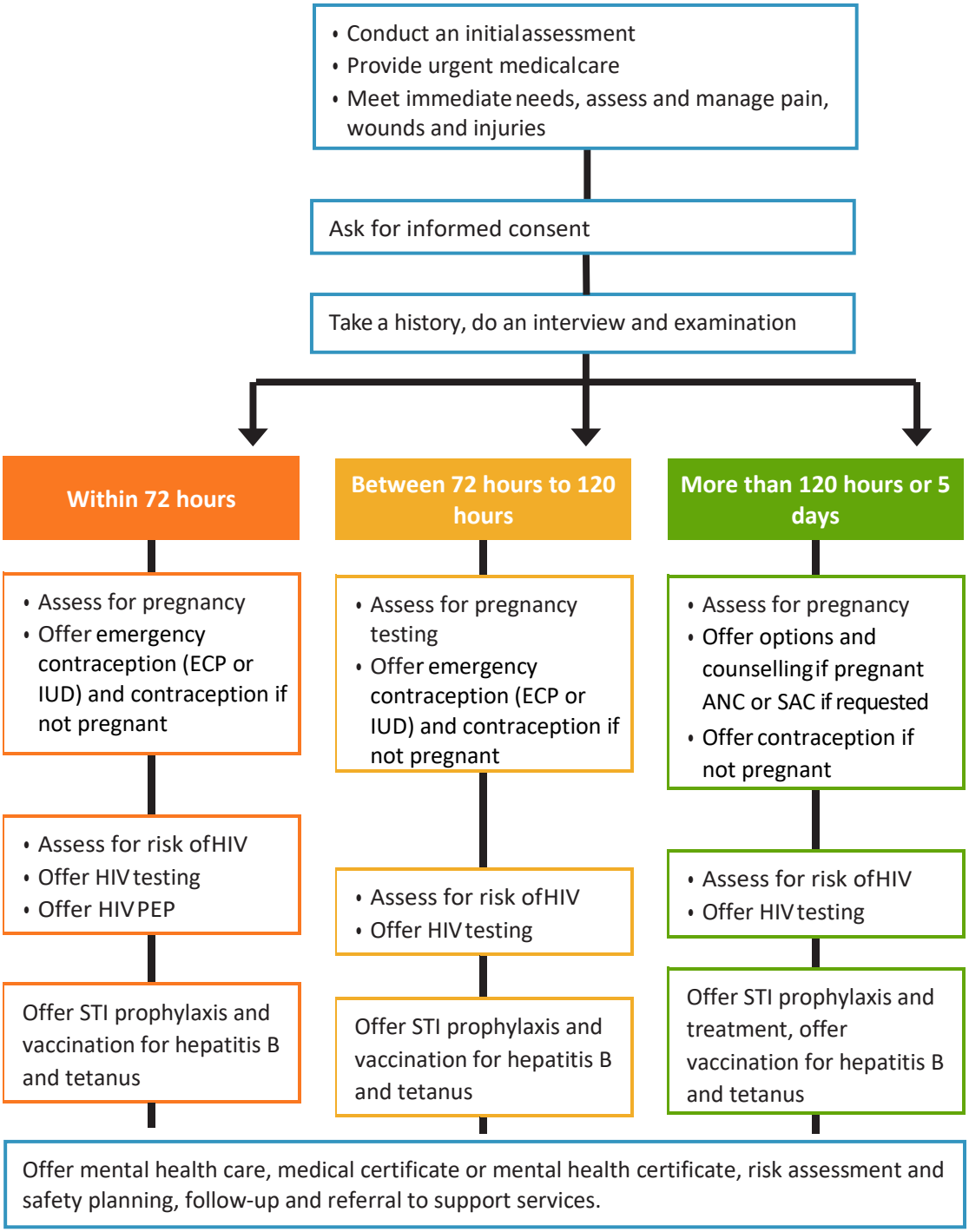
# Médecins Sans Frontières

# Job-aid for the Medical Protocol for Sexual Violence Care[1]

2020

[1] This Job-aid is based on the MSF international medical protocol for Sexual Violence Care, approved in July 2020 by the Medical Directors platform.

# 1 Care flowchart for survivors of sexual violence



# 2 Assessment and management of pain

Ask all patients about pain: cause, type, pattern, aggravating and relieving factors, locations(s) and intensity of pain(s).

## 2.1 Pain management

The correct use of analgesia should be based on the type, cause, and intensity of pain.

