



Module 2

HEALTH

Essential Services Package for
Women and Girls Subject to Violence
Core Elements and Quality Guidelines





MODULE 2

Health Services

The Essential Services Package comprises five Modules:

Module 1. Overview and introduction	Module 2. Health	Module 3. Justice and policing	Module 4. Social services	Module 5. Coordination and governance of coordination
<p>Chapter 1: Introduction to essential services package</p> <p>1.1 Introduction 1.2 Context 1.3 Purpose and scope 1.4 Language and terms</p>	<p>Chapter 1: Introduction to essential health services</p> <p>1.1 Introduction 1.2 Purpose and scope 1.3 Language and terms</p>	<p>Chapter 1: Introduction to essential justice and policing services</p> <p>1.1 Introduction 1.2 Purpose and scope 1.3 Language and terms</p>	<p>Chapter 1: Introduction to essential social services</p> <p>1.1 Introduction 1.2 Purpose and scope 1.3 Language and terms</p>	<p>Chapter 1: Introduction to essential coordination and governance actions</p> <p>1.1 Introduction 1.2 Purpose and scope 1.3 Language and terms</p>
<p>Chapter 2 Common principles, characteristics and foundational elements</p> <p>2.1 Principles 2.2 Common characteristics of quality essential services 2.3 Foundational elements</p>	<p>Chapter 2 Framework for essential services package</p> <p>2.1 The overall framework 2.2 Unique features of the framework specific to essential health services</p>	<p>Chapter 2 Framework for essential services package</p> <p>2.1 The overall framework 2.2 Unique features of the framework specific to essential justice and policing services</p>	<p>Chapter 2 Framework for essential services package</p> <p>2.1 The overall framework 2.2 Unique features of the framework specific to essential social services</p>	<p>Chapter 2 Framework for essential services package</p> <p>2.1 The overall framework</p>
<p>Chapter 3 How to use this tool</p> <p>3.1 Essential services guidelines framework</p>	<p>Chapter 3 Guidelines for essential health services</p>	<p>Chapter 3 Guidelines for essential justice and policing services</p>	<p>Chapter 3 Guidelines for essential social services</p>	<p>Chapter 3 Guidelines for essential coordination and governance actions</p> <p>3.1. Guidelines for national level coordination and governance of coordination of Essential Services 3.2. Guidelines for local level coordination and governance of coordination of essential services.</p>
<p>Chapter 4 Tools and resources</p>	<p>Chapter 4 Tools and resources</p>	<p>Chapter 4 Tools and resources</p>	<p>Chapter 4 Tools and resources</p>	<p>Chapter 4 Tools and resources</p>

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CHAPTER 1:

INTRODUCTION TO ESSENTIAL HEALTH SERVICES

1.1 INTRODUCTION

This guidance for **essential health services** is based on the World Health Organization (WHO) clinical and policy guidelines on *Responding to intimate partner violence and sexual violence against women*,¹ in keeping with WHO's mandate to set standards in the health system. These evidence-based guidelines were developed following WHO's guidelines development process which included: retrieval of up-to-date evidence through systematic reviews, assessment and synthesis of evidence and formulation of recommendations with inputs from a wide range of experts (Guideline Development Group) and peer review by another group of experts. They provide evidence-based guidance for the design, implementation and review of quality, women-centred health sector responses for women subjected to intimate partner violence and sexual violence, although they can also be useful for other forms of gender-based violence against women and available to girls, particularly girls that could use the essential services provided for women. The guidelines have been developed with a focus on low to middle income countries in stable settings but they are also applicable in high income countries.

Based on these guidelines WHO, UNFPA and UN Women developed a *Clinical Handbook on Health care for women subjected to intimate partner violence or*

*sexual violence*². This is a practical 'how to' manual for health service providers. It includes job aids, tips and practical recommendations. These recommendations form the basis for this Module on Essential Health Service, part of the Essential Services Package which aims to provide all women and girls who have experienced gender-based violence with greater access to a set of essential quality and coordinated multi-sectoral services. This Module should therefore be read in conjunction with the two documents mentioned above.

