6 Treatment and follow-up care

SUMMARY

- Exposure to sexual violence is associated with a range of health consequences for the victim. Comprehensive care must address the following issues: physical injuries; pregnancy; STIs, HIV and hepatitis B; counselling and social support; and follow-up consultations.

- The possibility of pregnancy resulting from the assault should be discussed. If the woman is first seen up to 5 days after the assault took place, emergency contraception should be offered. If she is first seen more than 5 days after the assault, she should be advised to return for pregnancy testing if she misses her next period.

- If sexual violence results in a pregnancy that a woman wishes to terminate, referral to legal abortion services should be made.

- When appropriate, patients should be offered testing for chlamydia, gonorrhoea, trichomoniasis, syphilis, HIV and hepatitis B; this may vary according to existing local protocols.

- The decision to offer STI prophylaxis should be made on a case-by-case basis. Routine prophylactic treatment of all patients is not generally recommended.

- Health workers must discuss thoroughly the risks and benefits of HIV post-exposure prophylaxis so that they can help their patients reach an informed decision about what is best for them.

- Social support and counselling are important for recovery. Patients should receive information about the range of normal physical and behavioural responses they can expect, and they should be offered emotional and social support.

- All patients should be offered access to follow-up services, including a medical review at 2 weeks, 3 months and 6 months post assault, and referrals for counselling and other support services.

6.1 Physical injuries

Patients with severe, life-threatening conditions should be referred for emergency treatment immediately. Patients with less severe injuries, for example, cuts, bruises and superficial wounds can usually be treated in situ by the examining health care worker or other nursing staff. Any wounds should be cleaned and treated as necessary. The following medications may be indicated:

- antibiotics to prevent wounds from becoming infected;
- a tetanus booster or vaccination (according to local protocols);
- medications for the relief of pain, anxiety or insomnia.
6.2 Pregnancy prevention and management

Most female victims of sexual violence are concerned about the possibility of becoming pregnant as a result of the assault. If a woman seeks health care within a few hours and up to 5 days after the sexual assault, emergency contraception should be offered (see section 6.2.1). If she presents more than 5 days after the assault she should be advised to return for pregnancy testing if she misses her next menstrual period (see section 6.2.2).

6.2.1 Emergency contraception

The most widely used means of pregnancy prevention is the oral administration of the emergency contraceptive pill (ECP), otherwise known as the “morning after pill”. ECPs act by preventing or delaying ovulation, by blocking fertilization, or by interfering with implantation. They are not abortion pills and do not affect an existing pregnancy (55).

Criteria for administering ECPs include:

— a risk of pregnancy;
— patient presents for treatment within 5 days of the assault and wants to prevent pregnancy;
— patient has a negative pregnancy test or it has been determined that she is not currently pregnant (if pregnancy cannot be ruled out with certainty, ECPs can still be prescribed so long as the patient is informed that if she is already pregnant, the pills will not be effective but neither will they affect the pregnancy nor harm the foetus).

There are no known medical conditions for which ECP use is contraindicated. Medical conditions that limit the continuous use of oral contraceptive pills are not relevant for the use of ECPs (56). Some jurisdictions require the patient to sign an informed consent form for emergency contraception.

ECP dosing regimens

Pre-packaged ECPs are available in some, but not all, countries. If pre-packaged pills are not available, other oral contraceptives can be substituted (the placebo tablets must not be used).

There are two main categories of ECPs, the combined estrogen-progesterone pill, and the progestin-only pill (i.e. levonorgestrel only). The preferred regimen for emergency contraception is the latter; relative to the progestin-only pill, the combined estrogen-progesterone pill appears to be less effective and more likely to cause side-effects such as nausea and vomiting (57). With all ECPs, the sooner they are taken after the assault, the more effective they are.

