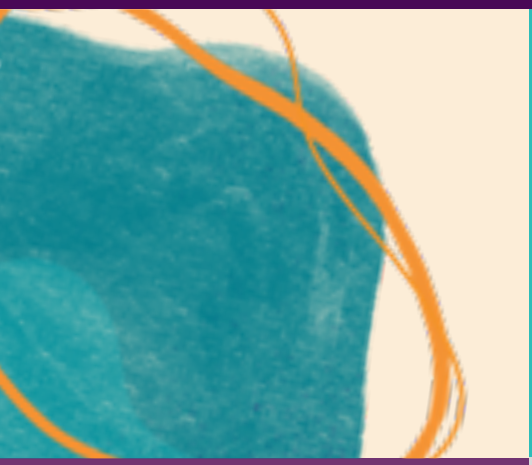
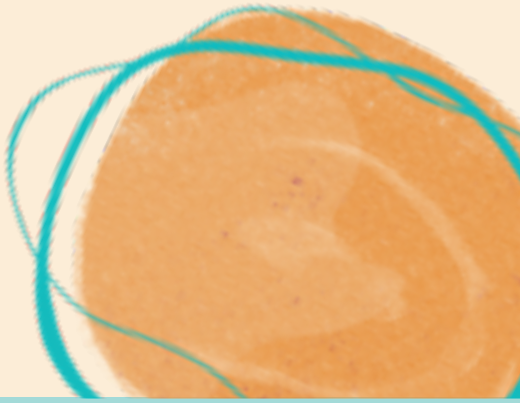
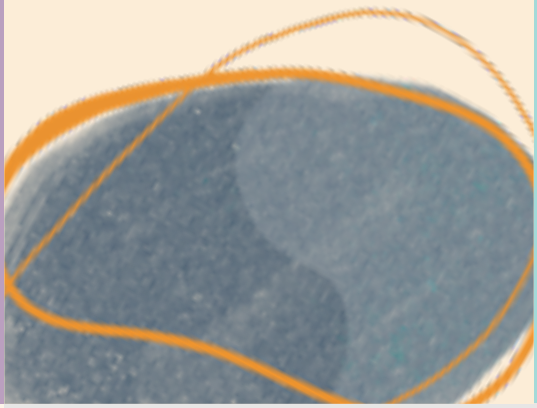
CLINICAL MANAGEMENT OF RAPE AND INTIMATE PARTNER VIOLENCE

TRAINING MANUAL







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CLINICAL MANAGEMENT OF RAPE AND INTIMATE PARTNER VIOLENCE

Training manual

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Acknowledgements

This training curriculum was prepared by Colleen Dockerty and Saria Novoa, with support from John Drollinger, Silje Heitmann, Purity Ikunda, Edna Mokaya, and Ilaria Porta. Layout design by Hugo Balandra

The training curriculum was primarily adapted from the World Health Organization (2019) Caring for women subjected to violence: a WHO curriculum for training health-care providers. Geneva: World Health Organization. Licence: CC BY-NC-SA 3.0 IGO. and training videos created by the International Rescue Committee and Norwegian Church Aid in 2020. The training was also adapted from various other resources:

- GBV IMS Steering Committee (2017) Interagency Gender-based Violence Case Management Guidelines Providing care and case management services to Gender-based violence survivors in humanitarian settings.
- Interagency Standing Committee (2010) Caring for Survivors of Sexual Violence in Emergencies Training Pack.
- International Rescue Committee and UNICEF (2012). Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings.
- IRC (2014) Clinical care for sexual assault survivors: Facilitator's guide.
- IRC (2014) Clinical Care for Sexual Assault Survivors: Psychosocial care toolkit.
- Medecins sans Frontieres Operational Centre Amsterdam (2019) Sexual violence and intimate partner violence Field training curriculum
- Norwegian Church Aid (2020) Integrating Therapeutic Interventions into Gender-based Violence Case Management
- UNHCR (2016) SGBV Prevention and Response Training Package.
- WHO, UNHCR (2004) Clinical Management of Rape Survivors Developing protocols for use with refugees and internally displaced persons.
- WHO (2014) Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook.
- WHO (2017) Responding to children and adolescents who have been sexually abused: WHO Clinical Guidelines.
- WHO (2017) Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: a manual for health managers.
- WHO, UNFPA, UNHCR (2020) Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO.

About the facilitator manual

This facilitator manual provides training materials to support facilitators to deliver a 5-day training on how to provide first line support and clinical care to survivors of sexual violence and intimate partner violence – including women, girls, men and boys. The manual also includes training on how to prepare the health facility to provide care.

Objectives

The main objectives of the training are for participants to:

- Demonstrate general knowledge of sexual violence and intimate partner violence as a public health problem
- Demonstrate behaviours and understand values contributing to safe, supportive services for survivors.
- Demonstrate knowledge and skills appropriate to one's profession and specialty to respond to sexual violence and intimate partner violence against women, sexual violence against men and boys, and child sexual abuse; including providing first line support, conducting a history and examination, providing clinical care and treatment, and safe referral to support services.

Intended audience

The target audience for this training manual is health care providers – including doctors, nurses, midwives, and community health workers who will provide clinical care and treatment to survivors of sexual violence and intimate partner violence. The intended audience is health care providers working in humanitarian emergencies, conflict and displacement, or in low- and middle-income countries.

The audience may also include health managers who train and supervise health care providers, and coordinate and manage health services – particularly Module 3 Understanding the legal and policy context and Module 10 Preparing the health facility. The audience may include all clinic staff and case workers who may interact with survivors – specifically for Modules 1 What every clinic worker needs to know about gender-based violence and Module 2 First line support and LIVES. Case workers who provide may also attend other modules to learn how to provide information about and referral to clinical care, and to improve collaboration with health care providers.

Ideally, this training should be delivered in a group setting of 20 or so different types of health-care providers to allow for time for discussions, participation, and interaction. It is helpful to have some health care providers from the same health facilities, to share challenges and develop an action plan to return to their health facility. It is also helpful to have health care providers from different facilities to share successes and best practices in their facilities.

How to prepare the training

1 REVIEW THE TRAINING MATERIALS

Please spend time to review and familiarize yourself with the presentations, videos and activities. Ensure you are familiar with the knowledge and various presentations, activities and videos before delivering the training. Gather information about national guidelines and protocols including on Clinical Management of Rape, HIV testing and treatment, HIV post-exposure prophylaxis, STI testing and treatment, vaccination availability and schedules, and emergency contraception and safe abortion care regulations. Ensure you have all print outs for activities and handouts prepared and organized, all presentations and videos ready to go and easily accessible on your computer.

2 PREPARE SUPPLIES

You will need to prepare supplies, materials, and equipment, including pens, notebooks, diagrams, pictures, flip charts, markers, projector, laptop, and speakers. It can be helpful to offer transport, meals, and refreshments to participants.

3 PREPARE THE SPACE

You will need a suitable room or space, and to set-up in a way that allows everyone to see the facilitator and presentation slides, encourages participation, interaction, discussions, and allows participants to break up and work in small groups around a table. Avoid rows of chairs and desk, where possible place participants in small groups around tables where everyone can easily see the facilitator, or the table in a semi-circle or u-shape. Ensure you dedicate enough time before the training to set up the room.

4 UNDERSTAND YOUR PARTICIPANTS NEEDS

It is important to know your audience, their current work role and responsibilities, past training received on this topic, the issues and concerns faced in their work, their knowledge, attitudes, and skills of clinical care for survivors or rape, and gaps in knowledge, and to adapt the training as needed. It is recommended to conduct a pre-training assessment before the training.

5 ADAPT AS NEEDED

The training materials are ready-to-use but may need to be adapted or shortened as needed. You can select, shorten and adapt the presentations as needed[1] , and choose which videos and activities you will use. The adaptions should be based on the participants needs, strengths and gaps in knowledge, specific challenges in the context, and available time. It can be helpful to prepare and review the training together with a colleague who has more experience working in the specific context.

[1] However if you adapt the power point presentations, it is suggested to not delete slides as the facilitator guide is organized by slide number. Instead either skip past slides, or simply right click on the slide you do not want to use and select 'hide slide'.

Guide to facilitating

Ideally the facilitator is a health care worker who has direct experience providing or managing clinical care for survivors of sexual violence and intimate partner violence in humanitarian settings, and has experiencing in facilitating interactive, participatory training.

A good facilitator should:

- Communicate ideas clearly and succinctly
- Be friendly, make participants feel welcome
- Encourage respect, build a safe, trusting environment
- Encourage participants to ask questions, and encourage discussion, participation, interaction and engagement amongst participants.
- Be sensitive, creative and flexible
- Listen closely and attentively, pay attention to both what is being said and is not being said

1 SET GROUND RULES

It can be helpful to set ground rules at the beginning of the training together with all participants to start to set a safe, trusting, and participatory learning environment and review these regularly.

2 MANAGE TIME

Pay careful attention to time and manage time well. Provide clear instructions about the agenda, length of the sessions and activities. Before the end of each group activity, tell the participants how much time remains. It can be helpful to "park" or write questions on a flip chart on the wall to be answered later when time allows.

3 ENCOURAGE GROUP DISCUSSIONS

While facilitating, ask the participants questions to facilitate discussions. During activities, circulate among the groups to check understanding. Offer suggestions to prompt further discussions, and provide feedback. Encourage participants to take turns presenting. Provide positive and constructive feedback.

4 EMPHASIZE THAT SHARING IS A CHOICE

Emphasize to participants that they do not have to share personal beliefs, opinions, values or experiences with the group. While group participation is both strongly encouraged and required, sharing personal beliefs or stories is not required.

5 PROMOTE CONFIDENTIALITY

Emphasize the importance of confidentiality. Explain that participants should not share any identifying information of patients, survivors, family or friends. They may share difficult cases at work, but information must be anonymous. Do not ask participants directly about any of their experiences of violence. If personal stories are shared, they should remain confidential and not shared with others. If someone does share a personal story of violence, connect with them privately and to offer support.

6 ACKNOWLEDGE DIFFICULTY OF THE TOPIC

Acknowledge that some training topics can be distressing and difficult, especially for participants who have experienced or witnessed violence. Discuss how participants can take care of themselves during the training. Offer the option for participants to leave the room if needed, speak to the facilitator for support or access support. Share available supports or hotline numbers.

7 ENCOURAGE SELF-REFLECTION AND EXPLORE PERSONAL BELIEFS AND ATTITUDES

Emphasize that everyone has their own experience, values, attitudes, and beliefs. Facilitators should create space for participants to openly and respectfully explore and reflect on their beliefs and values, and how this impacts a safe, supportive environment for survivors.

8 ADDRESSING HARMFUL POINTS OF VIEW AND MANAGING DIFFICULT DISCUSSIONS

This training can stimulate many questions and debates. Facilitators must challenge beliefs that justify, support, or condone violence and encourage participants to critically engage with their own values, beliefs, attitudes, and actions. If a participant does express a harmful statement:

- Stop and kindly explore the statement ("Let's talk about that statement for a minute") or if you cannot do so immediately, return to it later.
- Involve others: Ask the other participants what they think about the view, if they agree or disagree, have alternative views, and why.
- Learn why they hold the opinion: Ask the participant why they feel the way they do, probe and prompt further.
- Offer another opinion: If no one else has a different opinion, offer an alternative opinion in a respectful, non-threatening way and ask participants what they think.
- Avoid lecturing, telling people they are wrong, being confrontational or disrespectful
- Acknowledge the limits of 1 facilitator and 1 training to change long-standing harmful beliefs and attitudes
- Re-enforce that the role of health care providers to provide survivor-centred, empathetic, non-judgmental, safe and supportive first line support and clinical care to survivors of sexual violence and intimate partner violence, and to follow professional medical ethics.

TRAINING MATERIALS

The training is compiled of **11 training sessions.** Each session has various resources including a facilitator guide, presentation, activities, and videos.

FACILITATOR GUIDE

Each session has a facilitator guide with guidance on preparation and materials, presentations, activities, videos and discussions. There are additional notes to accompany each power point slide in the facilitator guide, and also under the power point slides. The facilitator guides are found within this manual.

PRESENTATION

Each session has a power point presentation found within the training package. There are additional notes under the power point slides, and in the facilitator guide. Notes provide further explanation, guide and support the facilitator, but are optional and should not be read word for word.
Feel free to adapt the power point presentation. It is suggested to not delete slides as the facilitator guide is organized by slide number. Instead either skip past slides, or simply right click on the slide you do not want to use and select 'hide slide'.

ACTIVITIES

There are various activities provided for each session to ensure participatory, interactive training. The activities can help provide an opportunity to demonstrate newly learned skills and increase knowledge retention. The activity guide can be found within the training package. Each activity has objectives, suggested time, suggested resources (sometime including power point presentation, print outs or supplies), facilitator instructions and key messages. These activities are optional. Choose the activities based on time, context, participants needs and preferences. Adapt as needed.

VIDEOS

There are videos to re-enforce presentations and demonstrate skills required to support survivors. The videos accompany the presentation, but it is not required to show all the videos. Choose videos based on time, context, and participants needs.

PARTICIPANT HANDOUTS

There are participant handouts for each session found within the training package, and a list within each session's facilitator guide. Choose the handouts based on your participants needs.

FURTHER RESOURCES FOR FACILITATOR (OPTIONAL)

There are further optional resources for the facilitator within each sessions' facilitator guide. These are not required reading, but provide further knowledge to support facilitators. They are found in the training package.

LIST OF TRAINING SESSIONS

SESSION 1	**WHAT EVERY CLINIC WORKER NEEDS TO KNOW ABOUT GENDER-BASED VIOLENCE**
OBJECTIVES	• Understand definitions of various forms of GBV • Understand core concepts related to GBV - gender, power, use of force, and consent. • Understand the health consequences of GBV • Understand the barriers survivors face to accessing care, and why GBV is underreported • Understanding the survivor's experience, reflect on values and beliefs • Demonstrate behaviors and understand values contributing to a safe & supportive service culture. • Recognize the importance of compassion and empathy of supporting survivors to heal • Understand the role of clinic staff • Know the guiding principles and understand how to apply them in practice
SESSION 2	**FIRST LINE SUPPORT AND LIVES**
OBJECTIVES	• Know the content of first-line support (LIVES) • Demonstrate skills in offering the first three elements of first-line support – Listen, Inquire, Validate
SESSION 3	**UNDERSTANDING THE LEGAL AND POLICY CONTEXT**
OBJECTIVES	• Understand the legal and policy context including health care providers' legal obligations
SESSION 4	**HISTORY AND EXAMINATION**
OBJECTIVES	• Describe the purpose of obtaining informed consent. • Demonstrate how to properly obtain informed consent, and what to do if the survivor declines to consent • Demonstrate skills to take history • Describe how to use information from the history to guide the exam • Know how to conduct physical examination
SESSION 5	**DOCUMENTATION**
OBJECTIVES	• Know how to document in a safe, confidential manner • Explain the importance of correct documentation. • Understand how to correctly fill out the medical exam form.
SESSION 6	**MEDICAL CERTIFICATE AND FORENSIC EXAMINATION**
OBJECTIVES	• Know how to complete a medical certificate • Know when to decide to collect forensic evidence • Know how to collect forensic evidence and how to support or facilitate this
SESSION 7	**CLINICAL CARE AND TREATMENT**
OBJECTIVES	• Know how to provide appropriate treatment and care and demonstrate clinical skills in how to respond to the needs of survivors of sexual assault within 72 hours after the assault and for those seeking care 72 hours or more after the assault • Describe the use of the emergency contraception pill, and which patients should be offered ECP • Describe the use of STI prophylaxis, and whcih patients should be offered STI prophylaxis" afer HIV PEP • Describe the use of HIV PEP, and which patients should be offered HIV PEP • Demonstrate the skills to assess immediate risk and safety and to support safety planning • Know what resources are available in the community, know how to collaborate with referral partners to help survivors obtain other services • Demonstrate knowledge of how to access resources and support for patients • Describe common psychological reactions to sexual violence and demonstrate the ability to provide psychosocial support • Know how to identify mental health issues and respond or offer referral

LIST OF TRAINING SESSIONS

SESSION 8

CHILD SEXUAL ABUSE

OBJECTIVES

- Learn how to provide first line support and medical care to child survivors of sexual abuse
- Describe the guiding principles of caring for child survivors
- Describe how to create a safe environment for child survivors
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP
- Describe what treatment you would offer for a child survivor
- Demonstrate how to advise parents or guardians on a child's possible reactions to sexual abuse

SESSION 9

SEXUAL VIOLENCE AGAINST MEN AND BOYS

OBJECTIVES

- Understand barriers faced by male survivors of sexual violence
- Describe how male survivors may react to a sexual assault.
- Gain knowledge and skills to provide first line support and medical care to male survivors of sexual violence or rape

SESSION 10

PREPARING YOUR HEALTH FACILITY

OBJECTIVES

- Demonstrate knowledge on how to ensure the health facility is ready to provide care to survivors, Gain skills to prepare the health facility and set up a consultation room
- Map out current patient flow and response to sexual assault survivors and identify areas for improvement.
- Describe what referral resources are needed for sexual assault survivors, what resources are currently missing in your referral network and develop a plan for filling gaps and improving communication between the various organizations.

SESSION 11

SELF-CARE FOR CARE PROVIDERS

OBJECTIVES

- Build an understanding of the various types of traumatic stress and how they impact you.
- Gain awareness of the signs of burnout and trauma.
- Demonstrate knowledge of how to access resources, support for ourselves and practice self-care
- Understand how to utilize tools and methods for staff care and managing stress.

PROPOSED AGENDA

DAY 1	DAY 2	DAY 3	DAY 4	DAY 5
		MORNING SESSION 09:00-11:00		
Introductions and ground rules **(30 minutes)** 1. What every clinic worker needs to know about GBV **(1.5 hours)**	Review of yesterday **(30 minutes)** 4. History and examination **(1.5 hours)**	Review of yesterday (30 minutes) 7. Clinical care and treatment continued **(1.5 hours)**	Review of yesterday **(30 minutes)** 8. Child sexual abuse **(1.5 hours)**	Review of yesterday **(30 minutes)** 10. Prepare your health facility **(1.5 hours)**
		BREAK 11:00-11:15		
		MORNING SESSION 11:15-12:00		
1. What every clinic worker needs to know about GBV continued **(45 minutes)**	4. History and examination continued **(45 minutes)**	7. Clinical care and treatment continued **(45 minutes)**	8. Child sexual abuse continued **(45 minutes)**	10. Prepare your health facility **(45 minutes)**
		BREAK 12:00-12:45		
		AFTERNOON SESSION 12:45-15:15		
1. What every clinic worker needs to know about GBV continued **(1 hour)** 2. First line support and LIVES **(1.5 hours)**	5. Documentation **(2.5 hours)**	7. Clinical care and treatment continued **(2.5 hours)**	9. Male survivors of sexual violence **(2.5 hours)**	11. Care for care providers **(2.5 hours)**
		BREAK 15:15-15:30		
		AFTERNOON SESSION 15:30-17:00		
2. First line support and LIVES continued **(30 minutes)** 3. Legal and policy context **(1 hour)**	6. Medical certificate and forensic evidence collection **(1.5 hours)**	7. Clinical care and treatment continued **(1.5 hours)**	9. Male survivors of sexual violence **(1.5 hours)**	Wrap up, Post-test and evaluation

LIST OF TRAINING MATERIALS

The following includes a list of all training materials. The facilitator guides can be found within this manual, and all other resources (presentations, activities and videos) can be found within the training package.

LIST OF PRESENTATIONS

1. What every clinic worker needs to know about GBV
2. First line support and LIVES
3. Understanding the legal and policy context
4. History and examination
5. Documentation
6. Medical certificate and forensic examination
7. Clinical care and treatment
8. Child sexual abuse
9. Sexual violence against men and boys
10. Preparing your health facility
11. Self-care for care providers

LIST OF ACTIVITIES

1.1 Introduction
1.2 Ground rules
1.3 Fears and motivations
1.4 Match the definitions
1.5 Sex and gender
1.6 Understanding power Option 1
1.7 Understanding power Option 2
1.8 Understanding Sexual Violence
1.9 Consequences of sexual violence – Option 1
1.10 Consequences of sexual violence: Option 2
1.11 Vote with your feet
1.12 Blaming vs Empowering
1.13 Privacy
1.14 Guiding principles
1.15 Guiding principles
2.1 Step by step guide to providing care and support
2.2 Active listening
2.3 Validating statements
2.4 Listening, inquiring and validating (LIV) role play
3 Understanding the legal and policy context
4.1 Informed consent role play
4.2 History taking role play
4.3 Virginity testing role play
5. Documentation
6. Forensic evidence collection
7.1 Case studies on ECP
7.2 Case studies on treatment for sexual assault
7.3 Grab bag on medical care
7.4 Role play Enhancing safety and offering support
7.5 Case studies on referral to support services
7.6 Brainstorm mental health consequences
7.7 Story telling – mental health consequences
7.8 Discussion on coping skills
7.9 Stress reduction and relaxation techniques
7.10 True or false – mental health care
8.1 Definition of child sexual abuse

8.2 Matching activity – Key terms related to child sexual abuse
8.3 Vote with your feet – Child sexual abuse
8.4 Discussion on barriers to care for child survivors of sexual abuse
8.5 Guiding principles when supporting child survivors
8.6 Case studies on medical care for survivors of child sexual abuse
8.7 Case studies on medical care for survivors of child sexual abuse Risks and safety
9.1 Myths about male sexual abuse
9.2 Barriers to care for male survivors
9.3 Case Study – male survivors of sexual abuse
10.1 String exercise – privacy
10.2 Mapping – Prepare the entry point, care pathway and consultation room
10.3 Small group discussion – Checklist for clinical care
10.4 Drawing a referral pathway
10.5 Develop an action plan

LIST OF VIDEOS

1.1 Consent
1.2 Strengthening the health system response to gender-based violence
4.1 Welcome the survivor
4.2 Informed consent
4.3 Medical history
4.4 History of the incident
4.5 General examination
4.6 Genital examination
4.7 Vaginal Speculum Exam
4.8 Anal examination
5. Documentation guidelines
6.1 Introduction to forensic evidence collection
6.2 Collecting forensic evidence
6.3 Documenting the survivors history
6.4 Collecting evidence before the physical exam
6.5 Collecting evidence during the physical exam
6.6 Collecting evidence from the external genitalia and anus
6.7 Collecting evidence from the vagina and rectum
6.8 Preparation, storage and dissemination of evidence
6.9 Release of evidence
6.10 The importance of forensic evidence
7.1 Preventing unwanted pregnancy
7.2 Preventing HIV
7.3 Preventing STIs
7.4 Hepatitis B vaccination
7.5 Enhancing safety and connecting with support
8.1 Welcoming child survivors
8.2 Informed consent with children and caregivers
8.3 Assessing the child alone
8.4 Medical history with a child
8.5 History of the incident with a child
8.6 General exam of a child
8.7 Genital exam of a child
8.8 Talking about virginity with adolescents
8.9 Preventing pregnancy for adolescents
8.10 Medical treatment and care of children
8.11 Psychosocial support for children
8.12 Enhancing safety with children

8.13 Connecting children with social support
9.1 Welcoming male survivors
9.2 History taking with male survivors
9.3 General examination of male survivors
9.4 Genital examination of male survivors
9.5 Medical care and treatment for male survivors
9.6 Validate, enhance safety and connect with support for male survivors

LIST OF HANDOUTS

1.1 Violence Against Women Global Picture
1.2 Guiding principles
2.1 Care pathway
2.2 LIVES
2.3 Communication skills and pathways
2.4 Active listening principles
2.5 Inquiring about needs and validating
2.6 Helping survivors cope with negative feelings
4.1 Sample Consent form
4.2 Preparing to gather the story
4.2 Topics to cover when taking the history with a survivor
4.3 Examination checklist
5.1 Documenting the Examination
5.2 Describing features of physical injuries
5.3 Sample history and examination form
5.4 Pictograms
6.1 Sample medical certificates
6.2 The forensic medical examination
6.3 Medico-legal evidence in sexual violence
7.1 Post-rape treatment timelines
7.2 Protocols for emergency contraception
7.3 Protocols for emergency contraception using oral contraception
7.4 Protocols for prevention and treatment of sexually transmitted infections
7.5 Protocols for post-exposure prophylaxis of HIV infection
7.6 Questions to assess immediate risk of violence and making a safety plan
7.7 Strengthening positive coping methods and exploring social support
7.8 Exercises to help reduce stress
7.9 Checklist for follow-up visits with a rape survivor
8.1 Pathways of care for child or adolescent survivors of sexual abuse
8.2 Why children do not disclose sexual abuse
8.3 Sexual Abuse impacts across age and developmental stages
8.4 Guidelines for communicating with children
8.5 Interview guidelines based on age and developmental stage
8.6 Mandatory reporting requirements
9.1 The Scope and Types of SGBV against Men and Boys
9.2 Barriers to care for male survivors of sexual violence
10.1 Assessing service readiness
10.2 Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence
10.3 Infrastructure considerations, barriers and suggestions to overcome them
10.4 Referral chart
11.1 Identifying different forms of stress
11.2 Staff care

1

WHAT EVERY CLINIC WORKER NEEDS TO KNOW ABOUT GENDER-BASED VIOLENCE

1. WHAT EVERY CLINIC WORKER NEEDS TO KNOW ABOUT GENDER-BASED VIOLENCE

PREPARATION AND MATERIALS

OBJECTIVES

- Understand definitions of various forms of GBV
- Understand core concepts related to GBV - gender, power, use of force, and consent.
- Understand the health consequences of GBV
- Understand the barriers survivors face to accessing care, and why GBV is underreported
- Understanding the survivor's experience, reflect on values and beliefs
- Demonstrate self-awareness of one's beliefs and values, and demonstrate behaviors and understand values contributing to a safe & supportive service culture.
- Recognize the importance of compassion and empathy of supporting survivors to heal
- Understand the role of clinic staff
- Know the guiding principles and understand how to apply them in practice

AVAILABLE TRAINING RESOURCES

Presentation
1. What every clinic worker needs to know about GBV

Facilitator guide
1. What every clinic worker needs to know about GBV

Activities
1.1 Introduction
1.2 Ground rules
1.3 Fears and motivations
1.4 Match the definitions
1.5 Sex and gender
1.6 Understanding power Option 1
1.7 Understanding power Option 2
1.8 Understanding Sexual Violence
1.9 Consequences of sexual violence – Option 1
1.10 Consequences of sexual violence: Option 2
1.11 Vote with your feet
1.12 Blaming vs Empowering
1.13 Privacy
1.14 Guiding principles

Videos
1.1 Consent
1.2 Strengthening the health system response to gender-based violence

Participant handouts
1.1 Violence Against Women Global Picture
1.2 Guiding principles

REQUIRED SUPPLIES & MATERIALS

- Projector
- Laptop
- Pen and blank paper workbook for each participant
- Space for small group discussion
- Space for groups to move around
- Wall to post flip charts
- Paper
- Sticky tack, tape or post-it notes
- Pens, markers
- Flip chart or white board
- Print outs of activities – depending on which activities you choose

KEY MESSAGES

- Gender-based violence is a harmful act, related to power, coercion, force, gender inequality and without consent
- Gender-based violence causes suffering and health consequences
- Harmful beliefs and attitudes can worsen the suffering of survivors
- Our role as health care workers is to provide supportive, compassionate health care
- Health care providers should provide care based on the guiding principles

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- Sex and gender:
  IOM LGBTI Terminology Guidance
- Guiding principles:
  WHO 2020 Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings, pg 4
  UNFPA 2019 The inter-agency Minimum Standards for Gender-Based Violence in Emergencies Programming, pg xi

WHAT EVERY CLINIC WORKER NEEDS TO KNOW ABOUT GBV FACILITATOR GUIDE

INTRODUCTION

Slide 1 Introduction
- Introduce all presenters and facilitators, their education and work experience.
- Ask the participants to introduce themselves or use Activity 1.1 Introduction.