The **Essential Services Package** reflects the vital components of coordinated multi-sectoral responses for women and girls subject to violence and includes guidelines for justice and policing services, social services, coordination and governance mechanisms as well as health services.

This module for essential health services should be read in conjunction with Module 1: Overview and Introduction which sets out the principles, common characteristics and foundational elements that apply across all essential services. This module is also complementary to the guidelines for justice and policing services (Module 3), social services (Module 4), and coordination and governance of coordination (Module 5).

¹ World Health Organization. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, Switzerland: World Health Organization; 2013.

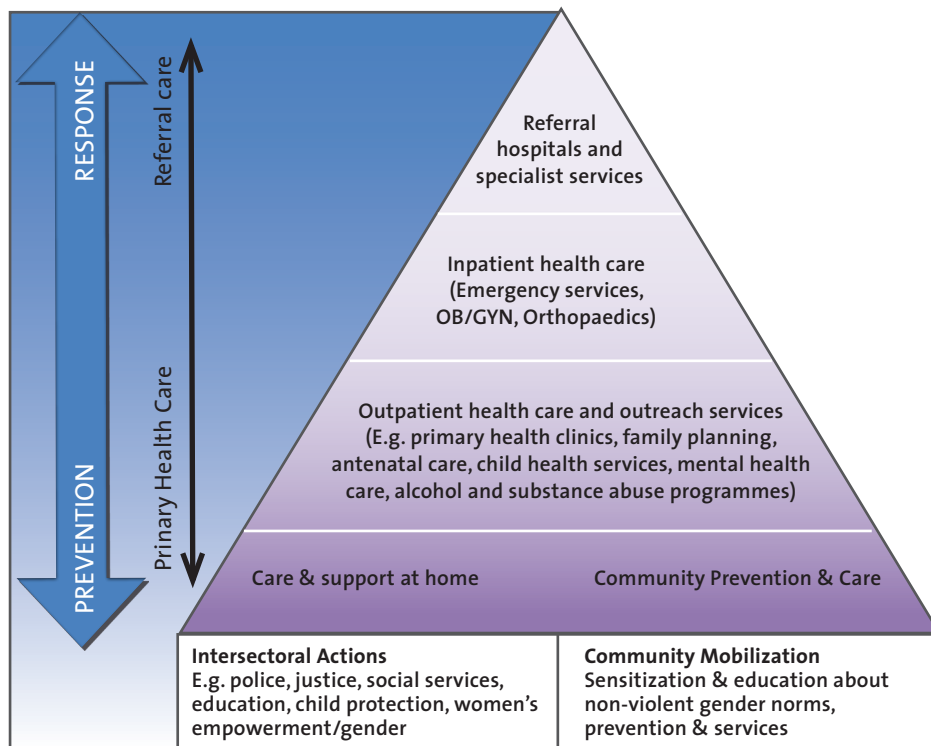
² WHO, UNW, UNFPA. *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook*. Geneva: WHO, 2014. (WHO/RHR/14.26)

1.2 PURPOSE AND SCOPE

A quality health service response to violence against women and girls is crucial, not only to ensure victims/survivors have access to the highest attainable health standard, but also because health care providers (such as nurses, midwives, doctors and others) are likely to be the first professional contact for women who have been subjected to intimate partner violence or sexual

In order to respond to women’s diverse needs and experiences, this Module addresses all health consequences, including the physical, mental and sexual and reproductive health consequences, of violence against women. As called for in the Agreed Conclusions from the 57th session of the Commission on the Status of Women, and as per the WHO guidelines, this Module covers various

FIGURE 1. Primary health care and the context of the wider health system, community mobilization, and inter-sectoral action.



Source: Adapted from Lawn JE et al, Lancet, 2008 30 years of Alma Ata

violence.³ Women and girls often seek health services, including for their injuries, even if they do not disclose the associated abuse or violence. Studies show that abused women use health care services more than non-abused women do.⁴ They also identify health care providers as the professionals they would most trust with disclosure of abuse.

health interventions: first line support; treatment of injuries and psychological and mental health support; for post rape care: emergency contraception, safe abortion where such services are permitted by national law, post exposure prophylaxis for HIV infections, and diagnosis and treatment for sexually transmitted infections. Training for medical and other health professionals to effectively identify and treat women subjected to violence as well as forensic examinations by appropriately

3 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013 at page 1.

