



# UNIT 3: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS

Sexual violence is among the most pervasive forms of violence and is a major public health concern. It is exacerbated in situations of conflict, forced migration, and natural disasters, with an estimated one in five women and girls experiencing sexual violence in complex humanitarian settings.<sup>39</sup> Anyone can experience sexual violence, including women, men, adolescents, persons with disabilities, young children, the elderly, lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA) people, ethnic and religious minorities, and sex workers, among others. All actors responding in an emergency should be aware of the risks of sexual violence and coordinate multisectoral activities to prevent them and protect the affected populations—particularly women, girls, and other at-risk populations.

Examples of protective measures include:

- ▶ safe access to health facilities;
- ▶ sex-segregated latrines and bathing facilities with locks on the inside;
- ▶ adequate lighting around the camp and in the health facilities; and
- ▶ partitioned homes or individual family tents to allow privacy.

Humanitarian actors must also ensure that women, girls, men, and boys, in all their diversity, who have experienced sexual violence receive clinical care and psychosocial, protection, and other supportive services as soon as possible after the incident. Sexual violence is a traumatic experience that may have a variety of serious and negative short- and long-term physical, psychological, personal, and social consequences for survivors that must be addressed. Sexual violence diminishes the ability of women and girls, along with other at-risk populations, to meaningfully participate in development, peacekeeping, educational opportunities, and economic activities. Entire families and communities suffer deeply due to the multilayered impacts of sexual violence.

An important resource that outlines the set of minimum multisectoral interventions to prevent and respond to sexual violence in emergency settings is the Inter-Agency Standing Committee (IASC) *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*.<sup>40</sup> These guidelines provide recommended interventions for all sector areas before an emergency, during the acute phase of an emergency, and once the immediate crisis subsides. A reference matrix of these guidelines is also available.

39 Alexander Vu, Atif Adam, Andrea Wirtz, Kiemanh Pham, Leonard Rubenstein, Nancy Glass, Chris Beyrer, and Sonal Singh “The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: A Systematic Review and Meta-Analysis,” PLOS Currents Disasters, March 18, 2014, DOI: 10.1371/currents.dis.835f10778fd80ae031aac12d3b533ca7.

40 Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action (website), accessed April 8, 2019, <https://gbvguidelines.org>.

## At the end of the unit, learners will be able to:

- ▶ explain what sexual violence is and why preventing sexual violence and responding to the needs of survivors is a priority;
- ▶ list what actions should occur to prevent sexual violence;
- ▶ describe the components of clinical care for survivors of sexual violence;
- ▶ explain who is responsible for preventing and managing incidents of sexual violence;
- ▶ describe the reasons sexual violence goes unreported; and
- ▶ understand what a Code of Conduct and complaints mechanism are.

## MISP for SRH objectives and activities:

### TO PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS.

To prevent sexual violence and respond to the needs of survivors from the onset of an emergency, the Sexual and Reproductive Health (SRH) Coordinator, program managers, and service providers must collaborate with the health sector/cluster to:

- ▶ work with other clusters, especially the protection cluster and gender-based violence (GBV) sub-cluster, to put in place preventative measures at community, local, and district levels, including health facilities to protect affected populations, particularly women and girls, from sexual violence;
- ▶ make clinical care and referral to other supportive services available for survivors of sexual violence; and
- ▶ ensure confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral.

## What is sexual violence?

Sexual violence is a violation of fundamental human rights and takes many forms, including rape, sexual harassment, forced pregnancies/abortions, sexual exploitation, and sex trafficking. It is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person sexually, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. The Minimum Initial Service Package (MISP) for SRH mainly addresses the following three areas of sexual violence:

**Rape/attempted rape:** Rape is an act of nonconsensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape.

**Sexual abuse:** Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.

**Sexual exploitation:** Any actual or attempted abuse of a position of vulnerability, differential power, or trust for sexual purposes, including, but not limited to, profiting monetarily, socially, or politically from the sexual exploitation of another.

## Why is preventing sexual violence and responding to the needs of survivors a priority?

During emergencies such as conflicts or natural disasters, the risk of violence, exploitation, and abuse is heightened, and pre-existing gender and other social inequalities may be exacerbated. Individuals may experience a loss of secure housing, limited economic opportunities, and instability, leading to opportunistic sexual violence by known and unknown perpetrators. In some conflict or post-conflict settings, sexual violence is used as a tactic of war. Further, national systems and community and social support networks may be weakened, and in an environment of impunity perpetrators may not be held accountable.

Survivors of sexual violence may suffer from depression and anxiety, attempt/complete suicide, contract human immunodeficiency virus (HIV) or other sexually transmitted infections (STIs), become pregnant, or be shunned or even killed, a practice that is sometimes referred to as an “honor killing,” by their families or members of their communities. Moreover, the impact of sexual violence is multifold: it impacts the survivor’s physical and mental health and social well-being while having possible consequences for the survivor’s family and wider community. The heightened risk for and fear of sexual violence can also lead to increases in harmful practices designed to ‘protect’ women and girls such as early and/or forced marriage, increased incidents of domestic and intimate partner violence, and loss of mobility for women and girls.

Once a situation stabilizes and all components of the MISP for SRH have been implemented, attention can be given to addressing the wider array of GBV issues, including domestic violence, intimate partner violence, early and/or forced marriage, female genital mutilation/cutting, forced sterilization or forced pregnancy, forced or coerced prostitution, and the trafficking of women, girls, and boys.

## Who is affected most by sexual violence?

People of any sex, gender, age, or ability can experience sexual violence. Most reported cases of sexual violence among crisis-affected communities—and in most settings around the world—involve male perpetrators committing violent acts against women and girls.<sup>41</sup> Perpetrators are often intimate partners (including spouses) or others known to the individual (relatives, friends, or community members). However, men and boys are also at risk of sexual violence, particularly in conflict settings and when they are subjected to detention or torture.<sup>42</sup> Adolescent girls, persons with disabilities (especially intellectual

<sup>41</sup> “Violence Against Women,” WHO, November 29, 2017, <https://www.who.int/news-room/fact-sheets/detail/violence-against-women>.