The recommended dosing regimens for ECPs are given in Table 10; important points are as follows:

- Progestin-only ECPs can be given in a single dose, up to 5 days after unprotected intercourse (58).
- In the absence of progestin-only pills, combined estrogen-progesterone pills can be given in two doses, 12 hours apart and within 72 hours of the assault.
If the patient vomits within 1 hour of taking ECPs the dose needs to be repeated (55).

Patients who are prescribed ECPs must be fully briefed about their medication; patient information is summarized in Box 7.

**Side effects**

Although nausea and vomiting, and breast tenderness have been associated with the use of ECPs in some patients, symptoms are usually only brief and mild. Women may also have some spotting/bleeding after taking ECPs. Serious side effects are rare.

**6.2.2 Pregnancy testing and management**

- Female patients should be assessed for the possibility of pregnancy. When available, pregnancy testing kits can be offered. However, most of the testing kits commonly available will not detect a pregnancy before expected menses.
BOX 7

**Instructions and information for patients prescribed ECPs**

Patients who are offered emergency contraception to prevent pregnancy following sexual assault must be made aware of the following facts about ECPs:

- The risk of becoming pregnant as a result of an assault will be decreased if the ECPs are taken within 5 days of the assault.
- ECPs are not 100% effective.
- ECPs do not cause abortion. They prevent or delay ovulation, block fertilization, or interfere with implantation; they will not affect an existing pregnancy.

Instructions for patients prescribed ECPs are as follows:

- Take pills as directed (see Table 10). (Note: The number of pills varies depending on the type of regimen prescribed).
- The pills may cause nausea and vomiting. If vomiting occurs within 1 hour of taking the ECPs, repeat the same dosage regimen.
- In most cases, the patient’s next menstrual period will occur around the expected time or earlier. If it is delayed, a pregnancy test should be performed to assess the possibility of pregnancy. ECPs do not cause immediate menstruation.

Finally, patients should be advised that if they experience any of the following symptoms, they should seek help immediately:

- severe abdominal pain;
- severe chest pain;
- shortness of breath;
- severe headaches;
- blurred vision or loss of vision;
- severe pain in the calf or thigh.

Advise the patient to make sure she gets tested for pregnancy in the event that she misses her next period.

- In the event of a confirmed pregnancy patients should be fully informed of their rights and briefed as to their options.

The choices to be made are then:

- maintaining the pregnancy, and either keeping the infant or giving up the infant for adoption;
- terminating the pregnancy.

In order to advise their patients, health workers must have a good working knowledge of the law governing matters of this nature as it applies to their local jurisdiction. In many countries where abortion is otherwise illegal, pregnancy termination is allowed after rape. If a woman wishes to terminate her pregnancy she should be referred to legal, safe abortion services.
Choices about emergency contraception and pregnancy termination are personal choices that can only be made by the patient herself. Your role is to provide the necessary information to help your patient make the decision that suits her best. Above all, respect your patient’s decision.

6.3 Sexually transmitted infections

Victims of sexual violence may contract a sexually transmitted infection (STI) as a direct result of the assault. Infections most frequently contracted by sexual violence victims, and for which there are effective treatment options, are:

— chlamydia;
— gonorrhoea;
— syphilis;
— trichomoniasis.

Victims of sexual violence may also be at risk of contracting human papilloma virus (HPV), herpes simplex virus type 2 (HSV-2), HIV and the hepatitis B virus; the latter two are covered separately (see sections 6.4 and 6.5, respectively).

6.3.1 STI testing

Where appropriate tests and laboratory facilities exist, the following tests for STIs should be offered:

— cultures for *Neisseria gonorrhoeae* and *Chlamydia trachomatis* (the nucleic acid amplification tests can be substituted for culture);
— wet mount and culture for *Trichomonas vaginalis*;
— blood sample for syphilis, HIV and hepatitis B testing (see sections 6.4 and 6.5, respectively).

