

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

DISPENSING PROPHYLACTIC MEDICATIONS POST-SEXUAL ASSAULT

Decision support tools (DSTs) are evidence-based documents used to guide the assessment, diagnosis and treatment of client-specific clinical problems and conditions. When DSTs are used to guide practice, they are implemented in conjunction with clinical judgement, available evidence, and consultation with the health care team as required. Decision making occurs in a person-centred manner, where nurses support client autonomy and decision making.

CRNBC SCOPE OF PRACTICE

RN dispensing of chemoprophylaxis for STI prevention post-sexual assault is a restricted activity (*Section 6: Nurses [Registered] and Nurse Practitioner Regulation*) with limits and conditions as set out in the *CRNBC Scope of Practice for Registered Nurses: Standards, Limits, Conditions*.

***BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault***

APPLICATION PARAMETERS

This DST is intended for use by RNs with CRNBC Reproductive Health – Sexually Transmitted Infection (STI) Certified Practice designation. It is not intended for RNs working in hospital emergency departments as sexual assault nurse examiners. RNs that do not possess Certified Practice designation in Reproductive Health – STI must obtain a “client-specific order” to enable dispensing of prophylactic medication.

Referral to, or consult with, a physician or nurse practitioner (NP) is required if sexual assault follow-up is indicated for the following clients (e.g., where transfer of care and/or client-specific orders may be required):

- are less than 14 years of age
- are pregnant
- are breast-/chest-feeding (only if prophylaxis is to be given)
- present with physical trauma post-sexual assault (e.g., recent history of strangulation, head injury, vaginal bleeding unlikely to be associated with a menstrual period)
- present with unexplained lower abdominal pain
- have had recent upper genital instrumentation (within previous 2 weeks)

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

CONFIDENTIALITY AND REPORTING SEXUAL ASSAULT

As with all health care, sexual assault STI testing and prophylaxis is handled in a confidential manner. RNs safeguard personal and health information learned in the context of the nurse-client relationship and discloses this information only with client consent or when there is a specific ethical or legal obligation to do so. Nurses have an ethical obligation to disclose in situations that involve a substantial risk of significant harm to the health or safety of the client or others (CRNBC, 2010, p.2).

Clients have a right to confidentiality. Reporting in cases of sexual assault is often a complex process. RNs have a duty to report to the Ministry of Children and Family Development (MCFD) in the cases of children if “the child has been, or likely to be, physically harmed, sexually abused, or sexually exploited by a parent or other person” (CRNBC, 2017, p.9). When working with sexual assault cases requiring a duty to report, RNs are to abide by their organizational or agency policies and consult with their supervisor as it pertains to the legal responsibility in the matter.

Additional documents to support RN practice related to confidentiality and duty to report include:

- CRNBC (2010). *Privacy and Confidentiality Practice Standard*. Pub. No. 400.
- CRNBC (2017). *Legislation Relevant to Nurses’ Practice*. Pub. No. 328.
- CRNBC (2011). *Consent Practice Standard*. Pub. 359.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

Clients Presenting Within 7 Days of Sexual Assault

Depending on community availability, clients who present for treatment within 7 days of a known or potential sexual assault are to be offered the option of attending the nearest facility where specialized sexual assault health care and forensic sample collection is available.

In addition to assessing the risk of having acquired a STI, blood-borne infection(s) (BBI), and pregnancy, sexual assault service programs are able to provide prophylaxis for STI/BBI, crisis counselling, information on relevant community supports, medical-legal options, collect forensic samples, document injuries, and prepare a medical-legal report.

It is important that RNs providing post-sexual assault care are familiar with sexual assault health care services and resources available in their communities. In some communities, community-based victim assistance workers may be able to accompany the client to the hospital or sexual assault care provider.

If the client chooses to attend specialized sexual assault services, the referring RN will offer to call the emergency department or other agency to alert them that the client will be attending. The referring RN may also provide a report to facilitate continuity of care (e.g., if medical care was already provided such as, if ECP was dispensed), and will facilitate transportation arrangements as possible.

Clients Declining Referral to Sexual Assault Care or Presenting between 7-21 Days Post-Sexual Assault

Clients who:

- present within 7 days post-sexual assault and decline the option of referral to specialized sexual assault health care services; or
- present more than 7 days and less than 21 days post-sexual assault.