<sup>42</sup> Sarah Chynoweth, *Sexual Violence Against Men and Boys in the Syria Crisis* (UNHCR, October 2017), <https://data2.unhcr.org/en/documents/download/60864>.

disabilities), and LGBTQIA individuals are exceptionally vulnerable because they are often targeted for sexual exploitation and rape while social protections are weakened.<sup>43</sup>

***It is important to recognize that anyone can experience sexual violence and to ensure that comprehensive and quality services are available and accessible to all.***

## **When does sexual violence occur during crises?**

Sexual violence can happen anytime during displacement, including prior to fleeing one's home, during flight, while in the country of asylum, during repatriation and reintegration, and in temporary shelters for internally displaced populations. It can occur in crisis-affected communities after a natural disaster or conflict, even among those who were not displaced from their homes.

## **Who is responsible for preventing and responding to incidents of sexual violence?**

All humanitarian actors are responsible for preventing sexual exploitation, reporting abuse, and ensuring humanitarian assistance is provided impartially, without bias or discrimination on the basis of age, sex, gender or gender identity, marital status, sexual orientation, location (e.g., rural/urban), disability, race, color, language, political or other opinion, religion, national, ethnic or social origin, property, birth, or other characteristics. Humanitarian actors are also responsible for ensuring that survivors have access to clinical care and other supportive services.

A multisectoral, multilevel approach is required to protect the crisis-affected population and respond appropriately to sexual violence. The global protection cluster, under the leadership of the United Nations High Commissioner for Refugees (UNHCR), is responsible for ensuring that protection is mainstreamed and integrated with other sectors and that support is provided as requested to the country-level protection cluster. The protection cluster working group is subdivided into five additional Areas of Responsibility, including child protection, under the leadership of the United Nations Children's Fund (UNICEF), and GBV, under the leadership of the United Nations Population Fund (UNFPA). The stated overarching objective of the GBV Area of Responsibility is "to develop effective and inclusive protection mechanisms which promote a coherent, comprehensive, and coordinated approach to GBV at the field level, including regarding prevention, care, support, recovery, and works to hold perpetrators accountable."<sup>44</sup>

At the field level, coordination to address sexual violence should encompass all technical sectors (e.g., protection; health; education; logistics; water, sanitation and hygiene [WASH]; community services; security/police; site planning; etc.) and all geographic areas affected by crises. Clinical care for survivors of sexual violence falls within the purview and accountability

<sup>43</sup> *Mean Streets: Identifying and Responding to Urban Refugees' Risks of Gender-Based Violence* (Women's Refugee Commission, February 2016), <https://www.womensrefugeecommission.org/gbv/resources/document/download/1455>.

<sup>44</sup> More information on the GBV AoR can be found at <http://gbvaor.net>.

of the health sector/cluster with the designated lead SRH agency.<sup>45</sup> The SRH Coordinator, SRH working group, and the health sector/cluster should work with the GBV Area of Responsibility lead agency to support a process to identify a clear division of roles and responsibilities among health partners and between all sector/cluster programs responding to the needs of survivors. This includes justice/legal, protection, security, psychosocial, and community services. Representatives of the affected community, United Nations partners, nongovernmental organizations (NGOs), and government authorities should inform and/or participate in this process and relevant sector/cluster coordination meetings.

Further, to ensure a coordinated, survivor-centered, and confidential referral mechanism for survivors, there should be linkages to community self-help groups, including those formed by adolescents, persons with disabilities, LGBTQIA populations, and sex workers.

### The MISP for SRH activity:

**Put in place preventative measures at community, local, and district levels to protect affected populations from sexual violence**

## **What are some situations that put women and girls at risk of sexual violence?**

Women and girls who have been displaced or are living in conflict or other emergency settings may be put at an increased risk of sexual violence in the following situations:

- ▶ If they are without personal documentation for collecting food rations, assistance, or essential services and dependent on males for their daily survival;
- ▶ When men (fellow affected persons, members of host communities, or humanitarian actors) alone are responsible for distributing food and other essential goods;
- ▶ If they have to travel to remote distribution points for food, firewood for cooking fuel, and water without security or other protection;
- ▶ If their sleeping quarters are unlocked and unprotected or the lighting is poor; and
- ▶ If male and female latrines and washing facilities are not separate, if they do not have internal locks, or are located in insecure areas of a camp or settlement.

A lack of police protection and lawlessness can also contribute to an increase in sexual violence. Police officers, military personnel, humanitarian workers, camp administrators, or other government officers may themselves be involved in forcing women and girls to engage in sexual activity for security, services, or other support. If there are no independent organizations, such as UNHCR or international NGOs, to help ensure personal security within a camp, the number of incidents often increases. Female protection officers should be hired and available because women and girls are often more comfortable reporting protection concerns and incidents of violence to another woman.

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<sup>45</sup> Inter-Agency Standing Committee, Humanitarian Response, <https://www.humanitarianresponse.info/en>.

## What are the key actions that should be taken to prevent sexual violence?

Health and protection coordination meetings should consistently address sexual violence to ensure coordination in the response between the SRH Coordinator and other sectoral actors. Confidential operating and coordination procedures should be agreed upon and implemented to assess and respond to at-risk situations or for risk mitigation.<sup>46</sup>

As part of the work of the overall health sector/cluster mechanism, the SRH Coordinator and SRH program staff must ensure that the humanitarian health sector/cluster and health actors do the following:

- ▶ Ensure safe access to basic health services, including SRH services, for women, men, adolescents, and children.
- ▶ Design and locate health facilities to enhance physical security and safety and be accessible to persons with disabilities, in consultation with the population, in particular, women, adolescents, persons with disabilities, and other marginalized populations.
- ▶ Consult with service providers and clients about security and safety concerns regarding access to and within health facilities.
- ▶ Ensure health facilities are in secure locations and have adequate path lighting at night.
- ▶ Ensure health facilities have confidential spaces, trained health providers and the essential supplies to provide clinical care for survivors of sexual violence.
- ▶ Consider the need for security personnel at facility entrances.
- ▶ Locate separate male and female latrines and washing areas in the health facility and ensure doors lock from the inside.<sup>47</sup>
- ▶ Hire and train female service providers, community health workers, program staff, and interpreters.<sup>48</sup>
- ▶ Ensure all ethnic subgroup languages are represented among service providers, or ensure interpreters are available.
- ▶ Inform service providers and all other facility staff of the importance of maintaining confidentiality, including protecting survivor information and data.
- ▶ Ensure health workers and all other facility staff have signed and abide by a Code of Conduct against sexual exploitation and abuse.
- ▶ Ensure that Code of Conducts and reporting mechanisms on sexual exploitation and abuse (which ensure whistleblower protection) are in place, as well as relevant investigative measures to enforce the codes of conduct.