Activity 1.1 Introduction or Ask the participants to introduce themselves

Slide 2 Agenda
- Add the agenda of the training, adapt with the dates and times that you will use.

Activity 1.2 Discuss ground rules
Activity 1.3 Fears and motivations

Slide 4 Introduce the objectives for this training

DEFINING GENDER-BASED VIOLENCE

Activity 1.4 Match the definitions

SLIDE 6-8 DEFINING GENDER-BASED VIOLENCE

Slide 7 notes
- GBV is an umbrella term for any **harmful act** that is perpetrated **against a person's will** and that is based on **socially ascribed differences** between males and females (i.e. gender) or on the unequal power relations between women and men.
- GBV includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty.

Slide 8 notes
There are many forms of gender-based violence, including:
- **Sexual violence** by a husband or partner, or by friends, family members, acquaintances and strangers.
- **Intimate partner violence** – a husband, ex-husband, boyfriend, ex-boyfriend or dating partner – including physical, sexual and psychological violence.
- Intimate partner violence can also include economic abuse, psychological abuse, reproductive control.
- In some settings this is known as domestic violence. However, domestic violence also includes violence by other family members.
- **Harmful practices** may include femicide/honour killing, forced and early marriage, human trafficking, female genital mutilation, acid throwing, sex-selective abortion, female infanticide, female genital cutting, dowry abuse, denial of opportunities (education) or widow ceremonies.

DISCUSS

Ask participants what harmful practices occur in their particular context.

SLIDES 9-11 DEFINING SEXUAL VIOLENCE, RAPE AND SEXUAL EXPLOITATION AND ABUSE

Slide 9 notes

- **Sexual violence** is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting including home and work
- Sexual violence includes **sexual assault**. Sexual assault is defined as any type of unwanted physical violence or contact that is of a sexual nature. Sexual assault also includes rape
- Sexual violence occurs against women and girls, men and boys, all ages, and in all situations including armed conflict, natural disasters, displacement, but also in stable settings.

Slide 10 notes

- **Rape and attempted rape** involve the use of force, threat of force, and/or coercion.

Slide 11 notes

- **Sexual exploitation and abuse** may include a person in a position of power profiting monetarily, socially, or politically from the sexual exploitation of another. The exploitation may include giving humanitarian assistance in exchange for sexual acts.
- The survivor may believe that they have no other choice than to agree (to protect their family, to receive food, etc.) so that even if verbal agreement is given it is forced or coerced due to the fear of harmful consequences.
- Common perpetrators include bosses, teachers, humanitarian workers, peacekeepers, soldiers, and police.

DISCUSS

Ask participants what examples of sexual exploitation or abuse they can think of in their particular context (without sharing specific private or confidential information).

UNDERSTANDING KEY CONCEPTS

SLIDE 12-13 DISCUSS TERMS VICTIM AND SURVIVOR

Slide 13 notes

- **Victim** is a term often used in the legal sectors. Victim recognizes the violation of a human rights and harm that has been caused.
- The word **survivor** is used by mental health and social support sectors. It can focuses on strength, resiliency, and the ability and capacity of an individual to cope, heal and recover. It is also used by psychological and social support sectors.
- **Respect** the language they use to describe themselves and their experience.

Activity 1.5 Sex and gender

SLIDES 15-17 EXPLAIN SEX, GENDER AND GENDER INEQUALITY

Slide 15 notes

- **Sex** is determined by biological or physiological characteristics that define males and females including type of predominant hormones circulating in body, anatomy and bodily characteristics, type of external and internal genitals and internal reproductive organs, ability to produce sperm or ova, ability to give birth and breastfeed children.
- **Gender**: describes the widely shared ideas and expectations about the roles, responsibilities, opportunities, privileges, power, limitations, ideas, norms, behaviours, activities and attributes given to males and females. These differences are socially constructed (not biologically constructed), learned, changeable over time, and have wide variations both within and between cultures.
  NOTE: Depending on the context, consider describing intersex and gender identity.
- **Intersex** - At birth, people may be classified as female, male or intersex. An intersex person is person with bodily variations in relation to culturally established standards of maleness and femaleness, including variations at the level of chromosomes, genitalia, hormones or secondary sex characteristics.
- **Gender Identity:** refers to each person's deeply felt internal and individual experience of gender of themselves as a man, woman, transgender or something else. This may or may not correspond with the sex they were assigned at birth or the

gender attributed to them by society. It includes the personal sense of self and of their body (which may involve, if freely chosen, modification of appearance or function by medical, surgical or other means) and expressions of gender, including dress, speech and mannerisms. Someone who is trans has a gender identity and expression that differs from what is typically associated with the sex they were assigned at birth. Individuals use a range of cues, such as names, pronouns, behaviour, clothing, voice, mannerisms and/or bodily characteristics, to interpret other individuals' genders. Gender expression is not necessarily an accurate reflection of gender identity. People with diverse sexual orientation, gender identity or sexcharacteristics do not necessarily have a diverse gender expression. Likewise, people who do not have a diverse sexual orientation, gender identity or sex characteristics may have a diverse gender expression.

Slide 16 notes
- **Gender inequality** exists in every society around the world.

Slide 17 notes
- In addition, gender inequality can lead to increased risk of GBV against transgender men and women and others who do not fit within typical gender roles of men and women and are excluded.

Activity 1.6 Understanding power option 1 or
Activity 1.7 Understanding power option 2

SLIDE 19-20 DISCUSS POWER, COERCION, FORCE

Slide 19 notes
- Power is the capacity or ability to make **choices** and **decisions**, have **control** over your life, and to lead and influence others.
- Power is distributed **unequally** in every community or society, there are some people with more and less power in every community or society.
  People with **authority, status** and **money** often have more power. The more power a person has, the more choice and control they have.
- The less power a person has, they less control and fewer choices.
- Power can be used in **positive** ways. People can use power for good, to share their power, join with others, help and support others.
- Power can be used in **negative** and **harmful** ways. People can use their power over others with less power, to assert their power. Power can be used to force, threats, coerce, manipulate and abuse others with less power.
- GBV is an **abuse of unequal power relationships**. People with less power are more vulnerable to abuse.
- Women, men with less power and transgender men and women and others with an excluded gender identities are at increased risk of GBV due to their limited power, choice and control.

Slide 20 notes
- Coercion, pressure, intimidation, threats can be used to persuade, compel or force someone to do something they would not want to do, against your own will or choice
- Threats may make a person feels a fear of real and harmful consequences - either of being hurt physically, mentally, emotionally or socially, or of having a benefit or material need withheld (such as food or school fees).
- Force can be physical, social or economic.

DISCUSS

Ask what are examples that you can think or know of when someone may be forced or coerced to have sex when they do not want to (without sharing private, confidential information)?

Explain and provide examples:
- A manager of a company tells a woman that he will only recruit and hire her for a job if she has sex with him. She does not want to have sex with him, but she has young children at home that she needs to feed and her husband has died.
- A teacher tells a young girl that she did very badly on the test and has failed. The teachers tells the girl that he can help her pass if she does some extra work. He asks her to stay after school. When she comes after school, he tells her that he wants her to take her clothes of, he wants to see her naked and touch her breasts. She does not want to, but feels afraid and does it because she is afraid of what might happen if she fails.
- An employer threatening that an employee will lose her job if she does meet his demand for sexual favours.
- A humanitarian worker promising to provide a displaced woman extra food vouchers or access to resettlement if she has sex with him.
- A teacher offering to help a young boy pay school fees if he accepts his demand for sexual favours.

Slide 21 Consent

- Consent is an **informed choice** to **freely** and **voluntarily** do something.
- They must understand the consequences of the choice.
- Consent is **not implied** or assumed.
- Consent can be **withdrawn, reversed, or changed.** Consent must be **specific** for the specific act.
- They must have the understanding, capacity, ability and right to say no.
- For example, children may not understand that they can refuse sexual activity, and people with disabilities may not be able to verbally express no, or community a refusal of sexual activity.
- If there is threat or coercion, there is no consent.
- Sexaul assault is sexual contact without consent. Rape is any penetration without consent.

Video 1.1 Consent

NOTE: review if this is appropriate and understood within the context.

Activity 1.8 Understanding sexual violence

PREVALENCE AND UNDERREPORTING OF GBV

SLIDE 24-28 PREVALENCE OF GENDER-BASED VIOLENCE

Slide 26 notes

- The prevalence varies in different regions.

Slide 27 notes

- If available, provide national or sub-national prevalence data for your country. These may be available through Demographic and Health Surveys or other national surveys.

Slide 28 notes

- It is important to remember that GBV is happening everywhere. It is under-reported worldwide. All humanitarians must assume GBV is occurring and threatening affected populations; treat it as a serious and life-threatening problem; and take action.. regardless of the presence or absence of concrete 'evidence'.

DISCUSS

Ask Why do survivors of gender-based violence not seek help?

Slide 29 Barriers to care

Common reasons for not seeking help

- The violence was perceived as normal or not serious.
- Survivors feels guilt and blames themselves.
- She was afraid of consequences/threats/more violence.
- She was embarrassed or afraid of being blamed or not believed.
- She was afraid of bringing shame on her family.
- She may fear economic hardship or manipulation.

Common reasosn for seeking help

- She could not endure any more.
- She was badly injured.
- Her partner had threatened or hit her children.
- She had been encouraged by friends or family.

CONSEQUENCES OF GENDER-BASED VIOLENCE

SLIDE 30-31 INTRODUCE SECTION

Activity 1.9 Consequences of sexual violence Option 1 or
Activity 1.10 Consequences of sexual violence Option 2

SLIDE 33-37 CONSEQUENCES OF GENDER-BASED VIOLENCE

Slide 36 Notes

- There are inter-generational consequences of GBV. Children exposed to violence or subjected to violence themselves are more likely to perpetrate or experience violence.
- It is important for health-care providers to see if the children who accompany women subjected to violence show signs or symptoms and offer support.

UNDERSTANDING SURVIVORS' EXPERIENCES AND HOW VALUES AND BELIEFS IMPACT CARE

SLIDES 38-39 INTRODUCE SECTION

Choose two or three of the activities:
Activity 1.11 Vote with your feet
Activity 1.12 Blaming vs empowering

Slide 41 Self-awareness of attitudes and beliefs

- Our **values, beliefs and attitudes** often reflect the norms and values of the societies we live in. We should **be aware of and reflect** on how our personal beliefs, attitudes and values, and how they might affect the care that we as health-care providers offer to survivors. It is important to reflect on these and whether they might harm survivors. We must challenge them in our interactions with survivors and as role models to our patients and communities.
- Women subjected to violence are often acutely aware and can sense when people have negative beliefs and opinions about them. If we are aware of our negative beliefs, we can better avoid communicating them to survivors of violence.

ROLE OF THE HEALTH SYSTEM AND HEALTH CARE PROVIDERS

SLIDE 41-44 THE ROLE OF HEALTH CARE PROVIDERS

Slide 43 notes

- Women in many settings identify health-care providers as the professionals they trust to disclose abuse and other personal matters.
- Violence against women and girls is linked with poor health outcomes.
- Health-care settings can be a confidential place to provide support and information.
- Addressing violence against women in the health sector reminds patients that violence against women and healthy relationships matter for their health and well-being.
- When health-care providers present assessment of violence against women as necessary for good health and relationships, it can relieve worries about stigma and judgement.
- Health-care providers' expressions of concern and support can validate women's experiences, help them recognize abuse and inspire them to strive for safety.

Video 1.2 Strengthening the health system response to gender-based violence
https://www.youtube.com/watch?v=Qc_GHITvTmI

Slide 46 What Health Care Providers can offer GBV survivors
- Health care providers need to offer empathic support and enable and help women to feel more in control in order to make their own choices and decisions, including whether they want to use referral services outside the health system.

DISCUSS

Ask for or provide an example of safety concerns and practical needs that require resources from other sectors.

GUIDING PRINCIPLES

SLIDES 47-51 GUIDING PRINCIPLES

Slide 50 notes
- **Dignity and respect -** The right to be treated with dignity and respect, and not be blamed or judged for violence
- **Self-determination and autonomy -** The right to make their own decisions; to decline or refuse examination, medical care or to take legal action. We empower them to be in control and make choices, respect their decisions, we trust the survivor to know what is best for herself and her situation.
- **Non-discrimination -** Offer health care without discrimination, survivors should receive equal and fair access, care, treatment and support. Treatment should not be refused based on race, ethnicity, caste, class, socio-economic status, sexual orientation, gender identity, religion, disability, health status (HIV), substance use, marital status, occupation, or political beliefs. Be aware that some survivors may face discrimination, this might impact their ability to seek health care, create obstacles or barriers, and their experience of health care. We may hold beliefs, values and attitudes about specific survivors or groups, and we should be aware of and recognize our own beliefs and how they may impact our ability to provide health care
- **Privacy and confidentiality -** Provide private and confidential care and treatment.
- Ensure visual and auditory privacy during consultation. Provide care in a place where no one else can see or hear, only those who need to be there should be. Only those who need to be present are allowed. Survivors should not have to move between rooms to provide care, minimize the number of places to receive care. Survivors should not be made to repeat their story to multiple providers.
- **Confidentiality** is the duty of those who receive private information not to disclose it without the patient's consent and must protect information shared by a survivor. Survivors have the right to control the information about themselves and choose who they will - or will not - share their information with. Information should not be shared with anyone without the survivors consent. Only disclose or share information with the consent or permission of the patient – including family, friends, police. Keep documents, records and information safely, securely stored. Limit who has access to documents. There are exceptions in cases of risk to safety for survivors and legal requirements of mandatory reporting. Breaches of privacy and confidentiality can put survivors at further at risk, especially in cases of partner violence.
- **Safety –** The safety and security of survivors and their children are the primary considerations.
- **Information –** Survivors should have the right to have access to information and to know what information is being collected about. Give information to support a survivor to make an informed, voluntary decision about which examinations and treatments are best for them
- **Life –** the right to a life free from fear and violence.
- **Health –** the right to health-care services of good quality, that are available, accessible and acceptable.

Activity 1.13 Privacy and
Activity 1.14 Guiding principles

SLIDES 53-54 GENDER EQUALITY AND SUMMARIZE

Slide 53 notes

- Understand that:
  1. Violence against women is related to **unequal power** between women and men, violence disempowers or takes power away from the survivor
  2. Women may have **less access to and control** over resources than men, such as money or information
  3. Women may not have the **freedom to make decisions** for themselves, may not be able to leave violent situations or seek care
  4. Women may be **blamed and stigmatized** for violence and may feel shame and low self-esteem
  5. Women may blame themselves, feel they did something is wrong and not seek help
- In your practice recognize these power differences, do not re-enforce gender inequality, and act to promote gender equality in your care.
- Provide care fairly to both women and men.
- Reinforce women's value as a person, respect her dignity, promote women's autonomy.
- Listen to her story, believe her, and take what she says seriously.
- Do not blame or judge her, validate her.
- Respect her autonomy by providing information that helps her to make her own choices and decisions.
- Help them reclaim the choice, control and power that the violence took away.

2

FIRST LINE SUPPORT AND LIVES

2. FIRST LINE SUPPORT AND LIVES

PREPARATION AND MATERIALS

OBJECTIVES

- Know the content of first-line support (LIVES)
- Demonstrate skills in offering the first three elements of first-line support – Listen, Inquire, Validate

AVAILABLE TRAINING RESOURCES

Presentation
2. First line support and LIVES presentation

Facilitator guide
2. First line support and LIVES Facilitator guide

Activities
2.1 Step by step guide to providing care and support
2.2 Active listening
2.3 Validating statements
2.4 Listening, inquiring and validating (LIV) role play

Participant handouts
2.1 Care pathway
2.2 LIVES
2.3 Communication skills and pathways
2.4 Active listening principles
2.5 Inquiring about needs and validating
2.6 Helping survivors cope with negative feelings

REQUIRED SUPPLIES & MATERIALS

- Projector
- Laptop
- Pen and blank paper workbook for each participant
- Tape, 15 pieces of paper, Markers
- Sufficient space for groups of three to spread out
- Print outs of activities – depending on which activities you choose

KEY MESSAGES

- Actively listen to the survivor verbally and non-verbally, without distractions.
- Inquire about the survivor's needs and concerns, focus on what the survivor wants
- Validate the survivor, show that they are not at fault or to be blamed, that you are there to listen and support them

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2014) Health care for women subjected to intimate partner violence or sexual violence: A Clinical handbook, First-line support for sexual assault and intimate partner violence pg 13-37
- WHO, UNFPA, UNHCR (2019) Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: WHO, Part 2: Providing first-line support pg 10-14
- NCA (2020) Integrating Therapeutic interventions into Gender-based Violence Case Management

FIRST LINE SUPPORT AND LIVES FACILITATOR GUIDE

SLIDES 1-3 INTRODUCE FIRST LINE SUPPORT AND LIVES

Slide 3 notes
Explain that first line support is the first steps in first-line support – after ensuring that urgent lifesaving care needs are addressed.

Activity 2.1 Step by step guide to providing care and support
Place '**First line support, Listen, enquire and validate**' on the wall.

SLIDES 4-7 INTRODUCE FIRST LINE SUPPORT AND LIVES

Slide 4 notes
- **First-line support** is the most important care that you can provide for a survivor of violence. It may be the only support you provide.
- First-line support responds to emotional, physical, safety and support needs. It involves responding to someone who discloses violence in a way that is supportive, helps to meet their needs, and prioritizes their continued safety without intruding on their privacy.
- First-line support is based on psychological first aid. It has helped people who have been through various upsetting or stressful events, including being subjected to violence.

Slide 5 notes
- Listen, ask questions, give information and support survivors to make decisions.
- We should not give advice, give orders or decide for them. Respect her wishes and respond to her needs, don't assume that you know what is best for her.
- Advice can be influenced by personal beliefs and culture, and can be subjective. However information is objective.

Slide 7 notes
- **First line support** and **LIVES** can be powerful healing tools.
- Sexual violence and intimate partner violence takes away the autonomy and self-determination of survivors.
- They often feel powerless and often silenced.
- Active, supportive listening helps survivors to feel heard – an important step towards **healing.**
- Asking survivors about their needs can give them back a sense of control, agency, autonomy and self-determination

Activity 2.2 Active listening

SLIDES 9-18 LISTENING, INQUIRING ABOUT NEEDS AND VALIDATING

Slide 9 notes
- **Good active listening** is important to support survivors to speak and share, to show understanding, communicate, empathy, help survivors to feel supported and start healing.
- We hear and listen all the time, but we do not pay attention to how we listen, or listen actively, intentionally, mindfully or consciously. Good listening skills can be practised.

Slide 10 notes
- **Listening is:**
  1. Giving her the chance to say what she wants to a caring person who wants to help and in a safe and private space
  2. Critical for healing and recovery
  3. Most important part of good communication
  4. Being aware of the feelings behind her words
  5. Hearing both what she says and what she does not say
  6. Paying attention to her body language
  7. Sitting or standing at the same level and close enough
  8. Through empathy, showing understanding of how she feels.

Slide 11 notes

- Interrupting can signal to the survivor that you are not listening or do not think what they have to say is important or of value.
- Focus on the survivor, do not talk about yourself, your feelings or other people. Do not say "One time this happened to..."

Slide 12 notes

- Let them speak at their own pace, do not interrupt or rush, do not speak too rapidly, wait until she has finished before asking questions.
- Do not guess what the person is saying or jumping into conclusions after a few sentences.
- Questions, comments, and minimal encouragers can always wait until the survivor has had the opportunity to convey the entirety of what they want to say.
- Allowing the survivor to control the pace helps them to regain some control.
- Respect silence, wait, be patient and calm, give her time to think, do not pressure them to speak.

Slide 13 notes

- Acknowledge what they want, show your respect for their wishes, do not offer advice or opinions, try to solve problems for them.

Slide 14 notes

- A position that shows you are attentive and listening is called **SOLER:**
  - **S -** Squarely face person
  - **O -** use Open posture
  - **L -** Lean a little toward the person
  - **E -** make Eye contact
  - **R -** Relax, keep it natural
- Show that you are interested and listening with your **body language** – with your posture, relaxed sitting, position, leaning forward, eye contact (appropriate to the culture), facial expression, gestures, nodding
- Pay attention to the **survivors' body language,** if you are sensing that they are uncomfortable in the conversation, ask to clarify.
- Don't look disinterested and distracted, look away from the person, cross your arms, stand above the patient, look at your watch, answer the telephone, look at a computer or write.

Slide 15 notes

- Before asking anything, remember the guiding principles of **confidentiality** and let the survivor know the limits of confidentiality. Talk about abuse only when you and the patient are alone. No one older than age 2 should overhear your conversation. Never discuss it if her husband or other family members or anyone else who has accompanied her—even a friend—may be able to overhear. You may need to think of an excuse to be able to see the woman alone, such as sending the person to do an errand or fill out a form. If her children are with her, ask a colleague to look after them while you talk.
- Encourage the survivor to keep talking if they wish.
- Phrase your questions as an **invitation to speak.**
  - "Would you like to tell me more?"
  - "What would you like to talk about?", "Would you like to tell me more?"
  - "How can we help you today?"
  - "What would you like me to do for you today?"
  - "Is there anything that you need or are concerned about?"
- Help to identify and express needs and concerns.
- Ask about **needs and concerns,** give her the opportunity to say what kind of help she wants, learn what is most important
- Help survivors express their needs and ensure you understand their needs.
- When the patient are talking, pay attention to what she says about her needs or concerns. She may let you know about physical needs, emotional needs, economic needs, need for social support or concerns about safety.

- Check your understanding, **para-phrasing or repeating** what they say. **Acknowledge and reflect back** how the survivor is feeling to show you are listening and understood.
  - "You mentioned that you feel very frustrated."
  - "You mentioned feeling worried about STIs..."
  - "It sounds like you are worried about your children."
  - "I hear how difficult this has been for you"; "It sounds like a very scary situation" "It sounds as if you are feeling angry about that" "You seem upset" "It sounds to me that you are feeling helpless right now," "You mentioned that you feel very frustrated."

Slide 17 notes

- Avoid asking **leading questions**, such as "I would imagine that made you feel upset, didn't it?" "I imagine that you are angry, aren't you?" "Are you worried about being pregnant?"
- Avoid **compound questions** "So what would you like to see the nurse, and then go to the women's safe space?". These can be confusing or overwhelming.

- Avoid asking **"why"** questions, such as "Why did you do that…?" They may sound accusing. Why didn't you tell anyone? Why did you go there? Why did you do that?" "Why didn't you fight them off?" "What did you learn from this that you might do differently in the future?" "Why won't you report it to the police?"
- They may sound accusing or may the survivor feel judged or blamed

Slide 18 notes

- **Validating** lets a survivor know that their feelings are normal, that it is safe to express them, that she has a right to live without violence and fear, and that you believe what she says without judgement.
- Address feelings of blame, guilt, shame & fear.
- Avoid saying
  - "I know how you feel."
  - "Everything will be okay."
  - "You should…"
  - "Are you sure?"
- Provide further information about normal stress reactions to an experience of violence and exploring and strengthening positive coping methods in the handouts.

Activity 2.3 Validating statements

Slide 20 Summarize LIVES

- Explain that we will continues LIVES with the ES (Enhance their safety, support to connect with service) after providing care.