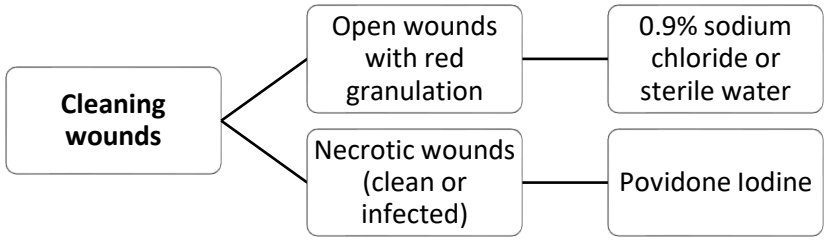
| Analgesics for children and adults | | | | |
|---|---|---|---|---|
| **Drug and route of administration** | **Dosage** | | **Side effects** | **Note** |
| | **Children > 1 month** | **Adults** | | |
| **Paracetamol PO** | 15 mg/kg every 6 to 8 hours (max. 60 mg/kg daily) | 500 mg to 1 g every 4 to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

# 3 Assessment and care of wounds and injuries

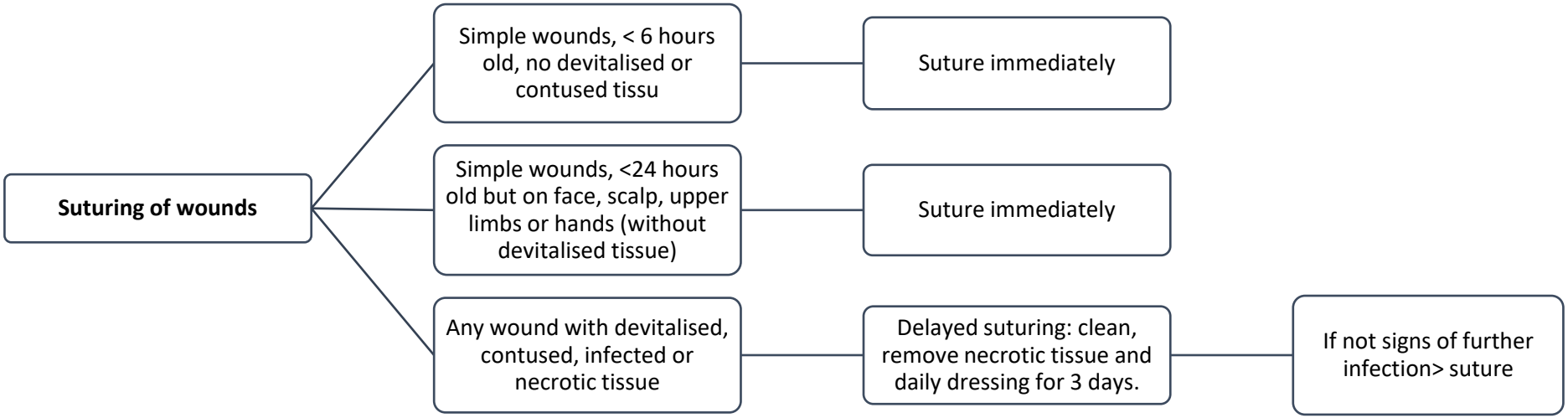
## 3.1 General wound care

Assess all wounds and injuries and maintain always aseptic technique

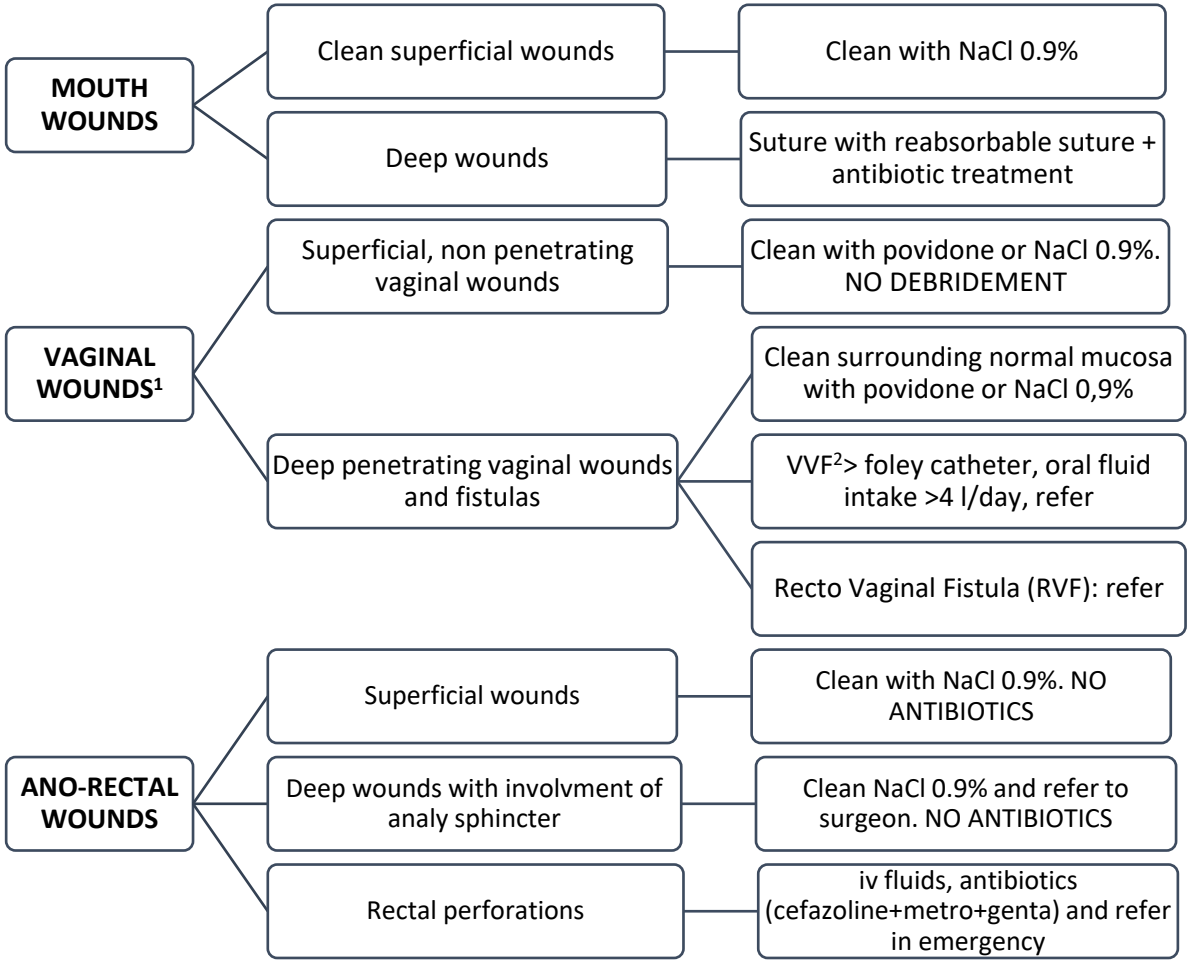
- **Cleaning**




- **Suturing**



## 3.2 Wounds in specific locations




[1] Vaginal speculum examinations are not indicated for most survivors of rape. Vaginal speculum examinations are indicated if there is vaginal bleeding, foul-smelling vaginal discharge, significant vaginal or uterine pain, penetrating injuries, suspicion of a foreign body. Examination under sedation can be offered to reduce impact of the exam to patients who would otherwise decline the vaginal exam or prepuberal patients.
[2] Vesico Vaginal Fistula (VVF)

# 4 HIV post-exposure prophylaxis (PEP)

## 4.1 Assessment of risk for HIV exposure

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

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

**Risk of transmission ➡ Offer HIV PEP - if presentation within 72 hours**

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

**When in doubt: offer HIV PEP.**

Certain factors increase the risk of HIV transmission:

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

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