4 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013 at page 1.

trained professionals are also necessary.⁵ In addition they take guidance from the Agreed Conclusions to ensure that health care services have the following characteristics: accessible; responsive to trauma; affordable; safe; effective and good quality.

Good service delivery is a vital element of any health system. The precise organization and content of health services will differ from one country to another, but the “typical” health provider works across different delivery levels:

- (1) Primary health care, for example, health post, health centres and dispensaries and district hospitals with outpatient general services and basic inpatient services.
- (2) Referral care that includes tertiary hospital with specialized services.

5 Commission on the Status of Women: 57th session (2013) *Agreed conclusions: Elimination and prevention of all forms of violence against women and girls and WHO. Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, WHO; 2013.

The entry points for providing care to women affected by violence at all levels of service delivery include sexual and reproductive health, including maternal health, family planning, post-abortion care services, HIV and AIDS as well as mental health services, provided either through the government or by non-governmental organizations.

The module focuses on health services that are close to the population, with a point of entry to the health service network at primary care level (rather than at the specialist or hospital level). The Module recognizes that the patient’s primary care provider facilitates the route through the needed services and works in collaboration with other levels and types of provider. Coordination also takes place with other sectors (such as social services) and partners (such as community organizations). The network of service delivery includes preventive, curative, palliative and rehabilitative services and health promotion activities.⁶

6 WHO. *Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies.* Geneva: WHO: 2010.

1.3 LANGUAGE AND TERMS

Case finding or clinical enquiry in the context of intimate partner violence 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”.⁷

Cognitive behaviour therapy (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. CBT typically has a cognitive component (helping the person develop the ability to identify and challenge unrealistic negative thoughts), as well as a

7 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, WHO; 2013 at the Glossary page vii.

behaviour component. CBT varies, depending on the specific mental health problems.⁸

Core elements are features or components of the essential services that apply in any context, and ensure the effective functioning of the service.

Essential Services encompass a core set of services provided by the health care, social service, police and justice sectors. The services must, at a minimum, secure the rights, safety and well-being of any woman or girl who experiences gender-based violence.

8 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines.* Geneva, WHO; 2013 at the Glossary page vii.

First-line support refers to the minimum level of (primary 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.⁹

Gender based violence is “any act of violence that is directed against a woman because she is a woman or that affects women disproportionately”.¹⁰

Health service provider is 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. Health organizations include hospitals, clinics, primary care centres and other service delivery points. Primary health care providers are nurses, midwives, doctors or others.¹¹

Health system refers to (i) all activities whose primary purpose is to promote, restore and/or maintain health; (ii) the people, institutions and resources, arranged together in accordance with established policies, to improve the health of the population they serve¹².

Intimate partner violence is “the most common form of violence experienced by women globally . . . and includes a range of sexually, psychologically and physically coercive acts used against adult and adolescent women by a current or former intimate partner, without her consent. Physical violence involves intentionally using physical force, strength or a weapon to harm or

injure the woman. Sexual violence includes abusive sexual contact, making a woman engage in a sexual act without her consent, and attempted or completed sex acts with a woman who is ill, disabled, under pressure or under the influence of alcohol or other drugs. Psychological violence includes controlling or isolating the woman, and humiliating or embarrassing her. Economic violence includes denying a woman access to and control over basic resources.”¹³

Mandatory reporting refers to legislation passed by some countries or states that requires individual 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.¹⁴

Medico-legal evidence is used in this tool as defined by the World Health Organization as “documented extra and ano-genital injuries and emotional state as well as those samples and specimens that are taken from the victim’s body or clothing solely for legal purposes. Such evidence includes saliva, seminal fluid, head hair, pubic hair, blood, urine, fibre, debris and soil”¹⁵.

