CLINICAL MANAGEMENT OF SEXUAL VIOLENCE SURVIVORS IN CRISIS SETTINGS

FACILITATOR'S GUIDE

Clinical Outreach Refresher Training Module for Health Care Providers Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises Training Partnership Initiative with Jhpiego

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This facilitator's guide was developed with input from IAWG membership. The 2017 materials were adapted from presentations originally created by Wilma Doedens and Marian Schilperoord, based on the World Health Organization (WHO) and United Nations High Commissioner for Refugees (UNHCR) publication: *Clinical management of rape survivors: Developing protocols for use with refugees and internally displaced persons*. Kristen Harker, IAWG, contributed substantially to content development. Wilma Doedens and Kristen Harker provided technical input. In 2020, Jennifer Breads, Jhpiego, led on revising the module and aligning it with the revised IAWG *Inter-Agency Field Manual* (2018) and WHO, United Nations Population Fund (UNFPA), and UNHCR's *Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings* (2019). Nadia Ahmed, Alison Greer, and Sandra Krause provided a review of and edits to the materials. The training materials were designed by Mikhail Hardy and Chelsea Ricker.

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LIST OF ABBREVIATIONS

3TC	Lamuvidine
ARV	Antiretrovirals
ATV	Atazanavir
AZT	Zidovudine
BP	Blood pressure
EC	Emergency contraception
GV	Gender-based violence
HPV	Human papillomavirus
IARH	Inter-Agency Emergency Reproductive Health (Kits)
IAWG	Inter-Agency Working Group (on Reproductive Health in Crises)
IDP	Internally displaced persons
IM	Intramuscular
IPV	Intimate partner violence
IRC	International Rescue Committee
LGBTQIA	Lesbian, gay, bisexual, transgender, queer, intersex, and asexual
LPV	Lopinavir
MSF	Médecins Sans Frontières
MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
MoH	Ministry of Health
PEP	Post-exposure prophylaxis
PTSD	Post-traumatic stress disorder
RPR	Rapid plasma reagin
S-CORT	Sexual and reproductive health clinical outreach refresher training
SOP	Standard operating procedures
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TDF	Tenofovir disoproxil fumarate
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
VCT	Voluntary counseling and testing
WHO	World Health Organization

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THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

Note: This guide provides what we hope is a simple and user-friendly set of instructions to plan, conduct, and evaluate a clinical refresher training. Throughout this document, additional notes to help you as a facilitator are marked using the symbol to the left. You will also find more details about the design and use of this guide below in the section marked "Description of Facilitator's Guide."

INTRODUCTION

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health is a priority set of lifesaving activities to be implemented at the onset of every emergency. The 2018 MISP has six objectives and another priority activity:

1. Ensure the health sector/cluster identifies an organization and a sexual and reproductive health coordinator to lead and coordinate the implementation for the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive sexual and reproductive health services, integrated into primary health care as soon as possible.

Other priority: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Neglecting the MISP for Sexual and Reproductive Health in humanitarian settings has serious consequences: preventable maternal and newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV.

Nurses, midwives, and physicians working in emergencies provide the sexual and reproductive health services needed to achieve the objectives of the MISP. IAWG has designed a series of short clinical outreach refresher trainings (S-CORTs) in order to reinforce previously acquired knowledge and skills of health care staff tasked with providing these priority services. *Clinical Management of Sexual Violence Survivors in Crisis Settings* is one of these modules. Please visit www.iawg.net/scorts to access all training materials in the series and more information on their use.

Additional resources for implementing sexual and reproductive health services in crisis settings are available on the IAWG site at iawg.net/resources. In particular, facilitators and participants in this training may also want to explore :

- *The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
- *IAWG Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During COVID-19 Pandemic*
- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: 2020 Edition*
- *Manual: Inter-Agency Emergency Reproductive Health Kits for Crisis Situations, 6th Edition*

FURTHER READING/RESOURCES:

- *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. (WHO, UNFPA, UNHCR. 2019).
- *Gender-based violence quality assurance tool*. (Jhpiego, CDC, WHO. 2018).
- *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Promoting resiliency and aiding recovery*. (Inter-Agency Standing Committee. 2015)
- *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, 1st Edition. (Internal Rescue Committee and UNICEF. 2012)
- Tran, Nguyen Toan, Kristen Harker, Wambi Maurice E. Yameogo, Seni Kouanda, Tieba Millogo, Emebet Dlasso Menna, Jeevan Raj Lohani, et al. "Clinical Outreach Refresher Trainings in Crisis Settings (S-CORT): Clinical Management of Sexual Violence Survivors and Manual Vacuum Aspiration in Burkina Faso, Nepal, and South Sudan.". (*Reproductive Health Matters* 25, no. 51. 2017).