**Additional laboratory baseline tests are not required to start HIV PEP.**

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

If a patient presents **after 72 hours of SV** ➡ Do **not** offer HIV PEP.
Carefully explain that HIV PEP will not be provided, it is not effective after 72 hours, could cause unnecessary side effects and r there are no benefits

## 4.2 HIV PEP in case of repeated rape

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

**Follow-up HIV testing**

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

## 4.3 HIV PEP

Offer the first dose of HIV PEP as soon as possible and provide full supplies for 28 days.

*Only regimes are summarized below, for special circumstances, contraindications, secondary effects, etc, please refer to the complete medical protocol.*

| **HIV PEP dosages for adults, children and adolescents > 30 kg[2]** | | | | | |
|---|---|---|---|---|---|
| Preferred regimen | | | Alternative regimens | | |
| Drug | Dose | Frequency | Drug | Dose | Frequency |
| Tenofovir (TDF)/ lamivudine (3TC)[3] | 300 mg/ 300 mg | 1 tablet once a day | Zidovudine (AZT)[4]/ lamivudine (3TC) | 300 mg/ 150 mg | 1 tablet twice a day |
| *And* | | | *and* | | |
| Dolutegravir (DTG) | 50 mg | 1 tablet once a day | Atazanavir (ATV)/ ritonavir (r) | 300 mg/ 100 mg | 1 tablet once a day |
| | | | *or* | | |
| | | | Lopinavir (LPV)/ ritonavir(r) | 200 mg/ 50 mg | 2 tablets twice a day |
| | | | *or* | | |
| | | | Darunavir (DRV)/ ritonavir (r) | DRV 400 mg + RTV 100 mg | (2 tablets of DRV + 1 tablet of RTV) once a day |
| | | | *or* | | |
| | | | Raltegravir (RAL) | 400 mg | 1 tablet twice a day |

[2] Children >30kg should be given **TLD**: **T**enofovir (TDF), **L**amivudine (3TC) and **D**olutegravir (DTG)