Activity 2.4 Listening, inquiring and validating (LIV) role play

DISCUSS

Ask what questions the participants have.

Slide 23 Summarize key messages

3

UNDERSTANDING THE LEGAL AND POLICY CONTEXT

3. UNDERSTANDING THE LEGAL AND POLICY CONTEXT

PREPARATION AND MATERIALS

OBJECTIVES

Understand the legal and policy context including health care providers' legal obligations

AVAILABLE TRAINING RESOURCES

Presentation
3. Understanding the legal and policy context

Facilitator guide
3. Legal and Policy context facilitator guide

Activities
3. Understanding the legal and policy context

REQUIRED SUPPLIES & MATERIALS

- Projector
- Laptop
- Pen and blank paper workbook for each participant

KEY MESSAGES

- It is crucial for health care providers to understand the legal and policy context – particularly health care provider's obligations regarding reporting and the protection of confidentiality for survivors.

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- None

LEGAL AND POLICY CONTEXT FACILITATOR GUIDE

INTRODUCTION

SLIDES 1-6 LEGAL AND POLICY CONTEXT (10-15 MINUTES)

Slide 2 notes
- It is important to understand what laws apply to or have implications for health-care providers' response to sexual violence, intimate partner violence and child sexual abuse.

Slide 3 notes
- It is the provider's responsibility to know the applicable laws and policies. It is the manager's responsibility to make providers aware of applicable law and policy.
- What forms of sexual violence and IPV are considered crimes under the applicable law?
- Are same-sex relationships criminalized?
- How are protection orders and regulations applied in practice? Do they protect or harm survivors?

Slide 4 notes
- Does the law have requirements about who may provide clinical care to survivors? For example, if the person wishes to report the rape officially to the authorities, the country's laws may require that a certified, accredited or licensed medical doctor provide the care and complete the official documentation.
- What are the national laws relevant to the management of the possible consequences of rape (e.g. emergency contraception, abortion, testing and prevention of HIV infection)?
- Specifically, what do laws and policies say age of parental consent for adolescents' access to care?

Slide 5 notes
- What are the legal requirements for health- care providers with regard to reporting cases of sexual violence or IPV to authorities?
- What are the consequences of not reporting for the survivors, and the health care provider?
- What are the legal and policy obligations or limitations to confidentiality of information and sharing data?
- Health-care providers need to be aware of the laws and obligations on mandatory reporting of sexual violence/rape and intimate partner/domestic violence to the police or authorities. While mandatory reporting is often intended to protect survivors, it may conflict with the guiding principles for working with survivors. It impinges on their autonomy, and ability to make their own decisions. It may raise safety concerns as women may experience retaliation, fear losing custody of their children, or face legal consequences (e.g. in countries where extramarital sex is illegal).
- Health- care providers need to understand their legal obligations (if any) and their professional codes of practice to ensure that survivors are informed fully about their choices and limitations of confidentiality where this is the case. By ensuring survivors are aware of mandatory reporting requirements, health-care providers can help survivors make informed decisions about what to disclose during a health visit.
- Who can issue/sign a medico-legal certificate?
- Who gets a copy of the certificate and where are the copies kept?

Slide 6
- What are the legal requirements with regard to forensic evidence? Who may collect it? Who can conduct forensic examinations? What is the minimum training required?
- Who can act as expert witness in court? Who is authorized to testify in court if applicable?
- What forms are required to document forensic evidence? Who keeps these or where are they kept?
- What samples and evidence can be stored and analyzed & in what time frame?
- What are the laws/policies regarding the chain of custody of the samples?

Activity 3 Understanding the legal and policy context (1-2 hours)

4

HISTORY AND EXAMINATION

4. HISTORY AND EXAMINATION

PREPARATION AND MATERIALS

OBJECTIVES

- Describe the purpose of obtaining informed consent and how to obtain informed consent
- Demonstrate skills to take history
- Describe how to use information from the history to guide the exam
- Know how to conduct physical examination
- Understand why there may not be injuries, and understand when a speculum exam is needed

AVAILABLE TRAINING RESOURCES

Presentation
4. History and examination

Facilitator guide
4. History and examination

Activities
2.1 Step by step guide to providing care and support
4.1 Informed consent role play
4.2 History taking role play
4.3 Virginity testing role play

Videos
4.1 Welcome the survivor
4.2 Informed consent
4.3 Medical history
4.4 History of the incident
4.5 Performing the general examination
4.6 Genital examination
4.7 Vaginal Speculum Exam
4.8 Anal examination

Participant handouts
4.1 Sample Consent form
4.2 Preparing to gather the story
4.2 Topics to cover when taking the history with a survivor
4.3 Examination checklist

REQUIRED SUPPLIES & MATERIALS

- Projector
- Laptop
- Space for group discussions
- Pen and blank paper
- Print outs of hand outs and scenarios for activities – depending on which activities you choose

KEY MESSAGES

- Before taking the history, providers should explain any obligations to report and the limitations of confidentiality
- Welcome the survivor, provide information, ask for consent
- Obtain consent separately for each aspect of the exam
- The history determines the examination, treatment and forensic evidence collection (if requested and feasible)
- The purpose of the examination is to guide medical care and treatment

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

Further resources for facilitators (optional)

- WHO (2014) Health care for women subjected to intimate partner violence or sexual violence: A clinical handbook, pg 40-48
- WHO (2020) Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings, pg 15-20

HISTORY AND EXAMINATION FACILITATOR GUIDE

INTRODUCTION

SLIDES 1-3 INTRODUCE THE SESSION

Slide 3 notes

- Briefly review the steps in care, and explain these steps will be explored in depth in this session and the next.
- Remind that at every step in the protocol, providers should always:
  1. Remember the **guiding principles,** treat the survivor with **dignity, respect** the survivor and their decisions, assure **privacy and confidentiality.**
  2. Practice the elements of **LIVES** - Listen, ask or inquire about needs, validate, enhance safety and support in connection with other services, and provide psychosocial support.

Activity 2.1 Step by step guide to providing care and support

Place **'Injuries that need care?'** on the wall, place lines with **YES** written on them, then **'Admit to hospital'** or **'Treat',** then a line with **NO** written on it to **First Line Support.** This should be placed above **First Line Support.**
Place **'Take complete history and physical exam. Assess emotional state'.**

ASSESS URGENT & LIFE-SAVING NEEDS

SLIDES 4-5 ASSESS AND TREAT URGENT AND LIFE-SAVING NEEDS

Slide 5 notes

- The **initial assessment** of a survivor may reveal severe medical complications that need to be treated urgently, and for which the patient may have to be admitted to hospital.
- These complications might include: extensive trauma (to genital region, head, chest or abdomen); asymmetric swelling of joints; neurological deficits; and/or respiratory distress.

SLIDES 6-7 CASE STUDY

Slide 6

Present the case study and ask the participants to choose 1 of the multiple choice answers.
A 25-year-old female comes to the clinic several hours after a sexual assault. She is crying and holding her right wrist, which is deformed and appears broken. The patient's vital signs are normal. She is awake and speaking normally.

What should the physician do?

A. Instruct the patient to calm down. Ask her about the sexual assault.
B. Call in support staff to keep the patient company until she stops crying and return after she is calm.
C. Perform a thorough physical examination.
D. Quickly order pain medication after ensuring that the patient has no medication allergies and set and apply a splint to the wrist.

Slide 7

The correct answer is D.

Quickly order pain medication after ensuring that the patient has no medication allergies and set and apply a splint to the wrist. The patient is awake, alert, and her vital signs are normal. After determining the patient has no immediate life-threatening conditions, care providers should treat the patient's pain. Quick pain control and supportive care, such as wrist splinting, creates trust and shows compassion. Leaving the patient in pain or instructing her to calm down is neither compassionate nor helpful. Delaying treating this patient's pain to perform a complete physical exam is not necessary or ethical given the patient's otherwise normal general appearance and stable vital signs.

WELCOME THE SURVIVOR AND ASK FOR INFORMED CONSENT

SLIDES 8-10 WELCOME THE SURVIVOR

Slide 8 notes

- Every clinic worker should be trained and knowledgeable in the first line support and LIVES after a survivor of GBV discloses that they have experienced GBV.
- However only health care providers trained in history, examination and providing medical care should conduct the history, examination.
- This may occur in different ways – the survivors comes for care and discloses to and receives all care from the same person, the survivor first discloses GBV to one health care worker and is referred to a 2nd health care worker.
- The following steps of welcoming the survivor may be done before providing first line support and LIVES – or should be done after the survivor is referred to you from another care provider.
- However you should continue to listen, inquire about needs and validate throughout the history and examination.

Slide 9 notes

- Assure her that you will keep what she says **confidential** and share it with only those who need to know in order to give care, unless she wants the police to take up her case or the law requires you to report. Any obligation to report disclosures of violence, particularly for children and adolescents, must be mentioned at the beginning, and the limitations of confidentiality must be highlighted.
- If the survivor is with someone, ask the survivor if it would be okay if you ask this other person to step out for a minute. Then ask the survivor if she/he want this person to be present during the consultation. Some survivors may come to the clinic with their partner, who may ask or demand to be present during the entire examination. This may not be safe for survivors, develop a plan on how to handle this (e.g., blame on clinic policy).
- Have an observer or **support person** present, preferably a trained support person or female health worker, introduce and explain role of observer

Slide 10 notes

IF...	The law requires you to report to police	THEN TELL HER	You will be doing this, what you must report & to whom
IF...	She wants to make a report to the police	THEN TELL HER	•What forensic evidence can be cillected •What evidence collection involves
IF...	She has not decided whether to go to police	THEN TELL HER	Evidence can be collected and held until she decides (if that is true in your context)

Video 4.1 Welcome the survivor

Discuss the video

- What did the physician do well?
- What was missing? What could be improved?

Ask:

- How did the provider demonstrate listening?
- Any non-verbal cues?
- What else could be done?
- Did the provider demonstrate inquiring or validating?
- What types of questions were used?
- How else could you response?

SLIDES 12-13 INFORMED CONSENT

Slide 12 notes

- Explain to the survivor will be examined and treated **only if** they want to.
- Describe **all aspects** of the exam: medical, pelvic exam, forensic evidence collection including photos if relevant and release of medical information and evidence to police (if the survivor chooses to).

- Explain that they can **refuse** to answer any questions in the history and can refuse any part of the examination and can stop at anytime.
- Invite and answer questions. Check if the survivor understands.

Slide 13 notes
- Ask the survivor to ask to decide whether they consent to each part (yes or no) and tick the corresponding boxes on the form. Ask the survivor to sign the consent form.
- Explain that this is a sample consent form, and will be provided in their handouts.

Video 4.2 Informed consent

- **Discuss the video**
- What did the physician do well?
- What was missing? What could be improved?
- **Summarize** that she provided clear information about what can be done, about privacy and confidentiality (this conversation is between me and you, unless your life is in danger"), the potential disadvantages of care (it can get uncomfortable), she let her know that she can take a break and can decline to answer any question ("If you are uncomfortable with a question you don't have to answer it. We can always stop anytime you want to."). However she did not mention medical care specifically and could mention this more. She did not say it is your choice and that Hawfswa could decline to receive care at all if she wanted to.
- **Discuss** confidentiality and the statement "This conversation is between me and you, unless your life is in danger. Can we continue?". Discuss that you must inform patients of mandatory reporting laws, and should consider breaching confidentiality if you fear that the patient is at risk of severe, imminent harm (such as suicide or child sexual abuse) and also consider the risks of breaching confidentiality.

SLIDES 15-16

Slide 15
Present the case study and ask the participants to choose 1 of the multiple choice answers.
A patient consents to a physical examination. The health care worker then explains the pelvic examination. The patient appears uncomfortable and becomes increasingly quiet and withdrawn. The health care worker asks if she would like more explanation. The patient nods "yes." The health care worker provides more information and then asks the patient if she consents to the examination. The patient shakes her head "no."

How should the health care worker respond?
A. Explain the pelvic examination in detail but accept the patient's final decision.
B. Explain that without the pelvic exam no one will believe her
C. Proceed with the entire exam, since it's in the best interest of patient.

Slide 16
Explain the answer is A. Explain the pelvic examination in detail but accept the patient's final decision. The health care worker provided a detailed explanation of the pelvic examination and the patient chose not to consent to it. The patient's choice must be respected. While a health care worker may disagree with a patient's decision, they must follow the patient's wishes. Saying no one will believe her is not supportive or respectful. The pelvic exam may be important if the case goes to court but it is not the only evidence that can be used. It is not appropriate for a care provider to give legal opinions or to pressure a patient into having an examination.

Activity 4.1 Informed consent

TAKING THE HISTORY

SLIDES 19-27 TAKING THE MEDICAL HISTORY

Slide 20 notes
- Taking the **history** is a critical element of sexual assault care. The patient's history guides and determines what to look for during the medical examination, what care and treatments to offer, what to document in the medical record, and what forensic evidence to collect

- Often, the history and the examination are the only documented evidence of the assault available, should the survivor decide to pursue legal options.

Slide 21 notes
- Review any papers so as to minimize requests to repeat the story as it can be traumatizing.
- Avoid asking questions already answered and documented.
- Explain **why** you asking each question and that learning what happened will help you give the best care, but they do not have to tell you anything that they do not want to. Do not force or pressure survivors to share details they do not want to.

Slide 25 notes
- **Assessment of mental state** is an important part of history-taking to ensure the survivor is competent to continue, and so that any mental health issues can be followed up. Also, documenting a confused mental state can help explain to courts, etc., any discrepancies in narrative or the impact on the survivor's mental health even if there is no physical evidence.
- There is no particular mental state that indicates, or is typical of, sexual abuse.

Video 4.3 Medical history

SLIDES 29-36 TAKING THE HISTORY OF THE INCIDENT

Slide 29 notes
- Ask "what happened" or **ask about the incident,** instead of using the words sexual violence, rape or abuse.
- Explain that learning what happened will help you give her the best care, but she does not have to tell you anything that she does not want to. She may omit or avoid describing painful, frightening or horrific details. It is the survivors' **choice** how much or little information they want to share. **Do not force** a survivor to talk about sexual violence she has experienced if she does not want to. Limit questions to what is required for medical care
- Let her tell her story in the way that she wants and **at her own pace.** Do not interrupt. If it is essential to clarify any details, ask after she has finished. Wait until the survivor pause or finish to ask clarification questions
- Continue use your active listening skills, to validate that the survivor is not to blame and it is not their fault.
- Do not make blaming remarks, such as "What were you doing there?"
- However, if a survivor clearly wants to talk about what happened, it is very important to listen actively, with empathy and without judgement.

Slide 30 notes
- Use **open-ended questions.** Open ended questions can not be answered with a yes or no, but allow the survivors to tell the full story without influencing or suggesting certain answers.
- Open-ended questions are the "who, what, when, where" questions that help you collect specific facts about a situation. Examples: Where did this happen?
- Do not ask **leading questions,** such as, "I would imagine that made you feel upset, didn't it?"
- Don't ask **"why"** questions, such as "Why did you do that?" They may sound accusing. Avoid questions that might suggest blame (for example, "What were you doing there alone?")

Slide 32 notes
- It is helpful to get an exact **timing of the incident** – to help guide what medication to provide.
- Ask about the **penetration** – if it was oral, vaginal or anal? Ask what the survivor was penetrated with – a penis, finger or foreign object?
- Ask about the **type of physical violence,** where on the body the violence was used. Ask about use of weapons, or restraints.

Slide 33 notes
- If there is more than one **assailant,** this increases the risk of potentially acquiring HIV.
- Assess if this is a **single or ongoing incident** – Ask has this happened before? When was the first time? How long has it been happening?
- If there are any **memory lapses or decreased level of consciousness,** consider asking if any substances were used as some perpetrators may use substances or drugs to facilitate abuse.

Slide 34 notes
- Survivors often do not have a linear way of sharing their experiences. They may often jump around, which can be confusing. They may also forget to tell a key part they intended to share.
- It can be **re-traumatizing** for some survivors to hear their story, so the care provider should ask the survivor whether or not the they would like to hear their story.

Slide 35 notes

- The medical history and examination form will help guide you on what to ask.

Video 4.4 History of the incident

Before showing the video, explain that this video describes a specific experience of sexual violence (or intimate partner violence depending on which video shown). This can be distressing or difficult for participants to hear, and they can feel free to step out if they need to.

SLIDES 37-38 CASE STUDY

Slide 37

Present the case study and ask the participants to choose 1 of the multiple choice answers
A health care worker asks the patient where and when the assault occurred. The patient replies, "It happened next to my grandmother's house." The patient has tears in her eyes and is quiet. The health care worker doesn't acknowledge the patient's answer, and quickly moves onto the next question. The patient declares she doesn't want to talk anymore.

What could the interviewer have done better?

A. Reassure the patient by saying, "I know this is hard, and you're doing great so far. Please continue only when you are ready and share only what you feel comfortable right now"
B. Ask the patient if she needs to take a break.
C. Both answers A and B.

Slide 38

Correct Answer C.

Comforting words, reassurance, and active listening might help the patient to feel more comfortable and allow the interview to continue. Rushing to the next question without acknowledging the patient's answer and emotions indicates that the health worker is more interested in filling in the form than in the caring for the patient. This could make the patient feel disrespected, uncared for, and that she is not in control of what is happening. Health workers should show compassion and patience by allowing a survivor to proceed through her care and treatment at her own pace or to stop at any time.

SLIDES 39-40 CASE STUDY

Slide 39

Present the case study and ask the participants to choose 1 of the multiple choice answers
A 22-year-old woman was sexually assaulted by soldiers and arrives at the clinic for care. During the patient history she states, "one of the soldiers raped me," and then pauses.

What is the most appropriate next question?

A. Did you fight back or scream?
B. Can you help me understand what you mean by rape?
C. Did he have any identifiable birth marks or scars?

Slide 40

Correct Answer B.

Asking her whether she fought back may seem judgmental and the patient may think you're saying that the assault was her fault because she did not resist the assailant.
Asking questions aimed at identifying the assailant is not directly related to her medical care and is the responsibility of police and legal authorities if the survivor chooses to report, not the responsibility of health workers.

See Activity 4.2 Taking the history role play

PERFORMING THE EXAMINATION

SLIDES 42-46 PERFORMING THE EXAMINATION

Slide 43 notes
- It is **not** the health care provider's responsibility to determine whether or not someone has been raped.
- The main reason for the physical and genital examinations is to **determine what medical care** is needed for the survivor. These examinations are also used to complete any **legal documentation.** Document your findings **without stating conclusions** about the rape.

Slide 44 notes
- Ask if the survivor wants to have a specific person present for support. Ask when the survivor is alone.
- If the survivor does not have someone specific, preferably an observer should be present. Seek consent for ensure that another person is present during the examination. The observer should be a trained support person or female health worker. It is essential to have a woman present if the provider conducting the examination is male. Introduce this person, explain that she is there to give the survivor help and support. Besides the observer, keep the number of people to a minimum
- Maximize efforts to have **only one examination.**
- Prepare all equipment and supplies before proceeding.
- Be professional, be organized, ensure that you have adequate time.

Slide 45 notes
- Give the patient **control** of the exam, of what will happen, of the pace, timing and components of the examination.
- **Explain** every step of examination and **obtain consent.** At each step of the examination, tell her what you are going to do, let her know when and where you will touch, and ask her permission before you do it.
- Explain every step of the examination and your findings as you go along using terms that she can understand
- Encourage her to **ask questions** and express her feelings and fears. Ask often if she has any questions and if you can proceed.
- Tell her that you will stop any time she says so, and can refuse any part of the exam. If she says "no", then stop the examination at that point.
- **Ask for permission** before touching her. Always look at the survivor before you touch her and pay attention to her appearance and emotional state.
- Ensure **privacy** keeping the room closed, having minimal interruptions and keeping the people in the room at a minimum. Never ask her to undress or uncover completely. Examine the upper half of her body first, then the lower half; and give her a gown, sheet or blanket to cover herself. Undress or uncover systematically - Respect her and restore her dignity.
- Reassure her that the examination findings will be kept **confidential** unless she decides to bring charges or if there are mandatory reporting laws.

Slide 46 notes
- Systematically examine the survivor,
- Look for signs that are consistent with the survivor's story, such as bruises, bite and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or perforated eardrums, which may be a result of being slapped.
- Examine the body area that was in contact with the surface on which the sexual violence occurred to see if there are injuries.
- If the survivor reports being throttled or choked, look in the eyes for petechial haemorrhages and on the neck for bruises or finger marks.

Video 4.5 Performing the general examination

This video includes sensitive images such as breasts and genitals to show how to correctly perform an examination and to document common injuries. The images are meant for educational purposes, some individuals or groups may find them inappropriate. Either make a group decision to block the photo viewer for sensitive images, or allow participants to leave if they choose.

Ask:
- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care worker should ask permission to remove head scarf or clothing.
Ask why do you think that physical examination can be difficult or even unbearable to the survivor?

SLIDE 48-51 PERFORMING THE GENITAL EXAMINATION

Slide 48 notes
- Being sexually assaulted/raped can be a traumatic event. Survivors may be sensitive to being examined or touched. Proceed slowly. Ask often if she is okay and if you can proceed. Be very careful not to increase distress.
- Ensure the survivor is as comfortable as possible
- Inform of when and where you will touch.
- Seek for permission/consent step by step.

Slide 49 notes
- Inspect in order: the mons pubis, inside of the thighs, perineum, anus, labia majora and minora, clitoris, urethra and introitus.
- Check for injuries to the vulva, introitus and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards.
- Look for any sign of **infection,** such as ulcers, vaginal discharge or warts.
- Look for **genital injury,** such as bruises, scratches, abrasions, tears (often located on the posterior fourchette).
- Note the location of any tears, abrasions and bruises on the pictogram and the examination form.
- Note any previous scars from female genital circumcision/mutilation or childbirth.

Slide 50 notes
- **Virginity testing** is a **harmful practice.**
- It increases distress and harms to those examined; can cause pain and mimic the original act of sexual violence, exacerbating the survivors' sense of disempowerment and re-victimization. and is a violation of their human rights.

Slide 51 notes
- **Virginity (or "two-finger") testing** has **no medical or scientific validity,** It should never be conducted. It has no role in clinical management of rape.
- Digital examination of anus or vagina is rarely warranted and not an indication of likelihood or frequency of penetration. They should **not** be used to assess the tone or elasticity of the vagina or anus or to comment on the likelihood or frequency of penetration.
- There is no examination that can prove that a girl or woman has had sexual intercourse or is sexually active, including the appearance of girl's or woman's hymen. Hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girl.
- A survivor's sexual history prior to the rape is irrelevant to determining whether or not rape occurred.

Video 4.6: Genital examination
This video includes sensitive images such as breasts and genitals to show how to correctly perform an examination and to document common injuries. The images are meant for educational purposes, some individuals or groups may find them inappropriate. Either make a group decision to block the photo viewer for sensitive images, or allow participants to leave if they choose.

Ask:
- What did the physician do well?
- What was missing? What could be improved?

Explain that you should ensure you get all the information when you ask the history – but of course we may forget and this is acceptable. Discuss the indications for a vaginal speculum exam, and that there was no indication for a vaginal examination in this exam.

See 4.3 Activity: Virginity testing

Slide 54 Vaginal speculum exam

- Perform a vaginal speculum exam **only for the following indications:**
  - heavy or uncontrolled vaginal bleeding
  - pain
  - foul smelling vaginal discharge
  - when a foreign object is suspected
  - for forensic evidence collection
- A speculum exam should not be performed on: a prepubescent child, any patient who declines the exam.
- A speculum exam on a woman in the second half of pregnancy with vaginal bleeding can cause increased bleeding and should be done only by a health care worker trained in the management of pregnancy complications.
- If there are signs of bleeding, evaluate its source:
  - Bleeding originating from inside the cervical os is usually due to normal menstruation and not related to injury, but may also signal miscarriage of a pre-existing pregnancy.
  - Bleeding originating from the vaginal wall or the outside of the cervix is usually due to injury.
  - Foul smelling discharge from the vagina or cervix may indicate the presence of foreign matter.
  - If you suspect retained foreign matter, gently try to retrieve it and carefully inspect the vaginal walls for injuries.
  - Do not remove a foreign object if it appears deeply embedded in tissue. Refer such patients to a higher level of care.

Video 4.7 Vaginal speculum exam

This video includes sensitive images such as breasts and genitals to show how to correctly perform an examination and to document common injuries. The images are meant for educational purposes, some individuals or groups may find them inappropriate. Either make a group decision to block the photo viewer for sensitive images, or allow participants to leave if they choose.

Slide 56 Anal exam

- Note the shape and dilatation of the anus; any fissures around the anus; the presence of faecal matter on the perianal skin; and any bleeding from rectal tears.
- Most rectal injuries heal without treatment.
- Heavy bleeding from the rectum (more than just blood on underclothes or when wiping) or loss of control over urine or feces may indicate more severe injuries.
- Internal injuries can result from either violent penile penetration or penetration by a foreign object.
- Such injuries can lead to severe complications, such as fistula or an intra-abdominal infection, and require referral to a facility that can perform surgical repair.

Video 4.8 Anal examination

SLIDES 58-59 INJURY INTERPRETATION AND SUMMARY

Slide 58 notes

- There may be no injuries found when there is a lack of provider training. Without training, providers may not perform an examination properly, know common locations of injuries, lack poor lighting, knowledge of techniques for examinations – and providers may miss injuries.
- Younger and post-menopausal survivors are more likely to have injuries.
- Even when a female survivor is examined immediately after rape, there is **only visible injury in less than 50%** of the survivors.