If the test results are positive, patients can be prescribed treatment according to the regimens listed in Tables 11 and 12. It is important to note that negative test results do not necessarily indicate a lack of infection as STIs can take between 3 days and 3 months to incubate and become identifiable through laboratory testing. Thus if the sexual assault was recent, any cultures will most likely be negative unless the victim already has a STI. Follow-up tests, at a suitable interval to account for each respective infection, are therefore recommended in the case of negative test results. Health care workers should follow national and local protocols on STI testing and diagnosis.

6.3.2 Prophylactic treatment for STIs

The decision to offer prophylactic treatment should be made on a case-by-case basis after the physical examination (see Tables 11 and 12 for recommended treatment regimens that can also be used for prophylaxis). Routine prophylactic treatment of patients who have been sexually assaulted is not recommended, as evidence regarding the effectiveness of this strategy is scant. Practitioners
should follow national and local protocols on this matter. Further guidance on STI treatment (including prophylactic treatment) is provided in the latest edition of the WHO Guidelines for the Management of Sexually Transmitted Infections (59).

### 6.4 HIV/AIDS

Although there are no accurate data on the number of victims of sexual violence who become infected with HIV as a result of an assault, the risk of contracting HIV from sexual violence is estimated to be relatively low (20, 25, 60).

The likelihood of acquiring HIV from sexual assault depends on several factors (20, 25, 60):

- type of assault (i.e. vaginal, oral, anal);
- vaginal or anal trauma (including bleeding);
- whether and where on, or in, the body ejaculation occurred;
- viral load of ejaculate;
- presence of STI(s);
- presence of genital lesions in either the victim or perpetrator;
- intravenous drug use by perpetrator;
- frequency of assaults;
- number of perpetrators;

#### Table 11  WHO recommended STI treatment regimens (may also be used for prophylaxis)*

<table>
<thead>
<tr>
<th>STI</th>
<th>MEDICATION</th>
<th>ADMINISTRATION ROUTE AND DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>Ciprofloxacin\b or \ or Ceftriaxone or Cefixime</td>
<td>500 mg orally in a single dose or 125 mg IM in a single dose or 400 mg orally in a single dose</td>
</tr>
<tr>
<td></td>
<td>PLUS</td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Azithromycin or Doxycycline\h</td>
<td>1 g orally in a single dose or 100 mg orally twice a day for 7 days</td>
</tr>
<tr>
<td></td>
<td>PLUS</td>
<td></td>
</tr>
<tr>
<td>Trichomoniasis and bacterial vaginosis</td>
<td>Metronidazole\c</td>
<td>2 g orally in a single dose or 1 g orally every 12 hours for 1 day</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Benzathine penicillin G\d or Doxycycline\h\e</td>
<td>2.4 million IU IM in a single dose or 100 mg orally twice a day for 14 days</td>
</tr>
<tr>
<td></td>
<td>or Tetracycline\h\e</td>
<td>500 mg orally 4 times a day for 14 days</td>
</tr>
</tbody>
</table>

IM = intramuscularly; IU = International Units.

* The following regimens are intended to be guidelines only and are not inclusive of all available treatment regimens for STIs. Accepted local regimens and protocols should be followed as appropriate.

\b Contraindicated during pregnancy (see Table 12).
\c Contraindicated in the 1st trimester of pregnancy.
\d If not allergic to penicillin.
\e If allergic to penicillin.