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

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

| HIV PEP dosages for children 20 to 30 kg | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| **Preferred regimen** | | | | | **Alternative regimens** | | | | |
| | **20-24.9 kg** | | **25-30 kg** | | | **20-24.9 kg** | | **25-30 kg** | |
| **Drug** | **Dose** | **Frequency** | **Dose** | **Frequency** | **Drug** | **Dose** | **Frequency** | **Dose** | **Frequency** |
| Zidovudine (AZT)/ lamivudine (3TC) | Dispersible tablet 60 mg/30 mg | 3 tablets twice a day | 300 mg/ 150 mg | 1 tablet twice a day | Abacavir (ABC)/ lamivudine (3TC)[5] | Dispersible tablet 120 mg/60 mg | 1.5 tablets twice a day | 600 mg/ 300 mg | 0.5 tablet twice a day |
| | | | | | | Dispersible tablet 60 mg/30 mg | 3 tablets twice a day | | |
| *And* | | | | | *and* | | | | |
| Dolutegravir (DTG) | 50 mg | 1 tablet once a day | 50 mg | 1 tablet once a day | Atazanavir (ATV)/ ritonavir (r) | ATV capsules 100 mg + r tablets 50 mg | 2 ATV tablets + 2 r tablets once a day | Tablet 300 mg/100 mg | 1 tablet once a day |
| | | | | | | ATV capsules 200 mg + r tablets 50 mg | 1 ATV tablet + 2 r tablets once a day | - | - |
| | | | | | *or* | | | | |
| | | | | | Lopinavir (LPV)/ ritonavir (r) | Tablet 100 mg/ 25 mg | 2 tablets twice a day | Tablet 100 mg/25 mg | 3 tablets twice a day |
| | | | | | | Tablet 200 mg/ 50 mg | 1 tablet twice a day | Tablet 200 mg/50 mg | 2 tablets in the morning, 1 tablet at night |
| | | | | | | Pellets or granules 40 mg/10 mg | 6 pellets or granules twice a day | - | - |
| | | | | | | Syrup 80/20 mg/ml | 3 mL twice a day | - | - |
| | | | | | *or* | | | | |
| | | | | | Darunavir (DRV)/ ritonavir (r) | 75 mg/25 mg | 5 DRV tablets and 2 r tablets twice a day | 400 mg/100 mg | (1 DRV tablet + 1 r tablet) twice a day |
| | | | | | *or* | | | | |
| | | | | | Raltegravir (RAL) | Chewable tablets 25 mg | 6 tablets twice a day | 400 mg tablets | 1 tablet twice a day |

## HIV PEP dosages for children < 20 kg

### Preferred regimen

| Drug | Dose | Number of tablets and frequency by weight | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 3-5.9 kg | | 6-9.9 kg | | 10-13.9 kg | | 14-19.9 kg | |
| | | ☀ | ☾ | ☀ | ☾ | ☀ | ☾ | ☀ | ☾ |
| Zidovudine (AZT)/ lamivudine (3TC)[Error! Bookmark not defined.] | Dispersible tablet 60 mg/30 mg | 1 | 1 | 1.5 | 1.5 | 2 | 2 | 2.5 | 2.5 |
| | | | | | | | | | |
| *And* | | | | | | | | | |
| Lopinavir (LPV)/ ritonavir (r)[8] | Pellets or granules 40 mg/10 mg | 2 | 2 | 3 | 3 | 4 | 4 | 5 | 5 |
| | Tablet 100 mg/25 mg | - | - | - | - | 2 | 1 | 2 | 2 |
| | Tablet 200 mg/50 mg | - | - | - | - | - | - | 1 | 1 |

### Alternative regimens

| Drug | Dose | Number of tablets and frequency by weight | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| | | 3-5.9 kg | | 6-9.9 kg | | 10-13.9 kg | | 14-19.9 kg | |
| | | ☀ | ☾ | ☀ | ☾ | ☀ | ☾ | ☀ | ☾ |
| Abacavir (ABC)/ lamivudine (3TC)[6] [7] | Dispersible tablet 120 mg/60 | 0.5 | 0.5 | 0.5 | 1 | 1 | 1 | 1 | 1.5 |
| | Dispersible tablet 60 mg/30 mg | 1 | 1 | 1.5 | 1.5 | 2 | 2 | 2.5 | 2.5 |
| *and* | | | | | | | | | |
| Atazanavir (ATV)/ ritonavir (r)[9] | ATV capsules 100 mg + r Tablet 25 mg[10] | - | - | - | - | 2 ATV + 4 r | - | 2 ATV + 4 r | - |
| | ATV capsules 200 mg+ r Tablet 50 mg[Error! Bookmark not defined.] | - | - | - | - | 1 ATV + 2 r | - | 1 ATV + 2 r | - |
| *or* | | | | | | | | | |
| Raltegravir (RAL) | 10 mg/ml (oral granules 100 mg/ sachet) | 3 ml | 3 ml | 5 ml | 5 ml | 8 ml | 8 ml | 10 ml | 10 ml |