5

DOCUMENTATION

5. DOCUMENTATION

PREPARATION AND MATERIALS

OBJECTIVES

- Know how to document in a safe, confidential manner
- Explain the importance of correct documentation.
- Understand how to correctly fill out the medical history and examination form.

AVAILABLE TRAINING RESOURCES

Presentation
5. Documentation

Facilitator guide
5. Documentation

Video
5. Documentation guidelines

Activities
5. Documentation

Participant handouts
5.1 Documenting the Examination
5.2 Describing features of physical injuries
5.3 Sample history and examination form

REQUIRED SUPPLIES & MATERIALS

- Projector, Laptop
- Pen and blank paper workbook for each participant
- Printouts of sample medical history and examination forms and pictograms for the activity

KEY MESSAGES

- Document the description of the incident in a clear, objective, non-judgmental way
- Document injuries clearly, precisely and systematically
- Documentation must be safely, securely stored

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO 2020 Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings, pg 20-21

DOCUMENTATION FACILITATOR GUIDE

SLIDES 1-14

Slide 3 notes
- It is **not** the health care provider's responsibility to determine whether or not someone has been raped or experienced violence, or to prove or disprove that rape or violence occurred.
- Your responsibility is to **document** your medical findings and observations in a **thorough and objective way.**
- Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.
- Your responsibility is to provide non-judgmental support and to listen and believe.
- The clinic record is sometimes the only documentation of the assault. It may be subpoenaed by the court. It can give information on the approximate timing of the assault. For this reason it should include descriptions of any pre- existing injuries.

Slide 4 notes
- Tell the survivor what you would like to write down and why. Ask if this is okay. Follow the survivors wishes. Offer a survivor a choice of what and how things are documented. If there is anything she does not want written down, do not record it.
- Do not interrupt or stop survivors from speaking while recording the history. While listening, write down relevant details they are describing
- Address any confidentiality concerns the survivor has about who has access to any written records and how they are stored.

Slide 6 notes
- **Record the interview** in a clear, complete, objective, non-judgemental way.
- Document verbatim/**in the survivors own words.** Use quotations to identify the patient's own words. Write the incident in a chronological order
- Do not reformulate the verbal account of the patient.
- Make sure to write their exact words of the most important details
- Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant such as "He said he'll break my neck if I shout out." There is no need to write everything the survivor says, but make sure not to miss relevant details
- Do not be afraid to include the name of the assailant, but use qualifying statements, such as "patient states" or "patient reports".
- Avoid the use of the term "alleged" or presumptive, as it can be interpreted as meaning that the survivor exaggerated or lied and gives the message we do not believe survivors.

Slide 7 notes
- **Document injuries** clearly, completely, objectively, precisely, systematically
- Document all injuries using standard terminology and describing the characteristics of the wounds.
- Record all your findings and observations clearly and fully on the examination form and the pictograms
- Document and record the type, size, colour, location and form of any bruises, lacerations, injuries, ecchymoses and petechiae.
- Health-care providers who have not been trained in injury interpretation should limit their role to describing injuries in as much detail as possible, without speculating about the cause, as this can have profound consequences.
- If you are trained, you may write the possible cause of injuries – but do not speculate. It may be helpful to note the cause or suspected cause of these injuries or other conditions, including who injured her.
- It is not the health care provider's responsibility to determine whether or not someone has been raped. Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings.

Slide 8 notes
Again, record your findings at the examination in a clear, complete, objective, non-judgemental way.
- Do not document anything regarding virginity. Virginity testing is a harmful practice and not recommended.
- If there are no injuries, simply write "no injuries seen". The absence of injuries should not lead to the conclusion that no sexual violence took place.

Slide 9 notes
- The medical history and examination form will guide you in what to ask and document.

Slide 10 notes
- Document the injuries on pictograms as well.

Slide 11 notes
- Document the injuries on pictograms as well.

Activity 5 Documentation

Video 5 Documentation guidelines

6

MEDICAL CERTIFICATE AND FORENSIC EXAMINATION

6. MEDICAL CERTIFICATE AND FORENSIC EXAMINATION

PREPARATION AND MATERIALS

OBJECTIVES

- Know how to complete a medical certificate
- Know when to decide to collect forensic evidence
- Know how to collect forensic evidence and how to support or facilitate this

AVAILABLE TRAINING RESOURCES

Presentation
6. Medical certificate and Forensic examination

Facilitator guide
6. Medical certificate and Forensic examination

Activity
6. Forensic evidence collection (30 minutes)

Videos
6.1 Introduction to forensic evidence collection
6.2 Collecting forensic evidence
6.3 Documenting the survivors history
6.4 Collecting evidence before the physical exam
6.5 Collecting evidence during the physical exam
6.6 Collecting evidence from the external genitalia and anus
6.7 Collecting evidence from the vagina and rectum
6.8 Preparation, storage and dissemination of evidence
6.9 Release of evidence
6.10 The importance of forensic evidence

Participant handouts
6.1: Sample medical certificates
*The following should **ONLY** be given if forensic evidence collection can be done within that context:*
6.2: The forensic medical examination
6.3: Medico-legal evidence in sexual violence

REQUIRED SUPPLIES & MATERIALS

- Projector, laptop
- Pen and blank paper workbook
- Print outs of the scenarios for the activity – depending on which activities you choose

KEY MESSAGES

- Collect forensic evidence only when all four conditions are met
- Separate consent is needed for a forensic examination
- The assault history guides forensic evidence collection
- Time elapsed and activities undertaken after the incident determines whether evidence can be found
- Storage that avoids contamination, labelling and detailed documentation are essential
- Health care providers may need to provide testimony. They cannot conclude whether evidence points to rape. That is for the courts to establish.

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2020) Clinical management of rape and intimate partner violence survivors Developing protocols for use in humanitarian settings, Annex 3 Forensic evidence collection, pg 46-48
- WHO, UNODC (2015) Strengthening the medico-legal response to sexual violence.

MEDICAL CERTIFICATE AND FORENSIC EXAMINATION FACILITATOR GUIDE

This session can be given in a short or longer version.
If forensic evidence will not be collected in the context, give a short version and **STOP** where indicated in the facilitator guide.
If forensic evidence will be collected in the context and if time allows, consider giving
the full version of the presentation – including the videos and the activity.

INTRODUCTION

Slides 1-2 Introduce the session

MEDICAL CERTIFICATE

SLIDES 3-4 MEDICAL CERTIFICATE

Slide 3 notes

- Physical and/or genital trauma or injuries can be **evidence** of force and should be documented and recorded on pictograms. Inform the survivor that some injuries might become more visible after some days and that, if this happens, they should return for examination and documentation.
- On the medical certificate: Note general appearance and functioning of the patient. Describe in detail all recent and old **injuries**. Note **limitations** to the examination (e.g., poor lighting, delays in reporting).
- The health-care provider should keep one copy of the medical certificate locked away with the survivor's file, in order to be able to certify the authenticity of the document supplied by the survivor before a court, if requested. The survivor has the sole **right to decide** whether and when to use this document.
- The medical certificate should be available for **free**; survivors should not be charged for it.
- Depending on the setting, the survivor may use the certificate up to 20 years after the event to seek justice or compensation.

Slide 4 notes

- Penetrative sexual activity of the vagina, anus or mouth **rarely** produces any objective signs of injury.
- The hymen may not appear injured even after penetration has occurred. Hence, the **absence of injury does not rule out penetration.**
- Penetration of the pre-pubertal genitalia (and some other forms of sexually abusive actions) do not necessarily result in physical injury.
- The health-care practitioner cannot make any comment on whether the activity was consensual or not.

FORENSIC EVIDENCE

SLIDES 5-7 FORENSIC EVIDENCE

Slide 5 notes

Forensic evidence may be used to support a survivor's story, to confirm recent sexual contact, to show that force or coercion was used, and possibly to identify the attacker. Proper collection and confidential and secure storage of forensic evidence can be key to a survivor's success in pursuing legal redress.

Slide 6 notes

- The **four conditions** listed on the slide must be met to conduct a forensic examination:
  1. Whether to collect forensic evidence depends on **whether the survivor wants** legal redress, or whether there is a legal obligation to report. However health care providers should not participate in forcible collection of forensic evidence. Evidence should only be collected and should only be released to the authorities if the survivor decides to proceed with a case. If a survivor is unsure if they want to report to the police and would like the option at a later time, you can still document findings on the medical certificate. Only if the survivor wants the option to report to the police at a later time, if there is the capacity to safely, securely store forensic evidence and if stored forensic evidence can be collected at a later time – then forensic evidence could be collected and stored. The role of the health practitioner is to provide relevant up to date information to the survivor so that they can make an informed decision about forensic examination. Their role is NOT to make the choice for them, we must respect their autonomy

2. Collection of forensic evidence should be based on the account of the sexual assault or abuse and **what evidence can be collected, stored and analysed.** Some types of forensic samples require simple laboratory facilities, others like DNA require specialized lab facilities. The capacity of laboratories to analyze forensic evidence varies considerably, and in humanitarian contexts is extremely limited. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence. Familiarize yourself with your national protocols and resources, what evidence can be collected, stored and accepted. Carefully consider whether or not to offer a forensic examination to a survivor, and provide all information to the survivor to help them make an informed decision. It is important to give the survivor information about the legal system, each step of reporting, and the potential harms and repercussions of reporting. Too often, evidence is collected when it is not required or relevant, or can be stored or analyzed. This adds unnecessary distress and trauma.
3. Whether to collect forensic evidence depends on **whether the survivor presents within 7 days of sexual assault.** If this is done, it can be used in court to argue that there is no evidence, when in fact no evidence could be expected if the person came after 7 days or had taken a bath, etc. Too often, also, evidence is collected when it cannot be storage or analysed. After 7 days finding any forensic evidence is not likely. Encourage the woman to receive medical care and treatment even if she declines a forensic exam.
4. Only **providers that are specifically trained** and have been supervised doing it, and are designated to collect forensic evidence should undertake full forensic examination.

Slide 7 notes
- Do not collect evidence that cannot be stored or used
- If the 4 elements are not present, then the evidence might not be recognized or used by a court, the harms of the invasive forensic evidence collection would outweigh any beneficial to the survivor. Too often, evidence is collected when it is not required or relevant, or can be stored or analyzed. This adds unnecessary distress and trauma.
- Even if evidence is not collected, conduct a full physical examination and document well – including offering a medical certificate (if the survivor consents). This can be useful if the survivor decides to pursue a legal case.

STOP HERE IF FORENSIC EVIDENCE WILL NOT BE COLLECTED IN THIS CONTEXT.

SLIDES 8-12 FORENSIC EVIDENCE COLLECTION AND STORAGE

Slide 8 notes
- If the health-care provider is collecting evidence, the narrative should guide what evidence to gather.

Slide 9 notes
- There are different purposes and processes for collecting specimens for health (pathology) and legal (forensic) investigations.
- Pathology specimens are analyzed to establish a diagnosis and/or monitor a condition.
- Forensic specimens are used to assess whether an offence has been committed and whether there is a link between individuals and/or locations.
- Pathology specimens may be significant as forensic evidence – for example, if an STI is found.

Slide 10 notes
- **Photographs** provide a useful adjunct to document injuries.
  1. Photograph any injuries while ensuring confidentiality if possible.
  2. Ensure that the photographs **do not allow direct identification of the individual.** Use a confidential code system to enable authorized staff to identify the individual. Note when photographs were taken.
  3. Obtain **separate consent** for collecting forensic evidence including any photographs
- Collect **specimens** from locations where biological material (for example, semen) might have been deposited: skin, hair and oral, vaginal and anal orifices. Swabs may be taken from the vagina, anus or oral cavity, if a penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis.
- **Foreign material** (soil, leaves, grass) on clothes or body or in hair may corroborate the survivor's story. Foreign hairs may be found on the survivor's clothes or body. Pubic and head hair from the survivor may be plucked or cut for comparison
- **Clothing:** torn or stained clothing may be useful to prove that physical force was used or may contain DNA, including underwear.
- **Hair** – cut from the scalp may be useful if there is suspicion or allegation of covert drug administration.

Slide 11 notes

- Persistence of biological material is variable. It will be **affected by time, activities (washing) and contamination** from other sources.
- These **maximum times** are those generally agreed by forensic experts, but more evidence is needed.

Slide 12 notes

- The forensic laboratory requires information about the specimen (time, date, patient name/ID number, nature and site of collection) and what is being looked for.

Forensic evidence videos

- Video 6.1: Introduction to forensic evidence collection
- Video 6.2: Collecting forensic evidence
- Video 6.3: Documenting the survivors history
- Video 6.4: Collecting evidence before the physical exam
- Video 6.5: Collecting evidence during the physical exam
- Video 6.6: Collecting evidence from the external genitalia and anus
- Video 6.7: Collecting evidence from the vagina and rectum
- Video 6.8: Preparation, storage and dissemination of evidence
- Video 6.9: Release of evidence
- Video 6.10: The importance of forensic evidence

Activity 6 Forensic evidence

SUMMARIZE

The **4 conditions** for collecting forensic evidence are:

1. The survivor **wants to** go to the police
2. The survivor has come **within 7 days** after sexual assault
3. **Health care provider trained** in forensic examination is available
4. **Forensic science laboratory is available**

7

CLINICAL CARE AND TREATMENT

7.CLINICAL CARE AND TREATMENT

PREPARATION AND MATERIALS

OBJECTIVES

- Know how to provide appropriate treatment and care and demonstrate clinical skills to respond to the needs of survivors of sexual assault within 72 hours after the assault and for those seeking care 72 hours or more after the assault
- Describe the use of the emergency contraception pill, and which patients should be offered ECP
- Describe the use of HIV PEP, and which patients should be offered HIV PEP
- Describe the use of STI prophylaxis, and which patients should be offered STI prophylaxis
- Demonstrate the skills to assess risk and to support safety planning
- Know what resources are available in the community, and demonstrate knowledge to help survivors access resources and services
- Describe common psychological reactions to sexual violence and demonstrate the ability to provide basic psychosocial support
- Know how to assess mental health issues and offer or refer to mental health care

AVAILABLE TRAINING RESOURCES

Presentation
7. Clinical care and treatment

Facilitator guide
7. Clinical care and treatment (below)

Activities
2.1 Step by step guide to providing care and support
7.1 Case studies on ECP
7.2 Case studies on treatment for sexual assault
7.3 Grab bag on medical care
7.4 Role play Enhancing safety and offering support
7.5 Case studies on referral to support services
7.6 Brainstorm mental health consequences
7.7 Story telling – mental health consequences
7.8 Discussion on coping skills
7.9 Stress reduction and relaxation techniques
7.10 True or false – mental health care

Videos
7.1 Preventing unwanted pregnancy
7.2 Preventing HIV
7.3 Preventing STIs
7.4 Hepatitis B vaccination
7.5 Enhancing safety and connecting with support
7.6 Assessing and managing suicide

Participant handouts
7.1 Post-rape treatment timelines
7.2 Protocols for emergency contraception
7.3 Protocols for emergency contraception using oral contraception
7.4 Protocols for prevention and treatment of sexually transmitted infections
7.5 Protocols for post-exposure prophylaxis of HIV infection
7.6 Questions to assess immediate risk of violence and making a safety plan
7.7 Strengthening positive coping methods and exploring social support
7.8 Exercises to help reduce stress
7.9 Checklist for follow-up visits with a rape survivor

REQUIRED SUPPLIES & MATERIALS

- Projector, laptop
- Pen and blank paper workbook for each participant
- Flip chart, markers
- Large space for participants to move around
- Sign with "yes" or "no"
- Print outs of activities – depending on which activities you choose

KEY MESSAGES

- Immediate treatment includes first-line support and, as needed, treatment of injuries, tetanus vaccination, ECP, HIV PEP, STI prophylaxis and hepatitis B prevention
- HIV PEP can be used up to 72 hours (3 days) to prevent transmission of HIV. It should be started as soon as possible after possible exposure to HIV.
- Emergency contraception pill (ECP) can be used within 120 hours (5 days) after the rape to prevent a potential pregnancy. It is more effective given as soon as possible after unprotected sex.
- Determine and offer appropriate care depending on the time of presentation. Discuss all available treatment options with the survivor.
- Risk assessment gauges immediate safety needs
- Trust your patient when she says that she faces severe danger
- Support the patient to make a plan to improve her safety
- Linking and referring her to support services that can respond to her needs is a key activity
- All front-line providers can offer basic psychosocial support
- Basic psychosocial support includes:
  - Assessing mental state, strengthening coping mechanisms, linking with social support and stress reduction exercises
  - Assessing survivors with thoughts of suicide or self-harm, continuing mental health symptoms for moderate–severe depression and PTSD and refer to MH specialists

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2019) Clinical management of rape and intimate partner violence survivors, Providing treatment, Enhancing safety and referring for additional support, pg 22-29, Additional care for mental health and psychosocial support, pg 33-35
- WHO Guidance on provider-initiated HIV testing and counselling in health facilities
- WHO Hepatitis B fact sheet
- WHO (2016). Guidelines for the treatment of Chlamydia trachomatis. Geneva
- WHO (2016). Guidelines for the treatment of Neisseria gonorrhoeae. Geneva.
- WHO (2016). Guidelines for the treatment of Treponema pallidum (syphilis). Geneva.
- WHO (2014) Clinical practice handbook for safe abortion. Geneva.
- International Consortium for Emergency Contraception (ICEC) (2018). Emergency contraceptive pills: medical and service delivery guidelines, fourth edition. Washington (DC).
- World Health Organization (WHO), United Nations High Commissioner for Refugees (UNHCR) (2015). mhGAP humanitarian intervention guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies. Geneva: WHO.
- Norwegian Church Aid (2020) Integrating Therapeutic Interventions into Gender-based Violence Case Management

CLINICAL CARE AND TREATMENT FACILITATOR GUIDE

INTRODUCTION

SLIDES 1-4 INTRODUCTION

Activity 2.1 Step by step guide to providing care and support

Place **'Conditions found that need treatment', and 'Treat or refer**' on the wall, with tape with yes written on it between **'Take complete history and physical exam. Assess emotional state' and 'Treat or refer'.**
Place '**Within 72 hours since assault'", 'Within 5 days?', Offer HIV PEP' 'Offer emergency contraception, and 'Offer STI prevention/ treatment' on the wall.'** Connect the signs with tape indicated yes or no based on the Pathway for initial care after assault.

Slide 5 Time of consultation
- Care depends on the time between the incident and the time survivors access care.

TREATMENT OF INJURIES

SLIDES 6-9 TREATMENT OF INJURIES

Slide 7 notes
- Some **injuries can be life threatening** such as extensive wounds or injuries, to the genital region, head, chest or abdomen, facial wounds with swelling, vaginal bleeding for pregnant women, internal bleeding, severe acute pain, broken/fracture bones, burns, gun shot wounds, extensive bleeding, neurological deficits including inability to speak or problems walking, respiratory distress and sepsis, suicide attempts.
- Be aware of your hospital or health facilities capacity and referral procedures. **Provide emergency care or refer** immediately for urgent hospitalization and management. This must take precedence over all other forms of care offered to the survivor.
- However, if feasible before referring make sure the patient is stable and that you have provided painkillers.
- Also, if feasible **quickly evaluate the possibility to administer immediate treatment (STI prevention, HIV PEP; ECP)** and offer, as the effectiveness decreases with the passage of time. This is because we may not be aware of how long the referral process will take, given such factors as availability of transport, the state of roads, checkpoints among others.

Slide 8 notes
- Less severe injuries can usually be treated on site.

Slide 9 notes
- Simple injuries such as tears, superficial cuts, abrasions can be treated at site.
- Clean any tears, cuts and abrasions and remove dirt, faeces and dead or damaged tissue. Simple clean, fresh wounds within 24 hours can be sutured at site. After this time, they will have to heal by second intention or delayed primary suture.
- Do not suture very dirty wounds or human bites.
- If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.

SLIDES 10-12 TETANUS VACCINATION

Slide 11 notes
- **Tetanus toxoid** is available in several different preparations. It offers **active protection** against tetanus infection. Please check local vaccination guidelines for recommendations.
- **Tetanus immunoglobin** offers **passive protection,** is expensive and is not always available.

Slide 12 notes
- Use this table to decide whether to administer tetanus toxoid vaccination (which gives active protection) and tetanus immunoglobulin, if available (which gives passive protection).
- Offer only tetanus toxoid if wounds are clean and < 6 hours old or minor wounds
- Ask if they have received doses in the past. Many people, especially women who have given birth, may have received the

tetanus vaccination. Ask the survivor. If the survivor does not recall, or is not sure of her vaccination status, go ahead and give the vaccination. Do not miss any opportunity to offer vaccination.
- If the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes, and different sites of administration.
- Advise survivors to return to a health facility to complete the vaccination schedule for full protection (i.e. second dose at 4 weeks, third dose at 6 months to 1 year).

Video 7.1 Tetanus vaccination

Discuss the video
- What did the physician do well?
- What was missing? What could be improved?

EMERGENCY CONTRACEPTION

SLIDES 14-20 EMERGENCY CONTRACEPTION

Slide 15 notes
- Emergency contraception pill (ECP) can be used **within 120 hours (5 days) after the rape** to prevent a potential pregnancy. It is more effective given as soon as possible after unprotected sex.
- You may ask the woman if she has been using an effective contraceptive method, such as oral contraceptive pills, injectables, implants, an intrauterine device (IUD) or female sterilization. If so, it is not likely that she will get pregnant
- There are **no absolute contraindications** to providing ECP. Any woman or girl can take EC pills; there is no need to screen for health conditions.
- For **pre-pubertal adolescent girls:** EC pills can be offered to those who have reached Tanner Stage 2 or 3 – that is, who have onset of secondary breast development – as they may face **risk of unwanted pregnancy** if they ovulate before the onset of menstruation.

Slide 16 notes
- Provide information, education and counselling so that she can make **an informed decision.** Allow her to ask any questions that she may have. The survivor should understand that it is her choice to whether or not use EC.
- It acts to delay the release of an egg.
- It is however **not 100% effective.** The efficacy decreases with passage of time. The longer the delay in taking ECP, the lower the effectiveness.
- If she had other acts of unprotected sex since her last menstrual period, she may already be pregnant. You will find this information during the history taking process. A review of the gynae history can give you information to rule out an existing pregnancy.
- However EC does not cause termination or abortion of an existing pregnancy, or harm the pregnancy or fetus.
- ECP may cause **nausea and vomiting**. If someone vomits within 2 hours after taking EC pills, return for another dose as soon as possible. The side effects are usually minor.
- While EC pills, STI antibiotics treatment and HIV PEP **can be taken together at the same** time without harm. However, since nausea is a common side effect an anti-vomiting or antiemetic tablet can be given as well. EC and PEP can be taken together, and antibiotics can be taken at different times and along with food to reduce nausea.

Slide 17 notes
- Advise the survivor to **return** if their next menstrual period is **more than 1 week late.**
- EC pills are not meant for regular use. More effective continuing contraceptive methods are available. If she requires long-term contraception, provide contraception or refer her appropriately.
- However, if a woman chooses not to use long-term contraception and is at risk of unintended pregnancy she can also receive a supply of EC pills to take home and use for future need.

Slide 18 Pregnancy test
- A **pregnancy test is not required** or necessary before giving ECP.
- Taking ECP will cause no harm if the woman is already pregnant, it will not end an existing pregnancy or harm the fetus. ECP should not be delayed or denied if a test is not available of if the survivors does not want one.
- However a pregnancy test can provide helpful information.
- Remember that pregnancies take about 2 weeks to be detected in a pregnancy test. A positive test result within 5 days from the rape indicates a pre-existing pregnancy.
- Pregnancy testing after 72 hours from the rape will be discussed later on.

Slide 19 notes
- There are three regimens for EC pills.
- Combined ECP are less effective and have more side-effects than LNG or UPA.

Slide 20 Copper IUD
- A copper IUD, sometimes called an intrauterine contraceptive device (IUCD), can also be used as a **method of emergency contraception.**
- The copper IUD works by preventing sperm from fertilizing the egg (by inhibiting sperm motility, reducing sperm function and survival).
- This option is more effective for EC than EC pills. The IUD offers long-term pregnancy protection and can be maintained for years after insertion. Fertility returns with no delay after this IUD is removed.
- IUD insertion may be distressing or traumatic after rape.
- A **negative pregnancy test is required before insertion.**
- If an IUD is inserted, make sure you **give full STI treatment** as per the protocol.
- Insertion of IUCD is a sterile and invasive procedure. It **requires skilled health care worker.**

Video 7.2 Preventing unwanted pregnancy

Discuss the video
- What did the physician do well?
- What was missing? What could be improved?

Explain that the doctor should also explain how ECP works, the side effects, ask if the patient wants to take ECP and explain when to expect her next period to come and discuss methods for ongoing contraception.

Activity 7.1 Emergency contraception case studies

HIV POST-EXPOSURE PROPHYLAXIS (PEP)

SLIDE 23-29 HIV POST-EXPOSURE PROPHYLAXIS

Slide 23 notes
- Start HIV PEP as **soon as possible and up to 72 hours** after possible exposure to HIV.

Slide 24 notes
- Health-care providers should **provide information on risk factors** for HIV transmission so that survivors are able to make an **informed decision** about whether to take HIV PEP.
- There is a **risk of HIV transmission** if the survivor has been exposed to bodily fluids that may pose a risk of HIV infection through wounds, broken skins or tears in other mucous membranes. Body fluids with potential to transmit HIV through wounds or tears in other mucous membranes include: blood, blood-stained saliva, genital secretions, rectal fluids blood, blood-stained saliva, genital secretions and rectal fluids.
- There is a **higher risk of HIV transmission with rape compared to consensual sex** due to potential physical force or violence contributing to vaginal abrasions, tears or lacerations – including non-visible injuries.

