence should be offered brief to medium-duration empowerment counselling (up to 12 sessions) and advocacy/support, including a safety component, offered by trained service providers where health systems can support this. The extent to which this may apply to settings outside of antenatal care, or its feasibility in low- or middle-income countries is uncertain.

Quality of evidence: Low
Strength of recommendation: Conditional

Remarks

(a) Information about exposure to violence should be recorded unless the woman declines, and this should always be conducted in a discreet manner (i.e. not with labels or noticeable markings that can be stigmatizing for women, especially when health-care professionals label them as "battered"). Women may not wish to have information recorded in their clinical history files, in the fear that their partner may find out. This concern will need to be balanced against the need to ensure adequate forensic evidence in circumstances where women decide to pursue a legal case.

(b) A woman should be helped to develop a plan to improve her safety and that of her children, where relevant.

(c) Attention should be paid to self-care for providers, including the potential for vicarious trauma (see Glossary).

2.2.3 Mother–child interventions

Evidence summary

Four studies were identified that evaluated mother–child interventions (Jouriles et al., 2001; Sullivan, 2002; Lieberman et al., 2005, 2006). Three randomized controlled trials (one involving follow-up of an earlier trial) of intensive interventions (at least 20 sessions) focusing on the mother–child dyad, found improvements in either the children's behaviour problems (Jouriles et al., 2001; Lieberman et al., 2005, 2006), their sense of competence and self-worth (Sullivan, 2002) and/or traumatic stress symptoms in children (Lieberman et al., 2005, 2006). One intervention showed reduction in some, but not other maternal post-traumatic stress symptoms (Lieberman et al., 2005, 2006). Of the two studies that considered maternal distress related to general psychiatric symptoms, one showed benefits (Sullivan et al., 2002) while the other showed no effect (Jouriles et al., 2009). A randomized controlled trial of community-provided trauma-focused CBT (TF-CBT; Cohen, 2011), with sessions provided to children and parents that focused exclusively on child outcomes, showed improvements in children's intimate partner violence-related PTSD and anxiety. This lends further support to the evidence for effectiveness of psychotherapeutic mother–child interventions, but specifically within the context of high-income countries.

From evidence to recommendations

The GDG judged the evidence for specific intensive mother–child dyad interventions was sufficiently strong to recommend this intervention, although the applicability of this to low-income settings is uncertain.

Recommendation

9 Where children are exposed to intimate partner violence, a psychotherapeutic intervention, including sessions where they are with, and sessions where they are without their mother, should be offered, although the extent to which this would apply in low- and middle-income settings is unclear.

Quality of evidence: Moderate
Strength of recommendation: Conditional

Remark

(a) The cost of intensive psychotherapeutic interventions focusing on the mother–child dyad makes it challenging to implement them in resource-poor settings.

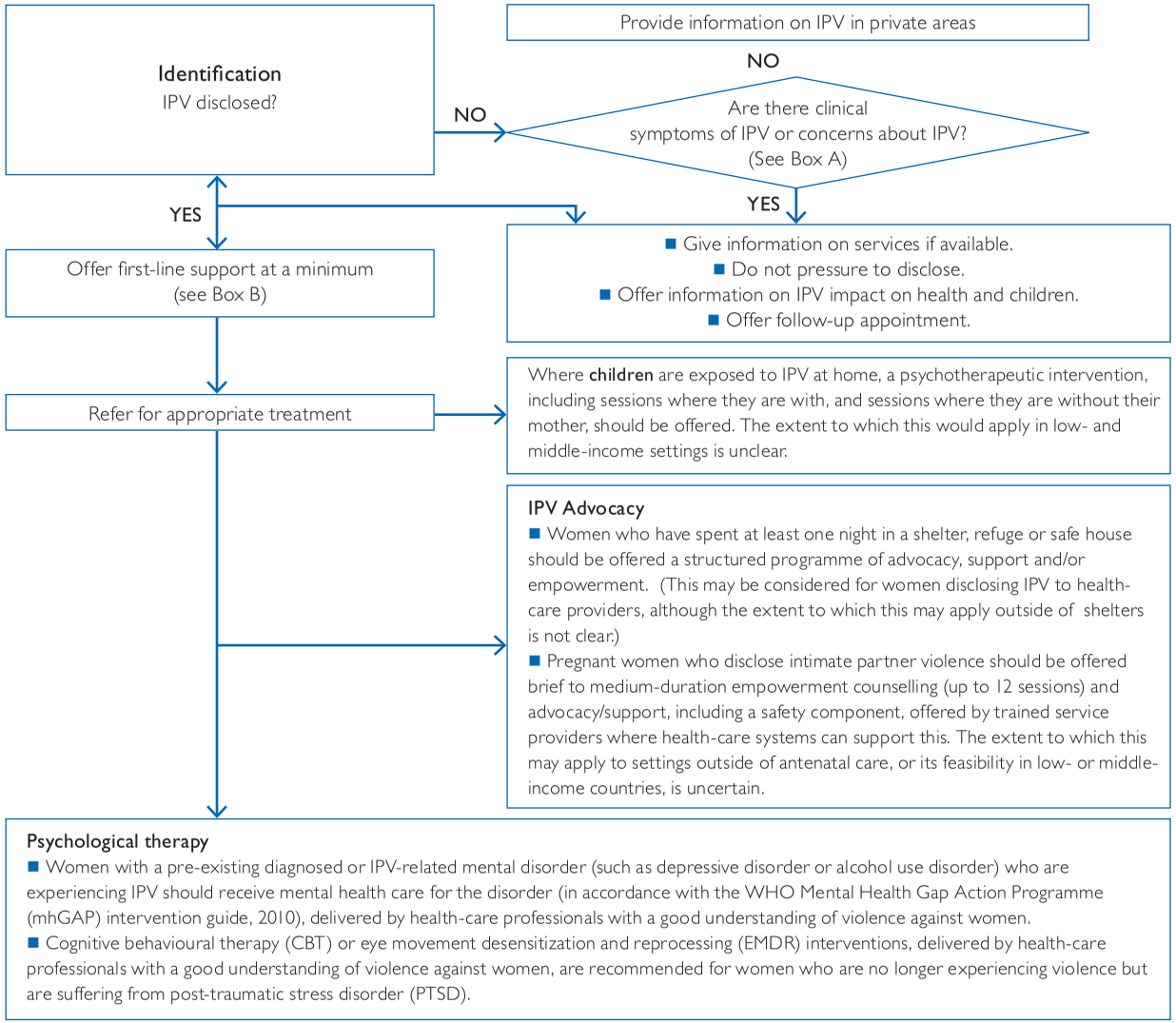
(b) The lack of providers trained to provide this type of interventions also poses challenges in resource-poor settings.

2.2.4 Other interventions

Studies evaluating expressive writing (Koopman et al., 2005) and yogic breathing (Franzblau et al., 2008) were reviewed. Both were community based without linkage to health-care services and were poor quality studies. The GDG did not regard the evidence as strong enough to make any recommendations.

Figure 1 summarizes the care pathway for intimate partner violence and should help guide providers in their response to women survivors of intimate partner violence.

Figure 1. Care pathway for intimate partner violence (IPV = intimate partner violence)



Box A – Clinical conditions associated with intimate partner violence

- Symptoms of depression, anxiety, PTSD, sleep disorders
- Suicidality or self-harm
- Alcohol and other substance use
- Chronic pain (unexplained)
- Unexplained chronic gastrointestinal symptoms
- Unexplained genitourinary symptoms, including frequent bladder or kidney infections or other
- Adverse reproductive outcomes, including multiple unintended pregnancies and/or terminations, delayed pregnancy care, adverse birth outcomes
- Unexplained reproductive symptoms, including pelvic pain, sexual dysfunction
- Repeated vaginal bleeding and sexually transmitted infections (STIs)
- Traumatic injury, particularly if repeated and with vague or implausible explanations
- Problems with the central nervous system – headaches, cognitive problems, hearing loss
- Repeated health consultations with no clear diagnosis
- Intrusive partner or husband in consultations

Box B – First-line support

Women who disclose any form of violence by an intimate partner (or other family member) or sexual assault by any perpetrator should be offered immediate support. This includes:

- ensuring consultation is conducted in private
- ensuring confidentiality, while informing women of the limits of confidentiality (e.g. when there is mandatory reporting)
- being non-judgemental, supportive and validating what the woman is saying
- providing practical care and support that responds to her concerns, but does not intrude
- asking about her history of violence, listening carefully, but not pressuring her to talk (care should be taken with the use of interpreters for sensitive topics)
- helping her access information about resources, including legal and other services that she might think helpful
- assisting her to increase safety for herself and her children, where needed
- providing or mobilizing social support.

If health-care providers are unable to provide first-line support, they should ensure that someone else (within their health-care setting or another that is easily accessible) is immediately available to do so.

3. Clinical care for survivors of sexual assault

Sexual assault is a potentially traumatic experience that may have a variety of negative consequences on women's mental, physical, sexual and reproductive health, meaning they may require acute and, at times, long-term care, particularly mental health care. In certain situations such as where there is a breakdown of law and order, armed conflict and post-conflict, or displacement, sexual violence may be exacerbated. In prisons, mental health facilities and other settings where people are institutionalized, sexual violence also appears to be more prevalent.

The gathering of forensic information is not covered by these guidelines, but is a critical element of post-rape care for those women who may want to pursue legal action. Please refer to the *WHO Guidelines for medico-legal care for victims of sexual violence* (2003) and the WHO/UNHCR Guidance on clinical management of rape guidelines (2004) and *e-learning programme* (2009) for further information on this.

3.1 Interventions during the first 5 days after the assault

3.1.1 First-line support

Recommendations

10 Offer first-line support to women survivors of sexual assault by any perpetrator (see also recommendation 1), which includes:

- **providing practical care and support, which responds to her concerns, but does not intrude on her autonomy**
- **listening without pressuring her to respond or disclose information**
- **offering comfort and help to alleviate or reduce her anxiety**
- **offering information and helping her to connect to services and social supports.**

Quality of evidence: Indirect evidence was identified[1]
Strength of recommendation: Strong

11 Take a complete history, recording events to determine what interventions are appropriate, and conduct a complete physical examination (head-to-toe including genitalia).[2] The history should include:

- **the time since assault and type of assault**
- **risk of pregnancy**
- **risk of HIV and other STIs**
- **mental health status.**

Quality of evidence: Indirect evidence was identified (WHO, 2002; WHO/UNHCR/UNFPA, 2009)
Strength of recommendation: Strong

3.1.2 Emergency contraception

Sexual assault may place women of reproductive age at risk of unwanted pregnancy. Although little research exists documenting the likelihood of pregnancy as a result of sexual assault, research conducted in the USA (namely, the National Women's Study) estimated a rape-induced pregnancy rate of 5% per rape of women of reproductive age (Holmes, 1996). Rape-induced pregnancy may be even more common among women who are sexually assaulted by intimate partners, with one small study finding that 20% out of 100 women sexually assaulted by intimate partners reported becoming pregnant as a result of this violence (McFarlane et al., 2005). Analysis of data from the WHO multi-country study on women's health and domestic violence against women shows that intimate partner violence is significantly associated with unwanted pregnancy and abortions (Pallitto et al., 2013).

Evidence summary

A search of the scientific literature did not identify any research studies that focused on the effects of emergency contraception used by survivors of sexual assault.

Given the absence of evidence for this particular PICOT question, and since there is no reason to believe that the effects of emergency contraception would differ in women who have been sexually assaulted compared to non-assaulted populations, four sets of evidence-based guidelines concerning emergency contraception for general populations of women were reviewed to help inform the recommendations, including those of:

- *Selected practice recommendations for contraceptive use* (WHO, 2004)
- *Guidelines for the management of female survivors of sexual assault*. Report of the International Federation of Gynaecology

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[1] See WHO, 2011.
[2] See WHO, 2003; WHO/UNHCR, 2004 and WHO/UNHCR/UNFPA, 2009.

and Obstetrics (FIGO) Working Group on Sexual Violence/HIV (Jina et al., 2010)
- *Emergency contraception* (American College of Obstetricians and Gynaecologists, 2010)
- *Interventions for emergency contraception* (Cheng et al., 2008), a Cochrane Collaboration systematic review.