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

[6] Lamivudine (3TC) and emtricitabine (FTC) are interchangeable

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

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

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

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

# 5 Preventing unwanted pregnancy

## Emergency contraception (EC)

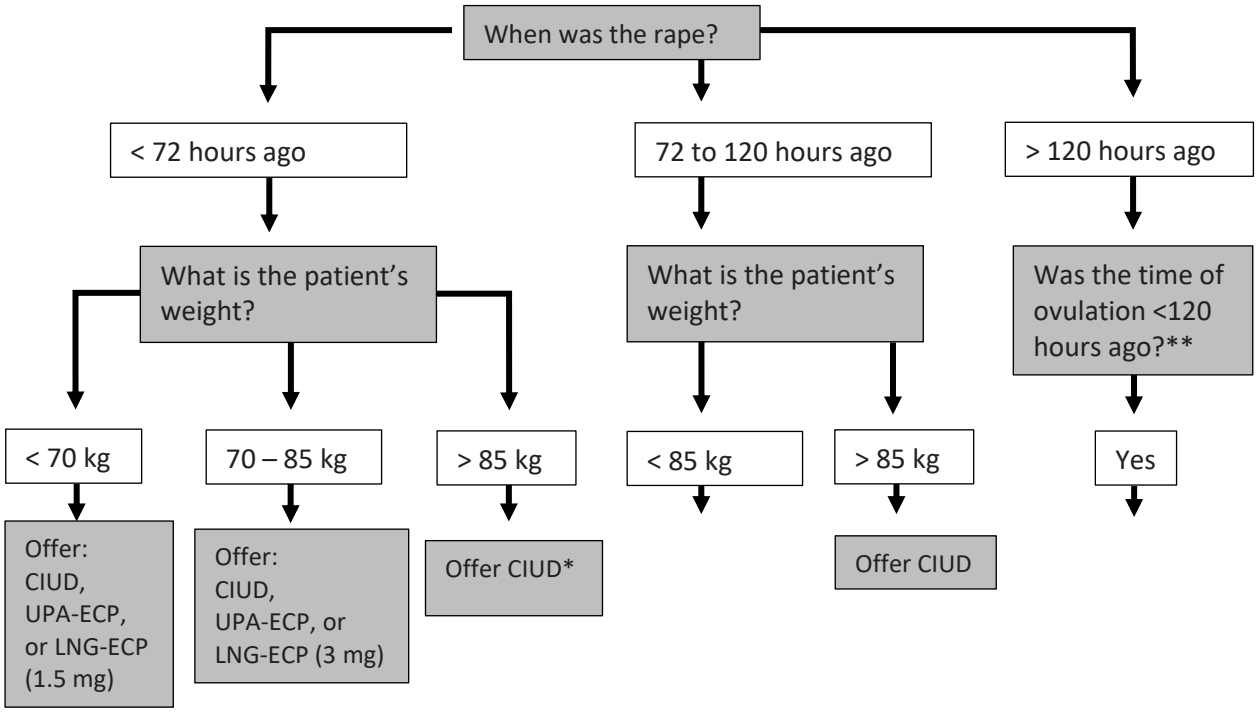
Prior to a decision about the EC method, it is useful to determine whether the patient was already pregnant. If it is not possible to determine a pregnancy:

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

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

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

### Emergency contraception decision making guide



Offer: CIUD, or UPA-ECP

Offer CIUD

*UPA-ECP is less effective for people who weigh mor , but it can be offered, it is advised to inform and discuss with the patient the risk of reduced effectiveness of UPA-ECP against the preference not
** The CIUD is highly effective in preventing pregnancy within 120 hours or 5 days after ovulation (if the timing of ovulation can be estimated) – whichever is later.

| Emergency contraception pill | | | | | |
|---|---|---|---|---|---|
| **Drug** | **Brand names** | **Strength** | **Dosage** | **Route of administration** | **Duration** |
| Ulipristal acetate | Ella, ellaOne | 30 mg | 30 mg | PO | Single dose |
| Levonorgestrel | Levonelle, Norlevo, Plan-B, Postinor-2, Vikela, Pregnon, Postpill | 0.75 mg or 1.5 mg | 1.5 mg | PO | Single dose |

| Oral contraception pills for emergency contraception | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Drugs** | **Brand names** | **Strength** | **# of tablets in 1st dose** | **# of tablets in 2nd dose** | **Total dosage** | **Route of administration** | **Duration** |
| Levonorgestrel only | Microlut, Microval, Norgeston | 30 mcg/0.03 mg | 50 | 0 | 1.5 mg | PO | Single dose |
| | Ovrette | 37.5 mcg | 40 | 0 | 1.5 mg | PO | Single dose |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Combined estrogen-progestogen | Eugynon 50, Fertilan, Neogynon, Noral, Neo- primovlar 4 Nodiol, Ovidon, Ovral, Ovran, Tetragynon/ PC-4, Preven, E-Gen-C, Neo-primovlar 4 | Ethinylestradiol 50 mcg and Levonorgestrel 250 mcg or Ethinylestradiol 50 mcg and Norgestrel 500 mcg | 2 | 2 | Ethinylestradiol 0.2 mg and Levonorgestrel 1 mg Or Ethinylestradiol 0.2 mg and Norgestrel 2 mg | PO | 2 doses, 12 hours apart |
| | Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon | Ethinylestradiol 30 mcg and Levonorgestrel 150 mcg or Ethinylestradiol 30 mcg and Norgestrel 300 mcg | 4 | 4 | Ethinylestradiol 0.24 mg and Levonorgestrel 1.2 mg or Ethinylestradiol 0.24 mcg and Norgestrel 2.4 mg | PO | 2 doses, 12 hours apart |

## 5.1 Contraception and Safe abortion care

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

Please refer to chapter 12 of MSF Essential Obstetric and newborn care guideline.