<sup>46</sup> See the GBV Responders Network at <https://gbvresponders.org/resources> for existing tools and resources to facilitate operationalization.

<sup>47</sup> WASH, *Protection and Accountability: Briefing Paper* (UNHCR, 2017), <http://wash.unhcr.org/download/wash-protection-and-accountability>.

<sup>48</sup> *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence: A Clinical Handbook* (WHO, September 2014), [http://apps.who.int/iris/bitstream/handle/10665/136101/WHO\\_RHR\\_14.26\\_eng.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/136101/WHO_RHR_14.26_eng.pdf?sequence=1).

## The MISP for SRH activity:

### Make Clinical Care and Referral to Other Supportive Services Available for Survivors

#### Guiding Principles When Responding to the Needs of Survivors of Sexual Violence

The following guiding principles should be respected at all times by all humanitarian actors who are responding to the needs of survivors:

- ▶ Safety
- ▶ Confidentiality
- ▶ Respect
- ▶ Nondiscrimination

#### Why is addressing sexual violence a critical concern for health professionals?

Health services are often the first—and sometimes the only—point of contact for survivors of sexual violence. The quality of care provided can have short- and long-term impacts on the well-being of the survivor and the willingness of the survivor to report the incident. Therefore, all health providers (even those not working in a facility that provides clinical care for survivors of sexual violence) must be prepared to provide the first line of psychosocial support.

First line psychosocial support includes:

- ▶ empathetic listening and validation;
- ▶ identifying immediate emotional, psychological, and physical needs;
- ▶ attending to the survivor's immediate and ongoing safety (protection) and health, including mental health needs through referral to psychosocial support;
- ▶ reassuring the survivor that they are not at fault or to blame;
- ▶ inquiring about the survivor's needs and concerns;
- ▶ identifying and offering information about other support services; and
- ▶ supporting the survivor's decisions.

#### What is a survivor-centered approach?

A survivor-centered approach means that survivors' rights, needs, and wishes are prioritized. This approach can guide health providers in their engagement with persons who have experienced sexual violence. It aims to create a supportive environment in which the



survivor's rights are respected, safety is ensured, and the survivor is treated with dignity and respect.

## **What are the key actions that should be taken when setting up clinical services?**

All humanitarian actors must respect a sexual violence survivor's rights to life, self-determination, good-quality health care, nondiscrimination, privacy, confidentiality, information, and respect. Survivors must have access to clinical care, including supportive psychosocial counseling, as well as emergency contraception and post-exposure prophylaxis (PEP) for HIV, as soon as possible after the incident.

To ensure health services can provide such care at the onset of a humanitarian response, SRH Coordinators and program staff must:

- ▶ establish a private, non-stigmatizing consultation area with a lockable filing cabinet;
- ▶ put in place clear protocols and a list of patient rights in the languages of providers and patients;
- ▶ have sufficient supplies and equipment available;
- ▶ hire male and female service providers fluent in local languages, and train male and female chaperones and interpreters;
- ▶ involve women, adolescent girls and boys, and other at-risk populations, such as persons with disabilities and LGBTQIA groups, in decisions on accessibility and acceptability of services;
- ▶ with the health cluster lead, ensure that services and a referral mechanism, including transport to a hospital in case of life-threatening complications, are available 24 hours a day, 7 days a week.

## **What can be done to inform the community about available services?**

Once services are established, SRH Coordinators and program staff should inform the community about:

- ▶ the hours and location of the services;
- ▶ the importance of seeking immediate medical care following sexual violence no later than 72 hours for prevention of HIV and 120 hours for prevention of pregnancy—the sooner the more effective for both; and
- ▶ what health services are offered to survivors who are unable to seek immediate care.

To ensure accessibility, multiple formats and languages should be used (e.g., Braille, sign language, pictorial formats) and distributed through community-led outreach (women, youth, LGBTQIA, and persons with disabilities groups) and other appropriate communication channels (e.g., schools, midwives, community health workers, community leaders, radio messages, or informational leaflets in women's latrines).



## What are the key actions that should be taken to ensure service providers are skilled and able to provide nondiscriminatory, unbiased, and survivor-centered services?

Where needed and feasible, the SRH Coordinator, with the SRH working group and health sector/cluster, should organize information sessions or short refresher trainings on clinical care for survivors of sexual violence.

## What are the components of clinical care for survivors of sexual violence?

**Supportive communication:** Ensure service providers can extend compassionate and confidential support to the survivor through communication that is accurate, clear, and nonjudgmental and that involves empathetic active listening without pressuring the survivor to respond. They should inform the survivor about available care options, encourage and address the survivor's questions and concerns, and obtain written or verbal consent for all aspects of care. Service providers must take care not to make promises or misrepresentations (particularly regarding security) that cannot be guaranteed.

**History and examination:**<sup>49</sup> The primary purpose of the history and examination is to determine the clinical care that is needed. During this process, the health and well-being of the survivor is the main priority. Allow the survivor to choose a trusted person to be present at the examination if they so desire. For children, this may be their (nonoffending) guardian or, where they are not available, a trained support person. The survivor should always be able to choose the sex of the support person; this is obligatory for children. A history and thorough medical examination (avoiding invasive procedures as much as possible in accordance with World Health Organization [WHO] guidelines<sup>50</sup>) are conducted. Providers must ensure the survivor understands and consents to each step. The history-taking includes:

- ▶ questions about the assault limited to what is needed for medical care and, where appropriate (capacity exists to test and use the evidence), the collection of samples for forensic evidence;
- ▶ general medical information;
- ▶ medical and gynecological history for women and girls; and
- ▶ an assessment of mental state by asking how the survivor is feeling and noting the survivor's emotions during the exam.