Comparison of these four guidelines, in terms of recommended drug regimens, shows that all groups except for Cheng and colleagues (2008) suggest that progestogen-only emergency contraceptive pills are the first choice of a drug regimen, with combined oestrogen–progestogen pills the secondary choice. By contrast, Cheng and colleagues (2008) recommend mifepristone as the first choice, followed by progestogen-only emergency contraceptive pills, and then a combined course of oestrogen–progestogen pills. It should, however, be noted that mifepristone in the dosage needed for emergency contraception is available in only four countries and is not recommended by WHO. All four groups agree that copper-bearing intrauterine devices (IUDs) may also be used as emergency contraception if not contraindicated. All four groups also agree that, if used, emergency contraception pills should be initiated as soon as possible after the unprotected sexual intercourse (or rape), to maximize effectiveness, with Cheng and colleagues (2008) specifying that this should occur within the first 24 hours. All groups also agree that these drugs may be initiated up to 5 days after the unprotected sexual intercourse (or rape), even though their effectiveness decreases with time. Two groups (the American College of Obstetricians and Gynecologists and the FIGO Working Group on Sexual Violence/HIV) recommend that anti-emetics be used to prevent nausea when using a combined oestrogen–progestogen regimen as emergency contraception. By contrast, WHO (2004) recommends that anti-emetics should not be used routinely; instead, they recommend that this decision be based on clinical judgment and availability. Cheng and colleagues (2008) did not make a specific recommendation on anti-emetics, although they did find that the combined oestrogen–progestogen regimen was commonly associated with the side-effects of nausea and vomiting.

In addition, information from recent randomized controlled trials of uliprisal acetate was reviewed (including studies by Creinin et al., 2006; Glasier, 2010). These studies suggest that ulipristal acetate is as effective as (and possibly more effective than) levonorgestrel in pregnancy prevention when taken close to ovulation, with somewhat similar side-effects.

From evidence to recommendations

The GDG accepted that guidance on emergency contraception for the general population would apply to women who had been sexually assaulted, and made recommendations accordingly, based on the review of the guidelines presented above. The FIGO and the American College of Obstetricians and Gynecologists classified the strength of their evidence and recommendations, but used different systems to do so.[1] The Cochrane review (Cheng et al, 2008) did not classify the strength of evidence. The strength of evidence in the following recommendations is based on the best assessment of the evidence provided in the guidelines reviewed.

Recommendations

12 Offer emergency contraception to survivors of sexual assault presenting within 5 days of sexual assault, ideally as soon as possible after the exposure, to maximize effectiveness.

Quality of evidence: Moderate
Strength of recommendation: Strong

Remarks

(a) If used, emergency contraception should be initiated as soon as possible after the rape, as it is more effective if given within 3 days, although it can be given up to 5 days (120 hours).

13 Health-care providers should offer levonorgestrel, if available. A single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart.

- **If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available.**
- **If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking on-going pregnancy prevention. Taking into**

[1] The FIGO guidelines used the Canadian Task Force on Preventive Health Care approach and classified this evidence and recommendation as I-A, denoting evidence from at least one properly controlled randomized controlled trial, so they felt there is good evidence to recommend clinical preventive action. The American College of Obstetricians and Gynecologists used the US Preventive Services Task Force approach and classified this as Level B, a recommendation based on limited or inconsistent scientific evidence.

account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (see *WHO medical eligibility criteria*, 2010).

Quality of evidence: Moderate
Strength of recommendation: Strong

Remarks

(a) The GDG discussed some of the contraindications and side-effects of the drugs. Emergency contraceptive pills on the market are extremely safe and well tolerated and meet the criteria for over-the-counter provision.

(b) Ulipristal acetate is a relatively new drug that appears to be as effective as, or more effective than, levonorgestrol. While the side-effect profile seems similar to that of levonorgestrol, it is not yet included in the WHO essential medicines list (WHO, 2011), although further evidence may change this. Levonorgestrel remains cheaper and is relatively widely available.

(c) The higher risk of STIs following rape should be considered if using a copper-bearing IUD. IUDs are an effective method of emergency contraception and should be made available to women seeking emergency contraception.

(d) A pregnancy test is not required, but if one was done and the result was positive, emergency contraception would not be necessary or effective.

14 If a woman presents after the time required for emergency contraception (5 days), emergency contraception fails, or the woman is pregnant as a result of rape, she should be offered safe abortion, in accordance with national law.

Quality of evidence: No relevant evidence was identified
Strength of recommendation: Strong

Remarks

(a) Where abortion is not permitted, other options such as adoption should be explored with the survivor.

3.1.3 HIV post-exposure prophylaxis: treatment and adherence

Sexual assault may be associated with the transmission of HIV. While the rate of sexual transmission of HIV is low (Boily et al., 2009), it is difficult to establish risk and there are several characteristics of sexual assaults (potential for tears, multiple perpetrators) that can affect this risk. Therefore, particularly in high-prevalence settings, there are strong ethical arguments to support the provision of post-exposure prophylaxis (PEP) for HIV infection.

Evidence summary: treatment

A search of the scientific literature did not identify any studies that examined the effects of HIV PEP for survivors of sexual assault that met all of the criteria specified in the PICOT question; however, four studies (Wiebe et al, 2000; Drezett, 2002; Garcia et al., 2005; Roland et al., 2012) were identified that focused on the effects of HIV PEP among survivors of sexual assault, even though they did not meet all the PICOT criteria. These studies were reviewed to shed some light on this important topic.

Two of the four studies used prospective double cohort follow-up study designs to compare HIV seroconversion among survivors of sexual assault who were prescribed HIV PEP, with survivors of sexual assault who were not prescribed HIV PEP (Drezett, 2002; Garcia et al., 2005). The other two studies (Wiebe et al., 2000; Roland et al., 2012) used prospective cohort follow-up study designs to examine seroconversion among survivors of sexual assault who all were prescribed HIV PEP (these studies did not include a comparison group).

Each of these studies had important methodological limitations, such as lack of a comparison group, small sample sizes, and low follow-up rates. In addition, three of the studies (Wiebe et al., 2000; Garcia et al., 2005; Roland et al., 2012) included men, with no subgroup analysis that reported exclusively on the findings from women; an analysis of interest for this WHO review focused on female survivors of sexual assault. In addition, the research was conducted in only three countries: Brazil, Canada and South Africa, which limits the generalizability of the findings.

Results showed that only one of the two prospective double cohort follow-up studies found that, when compared to no HIV PEP (Drezett, 2002), HIV PEP reduced the probability of HIV seroconversion. In the two prospective cohort follow-up studies, seroconversion rates ranged from 0% to 3.7% (Wiebe et al., 2000; Roland et al., 2012).

From evidence to recommendations: treatment

Since research on HIV PEP for survivors of sexual assault is limited, and as it is extremely unlikely that clinical trial studies will be undertaken on this issue (because of ethical and logistical reasons), recommendations need

to be established by extrapolating the findings from other research, including animal studies and research on people other than survivors of sexual assault. For example, there is evidence from a case-control study that a short course of antiretroviral therapy effectively reduces HIV transmission following needle-stick exposure (Cardo et al, 1997). Thus, the recommendations developed for these guidelines considered other relevant guidelines concerning this topic (CDC 2010; Jina R et al., 2010; WHO 2008).

The GDG discussed the generalizability of the evidence in all situations. Many women do not complete the 28 days of HIV PEP treatment required for it to be effective. This may be due to the side-effects of taking some of the drugs, and also related to the emotional consequences of the sexual assault. In addition, there are resource and logistic implications of providing HIV PEP. Taking this into consideration, the GDG questioned whether HIV PEP should be used routinely in locations where the prevalence of HIV is predicted to be low. There was a suggestion that health systems may wish to set a prevalence cut-off point, below which HIV PEP is not routinely offered. Additionally, in some circumstances, the risk of the individual perpetrator infecting the woman is low. It was therefore agreed that, particularly in low-prevalence settings, the risk should be considered in consultation with the woman before HIV PEP is offered.

Evidence summary: adherence

A search of the scientific literature did not find any studies that examined the effectiveness of interventions aimed at enhancing sexual assault survivors' adherence to HIV PEP, and that met all of the criteria specified in the PICOT question. However, one study was identified (Abrahams et al., 2010) that did examine this topic, even though it did not meet all the PICOT criteria (i.e. the study population included female children who were sexually assaulted, as well as adult women who were sexually assaulted, with no subgroup analyses conducted exclusively on the adult survivors). This study was reviewed to shed some light on this important topic.

Abrahams and colleagues (2010) examined whether psychosocial support via telephone would enhance adherence to HIV PEP. The study population included female child and adult survivors of sexual assault who were HIV negative when they presented at four sexual assault services in an urban and a rural site in South Africa. Participants were randomly allocated to receive a leaflet including an adherence diary, or the aforementioned plus psychosocial support by telephone. Adherence to HIV PEP was assessed during an interview that occurred 1–5 days after the 28-day period (the time during which the patients were supposed to take the HIV PEP).

Although this study used a strong research design to address the question, it also had several methodological limitations. One important limitation is that for nearly one third of participants the assessment of the primary outcome of interest (adherence to HIV PEP) was based on patients' reports of the amount of medication they did and did not take, a potentially unreliable measure, despite all study participants being provided with a diary to record when they took their medication. In addition, there were no subgroup analyses that reported exclusively on the findings from the adult participants, an analysis of interest for this review. Results showed that the intervention was not found to be effective. There were similar levels of extremely poor adherence to HIV PEP in both the intervention and comparison groups.

From evidence to recommendations: adherence

Given that only one study was identified on this topic, and showed a negative outcome in that the intervention did not enhance adherence to HIV PEP, there is a lack of good research evidence on this topic on which to make recommendations.

The view of the GDG was that, while adherence is an important issue to address in relation to HIV PEP, the current evidence did not show an effective approach to enhancing adherence.

Recommendations

15 **Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making (see Glossary) with the survivor to determine whether HIV PEP is appropriate (WHO, 2007).**

Quality of evidence: Very low, based on indirect evidence (see WHO/ILO [International Labour Organization], 2008)
Strength of recommendation: Strong

Remarks

(a) PEP should be initiated as soon as possible after the assault, ideally within a few hours and no later than 72 hours after the exposure.

(b) In low-prevalence settings, policies on offering routine HIV PEP will need to consider the local context, resources and opportunity and other costs of offering it.

16 **Discuss HIV risk to determine use of PEP with the survivor, including:**

- **HIV prevalence in the geographic area**
- **limitations of PEP**[1]
- **the HIV status and characteristics of the perpetrator if known**
- **assault characteristics, including the number of perpetrators**
- **side-effects of the antiretroviral drugs used in the PEP regimen**
- **the likelihood of HIV transmission.**

Quality of evidence: Indirect evidence was identified (WHO, 2008)
Strength of recommendation: Strong

17 **If HIV PEP is used:**

- **start the regimen as soon as possible and before 72 hours**
- **provide HIV testing and counselling at the initial consultation**
- **ensure patient follow-up at regular intervals**
- **two-drug regimens (using a fixed-dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side effects**
- **the choice of drug and regimens for HIV PEP should follow national guidance.**

Quality of evidence: Indirect evidence was identified (WHO, 2008)
Strength of recommendation: Strong

Remark

(a) The choice of PEP drugs should be based on the country's first-line antiretroviral regimen for HIV.

18 **Adherence counselling should be an important element in PEP provision.**

Quality of evidence: Very low, based on indirect evidence
Strength of recommendation: Strong

Remark

(a) Many female survivors of sexual assault provided with HIV PEP do not successfully complete the preventive regimen because HIV PEP results in physical side-effects such as nausea and vomiting, may trigger painful thoughts of the rape, and may be overtaken by other issues in the lives of survivors. Health-care providers should be aware that adherence is very difficult to attain and efforts should be made to ensure that it is maintained. As yet, no effective intervention to promote adherence has been identified.

General remarks

(a) It is important to determine the circumstances of the rape and whether HIV PEP is appropriate. The Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (WHO, 2007, p.52) recommend the following eligibility criteria for HIV PEP post-sexual assault:

- rape (penetration) took place less than 72 hours ago
- HIV status of perpetrator positive or unknown
- exposed individual not known to be HIV infected (need to offer HIV testing at time of consultation)
- defined risk of exposure, such as:
  - receptive vaginal or anal intercourse without a condom or with a condom that broke or slipped; or
  - contact between the perpetrator's blood or ejaculation and mucous membrane or non-intact skin during the assault ; or
  - recipient of oral sex with ejaculation; or
  - the person who was sexually assaulted was drugged or otherwise unconscious at a time of the alleged assault and is uncertain about the nature of the potential exposure; or
  - the person was gang-raped.

(b) HIV testing is recommended prior to giving PEP but should not preclude PEP being offered. However, people with HIV infection, should not be given PEP and should be linked to care and provided with antiretroviral therapy.

(c) Health policy-makers should consider whether to include routine offer of HIV PEP in post-rape care, based on local prevalence, ethical and resource considerations.