# 6 Prevention and treatment of sexually transmitted infections

## 6.1 Assess risk of STI transmission

**No risk of transmission ➡ Do not offer STI prophylactic treatment**

- SV with no genital contact

**Risk of transmission ➡ Offer STI prophylactic treatment up to 3 months after assault[11].**

- Vaginal, anal or oral penetration by penis with or without ejaculation
- Vaginal, anal or oral contact with perpetrators genitals
- Ejaculation onto genital area or mouth
- Unknown details due to intoxication, substance use, lack of consciousness, head injury, amnesia or other reasons but events are highly suggestive of STI risk
- Survivor is a child or person with a disability who cannot provide details, but history, change in behavior, signs and symptoms and/or examination is highly suggestive of STI risk

**STI testing is *not* required before giving STI prophylactic treatment.**

[11] If > 3 months see Annex 1, page 37 of the International medical protocol for Sexual Violence care.

## 6.2 Dosage

| Prophylactic treatment for STIs for adults and children > 45 kg | | | | |
|---|---|---|---|---|
| **STI** | **Drug** | **Dosage** | **Route of administration** | **Duration** |
| **Gonorrhoea** | Ceftriaxone[12] | 250 mg | IM | Single dose |
| | ***or*** | | | |
| | Cefixime | 400 mg | PO | Single dose |
| ***and*** | | | | |
| **Chlamydia, Syphilis and Chancroid** | Azithromycin[13] | 2 g | PO | Single dose |
| ***and*** | | | | |
| **Trichomoniasis** | Tinidazole[14] | 2 g | PO | Single dose |
| | ***or*** | | | |
| | Metronidazole | 2 g | PO | Single dose |

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

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

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

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

# 7 Hepatitis B vaccination

Hepatitis B vaccination is indicated if a patient is at risk of exposure to hepatitis B through:
- Bite or mucosal exposures to blood or semen
- Receptive or insertive oral, vaginal and anal sexual contact

Post-exposure hepatitis B vaccination should be initiated (1st dose) for all patients at risk of exposure ***regardless*** of hepatitis B vaccination history[15], and should not be delayed while waiting for hepatitis B serology results (if available). In the absence of serological results showing an effective protection against Hepatitis (anti-HBs ≥10 mIU/mL), the series of 3 doses should be completed ***unless*** the patient can provide documentation of ***two***[16] full series of hepatitis B vaccine.

## 7.1 Timing

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

## 7.2 Type and dosage of vaccine

Administer monovalent Hepatitis B vaccination formulation by IM injection.
- Adult presentation for adolescents and adults above 15 years: 10 to 20 µg
- Pediatric presentation for children from birth to 15 years: 5 to 10 µg

*Dosages vary according to the type of vaccine, always check the manufacturer's instructions.*

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

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

## 7.3 Vaccination schedule (accelerated for SV survivors)

*Should be initiated even if the completion of the series cannot be ensured*

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

# 8 Tetanus vaccination

## 8.1 Indication

All survivors of SV should be offered tetanus vaccination and HTIG

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

## 8.2 Type and dosage

**Tetanus toxoid containing vaccines available as IM**:

- Tetanus toxoid diphtheria vaccine (Td)[17]
- Monovalent tetanus toxoid vaccine (TT)[18]

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

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

**Human tetanus immunoglobulin (HTIG)**

- 250 international units (IU)[19]
- If more than 24 hours have elapsed since the SV, increase the dose to 500 IU.

Children and adults receive the same dosage.

## 8.3 Vaccination schedule

*Vaccination should be initiated even if the completion of the series cannot be ensured.*

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

[18] TT is being replaced by Td in most countries and is being withdrawn from the market.

[19] The quantity of human tetanus immunoglobulin is expressed in international units – IU

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

# 9 Psychosocial support

Mental health care and psychosocial support should be offered to all survivors of SV. If there is no mental health professional available or the survivor declines support from the mental health care professional, then the health care worker should provide psychological first aid - listening, asking about needs, validating and re-assuring, strengthening coping skills and exploring social support.

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

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

# 10 Follow-up

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

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

skills and livelihood support services.