Keep a carefully written record of all actions and referrals (medical, psychosocial, security, legal, community-based support) to facilitate follow-up care. Ensure the documentation is

49 An example of a history and exam form can be found on p. 44–47 of the *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (WHO, 2004), [http://iawg.net/wp-content/uploads/2016/08/Clinical\\_Management\\_2005\\_rev-1.pdf](http://iawg.net/wp-content/uploads/2016/08/Clinical_Management_2005_rev-1.pdf).

50 *Clinical Management of Rape Survivors: Developing Protocols for Use with Refugees and Internally Displaced Persons* (WHO, 2004), [http://iawg.net/wp-content/uploads/2016/08/Clinical\\_Management\\_2005\\_rev-1.pdf](http://iawg.net/wp-content/uploads/2016/08/Clinical_Management_2005_rev-1.pdf).

available for prosecution if the survivor chooses to pursue it.

During this process, survivors should be assured that they are in control, do not have to talk about anything they are uncomfortable with, and can stop the process at any time. It is the survivor's right to decide whether to be examined and refuse any part of the exam. All aspects of the exam should be explained, and consent obtained prior to touching the survivor. Allow the survivor to ask questions and agree to or refuse any aspect of the examination and treatment at any time.

**The medico-legal system and forensic evidence collection,<sup>51</sup> where feasible and when needed:**

- ▶ The SRH Coordinator, together with the GBV Area of Responsibility lead and legal experts, should determine the status of the national medico-legal system, including the relevant laws and policies about sexual violence, and share this information with stakeholders.
- ▶ Forensic evidence collection, where feasible and when it can be used, should be collected, stored, analyzed, and used only if the survivor consents after a full explanation of each procedure. Clinical management of survivors of sexual violence takes priority over the medico-legal process.

**Compassionate and confidential treatment and counseling:** Clinical treatment for survivors of sexual violence can be started without examination if that is the survivor's choice. This will be explored in more detail in this section but will include:

- 1. Emergency contraception;**
- 2. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care to the full extent of the law;**
- 3. Presumptive treatment of STIs;**
- 4. PEP to prevent HIV transmission;**
- 5. Prevention of hepatitis B and human papillomavirus (HPV);**
- 6. Care of wounds and prevention of tetanus;**
- 7. Referral for further services, such as other health, psychological, and social services; and**
- 8. Follow-up care.**

Treat life-threatening complications first and refer to higher-level health facilities, if appropriate. A useful resource that provides guidance to health care providers for medical management after rape of women, men, and children is the 2004 *Clinical Management of Rape Survivors: A Guide to the Development of Protocols for Use in Refugee and Internally Displaced Persons*.<sup>52</sup>

<sup>51</sup> More information on forensic collection can be found in the *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018 (IAWG, November 2018), p.27, <http://iawg.net/wp-content/uploads/2018/11/IAFM-web.pdf>.

<sup>52</sup> *Clinical Management of Rape Survivors: A Guide to the Development of Protocols for Use in Refugee and Internally Displaced Persons* (WHO, 2004), <https://www.unhcr.org/protection/health/403a0b7f4/clinical-management-rape-survivors-developing-protocols-use-refugees-internally.html>.

In addition, the WHO, UNHCR, and UNFPA have an e-learning program for health care providers on the *Clinical management of rape survivors*, which is available online in English and French.<sup>53</sup>

## 1. Emergency contraception

Emergency contraception can prevent unintended pregnancies and should be provided to survivors as soon as possible and within 120 hours after experiencing sexual violence.<sup>54</sup>

### Common Emergency Contraceptive Methods

**Progestin-only emergency contraceptive (EC) pills:** are the most widely available form of EC and contain 1.5 mg of levonorgestrel.

**Timeframe:** EC pills can be used up to 120 hours (5 days) after unprotected sex but are more effective the sooner they are taken.

**Safety:** Progestin-only EC pills are safe for all women, girls, and adolescents of reproductive age, even for those who are advised not to use combined oral contraceptives for ongoing contraception, as the dose of hormones is relatively small and the pills are used for a short time.

**Clinical screening:** No clinical examinations or tests (including a pregnancy test) are needed before providing progestin-only EC pills.

**Mechanism of action:** EC pills delay or prevent ovulation. An additional postulated mechanism is that they may stop the egg and sperm from meeting. EC pills do not have any effect after fertilization and cannot terminate or interfere with an established pregnancy. In other words, progestin-only EC does not induce an abortion.

**Side effects:** EC pills are safe, and there is no situation in which the risks of using them outweigh the benefits. Side effects are minor and may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. If vomiting (rare) occurs within two hours of taking a dose, the dose should be repeated and, if available, an antiemetic can be given.

**Counseling:** There is a small chance that the pills will not work. Inform the client that menstruation should occur around the time when it would normally be expected but may be up to a week early or late. If she has not had a period within a week after it was expected, she should return for a pregnancy test and/or to discuss options in case of pregnancy.<sup>55</sup>

**Repeated use:** EC pills remain safe and effective in preventing pregnancy if taken more than once, even within the same menstrual cycle, and there are no lifetime limits on the

53 "Clinical Management of Rape Survivors," WHO, accessed April 8, 2019, <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en>.

54 More information about emergency contraception and medical eligibility can be found at the International Consortium for Emergency Contraception's website: <http://www.ec-ec.org/ecmethod>.

55 How to Be Reasonably Certain a Client Is Not Pregnant (checklists)," FHI360, 2015, <https://www.fhi360.org/resource/how-be-reasonably-sure-client-not-pregnant-checklists>.

number of times a woman can take progestin-only EC pills. However, using an ongoing contraceptive method is recommended as the most effective way to prevent pregnancy.

**Copper-bearing intrauterine devices (IUDs)** can also be inserted in medically eligible women up to five days after unprotected sex, including in cases of sexual violence. This is a highly effective form of post-coital contraception and will prevent more than 99% of expected pregnancies. As the risk of ovulation is low through the seventh day of the menstrual cycle, a woman can have a copper-bearing IUD inserted beyond five days after the sexual violence occurred, when ovulation can be estimated, and as long as insertion does not occur more than five days after ovulation.

Providers should offer survivors full information and counseling about this service (taking care to avoid further traumatization), so they can make a voluntary and informed decision about whether to use EC pills or have an IUD inserted. Counseling should include information about risks, benefits, side effects, and complications. Only a skilled provider should insert the IUD and only after performing a pelvic exam.