3.1.4 Post-exposure prophylaxis for sexually transmitted infections

Evidence summary

A search of the scientific literature did not identify any studies that examined the effects of STI PEP provided by health-care providers to women survivors of sexual assault. In light of the absence of evidence on this particular PICOT question, and since there is no reason to think that the effects of PEP for STIs would work differently in women who have been sexually assaulted compared to non-assaulted populations, health organizations/groups, including the Centers for

[1] In two cohort studies of HIV PEP, seroconversion rates ranged from 0% to 3.7%.

Disease Control and Prevention (CDC) (2010) and the FIGO Working Group on Sexual Violence and HIV (Jina et al., 2010), have based their recommendations concerning this topic on research evidence from other populations, expert opinion, or reports of expert committees. Therefore, these two recent sets of evidence-based guidelines concerning PEP for STIs were reviewed to help inform the recommendations.

Comparison of the CDC and FIGO guidelines on this topic found them to be in general agreement. Both recommend that survivors of sexual assault be provided with prophylaxis/treatment for Chlamydia, gonorrhoea and Trichomonas; however, the FIGO guidelines also recommend prophylaxis/treatment for syphilis. Both the CDC and FIGO guidelines recommend that survivors of sexual assault receive vaccination for hepatitis B; however, the CDC guidelines also specify that this should be hepatitis B vaccination without hepatitis B immune globulin.

From evidence to recommendations

Similar to the earlier section on emergency contraception, evidence was extrapolated from studies gathered from the general population, on the grounds that the effectiveness of STI PEP was unlikely to be different for survivors of sexual assault. The view of the GDG was that to test first and then treat for a positive result would necessitate a time lag, and risk the woman not returning for the result or treatment. Therefore, the GDG recommended presumptive treatment for STIs without prior testing.

As the recommendations below were based on the CDC guidelines (which did not include strength of evidence or strength of recommendation), and the FIGO guidelines (which did include this information), the strength of evidence in the recommendations below is based on the best assessment of the evidence provided in these guidelines.

Recommendations

19 **Women survivors of sexual assault should be offered prophylaxis/presumptive treatment for:**

- **chlamydia**
- **gonorrhoea**
- **trichomonas**
- **syphilis, depending on the prevalence in the geographic area.**

The choice of drug and regimens should follow national guidance.

Quality of evidence: Indirect evidence; low–very low
Strength of recommendation: Strong

20 **Hepatitis B vaccination without hepatitis B immune globulin should be offered as per national guidance.**

- **Take blood for hepatitis B status prior to administering the first vaccine dose.**
- **If immune, no further course of vaccination is required.**

Quality of evidence: Indirect evidence; Very low
Strength of recommendation: Strong

Remark

(a) Presumptive treatment is preferable to testing for STIs, in order to avoid unnecessary delays. Therefore, the GDG does not recommend testing prior to treatment.

3.2 Psychological/mental health interventions

3.2.1 Interventions during the first days after the assault

Evidence summary

A search of the scientific literature identified nine studies examining the effects of mental health interventions provided by health-care providers for women survivors of sexual assault, with one of these studies meeting all of the PICOT question criteria (Echeburua et al., 1996) and eight of these studies (Rothbaum, 1997; Resick et al., 1988, 2002; Resick and Schnicke, 1992; Foa et al., 1991; Rothbaum et al., 2005; Galovski et al., 2009; Anderson et al., 2010) meeting most of the PICOT question criteria. Each of these studies was reviewed.

The nine studies evaluated 10 types of mental health therapies (assertion training, clinician assisted emotional disclosure, cognitive processing therapy, cognitive restructuring and coping skills, eye movement desensitization and reprocessing (EMDR) (see Glossary), prolonged exposure, progressive muscular relaxation, stress inoculation therapy, supportive counselling, and supportive psychotherapy and information). The first four and prolonged exposure and stress inoculation therapy represent different forms of cognitive behavioural therapy (CBT) (see Glossary). Seven studies focused on individually delivered therapies, while two studies focused on group therapies. The therapeutic interventions were delivered in sessions provided over a relatively short time (from 10 days to 12 weeks), with the total treatment time ranging from 5 to 18 hours.

The studies had both methodological strengths and limitations. In terms of strengths, six of the nine studies used a randomized controlled trial study design, one was a secondary analysis of data from a randomized controlled trial, and two were non-randomized controlled trials. Standardized assessment instruments were used in all studies, and multiple outcomes were assessed in most studies. The limitations included frequently not using a blinded assessment, having high loss to follow-up, no intent-to-treat analysis, and no control for potentially confounding variables. In addition, the studies often had multiple exclusion criteria, including psychological/psychiatric co-morbidity, substance abuse/dependence, and/or having experienced, or currently experiencing various forms of intimate partner violence and/or incest. Since many survivors of sexual assault have these types of problems, the generalizability of the findings of these studies to the greater population of survivors of sexual assault may be open to question. Moreover, most studies focused on survivors of sexual assault whose most recent assault had occurred at least 3 months before the study, with many of the study participants having been assaulted several years prior to the study. Although this inclusion criterion may be justified in that the investigators were trying to include only survivors of sexual assault whose levels of rape-related symptoms had not "naturally" decreased with time (or fulfilled the *Diagnostic and statistical manual of mental disorders* [DSM-IV; American Psychiatric Association, 1994] diagnostic criteria for PTSD, which include for the exposure to have occurred at least 1–3 months previously), this inclusion criterion may limit the generalizability of the findings, especially for women who seek care soon after the assault. In addition, most of the studies had extremely small sample sizes. Finally, it should be noted that eight of the nine studies were conducted in the USA, and eight of the nine studies focused on clinic samples.

Taken together, the study findings appear to suggest that relatively brief mental health interventions, in particular several forms of CBT as well as EMDR, may improve the psychological health of many adult female survivors of sexual assault. Moreover, although these mental health interventions appear to be more helpful than receiving no treatment, the research does not unequivocally demonstrate that one particular type of therapy is clearly superior to all others.

Finally, given the few studies on this specific population and the variety of mental health interventions assessed (with some interventions being assessed in only one study), as well as the aforementioned methodological concerns, caution is urged in making recommendations on these limited study findings. Recommendations therefore also considered the wider body of research evidence concerning mental health interventions for all trauma victims, not just victims of sexual assault (Bisson et al., 2007).

From evidence to recommendations

The strength of recommendations for the effects of mental health interventions for the care of survivors of sexual assault is limited by the relatively few studies on this topic and the methodological limitations of this research. However, this research does provide a modicum of evidence that offering survivors of sexual assault particular types of mental health interventions, such as CBT (in particular, cognitive processing therapy, prolonged exposure, and stress inoculation therapy), as well as EMDR leads to improved psychological health, including improvement of PTSD. This is supported by more general evidence on the effectiveness of these approaches for trauma survivors.

The GDG discussed the availability of resources. Complex therapies, delivered by specialists, are likely to be unavailable or would involve a long waiting time in many countries, although the costs of such services must be considered against the social and human costs of sexual violence. It is noted that there is a move to simplify and test these therapies in general health settings (Rahman et al.'s 2008 study on CBT by "lady health workers" for maternal depression). This approach needs to be tried and evaluated beyond research settings, which tend to involve higher levels of supervision and oversight to prove efficacy.

In addition to the evidence summarized above, the GDG reviewed the WHO (2011) publication *Psychological first aid*, which provides guidance for crisis situations, the WHO (2010) *mhGAP intervention guide for treating mental, neurological and substance use disorders for non-specialist health settings*, and the WHO (2009) guidelines for pharmacological treatment of mental disorder in primary care, which aim to enhance the provision of mental health services at primary care level. *Psychological first aid* is a very basic form of psychological support (see recommendations 1 and 10), suitable for primary care level, with limited or no referral possibilities.

Recommendations

21 Continue to offer support and care described in recommendation 10.

Quality of evidence: Indirect evidence was identified (WHO, 2011, *Psychological first aid*)
Strength of recommendation: Strong

22 Provide written information on coping strategies for dealing with severe stress (with appropriate warnings about taking printed material home if an abusive partner is there).

Quality of evidence: No relevant evidence was identified
Strength of recommendation: Strong

23 Psychological debriefing should not be used.

Quality of evidence: Very low–low (WHO, 2011, *Psychological first aid*)
Strength of recommendation: Strong

3.2.2 Interventions up to 3 months post-trauma

24 Continue to offer support and care described in recommendation 10.

Quality of evidence: Indirect evidence was identified (WHO, 2011, *Psychological first aid*)
Strength of recommendation: Strong

25 Unless the person is depressed, has alcohol or drug use problems, psychotic symptoms, is suicidal or self-harming or has difficulties functioning in day-to-day tasks, apply "watchful waiting" for 1–3 months after the event. Watchful waiting involves explaining to the woman that she is likely to improve over time and offering the option to come back for further support by making regular follow-up appointments.

Quality of evidence: Very low–low (WHO, 2010)
Strength of recommendation: Strong

26 If the person is incapacitated by the post-rape symptoms (i.e. she cannot function on a day-to-day basis), arrange for cognitive behaviour therapy (CBT)or eye movement and desensitization and reprocessing (EMDR), by a health-care provider with a good understanding of sexual violence.

Quality of evidence: Low–moderate
Strength of recommendation: Strong

27 If the person has any other mental health problems (symptoms of depression, alcohol or drug use problems, suicide or self-harm) provide care in accordance with the WHO mhGAP intervention guide (WHO, 2010).

Quality of evidence: Indirect evidence, variable (varies with the intervention, see http://www.who.int/mental_health/mhgap/evidence/en/)
Strength of recommendation: Strong

3.2.3 Interventions from 3 months post-trauma

28 Assess for mental health problems (symptoms of acute stress/PTSD, depression, alcohol and drug use problems, suicidality or self-harm) and treat depression, alcohol use disorder and other mental health disorders using the mhGAP intervention guide (WHO, 2010), which covers WHO evidence-based clinical protocols for mental health problems.

Quality of evidence: Indirect evidence; variable (varies with intervention, see http://www.who.int/mental_health/mhgap/evidence/en)
Strength of recommendation: Strong

29 If the person has been assessed as experiencing post-traumatic stress disorder (PTSD), arrange for PTSD treatment with cognitive behaviour therapy or eye movement and desensitization reprocessing.

Quality of evidence: Low–moderate
Strength of recommendation: Strong

3.2.4 General remarks

(a) Consider the potential harms of psychotherapy (including CBT) when not administered properly to potentially vulnerable survivors. Informed consent and attention to safety is essential. A trained health-care provider with a good understanding of sexual violence should implement therapy.

(b) Pre-existing mental health conditions should be considered when making an assessment and planning care and, where necessary, treatment or referral provided as per the WHO mhGAP intervention guide (WHO, 2010). Women with mental health and substance abuse problems may be at greater risk of rape than other women, so there is likely to be a disproportionate burden of pre-existing mental health and substance abuse problems among rape survivors. Similarly, pre-existing traumatic events (e.g. sexual abuse in childhood, intimate partner violence, war-related trauma, etc.) should be considered.

(c) It is important to recognize that sexual assault is sometimes perpetrated by a person the woman lives with. This can include not just a partner but other family

members, such as a stepfather, in-law, friend of the family, or other.

(d) Most women should have access to group or individual lay support, ideally based on the principles of Psychological first aid (WHO, 2011).

Figure 2 shows the care pathway for a woman presenting for sexual assault and should help guide the providers' response to a survivor of sexual assault.

4. Training of health-care providers on intimate partner violence and sexual violence

4.1 Evidence summary

Evidence was searched for the

- effects of training interventions for health-care providers on intimate partner violence and sexual violence that improves: (i) providers' skills/ability and/or (ii) outcomes for women
- elements of training courses that improve the skills and ability of providers to respond appropriately to women exposed to violence and/or improve outcomes for women
- effectiveness of training for health-care providers on intimate partner and sexual violence at pre-qualification level.

4.1.1 Training interventions for intimate partner violence

The review of the evidence for the effects of training health-care providers in intimate partner violence found that most studies showed some improvement in knowledge of providers following a training intervention. However, there is little support for interventions where health-care providers are only trained in the identification of intimate partner violence, without adequate training in care and referral (Coonrod et al., 2000). Yet many interventions currently focus only on training health-care providers in identification. Interventions involving training in multicomponent aspects of intimate partner violence (identification, clinical skills, documentation and provision of referral) that used interactive techniques, appear to improve identification rates and changes in attitude and behaviour of health-care providers. Very few studies evaluated the impact of training on outcomes for women survivors of intimate partner violence (Campbell et al., 2001; Dubowitz et al., 2011; Feder et al., 2011).