These and other publications can be downloaded through the links provided, at www.iawg.net, or by contacting info.iawg@wrcommission.org.

UNIVERSAL ACCESS: ENSURING SERVICES THAT ARE FREE OF STIGMA AND DISCRIMINATION

Words matter when describing and caring for individuals who need access to health care information and services and, in particular, the services presented in the S-CORT series. Language can have a significant impact on sexual and reproductive health and wellbeing as well as access to related information and services. At times, the terminology used in guidance, programs, and policies can be discriminating, stigmatizing, and dehumanizing. Conscious of the tensions that can arise when trying to use inclusive and appropriate language and, at the same time, be concise and efficient, especially in publications, the language used in the S-CORT series was guided by the following considerations:

- **On gender**. Throughout the S-CORT series, the terms "women," "girls," and, at times, the gender-neutral "person," "people," "client," "patient," or "individual" refer to those who use the services presented in the S-CORT. However, the authors recognize and emphasize that:
  - Not only cis-gendered women (women who identify as women and were assigned the female sex at birth) can get pregnant and have rights to quality health care, to be treated with dignity and respect, and to be protected from stigma, discrimination, and violence in all settings. Persons who are trans men/transmasculine, intersex, non-binary, and gender non-conforming can experience pregnancy and face unique barriers to accessing sexual and reproductive health information and services. The S-CORT language strives to reflect this diversity whenever possible but for ease of reference and use, "women" or "women and girls" may be often applied.
  - Sexual violence "survivors" can be women, men, trans, intersex, non-binary, gender non-conforming individuals, and individuals of all ages.
- **On age**.[1] Adolescents—girls, boys, trans, intersex, non-binary, and gender non-conforming—have unique sexual and reproductive health needs and should not be discriminated against in terms of access to sexual and reproductive health information, services, care, and support. Equally important are the sexual and reproductive health needs of older persons. The S-CORT language strives to reflect this age diversity whenever possible, but for ease of reference and use, it often does not use age-specific terminology.
- **On disability.** The sexual and reproductive health needs of persons living with disabilities have been widely neglected. They should not be discriminated against regarding access to sexual and reproductive health information, services, care, and support. While for ease of reference and use disability-specific terminology is not always applied, the S-CORTS were developed using universal design principles to ensure accessibility of these materials. Facilitators and organizations are encouraged to take into consideration the accessibility needs of participants in these trainings and persons living with disabilities in the communities they serve.
- **On diversity**. All individuals, no matter how diverse their personal, social, cultural, and economic background, have a right to access sexual and reproductive health information, services, care, and support free from stigma, discrimination, and violence. Images and language in this guide have been designed with diversity in mind, however, the S-CORT language is not always able to reflect the rich diversity of individuals who access sexual and reproductive health information, services, care, and support.

S-CORT facilitators should keep these inclusive considerations of gender, age, disability, and diversity in mind when rolling out these trainings to further universal access to sexual and reproductive health information, services, care, and support.

WHAT CAN HEALTH STAFF DO?

The use of inclusive, appropriate, and respectful language is a cornerstone of reducing harm and suffering. All terminology requires contextualization to the local language and socio-cultural environment as well as a pragmatic approach, but one that should not sacrifice the promotion and use of stigma-free and all-gender-age-disability-diversity inclusive language. To help mainstream such language, health staff should consider the following principles to guide the way they speak, write, and communicate among themselves and with and about the persons accessing sexual and reproductive health information and services. These principles can help health staff prioritize the use of terminology that adheres to their professional mandate: caring for all people.

- **Engage and ask people and respect their preferences.** As terminology requires adaptation in local languages and cultures, each linguistic and professional community should be engaged in discussing and contextualizing diversity-inclusive terms so that they are acceptable in the circumstances they are to be used. For example, avoid assuming the person's gender ("Miss" or "Mister") and ask instead: "Hello and welcome. My name is B and I am your provider today. Could you please tell me how I should address you?".
- **Use stigma-free, respectful, and accurate language.** Avoid using judgmental terms that are not person-centered. Favor the use of humane and constructive language that promotes respect, dignity, understanding, and positive outlooks (for example, prefer "survivor of sexual violence" to "victim").
- **Prioritize the individual.** It is recommended to place individuals at the center, and their characteristics or medical conditions second in the description (for example, persons living with disability or persons living with HIV). Therefore, the use of person-centered language should be preferred to describe what people have, their

1. For updated resources and support for organizations supporting adolescents, see the updated IAWG Adolescent *Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings*: 2020 Edition, available at: iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

characteristics, or the circumstances in which they live, which in the end should not define who they are and how health staff should treat them.