Slide 25 notes
- However there are instances when the risk is much higher

Slide 26 notes
- HIV PEP should be started **as soon as possible and up to 72 hours** after possible exposure to HIV. All survivors of rape are at risk of HIV infection.
- HIV PEP is **not recommended if the survivor presents after 72 hours,** it is no longer effective.
- HIV PEP is **not recommended,** even within 72 hours, **when the survivor is living with HIV.** If the survivor is living with HIV and not taking antiretroviral therapy, she should be referred for HIV treatment immediately.
- Not all survivors need PEP. If there is no penetration with a penis, or no contact with bodily fluids PEP is not indicated.

Slide 27 HIV testing

- **HIV test is recommended** before PEP but **NOT mandatory.**
- A positive HIV test within the window period of 3 months indicates the patient had a pre-existing HIV infection.
- **Offer HIV counselling** using language that the survivor is able to understand including: a brief and simple explanation of HIV, the different ways the virus can get into the body, window/Incubation period, testing procedure (waiting time, 1 line, 2 lines), the benefits of knowing one's HIV status.
- When a survivor is too overwhelmed, distressed or traumatized to receive an HIV test and declines the HIV test, offer HIV PEP without the HIV test. Offer for the patient to return for an HIV test.
- Do not offer HIV testing if you do not have the possibility to offer care or refer to care. If the test is not available, give the full course of PEP.

Slide 28 notes

- Taking PEP to prevent HIV is the survivor's decision. Provide adequate information for the survivor to make an **informed decision,** encourage the survivor to ask questions.
- Review with the risk factors for HIV infection (such as whether there was more than one perpetrator or whether the exam found lacerations).
- HIV PEP can lower her chances of acquiring HIV, but it is **not 100% effective.**
- The medication needs to be taken for **28 days,** either once or twice daily depending on the regimen used.
- It is important to **complete the full course of PEP** to ensure protective efficacy.
- **Side-effects** include nausea, tiredness and headaches. For most people, the side-effects decrease in a few days. Ensure that the survivor understands that these are not permanent and suggest that if they experiences any of the side effects, do not stop the drugs on her own but take her dose as prescribed. Advise the patient to return to the clinic if she experiences side-effects that do not go away in a few days, if she is unable to take the medications as prescribed, or if she has any other problems.

Slide 29 notes

- Administer HIV PEP **as soon as possible**. To avoid delay, PEP can be started before the complete history and physical.
- Choose drugs based on national guidelines or current WHO ARV guidelines
- Triple therapy (three medications) of antiretroviral (ARV) regimen is preferred, but 2 drug regimen is also effective.
- Where applicable, choose the fixed dose combinations. This reduces the number of pills the survivor has to take daily, enhancing adherence.
- Nevirapine (NVP) should not be offered for PEP due to high toxicity risks in HIV-negative individuals that can lead to a higher likelihood of PEP discontinuation.
- HIV PEP is safe for pregnant women and for children with dosage adjustment.
- A 28-day prescription of ARVs should be provided. The first visit may be the only opportunity for consultation. There are many barriers to coming back.
- If you don't have HIV PEP in your health facility, refer the survivor as soon as possible (within 72 hours) to a clinic where this service can be provided.

Slide 30 notes

- **Adherence** is an important element of delivering PEP. Discuss:
  1. It is important to remember to take each dose, and so it is helpful to take it at the same time every day, such as at breakfast and dinner. Taking the pills at regular intervals ensures that the level in the blood stays about the same.
  2. An alarm on a mobile phone or some other device can be a reminder to take the pills, or a family member or friend can help remember.
  3. Offer reminder calls or messages if safe and appropriate.
- Educate survivor what to do **in case of a missed dose of HIV PEP:**
  1. If it is a once daily regimen: if the survivors forgets to take medication on time and if it is less than 12 hours late should still take it, if it is more than 12 hours late she should wait and take the next dose at the regular time.
  2. If it is a twice-daily regimen and if a dose is missed, the survivor should not take two doses at the same time

- **If test result is positive: refer** for HIV treatment and care.
- Do not offer HIV testing if you do not have the possibility to offer care or refer to care.

Video 7.3 Preventing HIV

Discuss the video

- What did the physician do well?
- What was missing? What could be improved?

Explain that the doctor should explain what the side effects are, how to manage them, and discuss strategies to improve adherence.

SLIDE 32-33 CASE STUDY

Slide 32 notes
A 26 year old woman comes into your clinic, she was raped by 2 men at a checkpoint while fleeing her village 1 day ago. She is worried about contracting HIV.
What do you do?
A. Inform her the risk of HIV is low, re-assure her that she is healthy.
B. Ask her to tell you where the check point is and test the men at the checkpoint for HIV.
C. Offer her 28 days of HIV PEP and give her information on the risks, benefits and side effects.
D. Offer the patient 1 weeks of HIV PEP and ask them to come back

Slide 33 notes
Correct answer C.
Offer her 28 days of HIV PEP and give her information on the risks, benefits and side effects.

SLIDE 34-35 CASE STUDY

Slide 34 notes
This woman does not want to take an HIV test now, she just wants the HIV PEP to reduce her risk of HIV and needs to get back to her children.

What do you do?
A. Inform her you cannot give her the HIV PEP without an HIV test.
B. Explain the benefits of taking an HIV test now.
C. Respect her decision and offer that she can return for an HIV test in the future.
D. Both B and C.

Slide 35 notes
Correct answer D.
Both B and C. Explain the benefits of taking an HIV test now and Respect her decision and offer that she can return for an HIV test in the future.

SLIDE 36-37 CASE STUDY

Slide 36 notes
The patient returns to the clinic several days later. She complains of nausea and vomiting and is worried that she is seriously ill. She reports that she has been taking all her medications.

What is the appropriate response?
A. Advise the patient to stop the PEP treatment right away.
B. Reassure the patient that nausea and vomiting are common side effects of PEP.
C. Give the patient anti-nausea (anti- emetic) medication and encourage her to complete the treatment course.
D. Both answers B and C.

Slide 37 notes
Correct answer D.
Both answers B and C Reassure the patient that nausea and vomiting are common side effects of PEP. Give the patient anti-nausea (anti- emetic) medication and encourage her to complete the treatment course. Nausea and vomiting are well-recognized side effects of the medications used for HIV PEP. Patients should be encouraged to complete the regimen. Care-providers can provide anti-nausea (anti-emetic) medication to make the PEP medications more tolerable.

STI PREVENTION

SLIDES 38-41 STI PREVENTION

Slide 40 notes

- Do not wait to see if the survivor develops STI symptoms to offer medication.
- **Offer all survivors at risk of STIs prophylaxis/prevention/presumptive treatment** in their first visit. STIs can be asymptomatic and can cause infertility.
- Check the national protocols for types of drugs and doses available for STI prevention/treatment. Often it is a combination of antibiotics.
- Some antibiotics are not safe in pregnancy. If a woman is pregnant she should be treated according to appropriate guidelines.
- Adopt the combinations that are easy-to-take and are to be taken for a shortest period of time.
- Where there is access to a laboratory, **STI testing** can be offered.
- For **syphilis** use rapid point-of-care test if available. If the result is positive, offer treatment. Another test may be useful after 4 weeks if the initial result is negative. However, if a rapid test is not available, presumptive treatment is preferable, as many may not return for care.
- Negative test results, however, do not necessarily indicate a lack of infection. If the sexual assault was recent, the test results will most likely be negative unless the survivor already has an STI.
- You can also assess for STI/clinical symptoms, and offer syndromic management of vaginal or urethral discharge for gonorrhea, chlamydia, trichomoniasis, or of symptoms of herpes simplex virus, syphilis and chancroid, particularly in settings where lab testing is not feasible.

Video 7.4: Preventing STIs

HEPATITIS B VACCINE

SLIDES 43-46

Slide 44 notes

- If available, please include the prevalence of Hepatitis B in your setting and the dosage and vaccination schedule for the type of HB vaccine available in your setting.

Slide 45 notes

- The **hepatitis B virus** can be **sexually transmitted.** Hepatitis B can cause **liver cirrhosis.** Hepatitis B is more easily transmitted than HIV. Hepatitis B is preventable through vaccination. Therefore, people subjected to sexual violence should be offered immunization for hepatitis B, particularly in high-prevalence settings.
- Routine pre-vaccination serological testing is not recommended. Where lab facilities are available and cost-effective and hepatitis B vaccination status is unknown, a blood sample can be screened for hepatitis B before vaccination. If already immune (presence of hepatitis B surface antibody in serum), no further vaccination is needed. If testing is not possible, vaccinate.
- Several hepatitis B vaccines are available, each with different recommended dosages and schedules.
- Your choice will be guided by availability and the country protocols.

Slide 46 notes

- Several **hepatitis B vaccines** are available, each with different recommended dosages and schedules. Check and use the type of vaccine, dosage and immunization schedule **based on local protocols or guidelines.**
- In many settings hepatitis B vaccination is part of the national vaccination schedule, and many people will have already been vaccinated with the required 3 doses.
- **Ask about vaccination**. If the survivor has already been completely vaccinated, do not offer the vaccine.
- Survivors may not be aware of their immunization status for Hep B. Offer the vaccine. Do not miss the opportunity to offer vaccination to a survivor.
- If not vaccinated or the series was not completed, follow the guidance on the slide.
- Give the vaccine intramuscularly in the deltoid region of the arm.

Video 7.5 Hepatitis B vaccination

Explain that the video states "advise the person to return at 1 and 6 months to complete the immunization" but check with your national protocol or guidelines.

PROVIDE INFORMATION, DISCUSS SELF-CARE AND PLAN FOLLOW-UP

SLIDE 48-49 PROVIDE INFORMATION, DISCUSS SELF-CARE AND PLAN FOLLOW-UP

Slide 48 notes
- Provide information on the importance of **returning for treatment if signs or symptoms occur.**

Slide 49 notes
- Advise them to **use condoms** during sexual intercourse at least until for 7 days after STI prophylaxis/treatment and/or until HIV status has been determined at the 3- or 6-month visit – if it is safe to negotiate condom use with their partner.

SLIDE 50 KEY MESSAGES

Choose 1 or both of the activities:

Activity 7.2 Case studies on treatment for sexual assault and/or
Activity 7.3 Grab bag on medical care

Ask what questions the participants have.

TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT

SLIDE 52–58 TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT

Slide 52 notes
- This section includes **delayed treatment** of days, weeks or months.

Slide 54 notes
- When a survivor comes to the clinic **more than 72 hours** after the assault the examination and treatment will depend on their condition and history. Consider:
  1. treatment of injuries
  2. pregnancy prevention
  3. symptomatic treatment of STIs
  4. HIV counseling and testing
  5. vaccination against hepatitis B and tetanus
  6. information and referrals for other support services
- All survivors – including those who come months and years after - can receive first-line support (LIVES), and some may need additional mental health care. Information, referrals, and first line support can help the survivor heal and are important no matter how long it has been since the assault.

Slide 55 notes
- Depending on the time the survivor presents, and based on the history, exam and look for any signs of injuries, healing or unhealed wounds, fractures or abscesses, complications caused by injuries sustained during the assault.
- Also remember some survivors will not present with any wounds at all.
- If **simple healing wounds** are present, **manage** at site.
- Assess for any **large or complicated wounds** and **refer** accordingly.

Slide 57 notes
- If the survivor presents between 72 hours (3 days) and 120 hours (5 days) after the rape, **emergency contraceptive (EC) pills** will reduce the chance of a pregnancy. ECP is most effective if taken within 72 hours, but it is still moderately effective **within 120 hours** after unprotected intercourse.

- The effectiveness of an IUD is higher than ECP from 72 to 120 hours
- If an IUD is inserted, make sure you give full STI treatment as per the protocol, and test for pregnancy before insertion.
- Insertion of IUCD is a sterile and invasive procedure. It requires skilled health care worker.
- If a woman presents 5 or more days after the incident, EC will not be effective.

Slide 58 notes

- Most women are likely to be very concerned about the possibility of becoming pregnant as a result of rape.
- All patients should be **assessed for pregnancy status.**
- **Offer a pregnancy test.** Remember that pregnancy tests take approximately 2 weeks from the rape/unprotected sex to become positive.
- If positive, give emotional support and clear information in a non-judgmental way that a woman can understand and **discuss the choices available,** allow her to make her own decisions and **respect her choice.**
- **Safe abortion** may be available in your health facility – if service providers have the right training, and the appropriate methods available (medication or vacuum aspiration) depending on the gestational age. If you are unable to provide safe abortion, find out where it is available to provide accurate information and refer if requested, if they choose this option
- Also provide information on **antenatal care, parenting support, adoption and foster care services** as available.
- Also, be aware of any adoption or foster care services in your area. Inform the survivor, and if they choose this, give detailed information and facilitate their referral.
- Some survivors may require safe houses to stay during the pregnancy period. Have this information, and contacts to the referral centers.
- In very few countries abortion is completely restricted. In many countries, the law allows the termination of a pregnancy resulting from rape or to protect the mental and physical health of the woman. Find out whether this is the case in your setting: https://reproductiverights.org/worldabortionlaws

DISCUSS

Ask

- What is the **current law and practice** with respect to safe abortion for survivors of rape/sexual assault? To save the life of a woman?
- What are the **barriers** that may delay women and girls from accessing abortion services?
- What might happen to a woman who has a child as a result of rape?
- What are cultural and social norms about children born of rape? And the women pregnant from rape?
- Discuss **alternative options** where abortion is not permitted or possible and/or when a woman does not choose this option, including care for pregnancy and delivery, adoption, foster care and parenting support? What are the options (if any) available to women in your setting who become pregnant as a result of rape?

Depending on the context these discussions can be very sensitive and taboo and participants may not feel comfortable engaging in these discussions. Consider if this discussion is appropriate in your context.

SLIDE 60-63 CASE STUDIES

Slide 60

A 17 year old girl comes to your clinic 8 days after being raped by another student at her university. She is worried about pregnancy. You do a pregnancy test and it is negative.

What support do you provide her?

A. Offer the Emergency contraception pill
B. Inform her that she is not pregnant, but it is too early to know if she is pregnant from the rape and advise her to come back to the clinic if she does not see her menstrual period.
C. Inform her that she is not pregnant from the rape.

Slide 61

Correct answer B.

Inform her that she is not pregnant, but it is too early to know if she is pregnant from the rape and advise her to come back to the clinic if she does not see her menstrual period.
Emergency contraception can only be given within 5 days or 120 hours of condomless sexual intercourse or rape.
Most pregnancy tests take approximately 2 weeks to become positive after sexual intercourse or rape. If she is not taking contraceptive prior to the rape consistently and correctly, she should return for another pregnancy test or do a pregnancy test at home if her menstrual period does not return.

SLIDE 62-63 CASE STUDY

Slide 62
The 17 year old girl returns to your clinic 3 weeks after being raped by another student at her university. She is worried about pregnancy. You do a pregnancy test and it is positive.

What support do you provide her?
A. Inform her that she has come too late for emergency contraception, there is no further help you can provide.
B. Advise her that the best option is to continue the pregnancy and parent the child.
C. Provide her emotional support, and discuss her options – including safe abortion, adoption or parenting.

Slide 63
Correct answer C.
Provide her emotional support, and discuss her options – including safe abortion, adoption or parenting.
If positive, give emotional support and clear information in a non-judgmental way that a woman can understand and discuss the choices available, allow her to make her own decisions and respect her choice.

SLIDE 64-67 TREATMENT OF SURVIVORS WHO PRESENT 72 HOURS OR MORE AFTER THE INCIDENT

Slide 64 notes
- HIV PEP is **not effective after 72 hours** of rape. **Do not offer** prevention for HIV (PEP) to survivors presenting past 72 hours.
- However, offer information on HIV, **assess the risk of HIV** transmission, and **offer a HIV test.**
- In some settings, HIV testing can be done as early as 6 weeks after rape. If the test is done at 6 weeks, it should be repeated after 3 months. WHO recommends **HIV testing at least 3-6 months** after rape to avoid the need for repeat testing. Check the HIV testing protocols in your settings.
- If the survivor's **HIV test is positive,** offer **support and refer** for HIV management.
- Do not carry out a HIV test if you do not have the ability of offer or refer to antiretrovirals. Ensure you check the HIV services available in your settings.

Slide 65 notes
- **Assess for signs and symptoms of STI,** such as foul smelling vaginal or urethral discharge, lower abdominal pains, pain when passing urine, sores or blisters in the genital area etc. Remember that STI infection may be **asymptomatic.**
- You may be able to carry out laboratory screening for STIs. If available, carry out the tests and treat according to the results.
- Where there is no capacity to test, **offer syndromic treatment** for STIs – including vaginal or urethral discharge for gonorrhea, chlamydia, trichomoniasis, and for genital ulcer for herpes simplex virus, syphilis and chancroid. Follow your country's protocols.

Slide 66 notes
- Hepatitis B can be sexually transmitted.
- It has an **incubation period** of 2-3 months. Sometimes, the incubation period can last for 6 months.
- Examine for **any signs of Hepatitis B infection.** Some of the signs include: jaundice, fever, abdominal pain and unexplained fatigue, lasting from weeks to months. If you see signs of an acute infection, refer the person for treatment,
- Offer **Hep B vaccine** to the survivor if they have not been vaccinated, no matter how long it has been since the incident.

SLIDE 67-68 CASE STUDY

Slide 67
A 27-year-old female presents for care 4 days after being raped. The genital exam is normal and her pregnancy test is negative. She has multiple healing abrasions on her legs without signs of infection and was last vaccinated against tetanus as a child.

This patient should be given preventative care against all of the following except:
A. Gonorrhea and chlamydia
B. HIV
C. Pregnancy
D. Hepatitis B
E. Tetanus

Slide 68
Correct Answer: B.
- PEP against HIV infection needs to be started within 72 hours (three days) after the rape. Although more effective if given earlier, ECP are still quite effective up to 120 hours (five days) after rape or sexual intercourse.
- Hepatitis B, gonorrhea, and chlamydia medications can also be provided within this time frame.
- Ideally, a tetanus vaccine booster is administered within 72 hours of a break in the skin, but it can also be given later.

Slide 69 Key messages

DISCUSS

Ask what questions they may have.

ENHANCING SAFETY AND FACILITATE SUPPORT (LIVES)

Activity 2.1 Step by step guide to providing care and support
Place **'First line support, ensure safety and make plan, support – connect with community and health resources'** on the wall.

SLIDE 73-78 ENHANCING SAFETY AND FACILITATING SUPPORT

Slide 74 notes
- It is vital to acknowledge safety concerns, help a survivor to **assess the immediate risks** of violence, and **plan for safety.**
- Enhancing safety means helping a woman to assess her situation and make a plan that helps her to stay safer in the future. It is not possible to eliminate the risk of violence completely; however, it is possible to enhance her safety, even if only slightly, within a given situation. It often involves small, incremental steps that can reduce the risk or severity of further violence.
- **Assess safety after sexual violence:**
  1. Survivors of sexual violence often know the person who assaulted them, and sexual violence often happens at home. If it was someone she or he knows, discuss whether or not it is safe to go home.
  2. Survivors may be at risk of retaliation or reprisals.
  3. Some survivors, adolescent girls or unmarried women may be at risk of violence by their own family related to norms around honour and virginity.
  4. Male survivors of SV by another male, or sexual and gender minorities, may be at risk of violence by their family or community related to views of homosexuality, discrimination, persecution and criminalization of same-sex relationships.
- **Assess safety after intimate partner violence:**
  1. Survivors of intimate partner violence face the risk of ongoing harm, injury and even death
  2. Many women who have been subjected to violence have fears about their safety. Other women may not think that the violence will happen again.
  3. Explain that partner violence is not likely to stop on its own. It tends to continue and may over time become worse and happen more often.
  4. Harm, injury and death related to intimate partner violence is not spontaneous or random, it is often predictable and preventable.
- If she is worried about her safety, take her seriously. Ask specific questions to see if any situations or people continue to place her at risk.
- Explore existing safety and support strategies that she has used.
- Discuss any available and safe referral options (if she wishes to).
- Emphasize that you are there for her and encourage her to come back at any time.

Slide 75 notes
- Women who answer "yes" to at least 3 of these questions may face especially **high immediate risk**
- Women are often at **highest risk when they leave** their partners.
- Regardless of the above risk assessment, **trust your patient** if she tells you she is in severe danger.

Slide 76 notes
- **If it is not safe for the woman to return home,** make referrals to shelter, safe housing or help identify a safe place where she can go, a family or friends home, a local NGO that supports survivors, a church or mosque.
- Help to **make a safety plan if she chooses to leave**
  - **Safe place to go** - If you need to leave your home in a hurry, where could you go?
  - **Planning for children** - Would you go alone or take your children with you?
  - **Transport** - How will you get there?
  - **Items to take with you** - Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put together items in a safe place or leave them with someone, just in case?
  - **Financial** - Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
  - If she has decided that leaving is the best option, advise her to make her plans and leave for a safe place BEFORE letting her partner know. Otherwise, she may put herself and her children at more risk of violence.

- If **she chooses not to or cannot leave, respect her decision.**
- Discuss how she can **reduce the harms of violence to herself or her children if it happens again.**
- Discuss what she has done in the past, praise her for her skills and strength and ability to survive so far. Empower her to build on those skills.
- Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear sounds of violence coming from your home?
- Identify family, friends or neighbours who could intervene if violence occurs or provide protection,
- Provide a GBV hotline or helpline if available.
- Notify a trusted neighbors to watch for signs of violence and to call others for help
- If she cannot avoid discussions that may escalate with her partner, advise her to try to have the discussions in a room or an area that she can leave easily.
- If violence can't be avoided, advise her to stay away from any room where there might be weapons, or try to move to a room with an easy exit - a door or window to escape.

Slide 77 notes
- If she must take paperwork with her (for the police or agencies such as UNHCR, for example), discuss what she will do with the papers so that they will not put her safety at further risk.
- Talk about abuse alone.
- No one older than 2 years of age should overhear your conversation. Never discuss it if her husband or other family members or anyone else who has accompanied her – even a friend – may be able to overhear, unless it is her wish to be accompanied in this conversation.

Slide 78 notes
- Survivors often do not only have medical needs, but have multiple needs – psychological, social, economic, livelihood, safety, security, legal and justice supports
- Discuss **social support** – "Do you have a family member, friend, or trusted person in the community whom she could talk to?" "When you are not feeling well, who do you like to be with?" "Who do you turn to for advice?" "Who do you feel most comfortable sharing your problems with?"
- **Provide information about support services** and **offer referral** to support services. Use a referral pathway, provide clear information about what the support service offers, the name of a specific person, the address or contact information, how to get there
- Discuss ways to **help her access support services**
  1. Offer to call on her behalf, offer to make a call with her, Offer the survivor the option to call from a phone at the clinic and a private place where she can call. Accompany them to the support services
  2. Help her solve any practical problems that might interfere – no transportation, no childcare
  3. If she wants it, provide the written information that she needs – time, location, how to get there, name of person she will see. Ask her to think how she will make sure that no one else sees the paper.
  4. If possible, arrange for a trusted person to accompany her on the first appointment.

DO NOT:	RESPECT THEIR DECISION:
Try to convince her to leave a violent relationship, or try to convince her to go to the police or courts.	If they decide not to report to the police or access other supports.

- There are many potential risks of reporting to the police – repercussions, retaliation, lack of privacy and confidentiality, family and community rejection and exclusion, even the risk of further violence and death. The survivor is the best person to make a decision for themselves and their safety.

Video 7.6: Enhancing safety and connecting with support

Clarify that the doctor said "everything we discuss is confidential unless you and your son are in danger". However be aware of the mandatory reporting laws in your context, and potential risks of reporting as well.

Ask
- How did the health provider in the video enhance safety?
- How did the health provider facilitate support?
- What could have been improved?

Explain that the doctor did assess the risk to the survivor's safety and let her know she can come back at anytime, but did not support her to discuss safety strategies and plans. This could be improved.

Activity 7.4 Role play Enhancing safety and offering support
and/or
Activity 7.5 Case studies on referral to support services

Slide 81 Key messages

ASSESSING MENTAL HEALTH AND PROVIDING PSYCHOSOCIAL SUPPORT

SLIDE 82-83 INTRODUCTION AND OBJECTIVES

Activity 2.1 Step by step guide to providing care and support
Place assess for mental health problems. Treat or refer as appropriate.

Activity 7.6 Brainstorm mental health consequences
and/or
Activity 7.7 Story telling – mental health consequences

SLIDE 86-89 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Slide 86 notes

- Survivors are at an increased risk of a range of symptoms, including feelings of guilt and shame, anger, anxiety, fear, nightmares, suicidal thoughts or attempts, numbness, substance abuse, sexual dysfunction, medically unexplained somatic complaints and social withdrawal.
- Explain that it is **common** to experience emotional distress, strong negative emotions or numbness after rape. **These reactions are normal and common** in people who are have gone through a stressful and frightening experience.
- These emotions, however overwhelming, are **usually temporary** and are normal reactions to recent difficulties.
- These psychological or emotional problems **will likely get better,** especially if she has received practical and emotional support from others. **Most people recover.**
- **Provide information** about normal stress reactions to an experience of violence. This can **bring relief** to survivors and **help them to cope** better.