Clients are offered assessment, testing, and treatment as outlined in this DST. It is important that clients choosing not to attend sexual assault services are aware that any specimens collected as part of their care are for STI diagnosis only rather than forensic specimen collection.

Assess and treat clients who present greater than 21 days post-sexual assault, or with symptoms of an STI, using the appropriate CRNBC STI certified practice or non-certified practice DSTs.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

ASSESSMENT

Providing assessment for clients who have experienced sexual assault requires a thoughtful, comprehensive trauma-informed approach.

Nurses support client autonomy and decision making when obtaining informed-consent to offer, recommend, or provide assessment and care. Always follow a client's self-directed plan for care.

Sexual Assault History

Determine the type of sexual or physical contact that occurred during the sexual assault to assist with assessment, STI specimen collection, and prophylaxis (see *Diagnostic Tests* and/or *Prophylactic Treatment of Choice* tables). Given the sensitivity of obtaining a sexual health/assault history, the nurse may want to begin with generic questions such as, "Can you tell me what happened?", "What do you know about the assailant(s)?", to obtain some of the below information.

It is important to be aware that depending on the situation, clients may not know the answers to the assessment questions below. This is especially true for situations of possible drug-facilitated sexual assault or when the client may have experienced a loss of consciousness.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

Related Sexual Health/Assault History

- type/nature of sexual assault (i.e., potential exposure(s) such as, penetration – penis, oral, vagina, anal, digital)
- date and time of sexual assault
- number of assailants
- current pregnancy or risk of pregnancy
 - vaginal intercourse since last menstrual period
 - current contraception use and/or issues with use (e.g., missed pills)
 - date of last menstrual period
- immunization history/vaccination status (hepatitis B, human papillomavirus (HPV), hepatitis A)
- most recent STI and HIV screening and results

Physical Assessment

Follow the appropriate CRNBC STI certified practice or non-certified practice DST to assess, diagnose and treat clients presenting with symptoms.

Clients who do not present with symptoms should be offered assessment, screening and prophylactic treatment as outlined in this DST.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

SCREENING TESTS

Always follow a client's self-directed plan for care; offer and recommend full STI screening as per the table below. It is important both clients and practitioners understand that testing post-sexual assault is a choice, and not an absolute necessity.

Baseline STI Screening – Asymptomatic Clients	Notes
<u>Serology:</u> - HIV Ag/Ab - anti-HCV - HBsAg - anti-HBc Total - anti-HBs - syphilis EIA <u>Specimens for collection – as per sites exposed and if indicated in sexual health/assault history:</u> - Urine NAAT CT/GC/trichomoniasis OR - Vaginal specimen NAAT CT/GC/trichomoniasis - CT/GC NAAT (throat and/or rectum) <u>If applicable:</u> - Urine pregnancy test	- Inform clients that further follow-up testing (specimen collection and serology) may be indicated given window periods of tests. - In instances where the assailant is known to be HIV positive, or is identified as "high risk" for HIV infection, contact the medical microbiologist at BCCDC (604-661-7033) to discuss if HIV RNA testing is an option. - Offer client-collected urine, vaginal, rectal and/or throat) specimens, as appropriate. - Cervical specimens for GC/CT/trichomoniasis are not indicated in asymptomatic clients. Refer to the BCCDC non-certified practice Pelvic Examination DST for further information. - For symptomatic clients, follow the appropriate CRNBC STI certified practice or non-certified practice DST(s) to assess, diagnose and treat. - Trichomoniasis testing is not available for men unless specifically called in to the BCCDC Public Health Laboratory by an ordering physician or NP. - If HIV post-exposure prophylaxis (PEP) is given, HIV serology is done at 3 weeks, 6 weeks, and 3 months post-PEP completion. - Timelines for testing will be altered if hepatitis B immune globulin (HBIG) or hepatitis B vaccine given, or if any results are deemed positive; see appropriate guideline or DST for follow-up parameters. - Follow-up testing for CT/GC is not required for non-pregnant clients who have taken appropriate prophylaxis (unless there is a new risk of exposure or symptoms develop).
Follow-up Bloodwork (if baseline tests are negative)	
<u>Post-exposure:</u> 3 weeks: HIV Ag/Ab, HCV RNA (if source HCV positive or high risk group) 6 weeks: HIV Ag/Ab 3 months: HIV Ag/Ab, anti-HCV, HbsAg, anti-HBc Total, anti-HBs, syphilis EIA	