- **Cultivate self-awareness.** Professionals working with persons from diverse backgrounds should be conscious of the language they use as it can convey powerful images and meanings. They should develop cultural humility and self-reflection, be mindful, and refrain from repeating negative terms that discriminate, devalue, and perpetuate harmful stereotypes and power imbalances. They should also encourage colleagues, friends, and their community to do so. Values clarification workshops for health (and non-health) staff working with people with diverse backgrounds and characteristics could be transformative in clarifying values and changing attitudes to improve interactions.

FACILITATOR'S GUIDE AND TRAINING PLAN OVERVIEW

OBJECTIVE

The objective of this *Facilitator's Guide* for the module on *Clinical Management of Sexual Violence Survivors in Crisis Settings* is to guide clinical trainers to conduct a brief face-to-face training in a crisis setting in order to refresh health care providers' knowledge and skills on providing medical care to survivors of sexual violence. Where applicable, it could also be used as an introductory training.

TARGET AUDIENCE

The training program is designed for health care providers, including midwives, nurses, general practice physicians, obstetrician/gynecologists, and others working in crisis settings where the Inter-Agency Emergency Reproductive Health Kit 3 (Post-Rape Care), the Post-Exposure Prophylaxis (PEP) module of the Inter-Agency Emergency Reproductive Health Kit, or similar medical supplies to manage cases of sexual violence are available. A maximum of twenty participants per workshop is recommended.

FACILITATOR CONSIDERATIONS AND PREPARATION

Facilitators should be experienced clinical trainers with expertise in service delivery for survivors of sexual violence.

PARTICIPANT PREREQUISITES

At a minimum, participants should:

- Demonstrate knowledge of the male and female reproductive system
- Know how to perform a medical history and conduct a physical examination
- Understand how to prescribe treatment for the prevention of sexually transmitted infections and pregnancy, with appropriate counseling[2]
- Know how to perform care of wounds and prevent tetanus
- Demonstrate knowledge of survivor-centered therapeutic communication principles

It is important to assess the experience of participants prior to finalizing the contents of the training materials and beginning the training. Only providers with sexual and reproductive health care experience are eligible for this course.

Note: In crisis settings, training courses typically take place on-site. Be sure to bring all supplies to the training, including paper certificates, copies of the participant workbook or handouts, and additional resources in paper format or on a USB key. The IAWG S-CORTs site (www.iawg.net/scorts) provides recommendations for additional resources to download for participants. Bring paper copies of slides with notes for your use and extra flip chart paper as a backup in case a projector or electricity is not available. A flexible approach to facilitation will be needed to help you adapt to the context and participants' needs.

ACCOMPANYING PARTICIPANT WORKBOOK

One of the lessons learned from piloting the S-CORT series is that participants preferred to have the materials shared with them in advance of the training to review and help them prepare.

The accompanying *Participant Workbook* includes copies of the relevant materials that pertain to each section of the training and provides additional background. These materials should be shared with participants as soon as possible, but at least 2-3 weeks before the training, in hard or soft copy. **In addition, participants should become certified in the *MISP for Sexual and Reproductive Health Distance Learning Module* (available at www.iawg.net/misp-dlm). This will help to provide a foundation prior to the training.**

DESCRIPTION OF THE FACILITATOR'S GUIDE

This facilitator's guide includes discussion guides, case studies, and interactive activities. It provides information on the necessary skills and professional behaviors for the provision of survivor-centered medical care, and recommends resources for further study. It is accompanied by a slide presentation with further instructional notes for facilitators and a participant's workbook. The content is based on most recent guidelines by the WHO, UNFPA, UNHCR, and IAWG available at publication.

This guide is divided into ten units:

2. For training on contraceptive delivery, see *Long-Acting Reversible Contraception in Crisis Settings* in this series at www.iawg.net/scorts.

- Two units providing introductory information and core concepts
- Four units focused on the clinical management of sexual violence survivors
- Three units on programming for clinical management for sexual violence survivors
- One closing unit including information on self-care and a course evaluation

Each unit includes five elements:

1. **Timing and methodology:** An estimate of how long it will take to complete the unit, its components, and the training methodology used
2. **Objectives:** Specific learning objectives to be met by participants by the end of each unit
3. **Materials:** Copies of all participant materials for distribution and answer keys for facilitators, color-coded and highlighted to identify materials you will need to print, download, or gather
4. **Preparation:** Instructions regarding information, activities, and materials to be prepared ahead of time
5. **Detailed session guide:** Step-by-step guidance on how to facilitate interactive participatory learning

Facilitators are highly encouraged to adapt the units to fit local training needs and objectives.