Non-partner sexual violence “refers to violence by a relative, friend, acquaintance, neighbor, work colleague or stranger”.¹⁶ It includes being forced to perform any unwanted sexual act, sexual harassment and violence perpetrated against women and girls frequently by an

9 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013 at the Glossary. For further details, see also, WHO, UNW, UNFPA. *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook*. Geneva: WHO, 2014.

10 CEDAW, General Recommendation No. 19, paragraph 6, <http://www.un.org/womenwatch/daw/cedaw/recommendations/recomm.htm>.

11 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013 at the Glossary on page vii.

12 WHO, Health System Strengthening: Glossary, found at www.who.int/healthsystems/Glossary_January2011.pdf.

13 Report of the Secretary-General, In-depth study on all forms of violence against women, United Nations, A/61/122/Add.1, (6 July 2006) paras. 111- 112, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/No6/419/74/PDF/No641974.pdf?OpenElement>.

14 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013 at the Glossary on page vii.

15 Du Mont, Janice and D. White (2007), “The uses and impacts of medico-legal evidence in sexual assault cases: A Global Review (WHO: Geneva) and see also WHO. Guidelines for medico-legal care for victims of sexual violence. Geneva: WHO, 2003.

16 Report of the Secretary-General, In-depth study on all forms of violence against women, United Nations, A/61/122/Add.1, (6 July 2006) paragraph 128, <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/No6/419/74/PDF/No641974.pdf?OpenElement>.

offender known to them, including in public spaces, at school, in the workplace and in the community.

Quality guidelines support the delivery and implementation of the core elements of essential services to ensure that they are effective, and of sufficient quality to address the needs of women and girls. Quality standards provide ‘the how to’ for services to be delivered within a human rights-based, culturally-sensitive and women’s-empowerment approach. They are based on and complement international standards and reflect recognized best practices in responding to gender-based violence.

Victim / survivor refers to the women and girls who have experienced or are experiencing gender based violence to reflect both the terminology used in the

legal process and the agency of these women and girls in seeking essential services.¹⁷

Violence against women means “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.”¹⁸

17 United Nations (2006) *Secretary-General’s In-depth Study on Violence Against Women A/61/122/Add.1* notes the ongoing debate the terms victim and survivor. Some suggest that “the term “victim” should be avoided because it implies passivity, weakness and inherent vulnerability and fails to recognize the reality of women’s resilience and agency. For others the term “survivor” is problematic because it denies the sense of victimization experienced by women who have been the target of violent crime”. Therefore, these guidelines use the term “victim/survivor”.

18 United Nations 1993, Declaration on the Elimination of all Forms of Violence Against Women, United Nations: Geneva, Article 1.

CHAPTER 2:

FRAMEWORK FOR ESSENTIAL SERVICES PACKAGE

2.1

THE OVERALL FRAMEWORK

The Framework for guidelines for the delivery of quality essential health services incorporates four interlinked components:

- **Principles** which underpin the delivery of all essential services.
- **Common characteristics** which describe a range of activities and approaches that are common across all areas and which support the effective functioning and delivery of services.
- **Essential services** which set out the absolute minimum required services to secure the human rights, safety and well-being of any woman or adolescent girls who experience intimate partner violence and or non-partner sexual violence
- **Foundational elements** which must be in place to enable the delivery of quality services across all essential services and actions.

Essential Services Package: Overall framework diagram

Principles	A rights based approach	Advancing gender equality and women's empowerment	Culturally and age appropriate and sensitive
	Victim/survivor centred approach	Safety is paramount	Perpetrator accountability
Common characteristics	Availability	Accessibility	
	Adaptability	Appropriateness	
	Prioritize safety	Informed consent and confidentiality	
	Data collection and information management	Effective communication	
	Linking with other sectors and agencies through referral and coordination		