If an IUD is inserted, make sure to give a full STI treatment, including antibiotics to empirically treat possible STIs and/or pelvic inflammatory disease. The IUD may be removed at the time of the woman's next menstrual period or left in place as ongoing contraception.

If progestin-only EC pills are not available in the country, **combined hormonal oral contraceptives** can be used (the Yuzpe method).

- ▶ Two doses of combined oral contraceptive pills are needed. Combined oral contraceptive pills contain different dosages; the provider must calculate to ensure that each dose contains estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel or 1.0–1.2 mg norgestrel).
- ▶ The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days), and the second dose should be taken 12 hours later.
- ▶ If vomiting occurs within two hours of taking a dose, the dose should be repeated.
- ▶ Combined hormonal EC pills are less effective and have more side effects than progestin-only EC pills and ulipristal acetate.

## **2. Pregnancy testing, pregnancy options information, and safe abortion care/referral for safe abortion care to the full extent of the law**

Provide pregnancy testing at the time of the initial presentation, but do not withhold EC if this is not available. Provide additional pregnancy testing at the two-week and one-month follow-up visits. Provide accurate information about pregnancy options, including continuing the pregnancy and parenting, continuing the pregnancy and placing the child for adoption, and having an abortion, as applicable, and nonbiased counseling to facilitate informed decision-making. If the survivor is pregnant as a result of sexual violence and an abortion is desired, provide safe abortion care or a referral for that care to the full extent of the law.

### 3. Presumptive treatment of STIs

Provide survivors antibiotics to presumptively treat gonorrhea, chlamydial infection, and syphilis, as warranted and if desired.<sup>56</sup> If other STIs are prevalent in the area (e.g., trichomoniasis or chancroid), give presumptive treatment for these infections as well.

### 4. Post-exposure prophylaxis to prevent HIV transmission

The likelihood of HIV transmission after sexual violence can be reduced through the prompt administration of post-exposure prophylaxis (PEP).<sup>57</sup> PEP should be offered and initiated as soon as possible (no later than 72 hours following exposure and continued for 28 days) for all individuals with an exposure that has potential for HIV transmission. Pregnancy is not a contraindication (condition for which treatment should not be provided) for PEP.

### 5. Prevention of hepatitis B and HPV

Provide a hepatitis B vaccine within 14 days of the assault unless the survivor is fully vaccinated. Consider providing the HPV vaccine to anyone age 26 or younger, unless the survivor has been fully vaccinated.

### 6. Care of wounds and prevention of tetanus

Clean any tears, cuts, and abrasions and suture clean wounds within 24 hours. Give tetanus prophylaxis if there are any breaks in skin or mucosa and if the survivor is not vaccinated against tetanus or the vaccination status is uncertain.

### 7. Referral for further crisis intervention

With a survivor's consent or upon their request, offer referral to:

- ▶ a hospital in case of life-threatening complications or complications that cannot be dealt with at the health facility level;
- ▶ protection or social services if the survivor does not have a safe place to go when leaving the health facility; and
- ▶ psychosocial or mental health services where available; liaise with GBV and protection focal points to identify psychosocial services in the setting. This may include services offered by the affected populations, women's centers, and other support groups.

### 8. Follow-up care

- ▶ If feasible, follow-up post-rape care is recommended at two weeks, one month, three months, and six months following the incident.
- ▶ Continue first-line support and care, monitor mental health needs, and refer for psychosocial and/or mental health support as needed.

<sup>56</sup> *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 30–31.

<sup>57</sup> *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, p. 32–33.

- ▶ Offer pregnancy testing at two and four weeks following the incident.
- ▶ Monitor wounds for healing and follow up on a tetanus vaccination schedule as needed.
- ▶ Where relevant, discuss adherence to STI prophylaxis or treatment, including PEP and hepatitis B vaccination (additional doses at one month and six months), HIV testing at three months and six months, and pregnancy status and options.



## The Reality of Implementing the MISP for SRH in Jordan

The Women's Refugee Commission's 2013 MISP for SRH assessment in Jordan showed that planning to respond to sexual violence was inadequate in both camp and urban settings.<sup>58</sup> Challenges were related to a low number of trained providers, the lack of a national clinical management of rape protocol, and challenges around the use of EC and PEP. It was also taboo to talk about sexual violence in the community and many people did not know what services were available. These factors and the fear of retribution made it difficult for survivors to make an informed choice about seeking care.



## Noted Practice: Preventing and Managing the Consequences of Sexual Violence in Cox's Bazar, Bangladesh

- ▶ In the early phase of the emergency, organizations used incentives, such as transport vouchers, to promote the use and locations of facility-based services. An early rollout of a community volunteer program also helped to inform communities about the availability and location of services for survivors of sexual violence.<sup>59</sup>
- ▶ There was strong coordination between the SRH sub-cluster and the protection cluster/GBV sub-sector, which helped to quickly put in place measures to protect affected populations, particularly women and girls, from sexual violence.
- ▶ Clinical management of survivors of sexual violence training sessions were co-facilitated by the SRH sub-cluster and GBV sub-sector experts early on in the response.
- ▶ Women's safe spaces were immediately established near health facilities, which provided a close linkage and allowed for quick and easy referrals.

<sup>58</sup> Krause, et al., "Reproductive Health Services for Syrian Refugees."

<sup>59</sup> Site visit, Women's Refugee Commission, February 2018.