Source: adapted from reference (59)
6. TREATMENT AND FOLLOW-UP CARE

### Table 12  **WHO recommended STI treatment regimens for pregnant women (may also be used for prophylaxis)**

<table>
<thead>
<tr>
<th>STI</th>
<th>MEDICATION</th>
<th>ROUTE OF ADMINISTRATION AND DOSAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gonorrhoea</td>
<td>Ceftriaxone</td>
<td>125 mg IM in a single dose</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cefixime</td>
<td>400 mg orally in a single dose</td>
</tr>
<tr>
<td></td>
<td><strong>PLUS</strong></td>
<td></td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Erythromycin</td>
<td>500 mg orally 4 times a day for 7 days</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Amoxicillin</td>
<td>500 mg orally 3 times a day for 7 days</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Azithromycin</td>
<td>1 g orally in a single dose</td>
</tr>
<tr>
<td></td>
<td><strong>PLUS</strong></td>
<td></td>
</tr>
<tr>
<td>Trichomoniasis and bacterial vaginosis</td>
<td>Metronidazole**</td>
<td>2 g orally in a single dose or 1 g orally every 12 hours for 1 day</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Benzathine penicillin G**</td>
<td>2.4 million IU IM in a single dose</td>
</tr>
<tr>
<td></td>
<td>or</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Erythromycin</td>
<td>500 mg orally 4 times a day for 14 days</td>
</tr>
</tbody>
</table>

*a* The following regimens are intended to be guidelines only and are not inclusive of all available treatment regimens for STIs. Accepted local regimens and protocols should be followed as appropriate.

*b* Contraindicated in the 1st trimester of pregnancy.

*c* If not allergic to penicillin.

*d* If allergic to penicillin. If pregnant patients are allergic to penicillin it is recommended that they undergo desensitization and then be treated with penicillin.

Source: adapted from reference (59)

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— HIV status of perpetrator(s);
— high prevalence of HIV in the area;
— whether a barrier contraceptive method was used.

Male victims of sexual violence have a higher risk of acquiring HIV from an assault as they are usually penetrated anally (25, 60). Incarcerated males are likely to be at greater risk, given the high prevalence of HIV in prison populations and the fact that incarcerated males are at an increased risk of sexual violence relative to the general population.

### 6.4.1 HIV testing

Sexual assault victims should be offered a baseline test for HIV. If there are appropriate facilities for confidential HIV testing and counselling, this could be done on-site. Alternatively, the patient could be referred to a HIV specialist or to a centre that specializes in confidential HIV testing and counselling.

Appropriate counselling services should be made available before and after HIV testing. Ideally, these services should be available on site. If not, the appropriate referrals should be arranged.
6.4.2 Post-exposure prophylaxis

Post-exposure prophylaxis for HIV is an area where practice is changing frequently. Although the recommendations given here are valid at the time of writing, it is possible that they may change in the near future. For these reasons health workers are strongly urged to:

- maintain a knowledge of the current recommendations in this field;
- familiarize themselves with local or national policy and/or guidelines;
- ensure that they are aware of the costs, risks and benefits of the various regimes so that they are able to fully inform their patients of these issues.

At the present time, routine prophylaxis for HIV is a matter of considerable controversy and not a universally accepted standard of practice. The risk factors for acquiring HIV from a sexual assault (see list in section 6.4) will determine whether or not PEP should be offered to a patient. Health workers should refer to local protocols dealing with PEP, if they exist. The patient and health worker must evaluate the risks and benefits of initiating or refraining from post-exposure prophylactic (PEP) treatment and decide together the best option for the patient (20, 60).

The patient needs to be fully informed of the following:

- the limited data regarding the efficacy of PEP;
- possible side effects of the medications;
- the need for strict compliance when taking the medications;
- length of treatment;
- importance of follow-up;
- the need to begin treatment immediately for maximal effect of medications.

If prescribed, PEP should be initiated within 72 hours of an assault and be given for 28 days. Antiemetics should be offered to counteract the side effects of the medication. Patient liver enzyme levels should be measured and a complete blood count (CBC) made prior to the commencement of PEP (to establish baseline values) and then monitored at regular intervals until the treatment has been completed.

If the initial test results for HIV were negative, patients should have the test repeated at 6, 12 and 24 weeks after the assault.

6.5 Hepatitis B

Victims of sexual violence may be at risk for hepatitis B and should therefore be offered testing and immunization. A variety of hepatitis B vaccines, with varying dosages and immunization schedules, are available throughout the world. Health workers should use the appropriate type of vaccine, dosage and immunization schedule for their local area (61).