Essential services and actions	Health	Justice and Policing	Social services
	<ol style="list-style-type: none"> 1. Identification of survivors of intimate partner violence 2. First line support 3. Care of injuries and urgent medical treatment 4. Sexual assault examination and care 5. Mental health assessment and care 6. Documentation (medico-legal) 	<ol style="list-style-type: none"> 1. Prevention 2. Initial contact 3. Assessment/investigation 4. Pre-trial processes 5. Trial processes 6. Perpetrator accountability and reparations 7. Post-trial processes 8. Safety and protection 9. Assistance and support 10. Communication and information 11. Justice sector coordination 	<ol style="list-style-type: none"> 1. Crisis information 2. Crisis counselling 3. Help lines 4. Safe accommodations 5. Material and financial aid 6. Creation, recovery, replacement of identity documents 7. Legal and rights information, advice and representation, including in plural legal systems 8. Psycho-social support and counselling 9. Women-centred support 10. Children's services for any child affected by violence 10. Children's services for any child affected by violence 11. Community information, education and community outreach 12. Assistance towards economic independence, recovery and autonomy

Coordination and governance of coordination	
National level: Essential actions	Local level: Essential actions
<ol style="list-style-type: none"> 1. Law and policy making 2. Appropriation and allocation of resources 3. Standard setting for establishment of local level coordinated responses 4. Inclusive approaches to coordinated responses 5. Facilitate capacity development of policy makers and other decision-makers on coordinated responses to VAWG 6. Monitoring and evaluation of coordination at national and local levels 	<ol style="list-style-type: none"> 1. Creation of formal structures for local coordination and governance of coordination 2. Implementation of coordination and governance of coordination

Foundational elements	Comprehensive legislation and legal framework	Governance oversight and accountability	Resource and financing
	Training and workforce development	Gender sensitive policies and practices	Monitoring and evaluation

2.2

UNIQUE FEATURES OF THE FRAMEWORK SPECIFIC TO ESSENTIAL HEALTH SERVICES

Principles

In applying the overall principles, health service providers, should keep in mind:

- A rights-based approach includes the right to the highest attainable standard of health and the right to self-determination, which means women being entitled to make their own decisions including sexual and reproductive decisions; entitled to refuse medical procedures and/or take legal action.¹⁹
- Assuring gender equality in health means providing care fairly to both women and men, taking into account their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy. It requires also being cognizant of inequalities in power relationships between women and men and between providers and patients.

Common Characteristics

In applying the overall principles, health service providers, should keep in mind:

- Informed consent and safeguarding of confidentiality means the provision of health care, treatment and counselling should be private and confidential; information disclosed only with the consent of the women and includes the right to know what information has been collected about their health and having access to this information, including medical records.²⁰

Foundational Elements

In applying the overall principles, health service providers, should keep in mind:

- Violence against women health policies need to be linked to national policy, where it exists; include

addressing workplace / institutional violence and includes companion procedures and protocols. Care for women experiencing intimate partner violence and sexual violence should, as much as possible, be integrated into existing health services rather than as a stand-alone service.²¹

- Workforce development in the health sector includes building capacity on these issues at pre-service, as well as through continuing education and in-service training. It also requires inter-sectoral team building; and health work force supervision and mentoring. While a country needs multiple models of care for survivors for different levels of the health system, priority should be given to building capacity and service delivery at the primary level of care.²² Furthermore, 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.²³
- Engaging with the community and advocacy for women and young girl survivors is an important building block to essential health services for victims and survivors.
- Another important building block for health services is the availability of medical products / commodities and technology. This includes reproductive health commodity security and settings to enable confidentiality, privacy and safety.
- Monitoring and evaluation of essential health services requires health information systems; measures of accountability; client feedback and assessments.

19 WHO, UNW, UNFPA. *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook*. Geneva: WHO, 2014. (WHO/RHR/14.26) at page 3.

20 WHO, UNW, UNFPA. *Health care for women subjected to intimate partner violence or sexual violence. A clinical handbook*. Geneva: WHO, 2014. (WHO/RHR/14.26) at page 3.

21 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013. Recommendation 34.

22 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013. Recommendation 35.