Most of the evidence comes from high-income countries, with fewer, lower quality studies of the effectiveness of training interventions in low- and middle-income countries (PRIME, 2002; Grisurapong, 2004; Bott et al., 2005). In the studies carried out in high-income countries, there was some support in favour of brief multicomponent (20-minute to 1.5-day training) interactive, multimedia-based interventions that involved discussions, simulations and role-plays to train health-care providers in all aspect of intimate partner violence, including identifying, managing and providing links to agencies in the community. However, there is no conclusive evidence on what impact these interventions have on attitudes and beliefs regarding intimate partner violence, referral to services for intimate partner violence, or patient outcomes. The latter are rarely measured in evaluations of training.

There is some evidence that training in intimate partner violence, alongside other changes in systems of care and referral pathways, may be more beneficial in improving identification, and possibly even outcomes, for women survivors of intimate partner violence than training on its own (Lo Fo Wong et al., 2006; Garg et al., 2007).

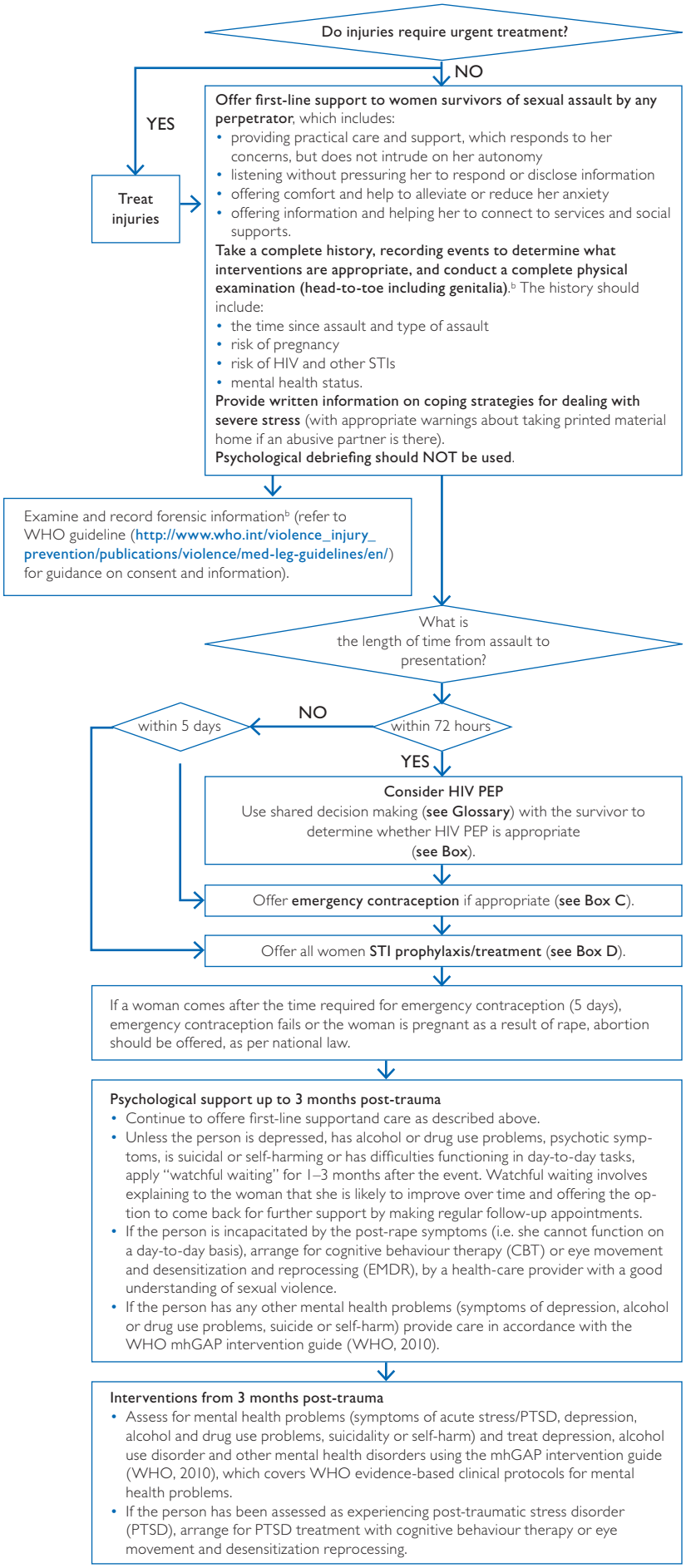
Most studies were of low to very low quality and did not report on lasting effects of the interventions.

4.1.2 Training interventions for sexual assault

Only four studies were identified (Parekh et al., 2005; McLaughlin et al., 2007; Donohoe, 2010; Milone et al., 2010) that focused on examining the effects of health-care provider training in sexual violence against women. Each study focused on outcomes of the health-care providers who were trained, but none examined whether this training translated into improved outcomes for the survivors of sexual assault. Moreover, each study had one or more important methodological limitation, such as the lack of a comparison group, no assessment made either before or after the training, lack of psychometrically sound assessment tools, and extremely small sample sizes. In addition, even though the research was done in three countries (Australia, UK and USA), no research studies on training in low-income countries were identified.

Given this limited evidence base, no firm conclusions can be drawn concerning the effects of training health-care providers in responding to sexual violence against women. However, the results from these studies do indeed provide some evidence that training health-care providers in sexual assault against women

Figure 2. Woman presents following sexual assault



Box A. HIV risk

Discuss HIV risk including:

- HIV prevalence in the geographic area
- Limitations of PEP[a]
- HIV status and characteristics of the perpetrator if known assault characteristics, including the number of perpetrators
- Side-effects of the antiretroviral drugs used in the PEP regimen
- The likelihood of HIV transmission.

Box B. HIV PEP

- Start the regimen *as soon as possible* and before 72 hours
- Provide HIV testing and counselling at the initial consultation
- Ensure patient follow-up at regular intervals
- Two-drug regimens (using a fixed-dose combination) are generally preferred over three-drug regimens, prioritizing drugs with fewer side effects
- The choice of drug and regimens for HIV PEP should follow national guidance.
- Adherence counselling should be an important element in PEP provision.

Box C. Emergency contraception

- Offer levonorgestrel, if available. A single dose of 1.5 mg is recommended, since it is as effective as two doses of 0.75 mg given 12–24 hours apart.
- If levonorgestrel is NOT available, the combined oestrogen–progestogen regimen may be offered, along with anti-emetics if available.
- If oral emergency contraception is not available and it is feasible, copper-bearing intrauterine devices (IUDs) may be offered to women seeking on-going pregnancy prevention. Taking into account the risk of STIs, the IUD may be inserted up to 5 days after sexual assault for those who are medically eligible (see *WHO medical eligibility criteria*, 2010).

Box D. STI PEP

Offer prophylaxis/presumptive treatment for:

- Chlamydia
- Gonorrhoea
- Trichomonas
- Syphilis, (depending on the prevalence in the geographic area).

The choice of drug and regimens should follow national guidance.

Offer Hepatitis B vaccination without hepatitis B immune globulin as per national guidance.

- Take blood for hepatitis B status prior to administering the first vaccine dose.
- If immune, no further course of vaccination is required.

[a] In two cohort studies of HIV PEP, seroconversion rates ranged from 0% to 3.7%.
[b] See WHO, 2003; WHO/UNHCR, 2004 and WHO/UNHCR/UNFPA, 2009.

may have some positive impacts. In particular, these studies suggest that such training may lead to positive changes in health-care providers' knowledge about sexual assault, and better equip them to care for survivors. This includes their attitudes towards survivors of sexual assault, and beliefs that particular groups of patients should be asked about sexual violence, as well as behaviours (in particular, clinical practices with sexual assault patients, including improved care for survivors of sexual assault, improved evidence collection, and improved writing of emergency department notes).

4.2 From evidence to recommendations

Although evidence was not found on the impact of training from low- and middle-income countries, consistent impact on knowledge, and, to some extent, on behaviours of health-care providers, was seen in studies from high-resource settings. The GDG agreed that training of health-care providers in intimate partner violence and sexual assault needs to be added to the curriculum of basic professional education and, at a minimum, provided in the form of continuing education of those providers most likely to encounter women. Although most of the interventions assessed through well-designed studies used resources such as computers, access to video players, etc., there was no evidence to indicate whether the success of the training in high-resource settings depended on these elements or not, which is something that might be difficult to replicate in a low-resource setting. The GDG agreed that the training should be tailored to requirements and provided on-site. The minimum training for staff should involve learning how to provide first-line support in response to women exposed to intimate partner violence and/or sexual violence and when to suspect and identify situations of violence, in order to provide appropriate clinical care and diagnosis.

4.3 Recommendations

30 Training at pre-qualification level in first-line support for women who have experienced intimate partner violence and sexual assault (see recommendation 1) should be provided to health-care providers (in particular doctors, nurses and midwives).

Quality of evidence: Very low
Strength of recommendation: Strong

Remark

(a) The health-care provider may have experience of gender-based violence, as either a victim or a perpetrator. This needs to be addressed in their training.

31 Health-care providers offering care to women should receive in-service training on violence against women, ensuring it:

- **enables them to provide first-line support (see recommendations 1 and 10)**
- **teaches them appropriate skills, including:**
  - **when and how to enquire about violence**
  - **the best way to respond to women (refer to sections 2, Identification and care for survivors of intimate partner violence and 3, Clinical care for survivors of sexual assault)**
  - **how to conduct forensic evidence collection where appropriate (See WHO, 2003; WHO/UNHCR, 2004; WHO/UNHCR/UNFPA, 2009)**
- **addresses:**
  - **basic knowledge about violence, including laws that are relevant to victims of intimate partner violence and sexual violence**
  - **knowledge of existing services that might offer support to survivors of intimate partner violence and sexual violence (this could be in the form of a directory of community services)**
  - **inappropriate attitudes among health-care providers (e.g., blaming women for the violence, expecting them to leave immediately, etc.), as well as their own experiences of partner and sexual violence.**

Quality of evidence: Low–moderate
Strength of recommendation: Strong

Remark

(a) Training should be intensive and content-appropriate to the context and setting.

(b) Attention should be paid to self-care for providers, including the potential for vicarious trauma.

32 Training for health-care providers on intimate partner violence and sexual assault should include different aspects of the response to intimate partner violence and sexual assault (e.g. identification, safety assessment and planning, communication and clinical skills, documentation and provision of referral pathways).

Quality of evidence: Low
Strength of recommendation: Strong

Remarks

(a) Intensive multidisciplinary training (e.g. involving different kinds of health-care providers and/or police and advocates) delivered by domestic violence advocates or support workers should be offered to health-care professionals where referrals to specialist domestic violence services are possible.

(b) Using interactive techniques may be helpful.

(c) Training should go beyond the providers and include system-level strategies (e.g. patient flows, reception area, incentives and support mechanisms) to enhance the quality of care and sustainability.

33 Training for both intimate partner violence and sexual assault should be integrated in the same programme, given the overlap between the two issues and the limited resources available for training health-care providers on these issues.

Quality of evidence: No relevant evidence was identified
Strength of recommendation: Strong

4.4 General remarks

(a) Priority for training should be given to those most likely to come into contact with women survivors of intimate partner violence and/or sexual assault, for example health-care providers in antenatal care, family planning or gynaecologic services, and post-abortion care, mental health and HIV, as well as primary care providers and those in emergency services.

(b) Training should include clinical examination and care for intimate partner violence and sexual assault, as well as attention to cultural competency, gender equality and human rights considerations.

(c) Training should take place within the health-care setting, to promote attendance.

(d) There should be reinforcement of initial training and the provision of continual support. Regular follow up and quality supervision are extremely important.

(e) A clear care pathway of management and referral, a designated and accessible (domestic) violence against women worker, and regular reminders (e.g. computer prompts) were shown in one study to be helpful in sustaining the benefit of training.

5. Health-care policy and provision

Evidence was searched for the following questions:

- "What are the effects of health system-level programmes/services for women survivors of partner violence?"
- "What are the effects of the components/features of health system-level interventions/programmes for women survivors of partner violence?"
- "What are the effects of integrating a sexual assault nurse examiner (SANE) programme, or another type of sexual assault programme, into a health-care setting, on the care of sexual assault survivors?"

5.1 Evidence summary

Health system-level programmes or interventions that could deliver care for intimate partner violence and/or sexual assault survivors, effectively and efficiently, were identified, particularly keeping in mind the needs in resource-poor settings. As most of the published evidence on health-system response to intimate partner violence and sexual assault came from high-income countries, a separate search of the grey literature was carried out, to identify practices and programmes that had not been published in peer-reviewed journals.

The evidence reviewed here overlapped substantially with that for training interventions, particularly as no study identified which components of multi-intervention studies (which included training) were found to be effective.