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

MANAGEMENT AND INTERVENTIONS

Goals of Prophylactic Treatment

- reduce potential for infection
- prevent complications from undiagnosed and untreated infection
- treat an existing infection

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

PROPHYLACTIC TREATMENT OF CHOICE

Treatment	Notes
First Choice	General: 1. Treatment covers both gonorrhea and chlamydia. 2. <i>Canadian Guidelines for STI</i> (CGSTI, PHAC, 2013) recommend ceftriaxone IM and azithromycin PO for the treatment of uncomplicated anogenital and pharyngeal infection; however BC surveillance patterns of GC resistance suggest that both cefixime and ceftriaxone are appropriate choices for the treatment of GC. 3. Future GC treatment regimens will continue to reflect national recommendations in association with local GC antimicrobial resistance trends (AMR) trends. 4. Retreatment is indicated if the client has missed 2 consecutive doses of doxycycline or has not completed a full 5 days of treatment. 5. Consult a physician or NP if client is unable to use cefixime, ceftriaxone, or azithromycin. 6. See BCCDC STI Medication Handouts for further medication reconciliation and client information. 7. See <i>Monitoring and Follow-up</i> section for test-of-cure (TOC) requirements.
cefixime 800 mg PO in a single dose and azithromycin 1 gm PO in a single dose OR ceftriaxone 250 mg IM in a single dose and azithromycin 1 gm PO in a single dose	
Second Choice	Allergy and Administration: 8. DO NOT USE ceftriaxone or cefixime if history of allergy to cephalosporins. Consult with or refer to a physician or NP if history of anaphylaxis or immediate reaction to penicillins. 9. DO NOT USE azithromycin if history of allergy to macrolides. 10. DO NOT USE doxycycline if pregnant and/or allergic to doxycycline or other tetracyclines. 11. If an azithromycin or doxycycline allergy or contraindication exists, consult with or refer to a physician or NP for alternate treatment. 12. Azithromycin and doxycycline are sometimes associated with gastrointestinal adverse effects. Taking medication with food and plenty of water may minimize adverse effects.
cefixime 800 mg PO in a single dose and doxycycline 100 mg PO bid for 7 days OR ceftriaxone 250 mg IM in a single dose and doxycycline 100 mg PO bid for 7 days	

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

Third Choice	
azithromycin 2 gm PO in a single dose	13. The preferred diluent for ceftriaxone IM is 0.9 mls lidocaine 1% (without epinephrine) to minimize discomfort. 14. DO NOT USE lidocaine if history of allergy to lidocaine or other local anesthetics. Use cefixime PO as alternate treatment. 15. For IM injections of ceftriaxone the ventrogluteal site is preferred. (See http://www.bccdc.ca/health-professionals/clinical-resources/immunization/vaccine-administration). 16. Advise client to remain in the clinic for at least 15 minutes post-IM injection in case of anaphylactic reaction to treatment. Provide anaphylaxis treatment as required, using BCCDC <i>Immunization Manual- Section V- Management of Anaphylaxis in a Non-Hospital Setting</i> BCCDC, April 2013, available at: http://www.bccdc.ca/resource-gallery/Documents/Guidelines%20and%20Forms/Guidelines%20and%20Manuals/Epid/CD%20Manual/Chapter%202%20-%20Imms/SectionV_Anaphylaxis.pdf. 17. If serious allergic reaction develops including difficulty breathing and/or severe itchiness, have the client inform clinic staff immediately. If symptoms develop after leaving the clinic, advise the client to seek immediate emergency care. 18. Advise client they may experience pain, redness and swelling at the injection site. If any of these effects persist or worsen advise, to contact health care provider. 19. Recent data has emerged regarding azithromycin and QT prolongation. Although rare, it is more significant in older populations, those with pre-existing heart conditions, arrhythmias or electrolyte disturbances. It is unclear how significant these findings are in young to mid-age healthy adults consuming a one-time dose of azithromycin; however, please use the following precautions: Consult with or refer to an NP or physician if the client: • has a history of congenital or documented QT prolongation. • has a history of electrolyte disturbance in particular hypokalemia, hypomagnesaemia. • has clinically relevant bradycardia, cardiac arrhythmia or cardiac insufficiency. • is on any of the following medications: ○ Antipsychotics: pimozide (Orap®), ziprasidone (Zeldox®) ○ Cardiac: dronedarone (Multaq®) ○ Migraine: dihydroergotamine (Migranal®), ergotamine (Cafergot®)