23 WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva, WHO; 2013. Recommendation 36.

CHAPTER 3:

GUIDELINES FOR ESSENTIAL HEALTH SERVICES

This module should be read in conjunction with WHO Clinical and Policy Guidelines and the WHO, UN Women, UNFPA Clinical Handbook on Health care for women subjected to intimate partner violence or

sexual violence. The information presented below summarizes some of the key points from those documents, particularly the clinical handbook.

ESSENTIAL SERVICE: 1. IDENTIFICATION OF SURVIVORS OF INTIMATE PARTNER VIOLENCE	
<p>It is important for health service providers to be aware that a woman’s health problems may be caused or made worse by violence. Women subjected to violence in relationships and sexual violence often seek health services for related emotional or physical conditions, including injuries. However, often they do not tell the provider about the violence due to shame or fear of being judged or fear of their partner.</p>	
CORE ELEMENTS	GUIDELINES
1.1 Information	<ul style="list-style-type: none"> • Written information on intimate partner violence and non-partner sexual assault should be available in healthcare 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).(WHO Guidelines Recommendation 4)
1.2 Identification of women suffering intimate partner violence	<ul style="list-style-type: none"> • Health service providers should ask about exposure to intimate partner violence when assessing conditions that may be caused or complicated by intimate partner violence in order to improve diagnosis / identification and subsequent care. (See Box 1, page 19 in WHO Guidelines and page 9 of the Clinical Handbook for a list of clinical and other conditions associated with intimate partner violence) <ul style="list-style-type: none"> • Asking women about violence needs to be linked to an effective response, which would include a first-line supportive response, appropriate medical treatment and care as needed and referral either within the health system itself or externally. • “Universal screening” or “routine enquiry” (i.e. asking women in all health-care encounters) should not be implemented. While it can increase the identification of women suffering violence it has not been shown to improve health outcomes or even referrals. It is challenging to implement in high-prevalence settings with limited resources or referral options. • Before asking about partner violence, the health system should put in place the following minimum requirements: <ul style="list-style-type: none"> • Private setting • Health care providers who have been trained to ask appropriately (for example, in an empathic, non-judgmental manner) and how to respond appropriately • System for referral in place • Protocol / standard operating procedure in place. <p>(See WHO Guidelines recommendations 2 and 3 and pages 10-12 of the Clinical Handbook)</p>

<p>1.2 Identification of women suffering intimate partner violence <i>continued</i></p>	<ul style="list-style-type: none"> • Where health service providers suspect violence but women do not disclose it: <ul style="list-style-type: none"> • Do not pressure her, give her time • Provide information <ul style="list-style-type: none"> - regarding available services - regarding effects of violence on women’s health and their children’s health • Offer a follow-up visit. <p>(See WHO Clinical Handbook, page 12)</p>
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ESSENTIAL SERVICE: 2. FIRST LINE SUPPORT

When providing first line support to a woman who has been subjected to violence, four kinds of needs deserve attention: (1) immediate emotional / psychological health needs; (2) immediate physical health needs; (3) ongoing safety needs; (4) ongoing support and mental health needs. First line support provides practical care and responds to a woman’s emotional, physical, safety and support needs, without intruding on her privacy. Often, first line support is the most important care that can be provided.

CORE ELEMENTS	GUIDELINES
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<p>2.1 Women- centred care</p>	<ul style="list-style-type: none"> • 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. • Health service providers should, as a minimum, offer first-line support when women disclose violence. First line support includes: <ul style="list-style-type: none"> • Being non-judgmental and supportive and validating what the women is saying • Providing practical care and support that responds to her concerns but does not intrude on her autonomy • 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) • Listening without pressuring her to respond or disclose information • Offering information; helping her access information about resources, including legal and other services that she might think helpful, and helping her to connect to services and social supports <ul style="list-style-type: none"> - 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) • Assisting her to increase safety for herself and her children, where needed • Offering comfort and help to alleviate or reduce her anxiety • Providing or mobilizing social support (including referrals). • Health service providers should ensure: <ul style="list-style-type: none"> • That the consultation is conducted in private • Confidentiality, while informing women of the limits of confidentiality (i.e. when there is mandatory reporting). • If health service providers are unable to provide first line support, they should ensure that someone else (within their healthcare setting or another that is easily accessible) is immediately available to do so. <p>(WHO Guidelines Recommendation 1)</p>
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<p>2.2 Mandatory Reporting</p>	<ul style="list-style-type: none"> • Mandatory reporting of violence against women to the police by health service providers is not recommended. <ul style="list-style-type: none"> • Health service 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. • Child maltreatment and life threatening incidents must be reported to the relevant authorities by the health service provider, where there is a legal requirement to do so. <p>(WHO Guidelines Recommendation 36 and 37)</p>
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ESSENTIAL SERVICE: 3. CARE OF INJURIES AND URGENT MEDICAL ISSUES