In high-income countries, there was some evidence indicating that a system-level intervention involving staff training does increase referral to other services. Five out of 10 studies (Coyer et al., 2006; Fanslow et al., 1998, 1999; Harwell et al., 1998; Spinola et al., 1998; McCaw et al., 2001; Muñoz et al., 2001; Ramsden and Bonner, 2002; Feder et al., 2011) reported an increase in referral rates. A recent cluster randomized controlled trial in general practices in the UK presented the strongest evidence of increased referrals to, and appointments with, specialist intimate partner violence agencies, as well as increased rates of disclosure (Feder et al., 2011).

In studies with positive findings, it was difficult to identify the actual factor or component responsible for the positive outcome, since interventions usually comprised various small components that were not evaluated independently. Studies also differed in the way interventions were constituted

and offered, making comparisons across interventions difficult. There is a need to understand the reasons why projects showed significant improvements or otherwise.

Many of the studies were of low quality, owing to study design (often observational), small sample sizes, or a lack of sample sizes being presented, high loss to follow-up of participants or short follow-up period, inadequate presentation of data (e.g. in graphs without the presentation of actual percentages), among other factors. Overall, there is a shortage of robust evaluations of the effectiveness of health-system interventions for intimate partner violence and sexual assualt. Despite the work that has been done, there remains insufficient evidence that specific policies, protocols or models of care are more effective than others in the delivery of care to women exposed to intimate partner violence and sexual violence.

In resource-poor countries, various models of care were described. The models for service delivery often depended on the availability of financial and human resources, and varied across settings. It was apparent that "one-stop crisis centres" were a popular approach, albeit not well evaluated, although these centres were constituted very differently in different countries. Almost all had a permanent nurse, who sometimes had other service obligations, but the involvement of other staff differed and included having a doctor, counsellor, advocate, psychiatrist or psychologist on-call or on-site. The role of NGOs also varied, from initiating the service to delivering it. Linkages with other government agencies were in some instances very formal and saw them playing a central role, but more often this occurred through the development or improvement of referral systems. The involvement and linkages with the police, social services and legal services also varied in "one-stop crisis centre" models. In many instances, the greatest challenge reported was in obtaining management and administrative support, mostly linked to financial support, especially for the long-term sustainability of the centres. There was not always a smooth replication of "good" models of service delivery, even within the same country. In addition, low- and middle-income countries face the challenge of not having sufficient skilled personnel, especially for counselling, mental health and advocacy/support services. Where staff, such as counsellors, social workers, psychologists and psychiatrists, are in short supply, there is a bigger dependence on NGOs. Table 1 summarizes the advantages and disadvantages of different sites for delivering care to survivors of intimate partner violence.

With regard to integrating a SANE or other type of sexual assault care programme

Table 1 A comparison of different models of delivering care for survivors of violence against women

Site	Advantages	Disadvantages
Health centres and clinics	• Located close to the community • Can provide some core services • Improves access for follow-up services • If a good network is established, can improve access to an intersectoral network of services, including legal, social, other	• May not be able to treat serious injuries or complications • May not have laboratory or specialized services • In services in small communities, where providers are members of the community, confidentiality and providers' fear of retaliation may be a challenge
District and regional hospitals	• Equipped to provide 24-hour services • Have specialized services • Can be centralized in one department (emergency department, gynaecology, reproductive health, HIV/STI) or distributed throughout the hospital)	• Can reduce accessibility • If services are split across departments, can hamper services, especially if some services are only available during working hours
One-stop centres	• More efficient and coordinated services • Provide a full range of services (sometimes including police, prosecutors, social worker, counsellors, psychological support, etc.)	• More space and resources required • Client load may be small (e.g. in rural areas), raising concerns on cost effectiveness • May draw staff and resources out of other services • May not be fully integrated into general health services • If administered by the judicial system, may focus too much on prosecution and not on women's health • Costly to sustain

into health-care settings, only four studies (Derhammer et al., 2000; Crandall et al., 2003; Kim et al., 2009; Sampsel et al., 2009) were identified that focused on this. Although each study had its strengths, they all had important methodological limitations (such as small sample sizes, low response rates, and much missing data on important variables). Moreover, three were conducted in North America (one in Canada and two in the USA), with only one from a middle-income country (South Africa). They all used a historical comparison group (comparing health-care services for survivors of sexual assault, before and after implementation of a new programme). The results from these studies were generally consistent and positive. They suggest that integrating sexual assault care programmes into health-care settings leads to greater percentages of sexual assault patients receiving potentially vital health-care services, including emergency contraception, STI prophylaxis, HIV counselling and PEP, and post-care referrals. Integration of SANEs into health-care settings does not always result in nurses becoming more involved in the sexual assault examination. Where they are involved, however, integration of SANEs into health-care settings appears to enhance the collection of forensic evidence often required for successful prosecution of perpetrators of sexual assault.

5.2 From evidence to recommendations

The GDG discussed the evidence and reached the conclusion that there is no evidence to accept or refute any one model of intimate partner violence or sexual assault service provision. There is also evidence that a model that appears to be working effectively in one setting may be rapidly adopted in another site and not necessarily be effective. This has been true of "one- stop crisis centres". Therefore, the advantages and disadvantages of the various models have been summarized to help policy-makers with decisions, taking into account local human and financial resources (see Table 1). In addition, an attempt was made to answer the following questions to help guide policy-makers when making decisions:

1. "What are the strengths and weaknesses of different models (one-stop centres, integrated services and well-articulated referral networks) for delivering services to women who have experienced violence by an intimate partner?"

These are presented in Table 1. One should consider these while also looking at the local infrastructure, resources, capacity and financial situation. The expected case-load should also be considered when setting up the service.

2. "Which sectors of the health-care delivery system (e.g. emergency department, primary care, antenatal care or other sexual and reproductive health services, HIV counselling and testing) are better sites for interventions for women suffering intimate partner violence or sexual violence? Do they require different approaches?"

Every site has some advantages and disadvantages. Some tend to be better equipped to deal with women's health problems as compared to others. Ideally, women experiencing partner violence should be identified at the point of contact with health services, although these settings are not always conducive to providing such services. When setting up the service, one should consider the strengths and weaknesses of each site within the facility, looking at the infrastructure, resources, capacity and financial situation. No matter what site within the facility is selected, the minimal requirements (see Box 3, p. 39) need to be in place, including training and support to staff to provide the service appropriately.

3. "Which patient groups (e.g. pregnant women, women admitted to the emergency department, women with mental health problems, women attending prevention of mother-to-child transmission [PMTCT] or HIV testing and counselling services) may benefit most from health-sector interventions?"

Women in any patient group can be exposed to violence. Women with unexplained injuries, signs or symptoms associated with depression, PTSD or other anxiety disorders (see Box 1 and recommendation 3, page 19), or those more likely to experience abuse, such as women with mental health disorders or other disabilities, may benefit from being asked about violence and receiving attention and care for sexual violence (whether by a partner or other perpetrator), or other forms of intimate partner violence, if needed. However, some health-care delivery sites may more easily lend themselves to integrating issues of violence into their routine provision of care.

4. "What kinds of surveillance, monitoring and quality control systems are required?"

It is important to keep accurate records, since data that are properly collected, managed and analysed can both improve the services provided to women and help raise awareness

Box 3	Minimum requirements for a health sector response to violence against women
Policies and protocols	Local policies and protocols defining roles and responsibilities, and procedures related to identification and management of survivors need to be developed and implemented (with appropriate training and continual support).
Management support/Finance	Management backing, often with financial support, is important, especially for the long-term sustainability of the integration of violence against women issues.
Comprehensive care	Ensure the provision of all aspects of medico-legal care either by provider/linked providers in health services, or through the support of NGOs or community-based organizations (CBOs) or community efforts, in a way that minimizes the number of contacts required.
Links with CBOs/NGOs	Build relationships with local NGOs and community-based organizations (CBOs). (It should be noted that it is a state responsibility to ensure the provision of services, so this should not rely exclusively on NGOs and CBOs).
Intersectoral collaboration	Establish clear working protocols, including the referral pathway of survivors, between services offered by the same facility or by different sectors, and establish regular (monthly) meetings to ensure coordination.
Resource material	Ensure the availability of some resource material (posters, pocket cards and/or leaflets).
Surveillance and recording	Develop systems for maintaining records and conducting surveillance that are confidential and do not put women in any risk.
Monitoring and evaluation	Implement a system for monitoring and evaluation, based on local policy and procedures, including considerations related to safety.
Support for the carers	Provide support to those delivering care.

about the issues. For example, it would be useful to have improved data collection on the nature of injuries and the perpetrator–victim relationship, although it must be recognized that intimate partner violence is not a disease that is easy to identify and record. For the effective inclusion of intimate partner violence indicators into the health information system, all health-care providers need training and sensitization to be able to document such cases, while ensuring this is done in a confidential way that does not put women at risk. In high-income countries with well-functioning electronic health information systems, this is easier to implement, compared to the paper-based systems in most low- and middle-income countries.

In many programmes, the major challenges faced are in monitoring referrals across sectors and maintaining the accuracy of data. Having standardized protocols/standard operating procedures/guidelines, including regular case-reviews and, if possible, monitoring of the clients' experience, can help to improve the quality of care provided.

5.3 Recommendations

34 Care for women experiencing intimate partner violence and sexual assault should, as much as possible, be integrated into existing health services rather than as a stand-alone service (see Box 3).

Quality of evidence: Very low
Strength of recommendation: Strong

Remark

(a) A multicomponent programme including training of health-care providers to make them aware of factors that would raise clinical suspicion and of how to provide first-line support is preferable. A clear referral pathway may also increase effectiveness. This training needs to be repeated regularly, in order to sustain the benefit (see section 2, Identification and care for survivors of intimate partner violence).

(b) Offering vertical stand-alone services may be difficult to sustain and have potential harmful effects. For instance, there might be a risk that a currently under-staffed mental health service would be further weakened if it had to provide services specifically for victims of violence, rather than ensuring that all clients (including survivors of violence) get the best possible care.

c) Providing support to the carers and the possibilities of debriefing should also be part of the health-systems response, although this requires additional human resources. It is also important for the health services to meet regularly with other agencies such as police or social workers, to ensure that there is coordination and coherence across services and that referrals are working effectively.

35 A country needs multiple models of care for survivors of intimate partner violence and sexual assault, for different levels of the health system (see Table 1, p. 37). However, priority should be given to providing training and service delivery at the primary level of care.

Quality of evidence: Very low
Strength of recommendation: Strong

36 A health-care provider (nurse, doctor or equivalent) who is trained in gender-sensitive sexual assault care and examination should be available at all times of the day or night (on location or on-call) at a district/area level.

Quality of evidence: Very low
Strength of recommendation: Strong

5.4 General remarks

(a) Until there is further evidence, countries need to have multiple models to provide care, but evaluation should be promoted to identify what works best and is most cost effective in different settings.

(b) One-stop centres, where appropriate, are best located within health services, where the priority for provision of services is women's health rather than being based on legal outcomes. They appear to be best suited for areas with high population density, whereas integrated services within or across health facilities may be more cost effective in rural areas.

(c) Whatever model is used, it should aim to reduce the number of services and providers that a woman has to contact (and tell her story to), and facilitate access to services she may need, in a manner that respects her dignity and confidentiality and prioritizes her safety.

(d) Violence against women is also a violation of a woman's human rights. Policies and laws need to be revised to ensure they do not discriminate against women and that they adequately penalize acts of violence, including those that take place within the home.

6. Mandatory reporting of intimate partner violence

Evidence was searched for the question: "What are the effects on women and their children of mandatory reporting of intimate partner violence to the police?"

6.1 Evidence summary

In total, 23 studies were reviewed, although only two studies (Sachs et al., 1998; Glass et al., 2001) attempted to measure the impact of mandatory reporting quantitatively. Five studies (Tilden et al., 1994; Rodriguez et al., 1998; Gerbert et al., 1999; Feldhaus et al., 2003; Smith et al., 2008) aimed to ascertain views of health-care providers, while 16 attempted to obtain the perspective of women.

Two studies quantitatively assessed the impact of introducing laws on mandatory reporting for intimate partner violence. Of these, a study (Sachs et al., 1998) that assessed the impact of mandatory reporting by health-care professionals on police dispatches to medical facilities in response to intimate partner violence, reported no significant effect of the mandatory reporting on the number of police dispatches to the facilities. In another study in the USA, the medical records of 36 acutely abused patients were reviewed. Notification to the police was the most consistently documented intervention for intimate partner violence in the medical records. However, only one in four cases was referred to domestic violence community resources such as shelters and hotlines.

The remaining studies attempted to obtain the views of health-care providers and women on the impact of mandatory reporting laws, as well as on barriers and facilitators to mandatory reporting. From the perspective of health-care providers, the advantages of mandatory reporting include improved collection of statistics, prosecution of the perpetrator and improved physician responsiveness.