Guideline protocols for the administration of the hepatitis B vaccine, according to patient immunization status, are given in Table 13. Generally speaking, it is not necessary to administer hepatitis B immune globulin (HBIG) unless the perpetrator is known to have acute hepatitis B. The administration of HBIG or the hepatitis vaccine is not contraindicated in pregnant women.
6.6 Patient information

On completion of the assessment and medical examination, it is important to discuss any findings, and what the findings may mean, with the patient. In particular: (20, 32, 61):

- Give the patient ample opportunity to voice questions and concerns.
- Reassure the patient that she did not deserve to be sexually assaulted and that the assault was not her fault.
- Teach patients how to properly care for any injuries they have sustained.
- Explain how injuries heal and describe the signs and symptoms of wound infection.
- Teach proper hygiene techniques and explain the importance of good hygiene.
- Discuss the signs and symptoms of STIs, including HIV, and the need to return for treatment if any signs and symptoms should occur. Stress the need to use a condom during sexual intercourse until STI/HIV status has been determined.
- Explain the importance of completing the course of any medications given.
- Discuss the side effects of any medications given.
- Explain the need to refrain from sexual intercourse until all treatments or prophylaxis for STIs have been completed and until her sexual partner has been treated for STIs, if necessary.
- Explain rape trauma syndrome (RTS) and the range of normal physical, psychological and behavioural responses that the patient can expect to experience to both the patient and (with the patient’s permission) family members and/or significant others. Encourage the patient to confide in and seek emotional support from a trusted friend or family member.
- Inform patients of their legal rights and how to exercise those rights.
- Give patients written documentation regarding:
  - any treatments received;
  - tests performed;
  - date and time to call for test results;
  - meaning of test results;
  - date and time of follow-up appointments;
  - information regarding the legal process.

<table>
<thead>
<tr>
<th>PATIENT IMMUNIZATION STATUS</th>
<th>TREATMENT GUIDELINES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never vaccinated for hepatitis B</td>
<td>First dose of vaccine should be administered at the initial visit, the second dose should be administered 1–2 months after the first dose, and the third dose should be administered 4–6 months after the first dose. The vaccine should be administered intramuscularly in the deltoid region. A vaccine without (HBIG) can be used.</td>
</tr>
<tr>
<td>Not completed a series of hepatitis B vaccinations</td>
<td>Complete the series as scheduled.</td>
</tr>
<tr>
<td>Completed a series of hepatitis B vaccinations</td>
<td>No need to re-vaccinate.</td>
</tr>
</tbody>
</table>

Table 13  **Hepatitis B immunization for victims of sexual violence**
Assess for patient safety. If it is not safe for the patient to return home, make appropriate referrals for shelter or safe housing, or work with her to identify a safe place that she can go to. Discuss strategies that may help prevent another assault.

Stress the importance of follow-up examinations at two weeks and three and six months.

Tell the patient that she can telephone or come into the health care facility at any time if she has any further questions, complications related to the assault, or other medical problems.

6.7 Follow-up care

6.7.1 Medical review

Follow-up visits are recommended at 2 weeks, 3 months and 6 months post assault (20, 32).

The 2-week follow-up visit

As part of the 2-week post-assault visit, the following routine tasks and checks should be performed:

- Examine any injuries for proper healing.
- Photograph injuries if indicated (i.e. to document healing, comparisons in court).
- Check that the patient has completed the course of any medications given for STIs.
- Obtain cultures and draw blood to assess STI status, especially if prophylactic antibiotics were not given at the initial visit.
- Discuss results of any tests performed.
- Test for pregnancy if indicated. If pregnant, advise about options.
- Remind patients to return for their hepatitis B vaccinations in 1 month and 6 months, other immunizations as indicated, and HIV testing at 3 and 6 months or to follow-up with their usual health care provider.
- Make follow-up appointments.
- Assess the patient’s emotional state and mental status, and encourage the patient to seek counselling if they have not yet done so.