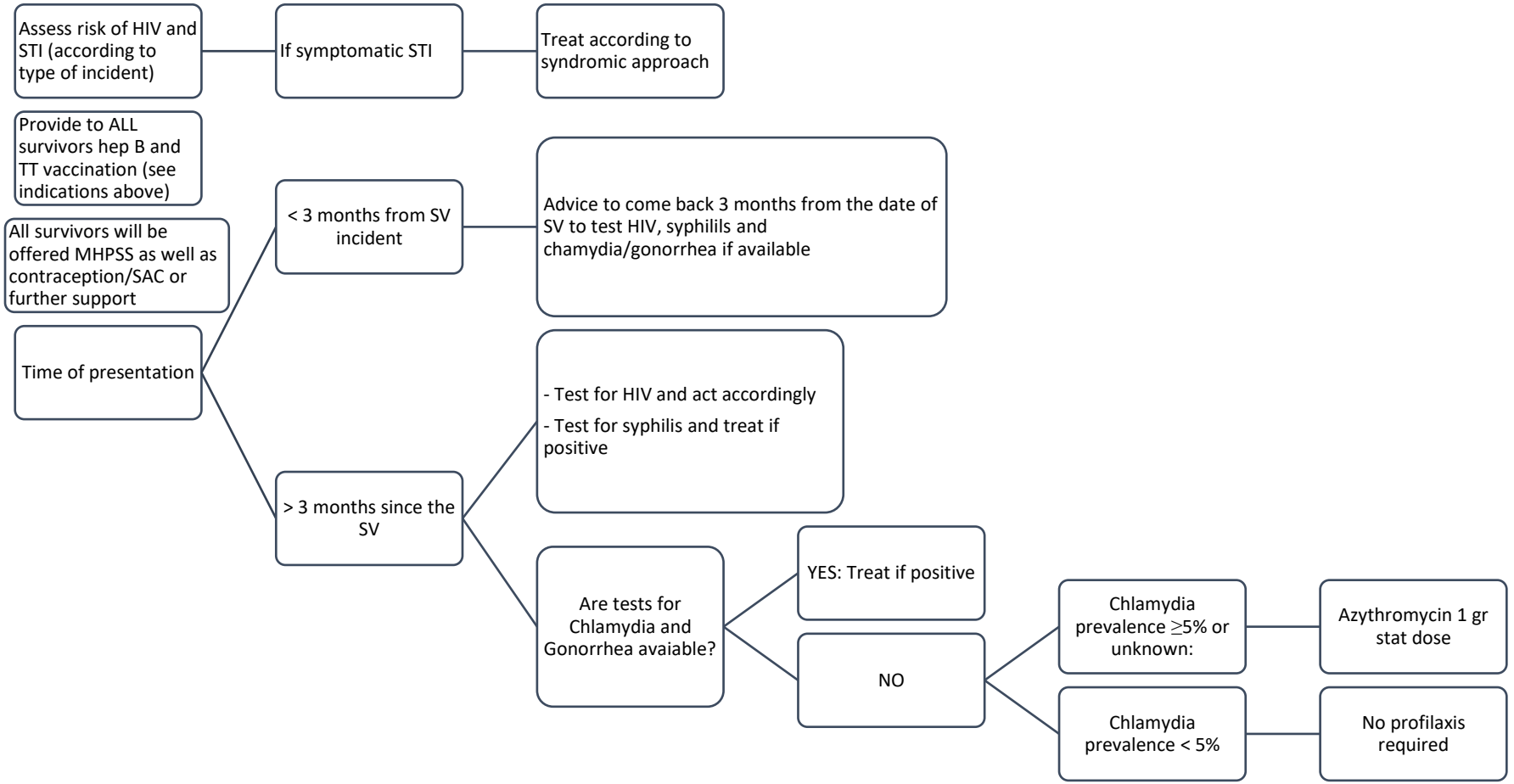
- Encourage the survivor to return for the next follow-up appointment.