Concerns shared by health-care providers included the time and resource requirements, the possibility that women may be discouraged from disclosing information, confidentiality and autonomy being compromised, the risk of retaliation, and the consequences of unsuccessful prosecutions.

From the perspective of the women, the advantages include: enabling them to get help while taking away the responsibility to report it themselves, making them feel less alone and less to blame, teaching partners the seriousness of abuse, and a potentially positive interaction with

the police, with the incident being on record if needed in the future.

Women's concerns included the risk of retaliation, the fear their children would be taken away, anxiety about interacting with a social worker or other people in authority, being victimized by the health system, and being left with bills to pay as a result of the intimate partner violence report, as well as worries over autonomy and confidentiality.

While a number of women supported mandatory reporting, there appears to be an equally large number who do not. In particular, abused women appear to be against mandatory reporting, especially if it involves the police. Women in these studies suggested that the decision about reporting should be up to the woman; and that the safety of the woman and her children should be the first priority. Furthermore, recovery should focus on healing for the victims, including through counselling. If a restraining/protection order is in place, and the partner presents at the health visit, the relevant authorities should be called.

6.2 From evidence to recommendations

The evidence does not support mandatory reporting of intimate partner violence to police because it can impinge on women's autonomy and decision-making.[1] While some women recognize there may be some benefits to legal action being taken on their behalf, it does not appear to be the preference for abused women. It is important to note that there may be differences between the reporting mandated by law and professional obligations/codes of conduct for health-care providers that mandate confidentiality and "do no harm". Health-care providers need to understand their legal obligations (if any), as well as their professional codes of practice, to ensure that women are informed fully about their choices and limitations of confidentiality where this is the case.

6.3 Recommendations

37 Mandatory reporting of intimate partner violence to the police by the health-care provider is not recommended. However, health-care providers should offer to report the incident to the appropriate authorities (including the police) if the woman wants this, and is aware of her rights.

Quality of evidence: Very low
Strength of recommendation: Strong

38 Child maltreatment and life-threatening incidents must be reported to the relevant authorities by the health-care provider, where there is a legal requirement to do so.

a) It is noted, however, that there is growing consensus that countries with mandatory child reporting laws should allow children and families greater access to confidential services where they can receive support on a voluntary basis.

b) Furthermore, the usefulness of mandatory reporting is particularly questionable in situations where there is no functioning legal or child protection system to act on a report.[2]

Quality of evidence: Very low
Strength of recommendation: Strong

6.4 General remark

(a) The issue of mandatory reporting is intertwined with that of child protection (which was outside of the scope of these guidelines).

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[1] This is different from reporting the potential exposure of children to abuse in the home to child welfare authorities.

[2] Butchart A, Harvey A, Mian M, Furniss T. (2006). *Preventing child maltreatment: a guide to taking action and generating evidence*. Geneva, World Health Organization. It's on the web at: http://www.who.int/violence_injury_prevention/publications/violence/child_maltreatment/en/index.html

Research implications

The GDG identified important knowledge gaps that need to be addressed through research. In general, in these guidelines, many of the recommendations are based on evidence that has been labelled "very low" or "low" quality, indicating that further research is needed. Even in some of the areas where there was better quality evidence, research evidence was unavailable to address certain aspects of the topic.

Research gaps based on guideline questions

The GDG identified the following gaps in the research. These were discussed at the meeting and agreed upon during the GDG review of the draft, but they do not represent a comprehensive assessment of research gaps.

Identification of intimate partner violence

- Assess the clinical effectiveness and cost effectiveness of clinical enquiry or case-finding versus universal screening in improving outcomes in a variety of settings (general practice/primary care, antenatal care, family planning, trauma and emergency settings, HIV testing and counselling clinics, substance abuse clinics, and mental health-care settings), and among different populations.
- The role of intimate partner violence (including coercion) in reproductive decision-making and reproductive health outcomes should be investigated.

Care for survivors of intimate partner violence

Psychological/mental health interventions

- There is a need to develop trials with sufficient statistical power to assess the effectiveness of different modes of psychological interventions/therapy for women survivors of intimate partner violence in a variety of settings, including primary care and emergency departments.
- The role of support groups, particularly in settings where problems are often addressed communally, should be explored through research.

Advocacy/support/empowerment interventions

- The feasibility, modality of delivery and effectiveness of advocacy/support interventions and medium-intensity empowerment sessions that have shown some effectiveness in high-income countries (see section 2.2.2) need to be tested in resource-poor settings.
- The effectiveness of advocacy/support interventions needs to be tested in settings outside of antenatal care in high-income countries. Ensuring the safety of the women is the prime consideration.

Mother–child interventions

- Intergenerational transmission of intimate partner violence is common, and intervention programmes to prevent this transmission are needed. Studies about care for mothers and children exposed to intimate partner violence are lacking, particularly from low-income settings.
- Trials of home visitation (as has been used for child maltreatment) that include a focus on women experiencing intimate partner violence and measure intimate partner violence as a primary outcome should be implemented.
- Mother–child interventions that have been shown to be effective in high-income settings need to be studied in low-resource settings, with alternatives to intensive psychotherapy identified and studied further.

Safe shelter

- Options for safe shelter should be evaluated, particularly in resource-poor settings.

Clinical care for survivors of sexual assault

Psychological/mental health interventions

- For women survivors of sexual assault, there is a need for studies of psychological interventions that are specific to this population, allow for subgroup analysis of this group when the population is a mix of trauma survivors, and take into consideration issues of co-morbidity, which are common in this population.
- There is a need to evaluate the provision of CBT by non-specialists and to study modalities of delivering CBT in different contexts.

HIV post-exposure prophylaxis

- Studies that assess different interventions to promote adherence to HIV PEP should be carried out, including looking at the impact of different modalities of providing PEP (e.g. starter pack with weekly supplies versus 28 days, at first contact).

Post-exposure prophylaxis for sexually transmitted infections

- Trichomonas is not life threatening and the treatment is unpleasant. A randomized controlled trial to test whether or not treating Trichomonas would increase adherence to other drugs would therefore provide useful information.
- A study is recommended to compare prophylactic treatment of STIs (except for hepatitis B) with testing and treatment only if positive, measuring the effectiveness and cost effectiveness.

Training of health-care providers on intimate partner violence and sexual violence

- Research should be carried out to establish the minimum content and duration of training on intimate partner and sexual violence for health-care providers required for improving provider skills.
- Cost-effective methods of providing in-service training in low- and middle-income countries, to sustain improvement in clinicians' behaviour, such as on-going education, should be investigated.

Health-care policy and provision

- There should be rigorous evaluation of any programme of service delivery, however successful, to investigate its applicability in other settings.
- More research is encouraged on SANE programmes, given the limited research on the impact of the integration of SANEs and other types of sexual assault programmes into health-care settings, particularly in low- and middle-income countries.
- Standard models of care (such as those for chronic conditions), which can be adapted for the care of survivors of intimate partner violence and/or sexual assault, could be evaluated.
- Research looking into the special considerations in delivering services to adolescents exposed to violence should be carried out.

Mandatory reporting of intimate partner violence

- Research is needed on how health services aimed at women suffering partner violence are best linked with child protection services and the police.

Dissemination and implementation of the guidelines

The ultimate goal of these guidelines is to improve the quality of care and health outcomes related to violence against women. Hence, dissemination and implementation of the guidelines by the international community, ministries of health and local health-care services is crucial. RHR has adopted a formal knowledge-to-action framework for the dissemination, adaptation and implementation of guidelines. In addition to this framework, a list of priority actions will be established to enable WHO and other partners to foster their dissemination and implementation.

Guideline dissemination

The recommendations in these guidelines will be disseminated through a broad network of international partners, including WHO country and regional offices, ministries of health, WHO collaborating centres, professional associations; other United Nations agencies, particularly UNFPA and UN Women; and NGOs. They will also be published on the WHO web site and in the WHO Reproductive Health Library, where they will be accompanied by an independent critical appraisal. In addition, a policy brief aimed at a wide range of policy-makers, programme managers and clinicians will be developed and disseminated through WHO country offices and its respective partners.

A clinical handbook will be developed based on the recommendations in this guideline for health-care providers, as well as policy briefs for policy-makers.

Guideline implementation

The successful introduction into national programmes and health-care services of evidence-based policies related to violence against women relies on well-planned and participatory consensus-driven processes of adaptation and implementation. These may include the development or revision of existing national guidelines or protocols.

The recommendations contained in these guidelines should be adapted into a locally appropriate document that can meet the needs of each country and health service, while taking the human and financial resources available into account. This needs to include national policy as well as local clinical guidance. In this context, modifications may be limited to conditional recommendations, and justification for any changes should be made in an explicit and transparent manner.

In addition, a framework should be established to ensure that an enabling environment is created for use of the recommendations and that the health-care practitioner is supported in the use of evidence-based practices. In this process, the role of local professional societies is also important, and an all-inclusive and participatory process should be encouraged.

Monitoring and evaluating implementation of the guidelines

Ideally, implementation of the recommendations should be monitored at a health-facility level. Interrupted time-series of clinical audits or criterion-based clinical audits could be used to obtain relevant data related to changes in the care that is given to women survivors of violence. Clearly defined review criteria and monitoring and evaluation indicators are needed and could be associated with locally agreed targets. In this context, *Violence against women and girls: a compendium of monitoring and evaluation indicators* by Measure Evaluation provides a comprehensive list of indicators that can be considered for health programmes addressing violence against women and girls (Bloom, 2005). A few indicative indicators are suggested below, but final selection should consider measurability and feasibility.

- The number of medical and allied health faculties that implemented compulsory undergraduate and postgraduate training on intimate partner violence and sexual violence.
- The number of countries establishing primary care guidelines on intimate partner violence/sexual violence; changes in national and health-care guidelines in accordance with WHO guidelines.
- The proportion of health-care providers trained in the prevalence and health consequences of intimate partner violence, first-line support/compassionate care, and existing community resources.
- The proportion of women survivors of intimate partner violence who received first-line (emotional) support by the end of their first contact with health-care providers following disclosure.
- The proportion of women survivors of intimate partner violence who have had a Danger Assessment[1] made by the end of their first contact with health-care providers following disclosure.
- The proportion of women seeking care within 72 hours following sexual assault who are provided with emergency contraception, with PEP for HIV, and first-line psychological support.
- The proportion of health services that have carried out an institution-wide assessment of all policies, protocols and practices that have implications for violence against women, including: privacy and confidentiality within clinical settings; human resources; training provided and gaps identified in training; and physical resources (written policies and protocols distributed).

[1] The Danger Assessment is an instrument that helps to determine the level of danger an abused woman has of being killed by her intimate partner. It has not yet been tested in low- and middle-income countries. For more information, see http://www.dangerassessment.org/About.aspx

Updating of the guidelines

These guidelines will be updated in 5 years, or following the identification of new evidence that shows a need for changing the recommendations. WHO welcomes suggestions regarding additional questions for inclusion in future guidelines. Please e-mail your suggestions to Dr Claudia García-Moreno at garciamorenoc@who.int

Annexes

I. References

Background

Ansara DL, Hindin MJ. Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Social Science and Medicine*, 2010, 70:1011–1018.

AuCoin K. *Family violence in Canada: a statistical profile*. Ottawa, Statistics Canada, 2005.

Black CM. Intimate partner violence and adverse health consequences : implications for clinicians. American Journal of Lifestyle Medicine, 2001, 5:428–439.

Bott S et al. *Violence against women in Latin America and Caribbean: a comparative analysis of population-based data from 12 countries*. Washington, PAHO, 2012.

Campbell J, García-Moreno C, Sharps P. Abuse during pregnancy in industrialized and developing countries. *Violence Against Women* 2004, 10(7):770–789.

Ellsberg M et al. Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study. *The Lancet*, 2008, 371(9619):1165–1172.

Feder GS et al. Women exposed to intimate partner violence: expectations and experiences when they encounter health care professionals: a meta-analysis of qualitative studies. *Archives of Internal Medicine*, 2006, 166:22–37.

García-Moreno C et al. *WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses*. Geneva, World Health Organization, 2005.

Taket A et al. Routinely asking women about domestic violence in health settings. *British Medical Journal*, 2003, 327(7416):673–676.

Tjaden P, Thoennes N. *Full report of the prevalence, incidence, and consequences of violence against women. Findings From the National Violence Against Women Survey*. Washington, DC, National Institute of Justice, 2000.

Walby S, Allen J. *Domestic violence, sexual assault and stalking: findings from the British Crime Survey*. London, Home Office, 2004 (Home Office Research Study 276).

World Health Organization. *Guidelines for medico-legal care of sexual violence survivors*. Geneva, World Health Organization, 2002 (**http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/**, accessed 10 April 2013).