## Special Considerations for Specific Populations

<b>Children</b>	The SRH Coordinator must understand and disseminate information about country-specific laws with regard to the age of consent for treatment, the professional who can give legal consent for clinical care if a parent or guardian is the suspected offender (for instance, a representative from the police, community services, or the court), and mandatory reporting requirements and procedures when service providers suspect, or are informed of, a case of child abuse. Digital or speculum vaginal or anal examinations should not be conducted on children unless absolutely necessary. In those cases, children should be referred to a specialist. Protocols showing appropriate drug dosages must be posted or easily available to service providers.
<b>Male survivors</b>	Male survivors are less likely to report an incident because of shame, criminalization of same-sex relations, negative or dismissive provider attitudes, and the lack of recognition regarding the extent of the problem. Male survivors suffer physical and psychological trauma and should have access to confidential, respectful, and nondiscriminatory services that provide comprehensive care.
<b>Persons with disabilities (intellectual and physical)</b>	Persons with disabilities including women, girls, boys, and men living with disabilities are at a higher risk of sexual violence and often face extreme discrimination by service providers. Caregivers (usually women or girls) of persons with disabilities can also be vulnerable to violence and exploitation due to isolation, which can limit their access to social, economic, and material support. Organizations of people with disabilities within the host community often have information that health providers can use to ensure clinical care is provided to this often-hidden population.
<b>LGBTQIA individuals</b>	LGBTQIA individuals face a variety of different risk factors for sexual violence, and it is important to acknowledge that each population has separate needs and faces different risks. LGBTQIA individuals may face discrimination by health providers, which prevents them from seeking SRH services. Engaging with LGBTQIA or rights groups and making health facilities more respectful of diversity would allow critical health services to become more accessible to these populations.
<b>People who engage in sex work</b>	People who engage in sex work often face stigmatization and discrimination by health providers, who may be less likely to take sexual violence against this population as a serious concern. Humanitarian actors should engage with this population to develop SRH care programming.
<b>Ethnic and religious minorities</b>	Ethnic and religious minorities face levels of stigma and discrimination that make them more vulnerable to sexual violence, including oppression and harassment. It is important to train caregivers, health providers, and other duty bearers on nondiscriminatory practices related to SRH service provision.



### Why are incidents of sexual violence often not reported?

Even in non-crisis settings, sexual violence often goes unreported due to a range of factors, including fear of retribution, shame, stigma, powerlessness, lack of knowledge about the benefits of seeking services and support, the unreliability of public health and other services, lack of trust in the services, and a lack of confidentiality. All of these circumstances are exacerbated in humanitarian settings, increasing the likelihood that incidents of sexual violence within the population will go unreported. While ensuring clinical management of sexual violence and other services is an essential part of the response, addressing sexual violence must also include an environment where women are protected, supported, and able to access this care.

Even in the absence of any reported cases, services should be put in place. ***All humanitarian personnel have the responsibility to assume sexual violence is taking place, to treat it as a serious and life-threatening protection issue, and to take action as described to minimize risks of sexual violence through their sectoral interventions, regardless of the presence or absence of concrete evidence.***

### What are some mechanisms to address sexual violence by agencies?

#### Code of Conduct

A Code of Conduct against sexual exploitation and abuse is a set of agency guidelines that promotes respect by the agency's staff for fundamental human rights, social justice, human dignity, and the rights of women, men, and children. It also informs staff that their obligation to show this respect is a condition of their employment. An enforceable Code of Conduct is a critical component of humanitarian accountability to beneficiaries. All humanitarian agencies, including those involved in MISP for SRH implementation, should have a Code of Conduct and policies in place to prevent sexual exploitation and abuse. Agencies should ensure that all staff are committed to adhering to the guidelines and have been oriented on their responsibilities. A good resource for agencies to develop these guidelines is the Core Humanitarian Standards Alliance's *Protection from Sexual Exploitation and Abuse Implementation Quick Reference Handbook*.<sup>60</sup> An additional resource is the *IASC Champion on Sexual Exploitation and Abuse and Sexual Harassment*.<sup>61</sup>

A Code of Conduct is relevant for all staff—international as well as local. Agencies must

60 Corinne Davey and Lucy Heaven Taylor, *PSEA Implementation Quick Reference Handbook* (Core Humanitarian Standards Alliance, July 2017), <http://www.pseataskforce.org/uploads/tools/1499958998.pdf>.

61 IASC Champion on Sexual Exploitation and Abuse and Sexual Harassment, <https://interagencystandingcommittee.org/iasc-champion-sexual-exploitation-and-abuse-and-sexual-harassment>.

ensure that any staff hired from local organizations or persons contracted from the local community sign and receive an orientation to and opportunities for discussion about the Code of Conduct. Beneficiaries and affected communities should also be informed and become familiar with the rules and the relevant site-specific systems so they can use them in case of a violation. The SRH Coordinator should support the development of a system for confidential reporting and follow-up of sexual exploitation and abuse.

## The IASC Task Force on Protection from Sexual Exploitation and Abuse's Six Principles for Inclusion in United Nations and NGO Code of Conducts

- ▶ Sexual exploitation and abuse by humanitarian workers constitute acts of gross misconduct and are therefore grounds for termination of employment.
- ▶ Sexual activity with children (persons under the age of 18) is prohibited regardless of the age of majority or age of consent locally. Mistaken belief regarding the age of a child is not a defense.
- ▶ Exchange of money, employment, goods, or services for sex, including sexual favors or other forms of humiliating, degrading, or exploitative behavior, is prohibited. This includes the exchange of assistance that is due to beneficiaries.
- ▶ Any sexual relationship between those providing humanitarian assistance and protection and a person benefitting from such humanitarian assistance and protection that involves improper use of rank or position is prohibited. Such relationships undermine the credibility and integrity of humanitarian aid work.
- ▶ Where humanitarian workers develop concerns or suspicions regarding sexual abuse or exploitation by a fellow worker, whether in the same agency or not, they must report such concerns via established agency reporting mechanisms.
- ▶ Humanitarian workers are obliged to create and maintain an environment that prevents sexual exploitation and abuse and promotes the implementation of their Code of Conduct. Managers at all levels have particular responsibilities to support and develop systems that maintain this environment.<sup>62</sup>

## Complaints Mechanism

Complaints of sexual exploitation and abuse must be taken very seriously. Agencies should develop a response system to correctly handle any complaints that are brought to the attention of the agency. These mechanisms should be safe, confidential, transparent, and accessible. They include the following:

- ▶ **Clear and established internal complaints procedures** so that staff, communities, and people affected by crisis know how and when to confidentially report cases of

<sup>62</sup> Cited in *Protection from Sexual Exploitation and Abuse (PSEA) Inter-Agency Cooperation in Community-Based Complaint Mechanisms: Global Standard Operating Procedures* (IASC, May 2016), <https://fscluster.org/document/iasc-psea-Inter-Agency-cooperation>.

sexual exploitation and abuse. This is particularly important if your agency is the only organization providing services in the community. Beneficiaries/people affected by crisis should be a part of the process to develop a system that is safe and accessible for everyone.