The 3-month follow-up visit

At 3 months post assault:

- Test for HIV. Make sure that pre- and post-testing counselling is available or make the appropriate referral. Assess pregnancy status and provide advice and support.
- Discuss results.
- Draw blood for syphilis testing if prophylactic antibiotics were not given previously.
- Assess patient’s emotional state and mental status and encourage the patient to seek counselling if they have not yet done so.
The 6-month follow-up visit

At 6 months post assault:

- Test for HIV. Make sure that pre- and post-testing counselling is available or make an appropriate referral.
- Discuss results.
- Administer the third dose of the hepatitis B vaccine.
- Assess the patient’s emotional health and refer as necessary.

6.7.2 Counselling and social support

Not all victims of sexual violence react in the same way. Some victims experience immediate psychological distress, others short-term and/or long-term psychological problems. The amount and length of social support and/or psychological counselling required by victims of violence varies enormously, depending on the degree of psychological trauma suffered and the victim's own coping skills and abilities. The level of social support post assault is therefore best determined on a case-by-case basis. Unfortunately, many victims of sexual violence do not pursue counselling; according to Campbell (36), for example, only about 24–40% of victims ever seek counselling post assault.

Male victims tend to be especially reluctant to go for counselling, but in fact have much the same needs as women in terms of counselling and crisis intervention post assault. Men should therefore be strongly encouraged to seek counselling and to this end, the following approaches may be useful:

- explain that counselling and social support will help to facilitate recovery;
- listen carefully to the history of the event, ask about his concerns and address them appropriately;
- explain to him that he did not deserve to be sexually violated;
- reinforce that the assault was not his fault;
- stress that sexual violence is an issue of power and control.

Counselling services take a variety of forms, and victims interested in counselling can choose between individual, family or group therapies, and/or opt for formal or more informal support groups. Overall, social support in a group setting is generally recommended as it offers the following benefits:

- it helps to decrease the isolation that victims often feel;
- it provides a supportive atmosphere;
- victims are encouraged to share their experiences;
- it helps victims to establish their own support network.

The group experience is especially helpful to victims who have little or no existing social support. However, individual therapy may be better for victims who have pre-existing psychopathology and thus find group settings more difficult to cope with.

Crisis intervention, critical incident stress debriefing, cognitive-behavioural therapy and feminist therapy are all forms of treatment that have been reported to work well with sexual assault victims (32, 34, 36). Regardless of the type of
therapy used or chosen, the therapist should have special training in matters relating to sexual violence.

The role of therapy, or psychological counselling, in recovery is well established, yet many victims do not have access to formal services of this nature. In such cases, informal systems of social support are vital to the healing process and should be discussed with the patient.

6.7.3 Referrals

Patients should be given both verbal and written referrals for support services which may include:

- rape crisis centres;
- shelters or safe houses;
- HIV/AIDS counselling;
- legal aid;
- victim witness programmes;
- support groups;
- therapists;
- financial assistance agencies;
- social service agencies.

The types of referrals given will vary depending on the patient’s individual needs and circumstances, and also on the availability of facilities and resources. Health care providers should be familiar with the full range of formal and informal resources that are available locally for victims of sexual violence. It is the role of the health care worker to help patients identify and choose the most suitable option(s) for their particular requirements.

Health workers may be required to provide a certificate for absenteeism from school or work; these should be non-specific as to the reason for the absence (i.e. not stating that the patient was sexually assaulted).

Information regarding sexual violence, and about support services for victims in particular, should be readily accessible; strategies that might be helpful in this regard include:

- Compile a list of local services and telephone numbers that can be kept in a place that is easily accessible.
- Display posters about sexual violence and where to go for help on the walls of health facilities (having information prominently displayed may make victims feel more comfortable in disclosing and talking about the sexual violence in their lives).
- Place pamphlets and brochures regarding sexual violence in examination rooms and women’s toilets so that patients can take them away with them or read the information in private.
- Develop small pocket-size materials with lists of useful telephone numbers and addresses.