WHO/UNHCR/UNFPA. *Clinical management of rape survivors. E-learing programme*. Geneva, WHO/UNHCR/UNFPA, 2009 (**http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/**, accessed 10 April 2013).

Methods

Schünemann H, Brozek J, Oxman A, eds. *GRADE handbook for grading quality of evidence and strength of recommendation. Version 3.2 [updated March 2009]*. The GRADE Working Group, 2009. (**http://www.who.int/hiv/topics/mtct/grade_handbook.pdf**, accessed 12 April 2013).

World Health Organization. *Expert meeting on health-sector responses to violence against women, 17–19 March 2009, Geneva, Switzerland*. Geneva, World Health Organization, 2010a (*http://www.who.int/reproductivehealth/publications/violence/9789241500630/en/*, accessed 10 April 2013).

World Health Organization. *Guidelines development handbook*, Geneva, World Health Organization 2010b.

World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010c (http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf).

Evidence and recommendations

1. Women-centred care

World Health Organization. *Psychological first aid*. Geneva, World Health Organization, 2011 (whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf, accessed 10 April 2011).

2. Identification and care for survivors of intimate partner violence

2.1 Identification of intimate partner violence

Ahmad F et al. Computer-assisted screening for intimate partner violence and control: a randomized trial. *Annals of Internal Medicine*, 2009, 151(2):93–102.

Bacchus LJ et al. Evaluation of a domestic violence intervention in the maternity and sexual health services of a UK hospital. *Reproductive Health Matters*, 2010, 18(36):147–157.

Feder G et al. How far does screening women for domestic (partner) violence in different health-care settings meet criteria for a screening programme? Systematic reviews of nine UK National Screening Committee criteria. *Health Technology Assessment*, 2009, 13(16).

Humphreys J et al. Increasing discussions of intimate partner violence in prenatal care using video doctor plus provider cueing: a randomized, controlled trial. *Women's Health Issues*, 2011, 21(2):136–144.

Klevens J et al. Effect of screening for partner violence on women's quality of life: a randomized controlled trial. *The Journal of the American Medical Association*, 2012, 308(7):681–689.

Koziol-McLain J et al. A randomized controlled trial of a brief emergency department intimate partner violence screening intervention. *Annals of Emergency Medicine*, 2010, 56(4):413–423.

MacMillan HL et al., McMaster Violence Against Women Research Group. Screening for intimate partner violence in health care settings: a randomized trial. *The Journal of the American Medical Association*, 2009, 302:493–501.

Rhodes KV et al. Lowering the threshold for discussions of domestic violence: a randomized controlled trial of computer screening. *Archives of Internal Medicine*, 2006, 166(10):1107–1114.

2.2 Care for survivors of intimate partner violence

Dua T et al. Evidence-based guidelines for mental, neurological, and substance use disorders in low- and middle-income countries: summary of WHO recommendations. *PLoS Medicine*, 2011, 8(11):e1001122.

Kiely M et al. An integrated intervention to reduce intimate partner violence in pregnancy. *Obstetrics and Gynecology*, 2010, 115:273–283.

Ramsay J et al. *Interventions to reduce violence and promote the physical and psychosocial well-being of women who experience partner abuse: a systematic review*. London, Department of Health, 2006.

Sadowski L, Casteel C. Intimate partner violence towards women. *Clinical Evidence (Online)*, 2010, Feb 24, pii:1013.

2.2.1 Psychological/mental health interventions

Bisson J, et al. Psychological treatments for chronic post-traumatic stress disorder: systematic review and meta-analysis. *British Journal of Psychiatry*, 2007 10(1):16-23.

Gilbert L et al. An integrated relapse prevention and relationship safety intervention for women on methadone: testing short-term effects on intimate partner violence and substance use. *Violence and Victims*, 2006, 21(5):657–672.

Howard LM, Trevillion K, Agnew-Davies R. Domestic violence and mental health. *International Review of Psychiatry*, 2010, 22(5):525–534.

Kiely M et al. An integrated intervention to reduce intimate partner violence in pregnancy. *Obstetrics and Gynecology*, 2010, 115:273–283.

Kubany ES, Hill EE, Owens JA. Cognitive trauma therapy for battered women with PTSD: preliminary findings. *Journal of Trauma and Stress*, 2003; 16(1):81–91

Kubany ES et al. Cognitive trauma therapy for battered women with PTSD (CTT-BW). *Journal of Consulting and Clinical Psychology*, 2004, 72(1):3–18.

Lieberman AF, Van HP, Ippen CG. Toward evidence-based treatment: child-parent psychotherapy with preschoolers exposed to marital violence. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2005, 44(12):1241–1248.

Lieberman AF, Ghosh IC, Van HP. Child-parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry*, 2006, 45(8):913–918.

World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010 (http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf).

Zlotnick C, Capezza N, Parker D. An interpersonally based intervention for low-income pregnant women with intimate partner violence: a pilot study. *Archives of Women's Mental Health*, 2011, 14(1):55–65.

2.2.2 Advocacy/empowerment interventions

Bair-Merritt MH et al. Reducing maternal intimate partner violence after the birth of a child: a randomized controlled trial of the Hawaii Healthy Start Home Visitation Program. *Archives of Pediatric and Adolescent Medicine*, 2010, 164:16–23.

Constantino R, Kim Y, Crane PA. Effects of a social support intervention on health outcomes in residents of a domestic violence shelter: a pilot study. *Issues in Mental Health Nursing*, 2005, 26(6):575–590

Cripe SW et al. Intimate partner violence during pregnancy: a pilot intervention program in Lima, Peru. *Journal of Interpersonal Violence*, 2010, 25:2054–2076.

Gillum TL, Sun CJ, Woods AB. Can a health clinic-based intervention increase safety in abused women: results from a pilot study. *Journal of Women's Health*, 2009, 18(8):1259–1264.

Humphreys J et al. Increasing discussions of intimate partner violence in prenatal care using video doctor plus provider cueing: a randomized, controlled trial. *Women's Health Issues*, 2011, 21(2):136–144.

Kiely M et al. An integrated intervention to reduce intimate partner violence in pregnancy. *Obstetrics and Gynecology*, 2010, 115:273–283.

McFarlane J, Soeken, Wiist W. An evaluation of interventions to decrease intimate partner violence to pregnant women. *Public Health Nursing*, 2000, 17(6):443–451.

McFarlane J et al. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nursing Research*, 2006, 55(1):52–61.

Ramsay J et al. Advocacy interventions to reduce or eliminate violence and promote the physical and psychosocial well-being of women who experience intimate partner abuse. *Cochrane Database of Systematic Reviews*, 2009, (3):CD005043 .

Sullivan CM, Bybee D, Allen N. Findings from a community based program for battered women and their children. *Journal of Interpersonal Violence*, 2002, 17:915–936.

Taft AJ et al. Mothers' Advocates In the Community (MOSAIC) – non-professional mentor support to reduce intimate partner violence and depression in mothers: a cluster randomized trial in primary care. *BMC Public Health*, 2011, 11:178–187.

Tiwari A et al. A randomized controlled trial of empowerment training for Chinese abused pregnant women in Hong Kong. *An International Journal of Obstetrics and Gynaecology*, 2005, 112(9):1249–1256.

Tiwari A et al. Effect of an advocacy intervention on mental health in Chinese women survivors of intimate partner violence: a randomized controlled trial. *The Journal of the American Medical Association*, 2010a, 304(5):536–543.

Tiwari A et al. Effectiveness of an empowerment intervention in abused Chinese women, Hong Kong. *Hong Kong Medical Journal*, 2010b, 16(3):33–37.

2.2.3 Mother–child interventions

Bair-Merritt MH et al. Reducing maternal intimate partner violence after the birth of a child: a randomized controlled trial of the Hawaii Healthy Start Home Visitation Program. *Archives of Pediatric and Adolescent Medicine*, 2010, 164:16–23.

Cohen J, Mannarino AP, Iyengar S. Community treatment of posttraumatic stress disorder in children exposed to intimate partner violence. A randomized controlled trial. *Archives of Pediatric and Adolescent Medicine*, 2011;165(1):16-21.

Jouriles EN et al. Reducing conduct problems among children of battered women. *Journal of Consulting and Clinical Psychology*, 2001, 69(5):774–785.

McFarlane J et al. Secondary prevention of intimate partner violence: a randomized controlled trial. *Nursing Research*, 2006, 55(1):52–61.

Lieberman AF, Van HP, Ippen CG. Toward evidence-based treatment: child–parent psychotherapy with pre-schoolers exposed to marital violence. *Journal of the American Academy of Child Adolescent Psychiatry*, 2005, 44(12):1241–1248.

Lieberman AF, Ghosh IC, Van HP. Child–parent psychotherapy: 6-month follow-up of a randomized controlled trial. *Journal of the American Academy of Child Adolescent Psychiatry*, 2006, 45(8):913–918.

Sullivan CM, Bybee D, Allen N. Findings from a community based program for battered women and their children. *Journal of Interpersonal Violence*, 2002, 17:915–936.

2.2.4 Other interventions

Franzblau SH et al. A preliminary investigation of the effects of giving testimony and learning yogic breathing techniques on battered women's feelings of depression. *Journal of Interpersonal Violence*, 2008, 23(12):1800–1808.

Koopman CF et al. The effects of expressive writing on pain, depression and posttraumatic stress disorder symptoms in survivors of intimate partner violence. *Journal of Health Psychology*, 2005, (10):211–221.

3. Clinical care for survivors of sexual assault

World Health Organization. *Guidelines for medico-legal care of sexual violence survivors*. Geneva, World Health Organization, 2003 (**http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/**, accessed 10 April 2013).

World Health Organization. *WHO/UNHCR Guidance on clinical management of rape*. Geneva, WHO/UNHCR,2004

WHO/UNHCR/UNFPA. *Clinical management of rape survivors. E-learning programme*. Geneva, WHO/UNHCR/UNFPA, 2009

World Health Organization. *Psychological first aid*. Geneva, World Health Organization, 2011 (**whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf**, accessed 10 April 2011).

3.1 Interventions during the first 5 days after the assault

3.1.2 Emergency contraception

American College of Obstetricians and Gynecologists. Emergency contraception: practice bulletin. *Obstetrics & Gynecology*, 2010, 115(5):1100–1109.

Cheng L et al. Interventions for emergency contraception. *Cochrane Database of Systematic Reviews*, 2008, (2):CD001324.

Creinin MD et al. Progesterone receptor modulator for emergency contraception: a randomized controlled trial. *Obstetrics & Gynecology*, 2006, 108(5):1089–1097.

Glasier AF et al. Ulipristal acetate versus levonorgestrel for emergency contraception: a randomized non-inferiority trial and meta-analysis. *The Lancet*, 2010, 375:555–562.

Holmes MM et al. Rape-related pregnancy: Estimates and descriptive characteristics from a national sample of women. American Journal of *Obstetrics and Gynecology*, 1996, 175:320–325.

Jina R et al. Report of the FIGO Working Group on Sexual Violence/HIV: guidelines for the management of female survivors of sexual assault. *International Journal of Gynecology and Obstetrics*, 2010, 109:85–92.

McFarlane J et al. Intimate partner sexual assault against women: frequency, health consequences, and treatment outcomes. *Obstetrics and Gynecology*, 2005, 105 (1):99–108.

PallittoCC et al. Intimate partner violence, abortion and unintended pregnancy: Results from the WHO Multi-country study on women's health and domestic violence. *International Journal of Gynecology and Obstetrics*, 2013, 120(1):3-9.

World Health Organization. *WHO medical eligibility citeria*. Geneva, World Health Organization, 2010.

WHO Department of Reproductive Health and Research and Family and Community Health. *Selected practice recommendations for contraceptive use*, 2nd ed. Geneva, World Health Organization, 2004.

World Health Organization. *WHO Model lists of essential medicines: Adults*. Geneva, World Health Organization, 2011

3.1.3 HIV post-exposure prophylaxis: treatment and adherence

Abrahams N et al. Impact of telephonic psycho-social support on adherence to post-exposure prophylaxis (PEP) after rape. *AIDS Care*, 2010, 22 (10):1173–1181.

Boily MC, Baggaley RF et al. Heterosexual risk of HIV infection per sexual act: systematic review and meta-analysis of observational studies. *Lancet Infectious Disease*, 2009, 9(2): 118–29.

Cardo DM et al. A case-control study of HIV seroconversion in health care workers after percutaneous exposure. *New England Journal of Medicine*, 1997, 337:1485–90.

Drezett J. Post-exposure prophylaxis in raped women. In: *IV International Conference on HIV infection in women and children*. Rio de Janeiro, Livro de Resumos. Universidade, Federal do Rio De Janeiro, Brazil e Institute of Virology of Maryland, USA, 2002.