- ▶ **A workplace culture that encourages discussion and questioning of appropriate behavior regarding the protection of beneficiaries from sexual exploitation and abuse.** Such a culture allows staff to bring questionable behavior to a supervisor's attention.
- ▶ **Quick and proper reference of sexual exploitation and abuse reports for investigation.** Agencies can make sure they are prepared to provide strong and committed investigations when cases are reported. They must respond quickly to provide help to the survivors of these cases.<sup>63</sup>
- ▶ **Appropriate discipline and penalization of acts of sexual exploitation and abuse,** which may include termination of contract, demotion, fine, and suspension without pay. If it constitutes a criminal offense, it may be referred to the proper law enforcement authorities.<sup>64</sup>
- ▶ **An agreement that the agency office will keep all original documents of allegations in the appropriate files for the record.** The documents must be kept confidential and only accessible to relevant personnel.



If you know someone who has been sexually exploited or abused, report the incident in a confidential manner to a relevant authority as predetermined in the established complaints mechanism.

### Unit 3: Key Points

- ▶ Sexual violence is defined as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person sexually, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. The MISP for SRH mainly addresses rape/attempted rape, sexual abuse, and sexual exploitation. Once the situation stabilizes and all components of the MISP for SRH have been implemented, attention can be given to addressing a wider array of GBV issues.
- ▶ Sexual violence is a human rights violation that affects the survivor's physical and mental health and social well-being while also having possible consequences for the survivor's family and the wider community.
- ▶ During emergencies such as conflicts or natural disasters, the risk of violence, exploitation, and abuse is heightened, particularly for women and girls.

<sup>63</sup> For example incident forms see Annex 4 in *Inter-Agency PSEA-CBCM Best Practice Guide* (Inter-Agency Standing Committee, 2016), <https://interagencystandingcommittee.org/accountability-affected-populations-including-protection-sexual-exploitation-and-abuse/documents-50>.

<sup>64</sup> *Inter-Agency PSEA-CBCM Best Practice Guide*.

- ▶ Adolescent girls, persons with disabilities (especially intellectual disabilities), and LGBTQIA populations are exceptionally vulnerable to sexual violence because they are often targeted for sexual exploitation and rape.
- ▶ All humanitarian actors are responsible for preventing and reporting sexual exploitation and abuse and ensuring humanitarian assistance is provided impartially, without bias or discrimination on the basis of age, sex, gender and gender identity, marital status, sexual orientation, location (e.g., rural/urban), disability, race, color, language, political or other opinion, religion, national, ethnic or social origin, property, birth, or other characteristics.
- ▶ A multisectoral approach following a standard operating procedure in each setting is required to prevent and protect the affected population and respond appropriately to sexual violence.
- ▶ The guiding principles when responding to the needs of survivors of sexual violence include safety, confidentiality, respect, and nondiscrimination.
- ▶ A survivor-centered approach means that survivors' rights, needs, and wishes are prioritized.
- ▶ Components of clinical care for survivors of sexual violence includes supportive communication; history and examination; medico-legal system and forensic evidence collection where feasible and when needed; and compassionate and confidential treatment and counseling, including EC, pregnancy testing, pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law, presumptive treatment for STIs, PEP, prevention of Hepatitis B and HPV, care of wounds and prevention of tetanus, and referral for further services, such as other health, psychological, and social services.
- ▶ The SRH Coordinator and program staff should inform the community about the importance of seeking immediate medical care following sexual violence and the type, location, and hours of services available for survivors of sexual violence.
- ▶ Reasons sexual violence often goes unreported include fear of retribution, shame, stigma, powerlessness, lack of knowledge about the benefits of seeking care and support, the unreliability of public health and other services, lack of trust in the services, and the lack of confidentiality.
- ▶ All humanitarian agencies, including those involved in MISP for SRH implementation, should have a Code of Conduct and policies for handling sexual exploitation and abuse in place.
- ▶ Agencies should develop a safe, confidential, transparent, and accessible response mechanism to correctly handle any complaints of sexual exploitation and abuse that are brought to the attention of the agency.

## Challenges and Solutions

Challenges	Solutions
<p>What if staff members have low capacity and lack the basic skills to provide psychosocial services?</p>	<p>Local staff will likely be able to help identify the most appropriate local persons with nonjudgmental, supportive attitudes and good communication skills for this role.</p> <p>It is crucial that all staff who come into contact with a survivor respect the survivor’s wishes and ensure that all related medical and health status information is kept confidential and private, including from the survivor’s family members.</p> <p>Staff members need to communicate with the survivor in a way that both ensures accurate information sharing and reflects a caring, nonjudgmental attitude.</p> <p>Training programs on psychosocial support can be established once the situation is stable. In-service training programs can be provided during the acute phase of an emergency, as necessary. Undertaking this training as part of emergency preparedness would also be useful.</p> <p>Recommended resources that focus on engagement strategies for work with survivors of sexual violence include:</p> <ul style="list-style-type: none"> <li>• <i>IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings</i><sup>65</sup></li> <li>• <i>Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings (1st ed.)</i><sup>66</sup></li> </ul>

<sup>65</sup> IASC *Guidelines on Mental Health and Psychosocial Support in Emergency Settings* (IASC, June 2007), [http://www.who.int/mental\\_health/emergencies/guidelines\\_iasc\\_mental\\_health\\_psychosocial\\_june\\_2007.pdf](http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf). Additional tools can be found on IASC’s webpage “Mental Health and Psychosocial Support,” <https://interagencystandingcommittee.org/product-categories/mental-health-and-psychosocial-support>.

<sup>66</sup> *Caring for Child Survivors of Sexual Abuse: Guidelines for Health and Psychosocial Service Providers in Humanitarian Settings* (IRC and UNICEF, 2012), <http://gbvaor.net/wp-content/uploads/2012/10/Caring-for-Child-Survivors-of-Sexual-Abuse-Guidelines-for-Health-and-psychosocial-service-providers-in-Humanitarian-settings-IRC-UNICEF-2012-ENGLISH.pdf>.