The examination and care of physical and emotional health should take place together. The services are divided here to provide clear guidance in terms of minimum standards.

CORE ELEMENTS	GUIDELINES
<p>3.1 History and examination</p>	<ul style="list-style-type: none"> • History taking should follow the standard medical procedures, but keeping in mind that women who have experienced intimate partner or sexual violence are likely to be traumatized, so review any papers she may have and avoid asking questions she has already answered. • Explain and obtain informed consent for each aspect: <ul style="list-style-type: none"> • medical examination • treatment • forensic evidence collection • for the release of information to third parties, ie police and courts. • If women want evidence collected, call in or refer to a specifically trained provider who can do this. See Essential Health Service 6. • Conduct a thorough physical examination. Record findings and observations clearly. <ul style="list-style-type: none"> • At each step of the exam, ensure communication and ask for permission first. <p>(See WHO Clinical Handbook for further details, pages 40-49)</p>
<p>3.2 Emergency treatment</p>	<ul style="list-style-type: none"> • Where a woman has suffered life threatening or severe conditions, immediately refer the woman to emergency treatment.

ESSENTIAL SERVICE: 4. SEXUAL ASSAULT EXAM AND CARE

Sexual violence 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.

CORE ELEMENTS	GUIDELINES
<p>4.1 Complete history</p>	<ul style="list-style-type: none"> • Take a complete history, recording events to determine what interventions are appropriate and conduct a complete physical examination (head-to-toe including genitalia). • The history should include: <ul style="list-style-type: none"> • The time since assault and type of assault • Risk of pregnancy • Risk of HIV and other sexually transmitted infections (STIs) • Mental health status. <p>(WHO Guidelines Recommendation 11. Also see WHO Clinical Handbook for further details, pages 40-48).</p>

<p>4.2 Emergency contraception</p>	<ul style="list-style-type: none"> • 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. • 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. <p>(WHO Guidelines Recommendations 12-14. Also see WHO Clinical Handbook for further details, pages 49-51).</p>
<p>4.3 HIV post-exposure prophylaxis</p>	<ul style="list-style-type: none"> • Consider offering HIV post-exposure prophylaxis (PEP) for women presenting within 72 hours of a sexual assault. Use shared decision-making with the survivor, to determine whether HIV PEP is appropriate and follow national guidelines for prophylaxis. <p>(WHO Guidelines Recommendations 15-18. Also see WHO Clinical Handbook for further details, section 2.4, pages 55-57).</p>
<p>4.4 Post-exposure prophylaxis for sexually transmitted infections</p>	<ul style="list-style-type: none"> • Women survivors of sexual assault should be offered prophylaxis for the most common sexually transmitted infections and hepatitis B vaccine following national guidance <p>(WHO Guidelines Recommendations 19-20. Also see WHO Clinical handbook for further details, section 2.3, pages 52-54).</p>