Garcia MT et al. Postexposure prophylaxis after sexual assaults: a prospective cohort study. *Sexually Transmitted Diseases*, 2005, 32 (4):214–219.

Roland ME et al. Preventing human immunodeficiency virus among sexual assault survivors in Cape Town, South Africa: an observational study. *AIDS and Behavior*, 2012, 16(4):990–998.

Wiebe ER et al. Offering HIV prophylaxis to people who have been sexually assaulted: 16 months' experience in a sexual assault service. *Canadian Medical Association Journal*, 2000, 162(5):641–645.

World Health Organization/International Labour Organization. *Post-exposure prophylaxis to prevent HIV infection. Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection*. Geneva, World Health Organization, 2007 (**http://www.who.int/hiv/pub/prophylaxis/pep_guidelines/en/index.htm**, accessed 10 April 2013).

3.1.4 Post-exposure prophylaxis for sexually transmitted infections

Centers for Disease Control and Prevention. Sexually Transmitted Diseases Treatment Guidelines, 2010. *Morbidity and Mortality Weekly Report*, 2010, 59:91–93.

Jina R et al. Report of the FIGO Working Group on Sexual Violence/HIV: Guidelines for the management of female survivors of sexual assault. *International Journal of Gynecology and Obstetrics*, 2010, 109: 85–92.

3.2 Psychological/mental health interventions

American Psychiatric Association. *Diagnostic and statistical manual of mental disorders*, 4th ed. Arlington, VA, American Psychiatric Association, 1994.

Anderson T et al. Effects of clinician-assisted emotional disclosure for sexual assault survivors: a pilot study. *Journal of Interpersonal Violence*, 2010, 25(6):1113–1131.

Bisson J, et al. Psychological treatments for chronic post-traumatic stress disorder: systematic review and meta-analysis. *British Journal of Psychiatry*, 2007 10(1):16–23.

Echeburua E et al. Treatment of acute posttraumatic stress disorder in rape victims: an experimental study. *Journal of Anxiety Disorders*, 1996, 10(3):185–199.

Foa EB et al. Treatment of posttraumatic stress disorder in rape victims: A comparison between cognitive-behavioural procedures and counseling. *Journal of Consulting and Clinical Psychology*, 1991, 59(5):715–723.

Galovski TE et al. Does cognitive-behavioural therapy for PTSD improve perceived health and sleep impairment? *Journal of Traumatic Stress*, 2009, 22(3):197–204.

Rahman A et al. Cognitive behaviour therapy based intervention by community health workers for mothers with depression and their infants in rural Pakistan: a randomized controlled trial. *Lancet*, 2008, 372(9642): 902–9.

Resick PA et al. A comparative outcome study of behavioural group therapy for sexual assault victims. *Behavior Therapy*, 1988, 19:385–401.

Resick PA et al. A comparison of cognitive-processing therapy with prolonged exposure and a waiting condition for the treatment of chronic posttraumatic stress disorder in female rape victims. *Journal of Consulting and Clinical Psychology*, 2002, 70(4):867–879.

Resick PA, Schnicke MK. Cognitive processing therapy for sexual assault victims. *Journal of Consulting and Clinical Psychology*, 1992, 60(5):748–756.

Rothbaum BO. A controlled study of eye movement desensitization and reprocessing in the treatment of posttraumatic stress disordered sexual assault victims. *Bulletin of the Menninger Clinic*, 1997, 61(3):1–18.

Rothbaum BO, Astin MC, Marsteller F. Prolonged exposure versus eye movement desensitization and reprocessing for PTSD rape victims. *Journal of Traumatic Stress*, 2005, 18(6):607–616.

World Health Organization. Psychological first aid. Geneva, World Health Organization, 2011 (*whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf*, accessed 10 April 2011).

World Health Organization. *Pharmacological treatment of mental disorders in primary health care*. Geneva, World Health Organization, 2009.

World Health Organization. *mhGAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva, World Health Organization, 2010c (http://whqlibdoc.who.int/publications/2010/9789241548069_eng.pdf).

4. Training of health-care providers on intimate partner violence and sexual violence

Bott S, Guedes AC, Guezmes A. The health service response to sexual violence: lessons from IPPF/WHR members associations in Latin America. In: Jejeeboy SJ, Shah I, Thapa S, eds. *Sex without consent: young people in developing countries*. London, Zed Books Ltd, 2005:251–268.

Campbell JC et al. An evaluation of a system-change training model to improve emergency department response to battered women. Academic Emergency Medicine: Official *Journal of the Society for Academic Emergency Medicine*, 2001, 8(2):131–138.

Coonrod DV et al. A randomized controlled study of brief interventions to teach residents about domestic violence. *Academic Medicine: Journal of the Association of American Medical Colleges*, 2000, 75(1):55–57.

Donohoe J. Uncovering sexual abuse: evaluation of the effectiveness of The Victims of Violence and Abuse Prevention Programme. *Journal of Psychiatric and Mental Health Nursing*, 2010, 17 (1):9–18.

Dubowitz H et al. The safe environment for every kid model: impact on pediatric primary care professionals. *Pediatrics*, 2011, 127 (4):e962–970.

Feder G et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence: a cluster randomised trial of a primary care training and support programme. *The Lancet*, 2011, 19:1788–1795.

Garg A et al. Improving the management of family psychosocial problems at low-income children's well-child care visits: the WE CARE Project. *Pediatrics*, 2007, 120(3):547–558.

Grisurapong S. Health sector responses to violence against women in Thailand. *Journal of the Medical Association of Thailand*, 2004, 87(Suppl. 3):S227–234.

Lo Fo Wong SLF et al. Increased awareness of intimate partner abuse after training: a randomized control trial. *British Journal of General Practice*, 2006, 56:249–257.

McLaughlin SA et al. Implementation and evaluation of a training program for the management of sexual assault in the emergency department. *Annals of Emergency Medicine*, 2007, 49(4):489–494.

Milone JM et al. The effect of lecture and a standardized patient encounter on medical student rape myth acceptance and attitudes toward screening patients for a history of sexual assault. *Teaching and Learning in Medicine*, 2010, 22(1):37–44.

Parekh V, Currie M, Brown CB. A postgraduate sexual assault forensic medicine program: sexual assault medicine from scratch. *Medicine, Science and the Law*, 2005, 45(2):121–128.

World Health Organization. *WHO medical eligibility citeria*. Geneva, World Health Organization, 2010.

World Health Organization. *Guidelines for medico-legal care of sexual violence survivors*. Geneva, World Health Organization, 2002.

WHO/UNHCR/UNFPA. *Clinical management of rape survivors. E-learing programme*. Geneva, WHO/UNHCR/UNFPA, 2009 (http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/, accessed 10 April 2013).

5. Health-care policy and provision

Coyer SM et al. Screening for violence against women in a rural health care clinic. *Online Journal of Rural Nursing and Health Care*, 2006, 6(1).

Crandall CS, Helitzer D. *Impact evaluation of a sexual assault nurse examiner (SANE) programme. Final Report for the U.S. Department of Justice, Document No. 203276, Award Number: 98-WT-VX-0027, December 2003*.

Derhammer F et al. Using a SANE interdisciplinary approach to care of sexual assault victims. *The Joint Commission Journal on Quality Improvement*, 2000, 26 (8):488–496.

Fanslow JL, Norton RN, Robinson EM. One year follow up of an emergency department protocol for abused women. *Australian and New Zealand Journal of Public Health*, 1999, 23(4):418–420.

Fanslow JL et al. Outcome evaluation of an emergency department protocol of care on partner abuse. *Australian and New Zealand Journal of Public Health*, 1998, 22(5):598–603.

Feder GS et al. Identification and Referral to Improve Safety (IRIS) of women experiencing domestic violence: a cluster randomized controlled trial of a primary care training and support programme. *The Lancet*, 2011, 378(9805):1788–1795.

Gregory A et al. Primary care Identification and Referral to Improve Safety of women experiencing domestic violence (IRIS): protocol for a pragmatic cluster randomized controlled trial. *BMC Public Health*, 2010, 10(1):54.

Harwell TS et al. Results of a domestic violence training programme offered to the staff of urban community health centres. *American Journal of Preventive Medicine*, 1998, 15(3):235–242.

Kim JC et al. Comprehensive care and HIV prophylaxis after sexual assault in rural South Africa: the Refentse intervention study. *BMJ*, 2009; 338:1559–1562.

McCaw B et al. Beyond screening for domestic violence: a systems model approach in a managed care setting. *American Journal of Preventive Medicine*, 2001, 21(3):170–176.

Muñoz CF et al. Improving care for victims of domestic violence. Impact of a priority intervention. *Atención primaria/Sociedad Española de Medicina de Familia y Comunitaria*, 2001, 28(4):241.

Ramsden C, Bonner M. A realistic view of domestic violence screening in an emergency department. *Accident and Emergency Nursing*, 2002, 10(1):31–39.

Sampsel K et al. The impact of a sexual assault/domestic violence program on ED care. *Journal of Emergency Nursing*, 2009, 35(4):282–289.

Spinola C et al. Developing and Implementing an Intervention. *Evaluation & The Health Professions*, 1998, 21(1):91.

6. Mandatory reporting of intimate partner violence

Feldhaus KM et al. Physicians' knowledge of and attitudes toward a domestic violence mandatory reporting law. *Annals of Emergency Medicine*, 2003, 41; 1:159.

Gerbert B et al. A qualitative analysis of how physicians with expertise in domestic violence approach the identification of victims. *Annals of Internal Medicine*, 1999, 19; 131(8):578–584.

Glass N, Dearwater S, Campbell JC. Intimate partner violence screening and intervention: data from eleven community hospital emergency departments in Pennsylvania and California Community Hospital Emergency Departments. *Journal of Emergency Nursing*, 2001, 27:141–149.

Rodriguez M et al. Patient attitudes about mandatory reporting of domestic violence: implications for health care professionals. *West Journal of Medicine*, 1998, 169:337–341.

Sachs C et al. Failure of the mandatory domestic violence reporting law to increase medical facility referral to police. *Annals of Emergency Medicine*, 1998, 31:488–494.

Smith JS et al. Barriers to the mandatory reporting of domestic violence encountered by nursing professionals. *Journal of Trauma Nursing*, 2008, 1:9–11.

Tilden VP et al. Factors that influence clinicians' assessment and management of family violence. *American Journal of Public Health*, 1994, 84(4):628–633.

Monitoring and evaluating the guideline implementation

Bloom SS. *Violence against women and girls: a compendium of monitoring and evaluation indicators*. Chapel Hill, NC, Measure Evaluation, 2005 (**http://www.cpc.unc.edu/measure/publications/ms-08-30**, accessed 12 April 2013).

World Health Organization. *Psychological first aid*. Geneva, World Health Organization, 2011 (**whqlibdoc.who.int/publications/2011/9789241548205_eng.pdf**, accessed 10 April 2011).

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Declaration of interests of the Guideline Development Group

All members submitted the Declaration of Interests form. At the beginning of the meeting, all members verbally declared their interests to the group. This is not a field where there are significant commercial interests; however, there are strong publicly stated opinions and research interests, including funded grants. It is also a small field and the authors of many of the papers being reviewed were part of the GDG. Therefore, prior to each topic being discussed, members declared if they were:

- an investigator in any of the studies being discussed
- conducting any research currently in the area
- known to hold a stated public opinion.

The Chairman had a stated public opinion regarding universal screening and therefore did not chair the screening discussion. Many GDG members were researchers who had participated in research trials under discussion, during which they acted as knowledge experts but did not take part in the discussion per se. Otherwise, full participation was considered as appropriate. Other participants did not present any potentially conflicting interest.

III. List of full reviews and evidence tables

The standardized criteria used in grading the evidence and the GRADE tables are not included in this document. The full reviews plus all evidence tables are available. A list of the separate documents (available upon request from rhr@who.int) is given below.

	Supplement	
	Review	**Evidence Tables**
Clinical interventions for intimate partner violence, including identification	*1a Evidence summary:* Identification and care for survivors of intimate partner violence	*1b Extraction tables:* Identification and care for survivors of intimate partner violence
Clinical interventions for sexual assault	*2a Evidence summary:* Care for survivors of sexual assault	*2b Extraction tables:* Care for survivors of sexual assault
Training	*3a Evidence summary:* Training of health-care providers on intimate partner violence and sexual violence	*3b Extraction tables:* Training of health-care providers on intimate partner violence and sexual violence
Health-care provision	*4a Evidence summary:* Health-care policy and provision	*4b Extraction tables:* Health-care policy and provision
Mandatory reporting	*5a Evidence summary:* Mandatory reporting of intimate partner violence	*5b Extraction tables:* Mandatory reporting of intimate partner violence

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