## 10.1 Suggested follow-up schedules

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

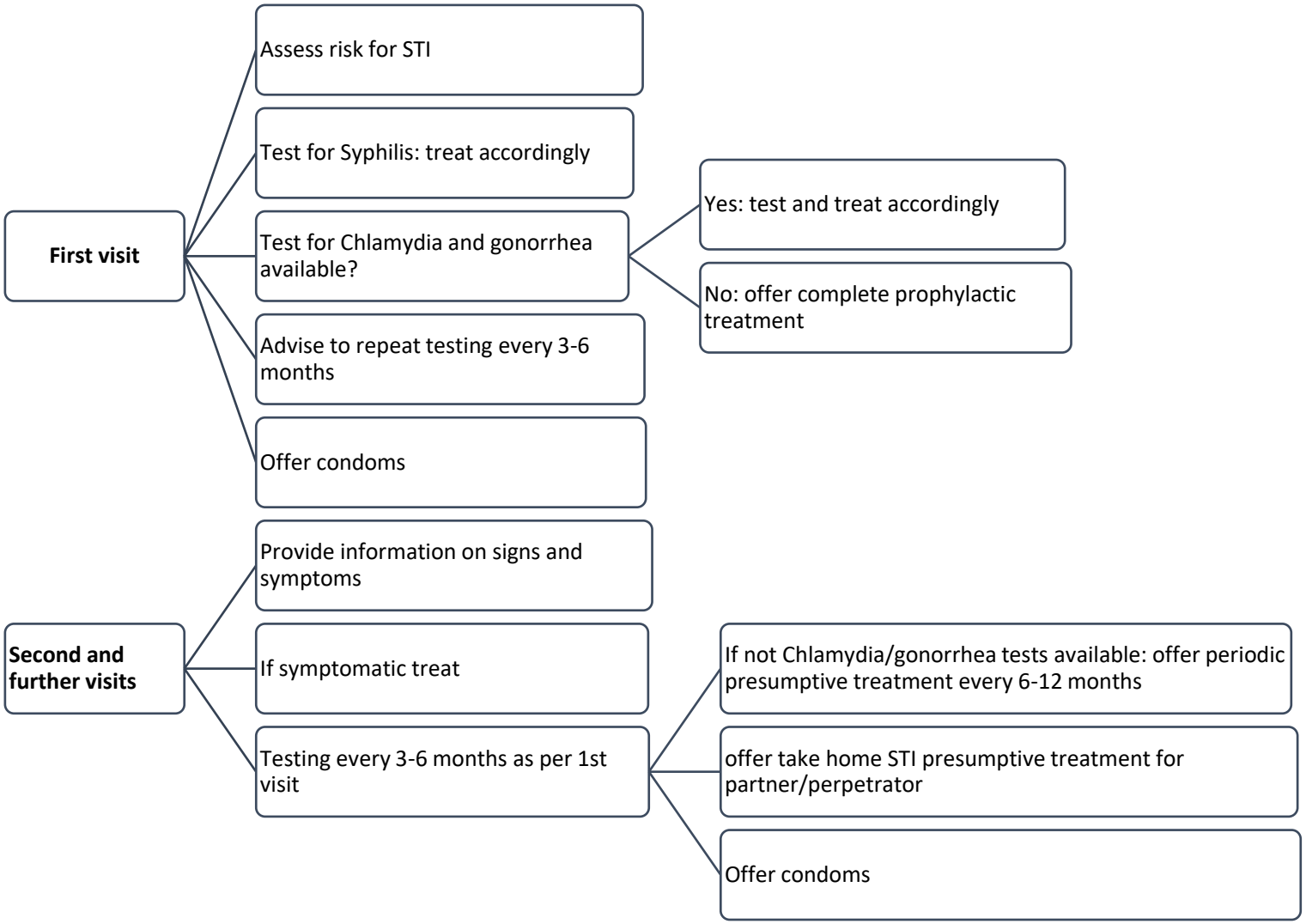
# Annex 1: Delayed presentation to care

Survivors may seek care weeks, months or years after SV and medical care has to be adapted to this time lapse.



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

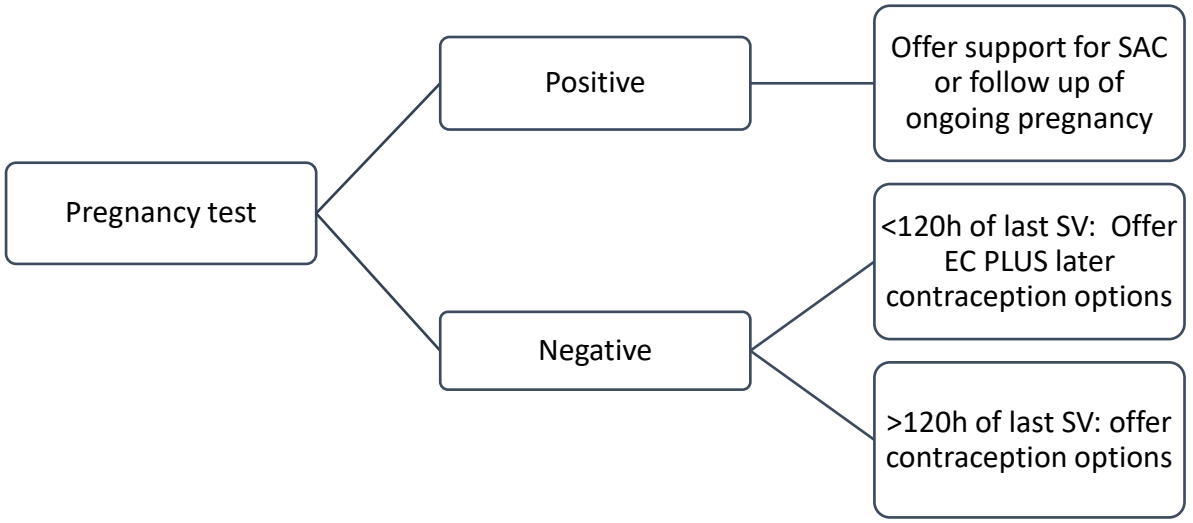
## 10.2 STI prevention and treatment



## 10.3 HIV PEP or PrEP

- Assess the risk of HIV and offer HIV testing.
- Discuss the future risk of transmission HIV with the survivor based on HIV prevalence in the region and characteristics of the perpetrator (e.g. known drug user).
- Repeat HIV testing every 3 months if there is an ongoing risk.
- **Discuss HIV PEP** - HIV PEP only prevents acquiring HIV within the last 72 hours (or 3 days) and not from multiple exposures in the past or future. HIV PEP is not intended for multiple, repeated, ongoing exposure to HIV and prolonged use.
- **Discuss HIV PrEP (if available)** - if there is ongoing substantial risk of acquiring HIV, and/or the ongoing perpetrator has a high risk of HIV.

## 10.4 Preventing unwanted pregnancy




## 10.5 Other:

- Discuss risks and explore strategies to improve safety, protection or referral to support services
- Offer hepatitis B vaccination. See hepatitis B vaccination page 30 in MSF SV medical protocol.
- Offer tetanus vaccination if indicated. See Tetanus vaccination page 32 in MSF SV medical protocol.
- Assess and treat for pain and wounds
- Offer mental health and psychosocial support.