ESSENTIAL SERVICE: 5. MENTAL HEALTH ASSESSMENT AND CARE	
<p>Many women who are subjected to intimate partner violence or sexual violence will have emotional or mental health problems as a consequence. Once the violence, assault or situation passes, these emotional problems will likely get better. Most people recover. There are specific ways health service providers can offer help and techniques to women to reduce her stress and promote healing. Some women, however, will suffer more severely than others. It is important to be able to recognize these women and to help them obtain care.</p>	
CORE ELEMENTS	GUIDELINES
<p>5.1 Mental health care for survivors of intimate partner violence</p>	<ul style="list-style-type: none"> • Women experiencing violence should be assessed for mental health problems (symptoms of acute stress/post-traumatic Stress Disorder (PTSD), depression, alcohol and drug use problems, suicidality or self-harm) and be treated accordingly, using the mhGAP intervention guide, which covers WHO evidence-based clinical protocols for mental health problems. • Mental health care should be delivered by health service providers with a good understanding of violence against women.
<p>5.2 Basic psychosocial support</p>	<ul style="list-style-type: none"> • After an assault, basic psychosocial support may be sufficient for the first 1-3 months, at the same time monitoring for more severe mental health problems. This includes: <ul style="list-style-type: none"> • Helping strengthen her positive coping methods • Exploring the availability of social support • Teaching and demonstrating stress reduction exercises • Providing regular follow-up
<p>5.3 More severe mental health problems</p>	<ul style="list-style-type: none"> • Conduct an assessment of mental status (at same time as physical examination) assessing for immediate risk or self-harm or suicide and for moderate-severe depressive disorder and PTSD. <ul style="list-style-type: none"> • Women with depression and PTSD will still benefit from first- line support, helping them strengthen social support, learning stress management and empathetic and support follow up. Referral to trained therapists if available. • Refer as necessary for brief psychological treatments or cognitive behaviour therapy. <p>(WHO Guidelines Recommendations 24-27. Also see WHO Clinical Handbook for further details, pages 67-83.)</p>

ESSENTIAL SERVICE: 6. DOCUMENTATION (MEDICO-LEGAL)

Health service providers have a professional obligation to record the details of any consultation with a patient. The notes should reflect what was said, by the patient, in her own words, and what was seen and done by the health care provider. In cases of violence, the taking of accurate and complete notes during the course of an examination is critical as medical records can be used in court as evidence. If the woman consents to a forensic examination, there might be need to call in a registered or official forensic examiner.

For more guidance, see the 2003 WHO *Guidelines for medico-legal care for victims of sexual violence*. These guidelines are complemented by Essential Justice and Policing Service number 3: Investigation, detailed in the Justice and Policing Module. See particularly: 3.3 “Relevant information and evidence is collected from the victim/survivor and witnesses” and 3.4 “A thorough investigation is conducted”.

CORE ELEMENTS	GUIDELINES
6.1 Comprehensive and accurate documentation	<ul style="list-style-type: none"> • Document in the medical record any health complaints, symptoms and signs, including a description of her injuries. • It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her <ul style="list-style-type: none"> • Get her permission to write this information in her record • Follow her wishes.
6.2 Collection and documentation of forensic specimens	<ul style="list-style-type: none"> • Where a woman has consented to forensic evidence collection, it is critical that the chain of custody evidence is maintained and that everything is clearly labeled.
6.3 Providing written evidence and court attendance	<ul style="list-style-type: none"> • Health service providers need to be familiar with the legal system; know how to write a good statement; as a minimum, document injuries in a complete and accurate way; make sound clinical observations; and reliably collect samples from victims for when they choose to follow a legal recourse.

CHAPTER 4:

TOOLS AND RESOURCES

WHO and UNHCR (2015) *Clinical management of mental, neurological and substance use conditions in humanitarian emergencies: mhGAP Humanitarian Intervention Guide (mhGAP-HIG)*. Geneva: Switzerland.

WHO, UN Women and UNFPA (2014) *Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook*. Geneva: Switzerland.

WHO (2013) *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*. Geneva: Switzerland.

WHO, War Trauma Foundation and World Vision International (2011) *Psychological first aid: guide for field workers*.

WHO (2010) *mhGap intervention guide for mental, neurological and substance use disorders in non-specialized health settings*. Geneva: Switzerland.

WHO and ILO (2007) *Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection (2007)*.

WHO, UNFPA and UNHCR (2004) *Clinical management of rape survivors*.

WHO (2003) *Guidelines for medico-legal care for victims of sexual violence*.