- *Responding to Children and Adolescents Who Have Been Sexually Abused*<sup>67</sup>
- *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action*<sup>68</sup>
- *Establishing GBV Standard Operating Procedures Guide*<sup>69</sup>

What can be done in settings where talking about sexual violence is taboo and/or where there is strong resistance to addressing sexual violence by local health workers and community members?

Even in settings where discussing sexual violence is strongly discouraged, it is important to find innovative ways to address it. For example, one local NGO working with an extremely conservative refugee population organized “family health” workshops for refugee women that covered a wide variety of health issues, including sexual violence. This way, the community gained knowledge on sexual violence, including why, where, and when to seek medical care if they or someone they know is assaulted.

What if staff have not been trained in clinical care for survivors of sexual violence?

It is important for organizations to deploy SRH staff trained in clinical management of survivors of sexual violence.

Work with the existing capacities of local staff and plan trainings on clinical care for survivors of sexual violence as soon as possible.

It is also useful to include training on clinical care of survivors of sexual violence as a component of emergency preparedness.

<sup>67</sup> *Responding to Children and Adolescents Who Have Been Sexually Abused: WHO Clinical Guidelines* (WHO, 2017), <http://apps.who.int/iris/bitstream/handle/10665/259270/9789241550147-eng.pdf?sequence=1>.

<sup>68</sup> *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery* (IASC, 2015), [https://gbvguidelines.org/wp/wp-content/uploads/2016/10/2015\\_IASC\\_Gender-based\\_Violence\\_Guidelines\\_full-res.pdf](https://gbvguidelines.org/wp/wp-content/uploads/2016/10/2015_IASC_Gender-based_Violence_Guidelines_full-res.pdf).

<sup>69</sup> *Gender-Based Violence Resource Tools: Establishing Gender-Based Violence Standard Operating Procedures* (IASC Sub-Working Group on Gender and Humanitarian Action, May 2008), <https://www.k4health.org/toolkits/igwg-gender/establishing-gbv-standard-operating-procedures-sops>.

# CHECKLIST: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS

The MISP for SRH Monitoring Checklist, below, can be used to monitor SRH service provision in humanitarian settings.

3. Prevent Sexual Violence and Respond to Survivors Needs			
		Yes	No
3.1	Multisectoral coordinated mechanisms to prevent sexual violence are in place		
3.2	Safe access to health facilities		
	Percentage of health facilities with safety measures (sex-segregated latrines with locks inside; lighting around health facility; system to control who is entering or leaving facility, such as guards or reception)		%
3.3	Confidential health services to manage survivors of sexual violence	Yes	No
	Percentage of health facilities providing clinical management of survivors of sexual violence: (number of health facilities offering care/all health facilities) x 100		%
	Emergency contraception (EC)		
	Pregnancy test (not required to access EC or post-exposure prophylaxis [PEP])		
	Pregnancy		
	PEP		
	Antibiotics to prevent and treat STIs		
	Tetanus toxoid/tetanus immunoglobulin		
	Hepatitis B vaccine		
	Safe abortion care (SAC)		
	Referral to health services		
	Referral to safe abortion services		
	Referral to psychological and social support services		
3.4	Number of incidents of sexual violence reported to health services		
	Percentage of eligible survivors of sexual violence who receive PEP within 72 hours of an incident: (number of eligible survivors who receive PEP within 72 hours of an incident/total number of survivors eligible to receive PEP) x 100		%
3.5	Information on the benefits and location of care for survivors of sexual violence		



# MATERIALS AND SUPPLIES

## Which supplies are needed or which IARH Kits could be ordered to provide clinical care to survivors of sexual violence?

### IARH Kits (2019)

The IARH Kits are categorized into three levels, targeting the three health service delivery levels. The kits are designed for use for a three-month period for a specific target population size.<sup>70</sup>

**Note:** The IARH Kits are not context specific or comprehensive. Organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies but also enable the expansion of SRH services from the MISIP to comprehensive care.

Health Care Level	Kit Number	Kit Name
Community/health post	Kit 3	Post-Rape Treatment
Community/health post	Kit 5	STI Treatment
Community/health post	Kit 8	Management of Complications of Miscarriage or Abortion
Community/health post	Kit 9	Repair of Cervical and Vaginal Tears

### Complementary commodities

Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. Complementary Commodities will be available from UNFPA in 2020.

Service Delivery Level	Item	To Complement
Community/health post	Misoprostol*	Kit 2B, 6A, 8
Primary health care facility (BEmONC)	Mifepristone	Kit 8

\*Misoprostol can also be procured to complement Kits 6A and 8 for the primary health care facility level.

Where feasible, it is important to pre-register IARH Kits and commodities prior to a crisis and to avoid procuring medicines that are not registered or allowed in a country during a humanitarian emergency.

<sup>70</sup> The 2019 IARH Kits will be available for procurement in early 2020. Check with UNFPA (<https://www.unfpa.org>) or IAWG (<http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>) to verify whether the revised kits are available. For information regarding kits available before 2020, see the *Inter-Agency Reproductive Health Kits for Crisis Situations* (5th ed., 2011) at <http://iawg.net/resource/inter-agency-reproductive-health-kits-2011>.

## Unit 3 Quiz: Prevent Sexual Violence and Respond to the Needs of Survivors

1. If a survivor does not feel comfortable with an examination and refuses to have one, the health provider should explain that treatment and medication can only be provided after an exam.

**True or False**

2. Clinical care for survivors of sexual violence includes all **except** for:
  - a. History and examination
  - b. Supportive communication
  - c. Presumptive treatment of STIs
  - d. Pregnancy test, and if negative only then give PEP
  - e. Emergency contraception as soon as possible and within 120 hours after the rape
  - f. Pregnancy options information and safe abortion care/referral for safe abortion care to the full extent of the law

3. Male survivors are more likely to report an incident of sexual violence.

**True or False**

4. Perpetrators of sexual violence are often intimate partners or others known to survivor.

**True or False**

5. What should you do if you suspect that a staff member is violating the protection against sexual exploitation and abuse core principles?
  - a. Investigate to see if the staff member is in violation
  - b. Speak to the staff member and tell them to stop
  - c. Report the staff member to your supervisor or focal point for protection against sexual exploitation and abuse
  - d. Do nothing