Slide 87 notes

- Medical care for survivors of rape includes **assessing for psychological and emotional problems.** Assessment of mental state is an important part of history-taking so that any mental health issues can be followed up. The purpose is to: assess the need for mental health referral, identify positive coping strategies and assess her sources of support.
- Pay attention to her **mental health status,** including:
- Overall appearance (e.g. taking care of her appearance);
  - Does she take care of her appearance? Are her clothing and hair cared for or in disarray? Is she distracted or agitated? Is she restless, or is she calm?
  - Are there any signs of intoxication or misuse of drugs?
- Behaviour (e.g. agitation);
- Facial expression, mood (e.g. crying, anxious, without expression);
  - Is she calm, crying, angry, anxious, very sad, without expression?
- Body language (e.g. posture, eye contact); and
- Speech (e.g. fast, slow, silent)
  - Is she silent?
  - How does she speak (clearly or with difficulty)? Too fast/too slow? Is she confused?
- Thoughts (e.g. recurrent memories).
  - Does she have thoughts about hurting herself?
  - Are there bad thoughts or memories that keep coming back?
  - Is she seeing the event over and over in her mind?

- Ask general questions about how she is feeling and what her emotions; for example:
  - How do you feel?
  - What is your biggest worry these days? Are you having any problems?
  - What are your most serious problems right now? How are these problems or worries affecting you? How has (the violence) been affecting you? How have things changed for you?
  - How do you deal/cope with these problems day by day? Are you having any difficulties coping with daily life? To what extent are your difficulties affecting your life, such as relationships with family and friends, or your work or other activities?
- ***IMPORTANT: There is no particular mental state that indicates, or is typical of, sexual abuse.***

Slide 89 notes
- If the survivor expresses guilt or shame, explain gently that **rape is never the fault of the survivor.** Assure her that she did not deserve to be raped, that the incident was not her fault, and that it was not caused by her behaviour, manner of dressing, or anything else. **Do not blame or judge** the survivor.

Activity 7.8 Discussion on coping skills

SLIDE 91-93 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Slide 91 Encourage positive coping strategies
- Explore **positive coping strategies** that are feasible for her, in a supportive and non-judgemental manner.
- Ask what is going well currently and how they have coped with difficulties in the past
- Encourage engaging in relaxing activities to reduce anxiety and tension (e.g. walk, sing, pray, play with children).

Slide 92 Explore social support
- People who experience abuse or violence often feel cut off from normal social circles or are unable to connect with them. This may be because they lack energy or feel ashamed.
- Good social support is one of the most important protections for anyone suffering from stress-related problems.
- Ask:
  - "When you are not feeling well, who do you like to be with?"
  - "Who do you turn to for advice?"
  - "Who do you feel most comfortable sharing your problems with?"
- Explain to the woman that, even if there is no one with whom she wishes to share what has happened to her, she still can connect with family and friends. Spending time with people she enjoys can distract her from her distress.
- Help them to identify past social activities or resources that may provide direct or indirect psychosocial support (ex family gatherings, visits with neighbours, sports, community and religious activities). Encourage them to participate.
- Collaborate with social workers, case managers or other trusted people in the community to connect her with resources for social support such as: community centres, self-help and support groups, income-generating activities and other vocational activities, formal/informal education.

Slide 93 Encourage stress-management and relaxation techniques
- Relaxation techniques is one way to reduce reactions or symptoms of anxiety or panic that threaten to overwhelm a survivor.
- Always remember to invite the survivor to participate, let it be an open invitation. If they does not feel ready to participate in an exercise, respect their wish

See Activity 7.9 Relaxation techniques

SLIDE 95-98 MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

Slide 95 Assess for mental health conditions
- If your assessment identifies problems with mood, thoughts or behaviour and if the woman is unable to function in her daily life (e.g. problems getting out of bed, taking care of children, going to work or doing housework), she may have more severe mental health problems.

Slide 96 Assessing suicide and self-harm

- Some health care workers fear that asking about suicide may provoke the woman to commit it.
- Talking about suicide often **reduces the woman's anxiety** around suicidal thoughts and **helps her feel understood.** It does not lead to suicide attempts.
- Ask a series of questions where any answer naturally leads to another question.
  - How do you feel?
  - You look sad/ upset. I want to ask you a few questions about it?
  - How do you see your future? What are your hopes for the future?
- If the survivor expresses hopelessness, **ask if she has current – or a history of – thoughts or plans to commit suicide or to harm herself.**
  - Some people with similar problems have told me that they felt life was not worth living.
  - Do you go to sleep wishing that you might not wake up in the morning?
  - Do you think about hurting yourself?
  - Have you made any plans to end your life? If so, how are you planning to do it?
  - Do you have the means to end your life? Have you considered when to do it?
  - Have you ever attempted suicide?

Slide 97 Assessing suicide and self-harm

- If a referral to a specialist is not possible work with the survivor to identify someone they trust in their life who can be with them at the clinic and when they go home. Provide info on a suicide hotline if available and safety plan for if/when thoughts become severe/high risk.

Slide 98 Managing suicide

Use this slide **only if there are no MH specialists available for referral.**

- Remove all possible means of self-harm/ suicide and, if possible, offer a separate, quiet room. However, do not leave the person alone. Have carers or staff stay with the person at all times.
- Instead, try to instil hope. Search together for solutions to the problems. Focus on the person's strengths by encouraging them to talk of how earlier problems have been resolved.
- Mobilize carers, friends, other trusted individuals and community resources to monitor and support the person if they are at imminent risk of suicide. Explain to them about the need for 24-hour-per-day monitoring. Ensure that they come up with a concrete and feasible plan (e.g. who is monitoring the person at what time of the day). Advise the person and carers to restrict access to means of self-harm/suicide (e.g. pesticides/toxic substances, prescription medications, firearms, etc.) when the person has thoughts or plans of self-harm/suicide.
- Make sure there is a concrete plan for follow-up sessions and that the carers take responsibility for ensuring follow-up.
- Maintain regular contact (e.g. via telephone, text messages or home visits) with the person.
- Follow up frequently in the beginning and decrease frequency as the person improves
- Follow up for as long as the suicide risk persists. At every contact, routinely assess suicidal thoughts and plans.

Video 7.7 Assessing suicide

https://www.youtube.com/watch?v=4gKIeWfGIEI

⚠ Use this video only if there are no MH specialists available for referral.

Slide 100 Assess mental health conditions

- If your assessment identifies problems with mood, thoughts or behaviour and if the woman is unable to function in her daily life (e.g. problems getting out of bed, taking care of children, going to work or doing housework), she may have more severe mental health problems. Conduct a more detailed mental health assessment if needed. Assess for pre-existing mental health conditions, depressive disorder, post-traumatic stress disorder (PTSD).
- If a survivor has suffered from MH problems before experiencing violence, they will be much more vulnerable to suffering from them again. Pre-existing mental health problems may be exacerbated or reoccur if they experience IPV or sexual violence.
- Assess for **moderate-to-severe depressive disorder.** When a person is unable to cope, has difficulty with daily functioning of normal activities and cannot carry out her normal activities, these symptoms persist over at least 2 weeks, they may have depressive disorder. Symptoms can include: low energy, fatigue, sleep problems, multiple physical symptoms with no clear cause (for example, aches and pains), persistent sadness or depressed mood; anxiety, little interest in or pleasure from activities
- Assess for **PTSD:** The following symptoms are present about 1 month after the violence:
  1. Re-experiencing symptoms: Repeated, unwanted recollections of the violence, frightening dreams, flashbacks or intrusive memories with intense fear or horror
  2. Avoidance symptoms: Deliberate avoidance of thoughts, memories, activities or situations that are reminders of the violence (e.g. avoiding talking reminders of the violence, or avoiding going back to places where the violence happened)
  3. Heightened sense of current threat: Excessive concern and alertness to danger, reacting strongly to loud noises or unexpected movements, being "jumpy" or "on edge"
  4. Considerable difficulty with daily functioning

Activity 7.9 True or false – mental health care

Slide 102 Key messages

DISCUSS

Ask what questions they have.

PROVIDE FOLLOW-UP CARE

Slide 104 Provide follow up care

Activity 2.1 Step by step guide to providing care and support
Place **'Plan follow-up at 2 weeks, 1 month, 3 months and 6 months'** on the wall.

SLIDE 105-108 FOLLOW UP CARE AND SUMMARY

8

CHILD SEXUAL ABUSE

8. CHILD SEXUAL ABUSE

PREPARATION AND MATERIALS

OBJECTIVES

- Learn how to provide first line support and medical care to child survivors of rape and sexual abuse
- Gain knowledge and skills to provide care and support to children who experience rape and sexual abuse
- Describe the guiding principles of caring for child survivors
- Describe how to create a safe environment for child survivors
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP if vaginal penetration has occurred.
- Describe what treatment you would offer for a child survivor.
- Demonstrate how to advise parents or guardians on a child's possible reactions to sexual assault.

AVAILABLE TRAINING RESOURCES

Presentation
8. Child sexual abuse

Facilitator guide
8. Child sexual abuse

Activities
8.1 Definition of child sexual abuse
8.2 Matching activity – Key terms related to child sexual abuse
8.3 Vote with your feet – Child sexual abuse
8.4 Discussion on barriers to care for child survivors of sexual abuse
8.5 Guiding principles when supporting child survivors
8.6 Case studies on medical care for survivors of child sexual abuse
8.7 Case studies on medical care for survivors of child sexual abuse Risks and safety

Videos
8.1 Welcoming child survivors
8.2 Informed consent
8.3 Assessing the child alone
8.4 Medical history of a child
8.5 History of the incident with a child
8.6 General exam of a child
8.7 Genital exam of a child
8.8 Talking about virginity with adolescents
8.9 Preventing pregnancy for adolescents
8.10 Medical treatment and care of children
8.11 Psychosocial support for children
8.12 Enhancing safety with children
8.13 Connecting children with social support

Participant handouts
8.1 Pathways of care for child or adolescent survivors of sexual abuse
8.2 Why children do not disclose sexual abuse
8.3 Sexual Abuse impacts across age and developmental stages
8.4 Guidelines for communicating with children
8.5 Interview guidelines based on age and developmental stage
8.6 Mandatory reporting requirements for children

REQUIRED SUPPLIES & MATERIALS

- Wall space to post papers
- Tape
- Pen and blank paper workbook for each participant
- Signs with the words “agree” or “disagree” written on them
- Flip chart, markers
- Print outs of statements and case studies for activities– depending on which activities you choose

KEY MESSAGES

- Ensure care for children and adolescents is:
  - provided in a safe, child-friendly space
  - promotes their best interest and evolving capacities
  - enhances their safety

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2019) Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings, Part 6: Caring for child survivors, pg 36-39
- IRC, UNHCR (2012) Caring for Child Survivors of Sexual abuse Guidelines
- World Health Organization (WHO) (2016). Clinical guidelines for responding to children and adolescents who have been sexually abused. Geneva
- WHO (2018) Eliminating Virginity Testing: An Interagency Statement

CARING FOR CHILD SURVIVORS FACILITATOR GUIDE

INTRODUCTION

Slide 1 Introduction

CORE CONCEPTS ON CHILD SEXUAL ABUSE

Slide 2-3 Introduction

Activity 8.1 Definition of child sexual abuse
And/or
Activity 8.2 Matching activity of key terms related to child sexual abuse

SLIDES 5-6

Slide 5 notes

- A **child** is defined by the United Nations Convention on the Rights of the Child as any person under the age of 18 years.
- **Child sexual abuse** as involvement of a child or an adolescent in sexual activity that he or she does not fully comprehend and is unable to give informed consent to, or for which the child or adolescent is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society.
- Child sexual abuse involves the intent to gratify or satisfy the needs of the perpetrator or another third party including that of seeking power over the child.

Slide 6 notes

- There are two main types of child sexual abuse:

1 CONTACT SEXUAL ABUSE:	2 NON-CONTACT SEXUAL:
• May involve sexual intercourse (i.e. sexual assault or rape, sexual touching of a child's breast, genitals, buttocks or other body parts or forcing a child to sexually touch another person	• Abuse may involve threats of sexual abuse, verbal sexual harassment, sexual solicitation, indecent exposure, exposing the child to pornography, showing their sexual parts to a child for sexual purposes (masturbating in front of a child), forcing a child to watch sexual acts or sexual movies, read stories or look at sexual images, taking pictures or videos of a child in sexual positions.
• May exclude sexual intercourse but involving other acts such as inappropriate touching, fondling and kissing.	

Activity 8.3: Vote with your feet

SLIDE 8-12 UNDERSTANDING CHILD SEXUAL ABUSE AND DISCLOSURE

Slide 8 notes

- Child sexual abuse is often carried out **without physical force,** but rather with **manipulation, intimidation, and psychological, emotional or material pressure.**
- Children can be abused by adults or other children in a **position of responsibility or trust or power**
- Children can be sexually abused by both adults and other children who are – by virtue of their age or stage of development – in a position of responsibility or trust or power over the victim.
- The **most common perpetrator** is a male family member. Abuse by teachers, childcare workers, family friends, religious leaders, and neighbors are also common.

- Adolescents may also experience sexual abuse at the hands of their peers, including in the context of dating or intimate relationships.
- It may occur on a frequent basis over weeks or even years, as repeated episodes that become more invasive over time.
- It can also occur on a single occasion.

Slide 11 notes
- Indirect disclosure may include someone may find out from the child becoming pregnancy or contracting an STI
- Learn if the child wanted the CSA to be discovered, if the child trusts those they disclosed it to, and if the primary caregiver is aware.

Slide 12 notes
- Children who have been sexually abused are most likely to come to your attention through a caregiver or another adult; abused children rarely seek help on their own.
- **Disclosure** may be a process, with children trying to explain or hinting that sexual abuse occurred to see how their caregiver or a trusted person may respond. If trusted adults show negative reactions (anger or blame) towards the child, the child may stop talking or later deny that the abuse occurred. This may result in the child refusing to share further information or even deny the abuse altogether in subsequent interviews because he/she does not feel safe. If a child perceives angry or accusatory reactions, the child may experience deeper levels of shame, anxiety and sadness. While a calm, affirming and supportive reaction will foster the child's feeling of safety and acceptance—helping recovery and healing.

Activity 8.4 Discussion on barriers to care for child survivors of sexual abuse

SLIDE 14-15 BARRIERS TO DISCLOSURE AND POTENTIAL SIGNS

Slide 14 notes
- The child **may not disclose due to:** guilt, shame, fear of not being believed, of revenge on family, of discrimination or dismissal, feeling physically threatened, or because they believe they will be taken away from their families or blamed for shaming the family or involving outside authorities. They may believes it's their fault, and they will be blamed. The child may want to protect the perpetrator and/or family in some way, especially if the perpetrator is close to the child and his/her family. The child may not have the knowledge or awareness to realize it is wrong: they may be too young to know, not have words for what happened, not know how to communicate the issue
- The perpetrator may tell the child that the parent/caregiver won't love the child anymore when parent/caregiver hears what the child has done, or threaten the child.
- Children may not understand what is happening to them or they may experience fear, embarrassment or shame about the abuse, which affects their willingness and ability to talk to service providers.

Slide 15 notes
- Other concerning physical signs include pregnancy, or STIs.
- The **majority of signs and symptoms are behavioral and emotiona**l in nature. It's important to consider the child's age and developmental stage to determine whether their behaviour is abnormal.
- Any one sign or symptom does not mean that a child has been abused, but the presence of several signs may suggest that a child is at risk. It is important to believe reports of sexual abuse no matter what you observe about the child. Also there is a need to be cautious – you cannot assume abuse, but if certain signs and symptoms are identified, it may be worth observing the situation, and posing certain questions. It is important to consider other causes of signs and symptoms (maternal to infant transmission of STIs, fungal infection, accidental/unintentional traumatic injury, psychological reactions to other traumatic events such as conflict, displacement).

GUIDING PRINCIPLES FOR WORKING WITH CHILD SURVIVORS

SLIDE 16-23

Slide 16 notes
- The role of a health-care provider is the same for child survivors of sexual abuse and for adults – to provide quality first-line support and medical care. However, the needs and capacities of children and the ways of responding to those needs differ.

Slide 19 notes
- There are **limits to confidentiality,** you may need to breach confidentiality to protect a child's physical and/or emotional safety.

Slide 20 notes

- Determine what the **best interest** of the child or adolescent is by carefully considering the child's situation. This can be done by having a meaningful discussion with the child and their non-offending caregiver about what they believe is the child's best interest, evaluating the positive and negative consequences of actions, with participation from the child and their caregiver, and seek the least harmful course of action. The children's or adolescent's physical and emotional safety, well-being and ongoing development in the short and long term should not be compromised.

Slide 21 notes

- Speak in a way that the child understands.

Slide 22 notes

- Ensure children and adolescents are **given age-appropriate information** and explanations, and are involved in their care. **Ask child's or adolescent's opinions,** take their opinions into account. **Respect the child's opinions,** beliefs and thoughts. Encourage them to participate in decision-making that have implications for their lives and express willingness to participate. **Do not force children** to do a history and interview, examination, receive medical care or to share their information with others – unless absolutely necessary for life saving medical care.
- While service providers may not always be able to follow the child's wishes (based on best interest considerations), they should always empower and support children and deal with them in a transparent manner with maximum respect.
- Parents or legal guardians are typically responsible for giving informed consent on behalf of the child for relevant clinical care. However, in situations where it is in the best interests of the child or adolescent, informed consent should be sought from the child or adolescent themselves.

Activity 8.5: Guiding principles when supporting child survivors

SLIDE 25-26 MANDATORY REPORTING

Slide 25 notes

- **Mandatory reporting:** is legislation passed by some countries or states that requires designated individuals, such as health-care providers, teachers or social workers, to report (usually to the child protection agency or the police) known and reasonably suspected cases of specified types of child abuse and neglect, normally including child sexual abuse.
- If it is obligatory to report cases of child abuse in your setting, obtain a copy of the national child abuse management protocol (and reporting form) and information on customary police and court procedures.
- Mandatory reporting requirements can raise **ethical and safety concerns,** and may risk further harm. For example, investigators may show up to a child's home, therefore, potentially breaching a child's confidentiality at the family or community level (prompting retaliation). In addition, services for children may be non-existent, thus creating additional risk (e.g., separation from family, placement in institutions, or confiscation of private records). The local authorities may themselves be abusive or they may simply be ignorant of best practice procedures or guiding principles.

Slide 26 notes

- Evaluate each case individually – in some settings, reporting suspected sexual abuse of a child can be harmful to the child if protection measures are not possible.
- Use these questions to guide decision-making:
  - Will reporting increase risk of harm for the child?
  - What are the positive and negative impacts of reporting?
  - What are the legal implications of not reporting?
- Involve your supervisor and to make a decision together with the child, non-offending caregiver and supervisor. Develop an action plan that first considers the child's safety and then the legal implications of not reporting.
- If you are reporting, before reporting share the following information to the child survivor and caregivers
  1. The agency/person to which/whom you will report
  2. The specific information being reported
  3. How the information must be reported (written, verbal, etc.).
  4. The likely outcome of the report
  5. The child's and family's rights in the process
- Some, not all information, may need to be shared to protect the child. Consider how much and what to share together with the child, non-offending caregiver and supervisor.

DISCUSS

Ask what questions or concerns the participants may have.

ENGAGING AND COMMUNICATING WITH CHILD AND ADOLESCENT SURVIVORS

SLIDE 28-30

Slide 29 notes

- Your initial reaction will impact their sense of safety and willingness to talk, as well as their psychological well-being. A positive, supportive response will help abused children to feel better. A negative response (such as not believing the child or getting angry with the child) could cause them further harm.

LISTEN	INQUIRE ABOUT NEEDS	VALIDATE
Listen actively, respectfully, and empathically to the child, and believe them when they speak.	Do no harm: be careful not to traumatize the child further. Do not become angry with the child, force the child to answer a question they are not ready to answer, force the child to speak about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people.	Be nurturing, comforting and supportive.
Pay attention to non-verbal communication. A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture. Be aware of your body language as well.	Respect the child's opinions, beliefs and thoughts.	Validate and reassure the child that they are not at fault for what has happened to them and that you believe them.
	Take into account the different needs of boys and girls and different ages and development stages.	Offer an empathetic, validating and non-judgemental response that reassures them that they are not to blame for the abuse
		Comfort, encourage and support them
		Believe their disclosure and never blame them in any way
		Make children feel safe and cared for

Slide 30 notes

- **Introduce yourself** to the child. Reassure the child that **you are there to help.** Tell the child why you are talking with them.
- Sit at eye level and maintain eye contact. Use appropriate eye contact, a friendly face, soft gentle voice
- Assure the child that he or she is **not in any trouble.**
- **Build trust and rapport** by asking about neutral topics before delving into direct questions about the abuse; Ask a few questions about neutral topics, such as school, friends, whom the child lives with, favourite activities.
- Have toys available if possible, especially for younger children.
- Help the child to feel safe.
- Children should be **interviewed briefly on their own** (i.e. separately from caregivers), while offering to have another adult or trusted person (such as a trained health worker) – present for support. Always ask the child for consent or assent according to their age, developmental stage and capacity to consent. Always ask the child whom they would like to be present, and respect their wishes. Remember that it is possible that an accompanying family member is the perpetrator of the abuse. Empower the child to know they can be interviewed and examined on their own - as some parents may expect or place pressure to be there. Some adolescents may want to be alone and this should be considered based on their evolving capacities.
- **Involved a trusted, supportive caregiver with the child's permission.**
- Choose appropriate people to help. In principle, only female service providers and interpreters should speak with girls about sexual abuse. Boy survivors of abuse should be offered the choice (if possible) to talk with a female or male provider, as some boys are likely to feel more comfortable with a female service provider. The best practice is to ask the child if he or she would prefer to speak with male or female trained staff.

Video 8.1: Welcoming child survivors
Explain that they are actors, explain that the child survivor is actually older but is acting as younger child.

Video 8.2: Informed consent

Discuss the video:
- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should also speak directly to the child, provide information to the child, involve the child in decision making and encourage her participation. The child should also express willingness to participate, not only her mother.

Video 8.3: Assessing the child alone

HISTORY TAKING WITH CHILDREN AND ADOLESCENTS

SLIDE 32-35

Slide 32 notes
- For younger children, make sure that there are dolls, crayons or other toys to keep them busy during the conversation.
- Be patient; go at the child's pace and do not interrupt. Observe whether the child becomes upset or distressed, and allow time for breaks.
- Provide age-appropriate information in an age- appropriate manner and environment.
- Speak in a way that the child understands.
- Tell the child why you are talking with them.

Slide 33 notes
- Begin the interview by **asking open-ended questions,** such as "What brings you here today?" or "What were you told about coming here?" to get information about the incident.
- Use questions or statements such as: "Has anyone ever touched you in a way that makes you confused or frightened? Where were you touched on your body?"
- **Avoid asking leading or suggestive questions.**
- Do not ask "Did he put his hands on your breasts?"
- Instead say: "Tell me what happened next." "Can you tell me more about..." "What do you mean by...." "Give me an example of..."
- Ask closed (yes/no) questions only for the clarification of details.
- Asking why can seem judgmental.

Slide 34 notes
- Use **dolls**
  1. To learn and use the words the child uses for male and female body parts and to have a correct understanding of the incident. Take the time to clarify the words and phrases used by children to ensure an accurate understanding of children's statements.
  2. To learn about the sexual assault. Ask children to show you what happened, where on the doll he or she was touched or hurt.
  3. Do not point to a child or the dolls's breast, vagina, penis or other body part and asking, "Did he touch you here?" Children may want to please the person asking and could answer "yes" when, in fact, the answer is "no."
- Children find it easier to **express emotions through drawings or stories.**
  1. Invite the child survivor to draw a picture or tell a story, without specific directions about what.
  2. Ask child to draw a picture "of their happiest memory" or a draw of "who lives in their house".
- Pay attention to **non-verbal communication.** A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture. Be aware of the cues your body language is giving as well, to gain the child's trust.
- Adapt interviewing techniques based on age, maturity and developmental stage, disability.
- **Potential challenges** may include:
  - **If a child refuses to talk,** consider: Is there somebody in the room the child does not feel safe speaking in front of? Are you acting in a way that is making the child uncomfortable? Is the interview place safe for the child to speak?
  - **If the child denies the abuse,** stay neutral, get more facts, be patient and do not force or pressure the child to speak if they are not ready.

Slide 35 notes

- Ask about **medical history** – including vaccination history.
- Ask girls ask about **menstrual and obstetric history.** Be mindful not to ask about sexual history in front of parents or caregivers.
- Ask **open ended questions** about **the abuse**
  - "Has anyone ever touched you in a way that makes you confused or frightened?"
  - "Your mum said something happened to you, can you tell me about what happened?"
  - "Share with me how you were touched" "Can you tell me what happened next?" "Can you tell me more about that..?"
  - "Can you give me an example of..?" or "Can you describe for me..?"
  - "Go on.." "And then what happened..?" "Anything else?"
  - "Is there anything else you think I should know about what happened?"
  - "Is there anything else you'd like to talk about?"
- Ask about the abuse – **when** did it happen, **type** of abuse (penetration), if it has **happened before,** how many times
- Sexual abuse of children is often **repeated** abuse.
- To get a clearer picture of what happened, try to obtain information on:
  - the home situation, whether the child has a safe place to stay
  - how the sexual assault was discovered
  - who did it, and whether he or she is still a threat ("Is the person who did this someone you know?" "Do you know where he is?")
  - if this has happened before, when the abuse began, how many times and the date of the last incident
  - if any siblings are at risk
  - whether there have been any physical symptoms (e.g. bleeding, dysuria, discharge, difficulty walking, etc.)
- There is a difference between adults and children, that with adults if they feel safe, not judged and blame they may just start to tell you the story, but with children we need to be sensitive to asking open-ended questions to gain information about the incident, children may not know what information you will find important.