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

Hepatitis B Immunoprophylaxis

If the sexual assault occurred within the previous 14 days, HBV prophylaxis (including hepatitis B vaccine and hepatitis B immune globulin - HBIG) may be indicated. When indicated, it is important to administer HBIG* as soon as possible after the sexual assault; preferably within 48 hours - though it may be given up to 14 days following percutaneous exposure. Refer to table 6.1 for HBV post-exposure prophylaxis (including serology) found in the BCCDC *Communicable Disease Control Manual - Chapter 1: [Hepatitis B](#)*.

Referral to a physician or NP is required in the management of immunocompromised individuals.

*HBIG can be obtained from Transfusion Medicine (Blood Bank) at the nearest local hospital.

HIV Post-exposure Prophylaxis (PEP)

If the sexual assault occurred within 72 hours and the client is at significant risk for exposure to HIV transmission, they may be offered post-exposure prophylaxis (PEP). When indicated, it is important to start HIV PEP as soon as possible after a sexual assault; preferably within 2 hours and not greater than 72 hours after. Refer to the BC Centre for Excellence in HIV/AIDS (BC-CfE) [Post-exposure Prophylaxis \(PEP\)](#) guidelines for dispensing parameters, eligibility and subsequent serology. PEP is available at hospital emergency departments, outpost nursing stations or in prisons. For further information on how to obtain medication for prevention of HIV infection following a high risk exposure, call the St Paul's Hospital Ambulatory Pharmacy 1-888-511-6222. PEP consultation is also available at several sites in the lower mainland. Refer to the BC-CfE's *HIV Post-exposure Prophylaxis* webpage for [Consultation Sites](#).

Ongoing management with a physician or NP will be necessary in the ongoing monitoring of individuals who have received PEP.

Hepatitis C (HCV)

Prophylaxis for potential exposure to HCV is not available. HCV serology to determine HCV status is available. See the BCCDC *Communicable Disease Control Manual - Chapter 1: [Blood and Body Fluid Exposure Management Guidelines](#)* for potential HCV exposure recommendations.

Syphilis

Consider/offer prophylaxis/treatment if:

- the client has signs or symptoms of syphilis
- there is potentially a high risk source in an area experiencing high rates of infectious syphilis*

Refer to the BCCDC *Communicable Disease Control Manual - Chapter 5 (Section 1) Non-certified Practice Decision Support Tools for STI – [Syphilis](#)* for diagnostic and treatment information.

*For the past several years, the majority (over 90%) of infectious syphilis cases have been in gay and bisexual men who have sex with men (gbMSM).

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

Emergency Contraception

Use of emergency contraception (EC) may be considered if the sexual assault occurred within the last 5-7 days.

Oral hormonal EC should be considered for clients presenting within 5 days. Insertion of a copper IUD can be considered for up to 7 days post-sexual assault.

Refer to the CRNBC *Contraceptive Management: [Progestin-Only Hormonal Contraceptives \(POHCs\) DST](#)* and your organizational or agency policies and/or procedures for provision around guidance of POHCs.

Consult with and/or refer to a physician or NP in incidences where insertion of a copper IUD may be warranted.

PREGNANT OR BREAST-/CHEST-FEEDING CLIENTS

For all pregnant or breast-/chest-feeding clients, consult with or refer to a physician or NP.

PARTNER COUNSELLING AND REFERRAL

RNs discussing sexual activity post-sexual assault need to be sensitive to the initial and ongoing impacts that the assault may have on clients and their sexual partner(s).

It is important to include discussions of window periods and ways of reducing potential infection transmission to sexual partner(s).

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

MONITORING AND FOLLOW-UP

Advise clients who:

- receive prophylactic treatment to return for repeat testing, as indicated.
- have symptoms occur or recur to return to the clinic for re-assessment.
- perform a TOC for GC if treatment was other than the recommended first choice.
- decline prophylactic treatment to return to the clinic in 7 to 14 days for repeat testing (GC and CT).
- have received immunoglobulin (HBIG) and/or have been immunized (hepatitis B, HPV, hepatitis A) to return for follow-up according to the respective immunization schedule.
- require follow-up serology to return, as indicated (HIV, HCV, HBV, HAV, syphilis).