Video 8.4: Medical history with a child

Discuss the video:

- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should also speak directly to the child, provide information to the child, involve the child in decision making and encourage her participation. The child should also express willingness to participate, not only her mother.

Video 8.5: History of the incident with a child

Discuss the video:

- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should ask open-ended questions "Are you comfortable sharing with me about what happened? Can you tell me what he did to you? Can you show me where?"

DO NOT ASK "Did he touch you using his penis?" "Did he touch you with his hands? Did he touch you with his private parts?". These are leading questions, can make a child feel that they are pressured to provide answers that are desired for the nurse. Instead ask open ended questions such as "How did he touch you, what did you touch you with, did you tell anyone, who did you tell?"

EXAMINATION

Slide 37 General examination

- The child should **only undergo 1 examination.** If you are not competent in examining a child, do not examine the child and await a skilled colleague.
- Seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents.
- With adequate preparation, most children will be able to relax and participate in the examination.
- If the child cannot relax, this may be because he or she is in pain. If this is a possibility, give paracetamol or other simple painkillers, and wait for them to take effect.
- As for adult examinations, in addition to the survivor and the health-care provider there should be a **support person** or trained health worker whom the child trusts in the examination room with them.

- Consider positions that **minimize physical discomfort and/or psychological distress.** Small children can be examined on the mother's lap. Older children should be offered the choice of sitting on a chair or on the mother's lap, or lying on the bed.
- **Encourage the child to ask questions** about anything he or she is concerned about or does not understand at any time during the examination.
- **Explain** what will happen during the examination, using words and terms the child can understand.
- It is useful to have a doll hand to demonstrate procedures and positions. Show the child the equipment and supplies, such as gloves, swabs, etc.; allow the child to use these on the doll.
- **Never restrain or force** a frightened, resistant child to complete an examination. Restraint and force are often part of sexual abuse and, if used by those attempting to help, will increase the child's fear and anxiety, and may worsen the psychological impact of the abuse.
- If the child is highly agitated: In rare cases, a child cannot be examined because he or she is highly agitated. Only if the child cannot be calmed down, and physical treatment is vital and life saving, the examination may be performed with the child under sedation using medications.
- Sedation does not provide pain relief. If you think the child is in pain, give simple pain relief first. Wait for this to take effect. Oral sedation will take 1–2 hours to fully take effect. In the meantime, allow the child to rest in a quiet environment.

Video 8.6: General exam of a child
Explain that you should conduct a full head to toe exam, however the video just shortened it for time.

SLIDE 39-40 GENITAL EXAM OF A CHILD

Slide 39 notes
- **Do not** use a **speculum to examine prepubertal girls;** it is extremely painful and may cause serious injury.
- A speculum may be used only when you suspect a penetrating vaginal injury and internal bleeding. In this case, a speculum examination of a prepubertal girl should be done under general anaesthesia. Depending on the setting, the child may need to be referred to a higher level of health care.
- **DO NOT** carry out **a digital examination of the vagina** (i.e. inserting fingers into the vaginal orifice to assess its size or laxity).
- **DO NOT** carry out **a digital examination of the anus** to assess anal sphincter tone.

Slide 40 notes
- **Genital examination in girls:** Note the location of any fresh or healed tears in the vulva, and vagina by holding the labia at the posterior edge between index finger and thumb and gently pulling outwards and downwards, look for vaginal discharge.
- **Genital examination in boys:** check for injuries to the frenulum, foreskin, prepuce (head of the penis, foreskin, and for anal or urethral discharge).
- **Anal examination in boys and girls:** examine the anus with the child in the supine or lateral position; consider avoiding the knee- chest position, as assailants often use it, do not carry out a digital examination to assess anal sphincter tone, note that reflex anal dilatation (opening of the anus on lateral traction on the buttocks) can be indicative of anal penetration, but also of constipation.
- Consider alternative explanations for injuries or examination findings – such as alternative traumatic injuries, fungal infections, maternal to neonatal STI transmission, etc. Be mindful not to make assumptions or statements proving that sexual abuse occurred. Instead, make observations about injuries.
- **The absence of injuries does not mean that abuse did not occur.**

Video 8.7: Genital exam of a child

Discuss the video:
- What did the nurse do well?
- What was missing? What could be improved?

Slide 42 Virginity testing
- Virginity testing has no medical or scientific validity, is a harmful practice, increases distress and physical, physiological and social harms to those examined and is a violation of their human rights.
- **DO NOT** perform virginity testing.

Video 8.8: Talking about virginity with adolescents

Explain why it is not possible to determine virginity. Have an open dialogue. Carefully, respectfully provide medically accurate information to patients and caregivers, including dispelling myths and misconceptions during consultations or among colleagues. Clearly communicate what your responsibilities are – to provide medical care and first line support.

SLIDES 44-45 CASE STUDY

Slide 44
Question: A 12-year-old female presents to the clinic 12 hours after being vaginally raped by her teacher. She complains of vaginal soreness and a few drops of blood on her underwear. The pelvic exam reveals bruising at her vaginal opening. And minor lacerations along the posterior opening of the vagina.

What is the appropriate message to convey to the patient in terms of her injuries?
A. Explain that the blood was caused by a minor cut on her vagina.
B. Encourage her to agree to a vaginal speculum exam.
C. Reassure her that her genitals will look normal once the injuries heal.
D. Do not discuss the patient's genital injuries, to avoid making her uncomfortable.
E. Both answers A and C are correct

Slide 45
Answer: E. Both answers A and C are correct – Explain that the blood was caused by a minor cut on her vagina. Reassure her that her genitals will look normal once the injuries heal. Explain to the patient that the assault caused a small tear in the vaginal opening. This wound is similar to a cut on the inside of the mouth that she might have experienced after biting her own cheek while chewing, and it will heal with similar speed. No one will be able to tell from looking at her genitals that she was raped. A speculum exam is not indicated because she is not actively bleeding and the source of the prior bleeding was found.

SLIDE 46-47 CASE STUDY

Slide 46
Question: Grace is a 14 year old girl. She comes to your clinic with her mother and stepfather. The mother tells you that she wants to you examine the daughter to determine if she is a virgin. Grace is looking down at the ground and crying. You ask the parents to step outside, so that you can speak to Grace alone. After helping her feel safe and comfortable, Grace tells you that the stepfather has been forcing her to have sex with him over the past 6 months. The last incident was 2 days ago. She has never told her mother. She discloses that her menses are 2 weeks late.

Do you conduct a virginity test upon the mother's request?
A. Yes
B. No

Slide 47
Answer: B No. Health care providers should not perform virginity testing. It is a not a medically valid practice and causes harm.
Additional question for discussion: How do you explain your reason to the mother?
Answer: Provide medically accurate information to patients and caregivers that does not reinforce harmful practices. Carefully and respectfully communicate medically accurate messages, including dispelling myths and misconceptions during consultations or among colleagues. Meet the requests with open dialogues and clearly communicate what your responsibilities are. Explain that your profession prohibits virginity testing. Discuss with your colleagues the reasons or motivations for requests for virginity testing in your context and how to respond in culturally appropriate, respectful ways.

DISCUSS

Ask the participants:
- Have you ever been asked to perform a 'virginity test'?
- How did you deal with it?
- How should you deal with it if a 'virginity test' is requested?

Explain that we should provide medically accurate information to patients and caregivers that does not reinforce harmful practices. Carefully and respectfully communicate medically accurate messages, including dispelling myths

and misconceptions during consultations or among colleagues. Meet the requests with open dialogues and clearly communicate what your responsibilities are. Explain that your profession prohibits virginity testing. Discuss with your colleagues the reasons or motivations for requests for virginity testing in your context and how to respond in culturally appropriate, respectful ways.

DOCUMENTATION

SLIDE 49-50 DOCUMENTATION

Slide 49 notes

- **Accurately, completely document** detailed findings of the medical history, physical examination and any other relevant information, for the purposes of appropriate follow-up and supporting survivors in accessing police and legal services if they choose to.
- Use a **structured format** for recording the findings;
- Record **verbatim statements** for accurate and complete documentation;
- Include **both the child and caregivers account**
- Note down **discrepancies** between the child's or adolescent's and the caregivers' account, if any, without interpretation;
- Record a detailed, accurate description of the **symptoms and injuries;**
- Where no physical injuries are found, **noting that absence of injuries does not mean that abuse did not occur;**
- Document the child's or adolescent's **emotional state,** while noting that no particular state is indicative of sexual abuse;
- Handle all collected information **confidentially.**

Slide 50 notes

- Use the pictograms to document injuries.

SPECIAL CONSIDERATIONS IN MEDICAL CARE FOR CHILDREN AND ADOLESCENTS

SLIDE 52-54 MEDICAL CARE

Slide 52 notes

- Examine for any **injuries** and manage accordingly.
- Where the patient has not been vaccinated, or there is doubt, **offer tetanus vaccine.** It is safe to use.
- Children have the same prevention and treatment needs as adults but may require different doses.
- **HIV PEP** should be offered, as appropriate, to children and adolescents who have been raped involving oral, vaginal or anal penetration with a penis, and who present **within 72 hours** of the incident.
- Offer **emergency contraception** to girls who have been raped involving peno-vaginal penetration and who present **within 120 hours (5 days)** of the incident.
- Ask pre-pubertal adolescent girls whether they have started menstruating. If so, they may be at risk of pregnancy. EC pills can be offered to girls who have attained menarche and also those who have reached Tanner Stage 2 or 3 – who are in the beginning stages of puberty, who have not started menstruating, and who have onset of secondary breast development – as they may face risk of unwanted pregnancy if they ovulate before the onset of menstruation.
- Offer presumptive (or prophylactic) treatment for gonorrhoea, chlamydia and syphilis for children and adolescents who have been sexually abused involving oral, genital or anal contact with a penis, or oral sex.
- For children and adolescents who have been sexually abused and who present with clinical symptoms, syndromic management is suggested for vaginal/ urethral discharge (gonorrhoea, chlamydia, trichomoniasis), and for genital ulcers (herpes simplex virus, syphilis, and chancroid)
- Offer **Hepatitis B vaccination** according to the vaccination schedule.
- Pre-vaccination serological testing is not recommended as routine practice. Testing may not be available in humanitarian settings, therefore offer the vaccine.
- However, in settings where laboratory facilities are available, quick and are cost effective, if it is not known whether the child or adolescent has been vaccinated against hepatitis B, blood should be taken for hepatitis B status prior to administering the first vaccine dose.
- **HPV vaccination** should be offered to girls in the age group 9–14 years, as per national guidance. HPV vaccine may be administered concomitantly with hepatitis B vaccine. If HPV vaccine is given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites using separate syringes.

Slide 53 notes
- **Check weight** to decide on which dose to give.

Slide 54 notes
- **Check weight** to decide on which dose to give.
- The choice of HIV PEP regimen should consider the antiretroviral medications already being procured within national HIV programmes. This is the WHO-recommended preferred regimen for HIV PEP for adults and adolescents. Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options.

Video 8.9: Preventing pregnancy for adolescents

- **Explain** that health care workers should speak directly to the patient – not only to their parent. Remind them to ask if there are any questions. Review the reason to give a girl who has not yet started menstrual periods.

Video 8.10: Medical treatment and care of children

Discuss the video:
- What did the physician do well?
- What was missing? What could be improved?

Explain that the health care provider should explain what the HIV PEP side effects are, and how to manage them.
Review the HIV PEP is for 28 days, and STI prophylaxis depending on the medication used is most often 1 single dose or a 7 day treatment. This was somewhat unclear in the video.
Remind the participants that health care providers should talk directly to children, and involved children to participate in their own health care.

SLIDE 56-57 CASE STUDY

Slide 56
Question A 12-year-old female named Nadia presents to the clinic 12 hours after being vaginally raped by her teacher. She complains of vaginal soreness and a few drops of blood on her underwear. The pelvic exam reveals minor lacerations along the posterior opening of the vagina. The patient has not yet begun menstruation.

Should you offer EC to this patient?
A. Yes
B. No

Slide 57
Answer: A. Yes. Emergency contraception is indicated for this child even though she has not officially begun menstruation. There are cases where the first ovulation results in pregnancy. Given the safety and efficacy of ECP, all females between puberty and menopause should be given ECP if they are possibly fertile and come in within 120 hours.

SLIDE 58-59

Slide 58
Question Grace is a 14 year old girl. She comes to your clinic with her mother and stepfather. Grace tells you that the stepfather has been forcing her to have sex with him over the past 6 months. The last incident was 2 days ago. She discloses that her menses are 2 weeks late.

What medical care will you provide Grace?
A.Assessment for pregnancy
B.Offer Emergency contraception pill
C.Offer HIV testing
D.Offer HIV PEP
E.Offer STI prophylaxis
F. Offer vaccination for Tetanus
G.Offer vaccination for Hepatitis B
H.Offer vaccination for Human Papilloma Virus

Answer
A. Assessment for pregnancy
B. Offer Emergency contraception pill – Do a pregnancy test. if the pregnancy test is positive, we do not provide emergency contraception pill.
C. Offer HIV testing – and offer her to return in 3 months for follow-up HIV testing.
D. Offer HIV PEP
E. Offer STI prophylaxis
F. Offer vaccination for Tetanus
G. Offer vaccination for Hepatitis B
H. Offer vaccination for Human Papilloma Virus

Activity 8.6 Case studies – Medical care for child survivors of sexual abuse

SPECIAL CONSIDERATIONS IN PSYCHOSOCIAL SUPPORT FOR CHILDREN AND ADOLESCENTS

SLIDES 61-64

Slide 62 notes
- Begin by a statement such as, "Other children who experienced situations like what you experienced sometimes act differently and feel differently from before it happened. I'd like to ask you some questions about your (or your child's) day-to-day activities now. Is that okay?"
- Assess the child's psychosocial status, emotional state and functioning.

Slide 63 notes
- Assess these areas helps to determine if the child and/or caregiver perceives significant changes following the experience of abuse.
- Ask
  - What are your main problems or worries?
  - Has the child stopped attending school?
  - Has the child stopped leaving the house?
  - Has the child stopped playing with friends?
  - Does the child feel sad or hopeless most of the time?
  - Has the child exhibited changes in sleeping or eating habits?
- Has the child had any other major challenges or difficulties.
- Also assess the strengths of the child and family. While children are deeply affected by the experience of sexual abuse, it is important to remember that children are strong and resilient.

Slide 64 notes
- Building on children's interests helps to reengage them in activities that bring happiness and joy to their daily lives, thus facilitating the healing process.
- Ask
  - What do you do when you are scared?
  - Who are some people you feel safe with?
  - What do you do to make yourself feel safe?
  - What are your interests?
  - What activities do you enjoy?

Video 8.11: Psychosocial support for children

Slide 66 LIV(ES) for children and adolescents

- **Enhance safety:** Child sexual abuse is often perpetrated by someone known and trusted and is often ongoing. Children may be at risk of ongoing sexual abuse
- **Assess the risk** of ongoing sexual abuse of the child and **discuss a safety plan**
  - Is the child safe at their home?
  - Is the child fearful of family members?
  - Can the perpetrator easily access the child where they live?
  - What is the ability of the caregiver(s) to protect the safety of the child and meet the needs and best interest of the child?• Ask and consider the opinions, feelings, wishes of the child and focus on the child's **safety** and **best interest**
- Discuss how to recognize danger and risk with the child
- Discuss with the child who they feel safe with and who they can go to for help
- Discuss with the parent what they can do to protect the child
- If the parent cannot protect the best interest and safety of the child, explore family, neighbours or community members, community or government agencies, NGOs, alternative care arrangements as safety resources together with your colleagues and manager.

- **Facilitate social support:** Social support is crucial for healing and recovery. At the family level support can include: positive attitudes and involvement on the part of parents/caregivers, family cohesion. At community level support can include involvement in community life, peer acceptance, and supportive mentors, and access to quality schools.
- The caregiver can decrease the child's emotional distress by spending time with their child and providing opportunities for their child to play with other children, create a supportive environment, understand their child's concerns, give the child space to talk, ask questions and play.
- Ask
  - Who did the child trust the most in the family before the abuse happened? Who does the child trust after the abuse? Is the child happy at home? Does the child have basic needs met (food, clothing, education, protection)? Is the child treated differently from other children in the family? Is the child able to play freely?

- However **non-offending caregivers also need support** in coping with their own feelings related to the CSA, in order to support their child.
- Caregivers may have many feelings:
  1. Blame themselves.
  2. Being in disbelief, shock, worry, sadness, or fear.
  3. Not knowing what to do or where to seek help.
  4. May become angry and scold or beat the child.
  5. They may choose not to enquired more, think they misunderstood the child or the situation as they don't want the problem to exist.
  6. Conflicting emotions especially if perpetrator is someone trusted.

The child will need the caregiver's support and attention to facilitate their own healing. Explain them their importance in the child recovery and that believing their child is crucial.

Video 8.12: Enhancing safety with children

Video 8.13: Connecting children with social support
Explain that both of these videos are brief, the conversations to enhance safety and connect with social support may be more in depth that these.

Activity 8.7: Case studies on enhancing safety and facilitating support for survivors of child sexual abuse

Slide 69 Key messages

9

SEXUAL VIOLENCE AGAINST MEN AND BOYS

9. SEXUAL VIOLENCE AGAINST MEN AND BOYS

PREPARATION AND MATERIALS

OBJECTIVES

- Understand the barriers faced by male survivors of sexual violence
- Describe how male survivors may react to a sexual assault.
- Gain knowledge and skills to provide first line support and medical care to male survivors of sexual violence or rape

AVAILABLE TRAINING RESOURCES

Presentation
9. Sexual violence against men and boys

Facilitator guide
9. Sexual violence against men and boys

Activities
9.1 Myths about male sexual abuse
9.2 Barriers to care for male survivors
9.3 Case Study – male survivors of sexual abuse

Videos
9.1 Welcoming male survivors
9.2 History taking with male survivors
9.3 General examination of male survivors
9.4 Genital examination of male survivors
9.5 Medical care and treatment for male survivors
9.6 Validate, enhance safety and connect with support for male survivors

Participant handouts
9.1 The Scope and Types of SGBV against Men and Boys
9.2 Barriers to care for male survivors of sexual violence

REQUIRED SUPPLIES & MATERIALS

- Projector, laptop
- Pen and blank paper workbook for each participant
- Flip chart, markers
- Print outs of activities – depending on which activities you choose
- Masking tape or string to separate the room
- Papers with a True/Agree and False/Disagree
- Large space for participants to move around

KEY MESSAGES

- Male survivors of sexual violence face similar and unique consequences to other survivors of sexual violence
- Male survivors should receive support and empathetic care, including:
    - Listening, inquiring about needs, validating
    - Medical care – prevention of HIV, STIs, tetanus, hepatitis B and treatment of wounds and injuries
    - Enhancing safety and connecting with support

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- UNHCR 2012 Working with men and boy survivors of sexual and gender-based violence in forced displacement
- Sexual Violence Research Institute Briefing paper: Care and Support of Male Survivors of Conflict-Related Sexual Violence
- GBV IMS Steering Committee (2017) Interagency Gender-based Violence Case Management Guidelines Providing care and case management services to Gender-based violence survivors in humanitarian settings; Part 4, Chapter 2 GBV Case Management with Male Survivors of Sexual Violence
- UNHCR (2016) SGBV Prevention and Response Training Package, Module 7 Working with Men and Boy Survivors of SGBV

SEXUAL VIOLENCE AGAINST MEN AND BOYS FACILITATOR GUIDE

INTRODUCTION

SLIDES 1-4

Slide 3 notes

- Sexual violence may be used to demoralize, destroy, stigmatize men and boys. Sexual violence can destroy family and community cohesion.
- Within gender discrimination that promotes men as superior and women as inferior, sexual violence can be used to attack and destroy a sense of masculinity, and feminize men and make them feel like they have the lower status of women.
- Within stigma and discrimination against people of minority sexual orientations, sexual violence against men by another man can make men feel as if their heterosexual status is removed and feel as if they have a stigmatized homosexual identity. However, it is important to re-inforce the harms of homophobia against all people – including heterosexual, gay and bisexual men.

TYPES OF SV AGAINST MEN AND BOYS

SLIDES 5-7

Slide 6 notes

- Sexual violence against men and boys includes:
  1. rape – anal rape and oral rape with a penis or objects, sexual torture and mutilation, beating, blunt trauma to genitals, castration, enforced sterilisation
  2. sexual humiliation and degrading sexual acts, forced nudity, forced masturbation of themselves or others
  3. enforced rape – being forced to rape another person, against family members, other men or peers including in front of others
  4. enforced sexual acts – being forced to perform sexual acts on another person, often humiliating sexual acts, to participate in sexual acts
  5. being forced to witness sexual violence – including against their own family
- Sexual torture often goes unrecognized as a form of sexual violence against men and boys.

Activity: 9.1 Myths about sexual violence against men and boys

THE IMPACT OF SV AGAINST MEN AND BOYS

SLIDES 9-14

Slide 10 notes

Many of the **impacts of sexual violence on men and boys are similar to those that are experienced by women and girls,** however there are some particular experiences that can be helpful for service providers to understand in order to best serve this population.

Slide 11 notes

- Male survivors may experience damage to the penis and testicles; penile, testicular, anal, rectal pain; genital, rectal or prostate infections; abscesses; rectal rupture, damage to reproductive capacity; or sexual dysfunction, infertility, impotence.

Slide 13 notes

- SV against men and boys may challenge their perception of their **masculinity**, sexuality, and reproductive capacity. Men may have feelings of worthlessness, guilt, shame and humiliation
- Male survivors may struggle related to ideas about masculinity as strong and tough, that sexual violence is incompatible with "being a man"., "A man should have been able to protect himself" and "A man should be able to cope". They may feel weakness because they may have been surprised by the unexpected freeze reaction to the threat or feeling of being paralyzed with fear. They may have feelings of guilt for not having or being able to defend himself as he may believe he should have done. Men may feel that they have lost their sense of masculinity.
- Boys and men survivors may struggle with **gender identity and sexual orientation** given the common myth that male survivors are, or become, gay and discrimination and stigma against sexual minorities. Sexual violence may be perpetrated

to attack a man's sense of heterosexuality or be perceived as "invited" or "punishment" if a man or boy is viewed as homosexual. It is not uncommon for men to experience sexual arousal, erection and ejaculation during an abusive experience. This is a normal physiological response and does not suggest consenting to, desiring or enjoying the experience. This reaction can leave the survivor feeling ambivalence, confusion, disgust, doubting or question his sexual orientation or identity. This is particularly in in cultures where homosexuality is taboo, shameful or punished. Men may have stronger feelings of homophobia if they had experienced sexual violence.

- Survivors may experience an erection or orgasm during the attack—reassure them that this is **physiological response**— as this may make them experience additional confusion and anxiety.

Slide 14 notes

- They may lose sexual interest and avoid intimacy.
- They may withdraw from relationships, family, parenting and community activities. They may lose respect from their spouse or family, or may be rejected or abandoned by their spouse or family.
- They may be excluded from places of worship, recreation, and employment,
- They may lose their job – and then losing one's job may also contribute to or exacerbate his distress due to prevalent gender norms about a man's role as a provider.
- They may face criminalization where same sex relationships – even without consent - are penalized, or for being forced to rape others.
- The social consequences may be linked to social norms about masculinity, power, dominance, social norms expecting men to be strong, aggressive, protectors and providers.

BARRIERS TO SERVICE ACCESSIBILITY AND PROVISION

9.2 Activity – Barriers to care for male survivors

Slide 17 notes

- Many of the barriers to care experienced by men are similar to those already discussed for other survivors of sexual violence but may be experienced slightly differently. The barriers will vary from context to context, and will depend upon specific cultural and social norms and other characteristics of the survivor such as ethnicity, religion, socio-economic status and sexual orientation.
- As with violence against women and girls, such violence often goes underreported.

The barriers include:

- **Traditional masculine norms do not promote help-seeking**. Traditional norms of masculinity that suggest that men must be strong, in-control, independent and not express emotions, make it less likely for men to seek help even when they have experienced a stressful event. These norms make it difficult for men to seek help and may result in a lack of compassion from family, friends, service providers and the police.
- **Feelings of shame, confusion and guilt, and fear of stigma.** Related to the masculine norms discussed above, male survivors may experience strong feelings of shame and fear being stigmatized because they have been sexually violated. This is particularly the case if the masculine norms in their environment suggest that men must be powerful and dominant sexually. Regardless of the gender of the perpetrator, male survivors may be grappling with what their experience of sexual violence means for their gender identity and sexual orientation. This is particularly the case if the abuse has happened more than once or happened in their childhood.
- Fear of **not being believed.**
- Fear of **judgement, stigma, social marginalization and isolation** or being labelled as homosexual in cultures of homophobia
- **Concerns and fears about sexuality.** A common myth is that men who have experienced sexual violence perpetrated by men are gay or will become gay. There is no evidence to suggest that an experience of sexual violence is a predictor for sexual orientation. However, if this myth is a common perception and homophobia is also prevalent in a community, male survivors may not seek help because they are grappling with these questions themselves and/or fear the reactions from others. This can be a significant barrier to help-seeking in societies that police or criminalize homosexuality.
- **Lack of knowledge** or ability to label and describe the act of sexual violence
- Lack of awareness that sexual violence is also perpetrated towards men and boys and has medical and psychological consequences
- Information about SV and health services are focused on children and women
- **Lack of existing or accessible support services** for male survivors of sexual violence
- Harmful attitudes, discrimination, stigmatization and disgust by health care providers
- **Fear of not being believed**. Because of traditional masculine social norms, male survivors may fear that they will not be believed if they tell someone about what they experienced.
- Legal environment that **criminalizes and punishes homosexuality,** including non-consensual same-sex acts

SPECIAL CONSIDERATIONS FOR HEALTH CARE AND PSYCHOSOCIAL SUPPORT FOR MALE SURVIVORS

SLIDES 18-20

Slide 19 notes
Just as female survivors, men should be listened to, asked about their needs and validated.