CLIENT EDUCATION

Counsel client:

- to return for follow-up assessment if symptoms occur or recur.
- on importance of abstaining from sexual contact for 7 days following single-dose treatment and during the full course of multi-day treatments.
- regarding the appropriate use of medications (dosage, side effects, and need for re-treatment if dosage not completed).
- regarding the asymptomatic nature of STI.
- regarding follow-up care, community supports and referral services available for individuals who have been sexually assaulted; support and arrange for referrals as needed (See *Appendix C*).
- as to eligibility for hepatitis B, HPV, and hepatitis A immunizations.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

CONSULTATION AND/OR REFERRAL

Consult with or refer to a physician or NP in the following situations; clients who:

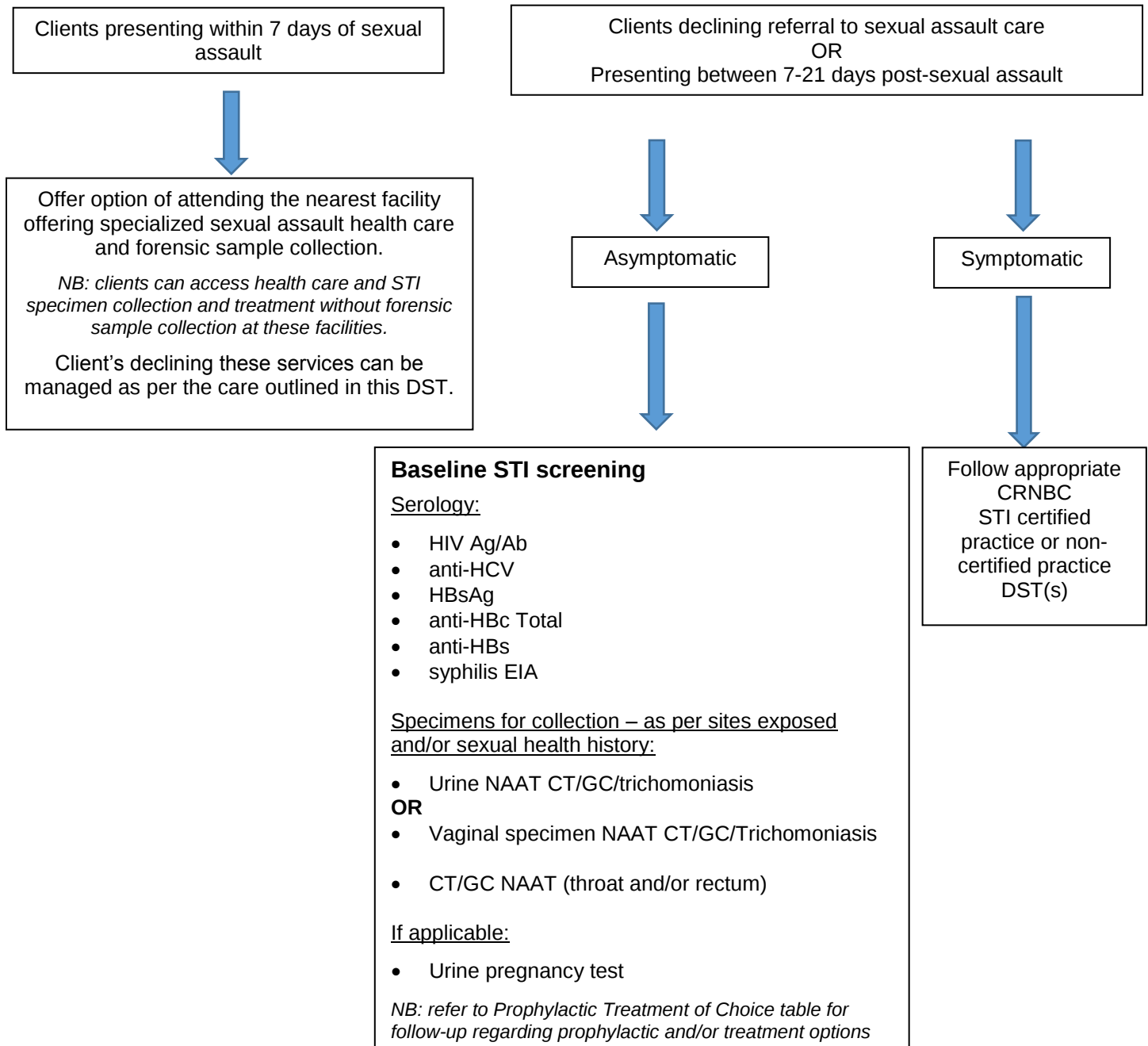
- are less than 14 years of age
- are pregnant
- are breast-/chest-feeding (only if prophylaxis is to be given)
- present with physical trauma post-sexual assault (e.g., recent history of strangulation, head injury, vaginal bleeding unlikely to be associated with a menstrual period)
- present with unexplained lower abdominal pain
- have had recent upper genital instrumentation (within previous 2 weeks)