Slide 20 notes
- There are some specific messages to help validate male survivors of sexual violence:
- Reassure the person that their **reactions are normal.** Let them know that their responses and feelings to what happened are okay and that they are normal to feel. Male survivors may need to hear in particular that feelings such as sadness and fear—which traditional masculine norms often don't allow men to feel or express—are normal. Reassure them that it is safe for them to express their feelings—whatever they are— and that you will be there to listen.
- When a man is raped anally, pressure on the prostate can cause an erection, orgasm or ejaculation, which can contribute to feelings of shame and self-blame. Survivors are often particularly confused and ashamed by involuntary physical arousal to physical stimulation during an assault. Reassure the survivor that, if this has occurred during the rape, it was a normal physiological reaction and was beyond his control and separate from his sexual orientation.
- **You are not alone.** Male survivors often feel isolated and stigmatized due to the silence surrounding sexual violence against males. Help survivors understand that sexual violence towards men and boys happens around the world, and that they are not the only ones that this happened to. This can also help to reduce any self-blame.
- **It was not your fault.** Male survivors need to be reassured that they have not brought sexual violence on themselves through their appearance, behaviour or any other personal factor, their lack of ability to defend themselves. Validate that they did what seemed best at the time to survive.
- **Validate and reaffirm their bravery and strength.** Just as with other survivors, it is important for male to survivors to hear that they were courageous, brave and strong to come for help. By emphasizing this, you are helping to reduce their fears and concerns related to the stigma of men reaching out for help.
- **The experience of SV does not make you "less of a man."** Help survivors to move away from masculine forms of self-blame. Provide messages that move ideas masculinity aware from strength or aggression, and provide hope and sense of masculinity on being a loving husband, father, son, brother, friend and a constructive member of the community.
- **Do not make assumption**s about the person and their experience, about their sexual orientation or gender identity. Validate concerns about sexuality, but provide accurate information that a sexual assault does not change someone's sexual orientation. Do not community any stigma, taboo or discrimination towards sexual or gender minorities.
- Respect the language that they use to describe themselves and their experience.
- Male as well as female survivors need to be believed; to feel physically safe; to feel that their service providers empathizes with them; to feel free from judgment or blame; to be certain that they can speak confidentially; to be given time and encouragement; and to be accepted as a whole person, rather than being reduced to the status of 'victim' or 'perpetrator.'

Video 9.1: Welcoming male survivors

Discuss the video:
- What did the nurse do well in welcoming the survivor?
- What was missing? What could be improved?

Explain that survivors should be give them the option of the gender of care provider if possible. Some men may prefer a female provider, especially if they experienced SV by a man or fear judgement from other men.
Explain that health care providers should respect if survivors do not want to sit, they may be in pain and it is acceptable for them to stand.

SLIDE 22-23 CASE STUDY

Slide 22
Question A 20-year-old male arrives at the clinic one day after being gang raped by enemy soldiers. He complains of general body aches, anal soreness and mild bleeding with bowel movements. His exam reveals multiple anal cuts with significant tenderness.

The patient appears increasingly anxious and reluctantly tells you that he thinks he experienced an erection during the assault. He expresses shame and feelings of disgust with himself.

What are the appropriate messages that you should communicate to him?

A. Explain that, in such circumstances, erections are a reflex that he could not control.
B. Reassure him that he is not alone, and that it is common for survivors to experience guilt and shame.
C. Advise him to keep the incident a secret from everyone.
D. Both A and B.

Slide 23
Correct answer D.
Both A and B. Explain that, in such circumstances, erections are a reflex that he could not control. Reassure him that he is not alone, and that it is common for survivors to experience guilt and shame. Both answers A and B reflect the importance of providing basic, healing support to this patient. Keeping sexual assault a secret can intensify feelings of embarrassment and shame. Reassure the patient, encourage him to seek emotional support from people he trusts, and refer him to counseling services.

Slide 24 History taking and examination for men
Provide information about why you are asking questions. They may feel intrusive or judgmental.

Video 9.2: History

Discuss the video:
- What did the nurse do well in welcoming the survivor?
- What was missing? What could be improved?

Discuss how James said "I don't want to talk about it". Reenforce that it is the survivors choice whether or not they want to talk about the incident, and how much they want to share.
Reenforce that it is the survivors choice whether or not to report to the police,
James said "I want to kill him". Validate emotional responses – anger and the desire for revenge and retaliation can be normal responses.
However assess if there is a clear plan to harm another person, try to speak non-judgementally about healthier alternatives that can reduce risk and improve safety.

Slide 26 General examination of male survivors

Video 9.3: General examination of male survivors

Slide 28 Genital examination of male survivors
- Seek voluntary informed consent
- Communicate with the survivor, step by step
- The examination should be guided by the history.
  Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus and anus.
- Note if the survivor has been circumcised
- Look for injuries, pain, swelling
- Look for hyperaemia, swelling. torsion of testis, bruising, anal tears, etc.
- If there is testicular swelling or pain it could be inguinal hernia, hydrocele (type of swelling in the scrotum that occurs when fluid collects in the thin sheath surrounding a testicle from injury or infection) and haematocele (blood clot caused by trauma or injury to the testicles or scrotum), torsion of testis. They should be referred for further care.
- Pain and swelling of the testicles may be testicular torsion, which is a medical emergency and requires immediate surgical referral.
- If the urine contains large amounts of blood, check for penile and urethral trauma.
- Digital rectal examinations are recommended if there is a reason to suspect that a foreign object has been inserted in the anal canal, if there is fecal incontinence.
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection.
- Provide re-assure (if this is correct).

Video 9.4: Genital examination of male survivors

SLIDE 30-31 DOCUMENTATION

Slide 30 notes
- Document your findings clearly, objectively and completely in the medical examination forms
- These are pictograms to aid in documentation of injuries
- Keep all medical records confidential.

Slide 32 Medical care
- Seek informed consent before you offer treatment.
- All medical care for men and boys is the same as medical care for women and girls, with the exception of pregnancy.
- Prostate infections caused by anal penetration can be difficult to treat and require antibiotics for an extended period of time.

Video 9.5: Medical care and treatment for male survivors

Discuss the video:
- What did the nurse do well in welcoming the survivor?
- What was missing? What could be improved?

Explain that the health care provider should explain each the medications separately, how they work, side effects and always ask the patient if they would like to take medicine, instead of saying "please take them now."
Explain that STI prophylaxis is most often given as a single dose depending on your protocol. Explain that the HIV PEP is given daily for 28 days.

SLIDE 34-35 CASE STUDY

Slide 34
Question: A 20-year-old male arrives at the clinic one day after being gang raped by enemy soldiers. He complains of general body aches, anal soreness and mild bleeding with bowel movements. His exam reveals multiple anal cuts with significant tenderness.

What is the best response to the patient's question regarding his risk of becoming infected with HIV as the result of the assault?
A. Reassure him saying, "Don't worry. You will be fine. "
B. Inform him he is at potential risk for HIV given the nature of the assault.
C. Explain to him that his risk of infection may be lowered with PEP.
D. Both B and C.

Slide 35
Answer Both B and C. Inform him he is at potential risk for HIV given the nature of the assault. Explain to him that his risk of infection may be lowered with PEP. The patient has suffered a potentially significant exposure to HIV . You do not know his exact risk of getting HIV but he has a right to be informed. Never give false reassurances. While some patients who take HIV PEP develop side effects like nausea, headaches, and vomiting, it will not be effective if it is not taken for the full 28 days.

SLIDE 36-37

Slide 36
Question: Joshua is a 23-year-old man. He is arresting at anti-government protest and taken to the government prison. The prison guards beat him with metal pipes, force him to be naked and 2 of them anally rape him in front of other prisoners. He is released from prison and comes to your clinic 7 days after the incident.

What medical care will you provide Joshua?
A. Assessment and treatment of injuries
B. Offer HIV testing
C. Offer HIV PEP
D. Offer STI prophylaxis
E. Offer vaccination for Tetanus
F. Offer vaccination for Hepatitis B
G. All of the above

Slide 37
Answer
A. Assessment and treatment of injuries
B. Offer HIV testing. Also recommend that Joshua returns 3 months after the rape. The window period for HIV testing is 3 months, so testing him 1 week after the rape will not show whether or not HIV was transmitted during the rape.
D. Offer STI prophylaxis.
E. Offer vaccination for Tetanus
F. Offer vaccination for Hepatitis B
DO NOT offer HIV PEP because Joshua presented to the health facility 7 days after the anal rape. HIV PEP is only effective within 72 hours or 3 days of an incident of rape

Activity 3.3 Case study

Slide 39 LIV(ES) FOR MEN AND BOYS

- **Assess risks and enhance safety:** If the incident of sexual assault is known to others in the community or the authorities, the person may be at risk for further violence. Finding formal or community-based sources of protection and security for the person might be very difficult and even the act of seeking such support could put the person in danger.
- The significant stigma that male survivors may experience may make it difficult for the person to come up with people whom they can trust and can go to for safety. In cases where the person is at imminent risk, this may mean you have to play a more active role in suggesting options to the person that can help with immediate safety. You should go through each option carefully to understand what the risks could be and help the person choose the option that poses the least risk.
- Depending on the context they may fear: persecution, violence, SV, or death from their community and government, due to social norms that discriminate men who has sex with men and/or laws criminalizing same sex relationships in any extent.
- Be creative! Think about the safety of LGBT survivors.

- **Offer support:** mental health and psychosocial support may include substance use services, helping men to understand they are not to blame, how to engage in relationships and parenting.
- With legal and justice support, be careful to think about the risks – in some countries same-sex relationships are punished and male survivors may be criminalized.

Video 9.6: Validate, enhance safety and connect with support for male survivors

Slide 41 Key messages

10

PREPARING YOUR HEALTH FACILITY

10. PREPARING YOUR HEALTH FACILITY

PREPARATION AND MATERIALS

OBJECTIVES

- Demonstrate knowledge on how to ensure the health facility is ready to provide care to survivors
- Gain the knowledge and skills to prepare the health facility and set up a consultation room
- Map out current patient flow and response to sexual assault survivors and identify areas for improvement within the health facility
- Describe what referral resources are needed for sexual assault survivors, determine what resources are currently missing in your network and develop a plan for filling gaps and improving communication between the various organizations.

AVAILABLE TRAINING RESOURCES

Presentation
10. Prepare your health facility

Facilitator guide
10. Prepare your health facility

Activities
10.1 String exercise – privacy
10.2 Mapping – Prepare the entry point, care pathway and consultation room
10.3 Small group discussion – Checklist for clinical care
10.4 – drawing a referral pathway
10.5 Develop an action plan

Participant handouts
10.1 Assessing service readiness
10.2 Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence
10.3 Infrastructure considerations, barriers and suggestions to overcome them
10.4 Referral chart

REQUIRED SUPPLIES & MATERIALS

- Laptop, projector
- Pen and blank paper workbook for each participant
- Ball of string or wool
- Flip charts and markers
- Space large enough for participants to form a circle
- Print outs of activities – depending on which activities you choose

KEY MESSAGES

- Prepare your health facility
  - Entry point, care pathway, consultation room
  - Medications, supplies, equipment, documentation, protocols
  - Trained staff
- Identify support services, create a referral directory, coordinate between support services to meet survivors' multiple needs and offer referral to survivors

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- WHO (2017) Strengthening health systems to respond to women subjected to violence. A manual for health managers (pg 87-90)

PREPARING YOUR HEALTH FACILITY FACILITATOR GUIDE

INTRODUCTION

Slide 1-2 Introduction

PREPARE YOUR HEALTH FACILITY

SLIDE 3-4 PREPARE YOUR HEALTH FACILITY

Slide 4 notes

- Explore and decide on an **entry point, care pathway, patient circuit**
- Ensuring that the number of places that the survivor will need to go to, the number of people they will need to speak to and the number of times they will need to disclose the violence are minimal.
- Think of a code word, colour, image, coupon, CHWs or women's friendly/safe space giving out a green coupon, white flower so the survivor does not need to say anything or disclose an experience of abuse.

- Decide on a **consultation room** to ensure privacy, confidentiality and accessibility— a separate room with 4 walls and a lockable door, where the patient cannot be seen and overheard from outside the consultation room.
- Ideally, all medical care and psychosocial support will be offered in **one accessible, safe, private and confidential location**
- The consultation room should feel welcoming, comfortable, friendly, non-threatening and non-threatening. Consider how to make the space child and adolescent friendly.
- Prepare sign for the door 'Do not disturb' to improve privacy and confidentiality.
- If resources permit, consider having a private, separate or outside entrance to the examination and consultation room, access to a toilet or latrine, and creating a space where children accompanying their mothers can play, watched by other health facility staff. Or Consider changing patient flow so that women can bypass public waiting areas. If this is not possible, instruct staff to ask intake information only in a private space or in writing. Reduce stigma by avoiding explicit names and signs that indicate that those who enter the exam room have been subjected to violence.
- Ensure a confidential space to safely secure documents.
- Ensure the room is accessible for people with disabilities.

Activity 10.1 String exercise – privacy
and/or
Activity 10.2 Mapping – Prepare the entry point, care pathway and consultation room
The activity privacy may be done in the module "What every clinic worker needs to know" so do the activity only once in the week either in the module "What every clinic worker needs to know" or here.

SLIDE 6-7

Slide 6 notes

- Prepare **medications, supplies and equipment**
  - HIV test and HIV PEP
  - STI medication
  - Pregnancy tests, emergency contraception
  - Vaccines, needles, syringes
  - Analgesia, antiemetics, wound care supplies
  - Documentation, medical certificate
  - Protocols and job aids
  - Lights, an examination bed
  - Sheets, blankets, sanitary pads.
- Do you have SRH services? Obstetrical care? X-ray? A lab? Counsellors? Mental health services? ARV services? Ensure you can offer referral to other services.
- Ensure adequate and continuous stock of medical products.
- Provide the checklist of medical products to the department caring for sexual assault survivors and ask them to order the individual items in required quantities.
- Instruct the responsible health-care providers to gather equipment and medicines on a shelf, in a file cabinet or in a mobile kit. Establish processes to restock after each client and to check medication expiration dates.

- Ensure there are well displayed visual information, education and communication (IEC) materials service areas of the available CMR/IPV services

Slide 7 notes
- Ensure **documentation** is safely, securely and confidentially stored.

Activity 10.3 Small group discussion – Checklist for clinical care

PREPARE AND TRAIN STAFF TO CARE FOR SURVIVORS

SLIDE 9-10

Slide 10 notes
- **Identify, sensitize and train staff** based on their roles and responsibilities. Develop a training plan
- Identify a **focal person** in the health facility to be responsible for the response to violence, to coordinate, manage and deliver services for women subjected to violence
- A **health-care provider** (nurse, doctor or equivalent) trained in sexual assault care and examination should be **available at all times of the day and night** (at location or on-call).
- Identify who on your staff can be assigned and offer training for this role. An on-call roster system (with appropriate remuneration) may be useful.
- Offer regular follow-up, mentoring and supervision after training.

IDENTIFY AND MAP YOUR REFERRAL NETWORK

SLIDES 11-16

Slide 12 notes
- Survivors of IPV and rape often have **multiple needs.** We should offer support for medical needs and referral to further support services, and establish coordination and referrals between health services and services of other sectors
- **Identify and map the available services** or organizations in your community - particularly those that are reasonably accessible in terms of distance, availability of transport and cost. This includes:
- **Medical care** - government supported, faith based, INGO or NGO supported and private health facilities, pharmacies, traditional healers and traditional birth attendants, primary care, HIV care, ART, safe abortion care, antenatal and obstetrical care, surgical services are available? X-rays, orthopaedic services? Burn care? forensic medicine services
- Mental health and psychosocial support - psychosocial support, Mental health counsellor, social worker, psychologist, counselling, psychiatrist or mhGap trained health care worker, Support groups, Safe spaces, social or recreational activities
- **Community support** - Peer groups, Traditional healers, religious leaders, religious groups, community leaders or community groups, Women's groups, peer support groups, faith-based organizations and organizations working with marginalized groups or special needs populations or people with disabilities, women safe or friendly spaces
- **Legal support** - legal aid, Legal Assistance Services – information about their rights, representation in courts for protection, divorce or child custody, courts
- **Protection, safety and security** - safe accommodation, safe House, shelter housing
- **Police** - law enforcement, security actor, investigators, forensic/medico-legal investigations
- **Education, economic support** - Financial aid including livelihood or income generation, vocational training, microcredit loans, food assistance, material support
- **Child protection services and foster services**
- **Practical needs** - securing/replacing identity documents, transportation assistance, child care, interpreters
- Other - Crisis centre, one stop centre

Slide 13 notes
- **Assess the accessibility and quality of the support services,** consider: cost, opening hours, wait times, availability of transport, barriers to access, possible groups being discriminated against or excluded in service provision, whether there are any mandatory reporting requirements associated with the referral (for example, whether referral for medical treatment will require the doctor or nurse to report the case to the police)

Slide 14 notes

- Develop a **list with the name of the support service,** Contact name, Contact number, E-mail of a focal person in each referring and receiving service, Address, Type of support service, Description of services provided, Hours of operation, Cost (if any), Procedures to access and obtain services, Population served, Possibilities and limitations for collaboration
- **Know at least one person at that service,** be able to refer to these people by name
- Know **what services are provided,** so that you can tell patients
- Ensure that **all health facilities have a copy** of the directory and if possible develop personal contacts with receiving services.

Slide 15 notes

- **Consider privacy and confidentiality** - minimize points of care and retelling of the story, protect the and confidentiality of her information
- Identify **a focal point for coordinating referrals** – who facilitates referrals, access to care, can follow-up, can improve relationships with other agencies, address any challenges
- Their roles should be to:
  1. maintains an updated referral directory with contact details of referral services
  2. refers client for services not provided onsite
  3. follows up with client and receiving organization
  4. documents referral activity
  5. conducts quality assurance.
- **Prepare to monitor referrals** - Develop tools for monitoring referrals and coordination including referral cards and documentation forms that assure confidential transfer of medical information, and that enable you to monitor whether women are able to access different services and receive quality care. You can ask stakeholders from the different services, as well as clients, for their views on how the referral process of the health service or facility could better meet the needs of women subjected to violence.
- **Improve coordination,** participate in multi-sectoral coordination mechanisms, or develop this with other support services – establish a common aim, agree on guiding principles (do no harm, respect autonomy and choice, privacy and confidentiality), establish roles and responsibilities, establish informal or formal agreements (memorandum of understanding (MOU) among services, maintain relationships through hosting cross-trainings, workshops or regular meetings, identify gaps and challenges.

Slide 16 notes

Provide information to the survivor about available supports:

- What **support will be available,** location, how to get there, who s/he will see.
- The **benefits and risks** of the service (and whether there are any mandatory reporting requirements associated with the referral
- That the person has the **right to decline** or refuse any part of an intervention provided by the caseworker and/ or referral agency
- **What information will be shared** about the case in the referral process and with whom.
- Ask **if they have questions,** always check to see if she has questions or concerns and to be sure that she has understood.
- Ask **if they want to be referred** to a service, and **get informed consent**.

If she accepts a referral, here are some things you can do to make it easier for her:

- Offer to **telephone** to make an appointment for her if this would be of help (for example, she does not have a phone or a safe place to make a call).
- Offer to help **make an appointment**, if it helps: Offer to call on her behalf OR Offer to make a call with her OR Offer a private place where she can call.
- Offer to **provide information or documentation** to survivor for the service provider, so that survivor won't have to repeat information – including what happened.
- If she wants it, **provide written information** – time, location, how to get there, name of person she will see. Ask her to think how she will make sure that no one else sees the paper.
- If possible, arrange for a trusted person or staff to **accompany** her on the first appointment. You should talk this through carefully with the survivor, always thinking about safety risks. In some settings, GBV caseworkers are known in the community, so walking a survivor to a medical facility or a police station automatically raises curiosity and may inadvertently put the survivor at risk. If you will not accompany them, is there someone else they trust who can?
- If possible, discuss **childcare** and who can care for her children
- Discuss what might happen if her partner or family finds out she is going to the support services.
- Discuss **transport**, considering offering transport or payment for transport.

Activity 10.4 Drawing a referral pathway and/or
Activity 10.5 Develop an action plan

Slide 18 Key messages

11

SELF-CARE FOR CARE PROVIDERS

11. SELF-CARE FOR CARE PROVIDERS

PREPARATION AND MATERIALS

OBJECTIVES

- Build an understanding of the various types of traumatic stress and how they impact you.
- Gain awareness of the signs of burnout and vicarious trauma.
- Demonstrate knowledge of how to access resources, support for ourselves and practice self-care
- Understand how to utilize tools and methods for staff care and managing stress.

AVAILABLE TRAINING RESOURCES

Presentation
11. Self-care for care providers

Facilitator guide
11. Self-care for care providers

Activities
11. Self-care for care providers

Participant handouts
11.1 Identifying different forms of stress
11.2 Staff care

REQUIRED SUPPLIES & MATERIALS

- Projector, laptop
- Pen and blank paper workbook for each participant
- Flip chart, post-it notes or small pieces of paper, tape

KEY MESSAGES

- Health care providers may be at risk of burnout or secondary trauma
- Health care providers should be aware of the potential signs of burnout and secondary trauma
- Self-care is an important way to prevent or manage burnout or secondary trauma
- Workplaces should support staff through staff care

FURTHER RESOURCES FOR FACILITATORS (OPTIONAL)

- None

SELF-CARE FOR CARE PROVIDERS FACILITATOR GUIDE

SLIDES 1-2 INTRODUCTION

Activity 11: Self-care for care providers
Option 1: Do the entire activity now
or
Option 2: Explain the entire activity, but start with Activity 11.1 question only - Our work environment can be a major source of stress. What do you see as the biggest stressors in your work?

SLIDES 4-6 TYPES OF STRESS

Slide 4 notes
- **Stress** is a normal and natural response designed to protect, maintain and enhance life. We may find stress to be a positive if how we manage stress is adaptive and healthy, and we have the feeling that we can control stressors. It motivates us to get up in the morning, accomplish tasks, and seek out the new projects and relationships which we enjoy.
- Stress that we cannot manage or control well is experienced more negatively.

Slide 5 notes
- **Cumulative stress** is the result of prolonged, accumulated, unrelieved exposure to stressors. It is the most common form of stress experienced by humanitarian workers. When not recognized and managed, cumulative stress leads to burnout.

Slide 6 notes
- **Critical incident stress** is caused by extraordinary events which provoke high level of stress. These events may be sudden and disruptive; it involves an actual or perceived threat or loss; it causes a sense of vulnerability; and it disrupts our sense of being in control and perception of world as safe and predictable.
- While not everyone will experience the stress the same way, critical incident stress is commonly understood as a response to an event in which nearly everyone involved has a stress reaction.
- When we think of "trauma," we typically are thinking of events that would cause a critical stress reaction.

Activity 11. Self care for care providers
Question 11.2: impacts of work - How do you find this work – supporting survivors of sexual violence and intimate partner violence – impacts your emotional well-being, mental health and relationships? What do you notice about yourself when you feel overwhelmed, exhausted, drained or burnt-out related to work?

SLIDES 8-10 BURNOUT AND SECONDARY TRAUMATIZATION

Slide 8 notes
- **Burnout** is a type of cumulative stress reaction that occurs over time after prolonged exposure to occupational stressors. When we are regularly exposed to demanding situations with inadequate support, over time we may no longer have the resources to be able to deal with the stress. This can result in burnout.

Slide 10 notes
- Fatigue, guilt, powerlessness, despair, loss of compassion and empathy, cynicism, resentment, aggression, anger
- Feeling overwhelmed, diminished sense of enjoyment, lack of time or energy for oneself, hypervigilance, sleep disturbances, nightmares
- Intrusive thoughts of patients, families. nightmares, recurring images, or vivid mental replaying of client's trauma.
- Feeling very emotional during or after working with a survivor or having no expression of emotions, no matter what you experience (flat affect).
- Taking your work "home" with you. Even when you are not at work, when you are home or with your own family, you are unable to stop thinking about work.
- Negative impacts on personal lives, social withdrawal or isolation from family and friends, Absenteeism or repeated, prolonged or unexplained sick leaves from work

Activity 11: Self care for care providers
Question 11.3: self-care What you can do to care for yourself? What do you do to take care of yourself, to care for yourself when you feel overwhelmed or burnt out?

SLIDE 12-13 SELF-CARE

Slide 12 notes
- Remind providers to practice self-care not only for themselves, but also as an example to their colleagues and patients.

Slide 13 notes
- Communication with others breaks the silence of unacknowledged pain. Connections can also increase feelings of hope.

Activity 11: Self care for care providers
Question 11.4: workplace prevention and support

SAVE LIVES AND SEEK JUSTICE

Norwegian Church Aid works to save lives and seek justice. Our support is provided unconditionally with no intention of influencing anyone's religious affiliation.
Norwegian Church Aid is a member of the ACT Alliance, one of the world's largest humanitarian coalitions. Together, we work throughout the world to create positive and sustainable change.

To save lives and seek justice is, for us, faith in action.

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