DOCUMENTATION

- as per agency policy

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

APPENDIX A: SEXUAL ASSAULT FOLLOW-UP



BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

APPENDIX B: DEFINITIONS

HIV Post-exposure prophylaxis (PEP):

Short-term antiretroviral treatment used to reduce the likelihood of HIV infection after potential exposure, either occupationally or through sexual intercourse.

The BC-CfE provides 5-day starter kits of antiretroviral PEP in all emergency rooms in BC, and outpost nursing stations and provincial prisons. It is recommended that the 5-day starter kit be initiated within two hours of the potential exposure event, if at all possible. The remaining 23 days of treatment will be dispensed by the BC-CfE pharmacy in consultation with a BC-CfE physician. Inquiries about the PEP program should be directed to the BC-CfE Pharmacy: 1-888- 511-6222.

PEP is usually taken for 28 days following exposure, and is most effective if given within 72 hours of exposure.

For more information refer to the [BC Centre for Excellence Post-exposure Prophylaxis \(PEP\) Guidelines](#).

Trauma-informed care:

Trauma-informed services take into account an understanding of trauma in all aspects of service delivery and place priority on the individual's safety, choice, and control. Such services create a culture of nonviolence, learning, and collaboration

Person-centred care:

Providing care that is respectful of and responsive to individual client preferences, needs, and values, and ensuring that the client guides clinical decisions.

It is essential for practitioners to listen to clients describe their reality in their own words and in their own ways.

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

APPENDIX C: CLIENT RESOURCES

- **bc211** – Provides information and referral regarding community, government and social services in BC; including those linked to victim services.

<http://www.bc211.ca/>

- **British Columbia Society for Male Survivors of Sexual Abuse** – Supports for boys and men who have been either sexually abused, sexually assaulted or experience partner violence.

<https://bc-malesurvivors.com/>

- **Ending Violence Association of BC** – Works with over 300 community-based services and initiatives supporting survivors of sexual assault, relationship violence, child abuse and criminal harassment.

<http://endingviolence.org/>

- **HIM – Health Initiative for Men** – Involves and engages gay men to improve foundations of their physical, sexual, social and mental health.

<http://checkhimout.ca/>

- **Options for Sexual Health** – Sexual and reproductive health care, information, and education.

<https://www.optionsforsexualhealth.org/>

- **Qmunity BC's Queer, Trans, and Two-Spirit Resource Centre** - responds to BC's queer, trans, and Two-spirit communities' needs.

<https://qmunity.ca/>

- **Smart Sex Resource** - Website from the BC Centre for Disease Control (BCCDC) that provides local, relevant sexual health information and resources for BC.

<https://smartsexresource.com/>

- **TransCare BC** - Aims to enhance the coordination of trans health services and supports across the province, by bringing gender-affirming care.

<http://www.phsa.ca/our-services/programs-services/trans-care-bc>

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

- **VictimLinkBC** - provides information and referral services to all victims of crime and immediate crisis support to victims of family and sexual violence.

<https://www2.gov.bc.ca/gov/content/justice/criminal-justice/victims-of-crime/victimlinkbc>

- **Women Against Violence Against Women (WAVAW)** – Rape crisis centre.

<http://www.wavaw.ca/>

BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

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BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault

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***BCCDC Non-Certified Practice Decision Support Tool
Dispensing Prophylactic Medications Post-sexual Assault***

DST DEVELOPMENT

The 2018 edition of competencies and decision support tool for dispensing prophylactic medications post sexual assault were developed by the Provincial Sexual Assault DST Working Group.

While every effort has been made to ensure the accuracy of the information, data or material contained in these tools, the developers assume no legal liability or responsibility for the completeness, accuracy or usefulness of any of the information.

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