DOCUMENTATION AND CERTIFICATE

Facilitators should document attendance and present certificates of completion as appropriate. A sample certificate template is included in the training package. Participants will also complete both a multiple-choice pre-test and post-test to assess their understanding of the subject.

TRAINING EVALUATION

Facilitators should conduct an informal process evaluation at the end of each workshop day to assess progress and participant satisfaction with the topics and activities. At the end of the course, participants should complete the final evaluation to provide feedback, which will allow adaptation of future trainings.

PREPARATION FOR THE TRAINING

Facilitators should go through the sample agenda (Annex 1), facilitation plan, and tables below that outline the preparatory work that must be undertaken to successfully implement this course.

COURSE MATERIALS

The written or digital materials and complementary resources for this training are freely available for download at www.iawg.net/scorts. In advance of the course, it is recommended to download all the materials and resources to be used during the training, including all handouts and slide presentations. These materials can be stored on a USB key for use during the training and while offline. Copies of the materials can be shared with participants and other colleagues who are interested.

MATERIALS LIST

The following is a complete list of supplies needed for the successful implementation of the training which should be gathered in the month before the training. Each unit specifies from these lists which materials to print, download, or gather for that topic. Verify which supplies are already available at the training venue and make arrangements to bring any missing supplies with you.

COURSE MATERIALS CHECKLIST: ITEMS TO GATHER

Unit	Materials	Quantity	Acquired? (Yes/No)
All	Laptop	1	
All	Projector	1	
All	Screen or white wall to project image	1	
All	Flip chart paper	2-3	
All	Markers, pens, or crayons	3 of each color	
All	Speakers for the laptop	2	
All	Blank paper/note pads	1 per participant	
All	Tape	2-3 rolls	
All	Pens	1-2 per participant	
All	Post-it notes, multi-colored	4 pads	
2	Shawls, scarves, or newspaper sheets	11	
5	Sample medicines for demonstration: emergency contraception, PEP, ARVs, antibiotics as relevant (optional)	1 packet/box of each	
6	Yarn, string, or twine	1 skein	
6	Name tag stickers	1 pack	
	Hand or liquid soap, hand sanitizer gel if available	Based on number of participants	

CONTEXTUALIZING THE COURSE

In preparation for delivering the course, it is necessary to adapt certain elements of the units to the local context. In the month prior to the training, facilitators should gather the following information on the context in which the training will be delivered and update the appropriate slides in the accompanying units as noted. Use the checklist below to keep track of the necessary information.

Unit	Description	Completed? (Yes/No)
2	The inter-agency GBV coordination structure in the emergency setting, if any	
2	Information on reports of GBV in the setting, such as GBV data collected at the facility-level; location and type of services for survivors of GBV (health, community support, social, psychological, legal); SRH program staff and health care provider training needs	
	Ask a legal expert to write a short briefing about:	
2	• The legal definition of rape in the country of the training	
2	• Recognized forms of gender-based violence in legal texts	
4	• Mandatory reporting laws for cases of sexual abuse and sexual assault	
4	• National laws on abortion in the context of rape and incest	
4	• The national child abuse protocol, including reporting requirements and laws relating to age of consent	
4	• The type of lab specimens that can be locally processed as forensic evidence, if any	
4	• Cadres of health service providers authorized to collect forensic evidence and the range of forensic evidence admissible in courts of law	
4	• Legal requirements for completing a medical certificate/ police form, including who may fill it out	
4	• Court procedures in cases of sexual violence, including rape, and what to expect if asked to give testimony in court	
4	National protocol related to gender-based violence medical care and referral	
5	National treatment protocols for sexually transmitted infections including post-exposure prophylaxis for HIV, if any	
5	Any existing GBV standard operating procedures (SOPs) or written referral pathways between health care, psychological counseling services, social support, legal support, higher level care (gynecology, urology, psychiatric care)	
6,7	Discuss with the local GBV coordinator ask her/him to attend or facilitate Units 6 and 7	

ADVANCE PREPARATION CHECKLIST: ITEMS TO DOWNLOAD, PRINT, AND PREPARE

Use the following checklist to ensure that all the necessary materials are prepared in the weeks before the training.

Unit	Description	Completed? (Yes/No)
All	Review all course materials and update information from contextual checklist in the appropriate slides	
All	Make copies of the *Participant Workbook* for each participant	
All	Gather, pack, and/or ship all materials	
All	Ensure the training space and set-up meets training and learning needs	
All	Check projector and laptop for image and sound quality of videos and presentations	
All	Review all slide presentations, hiding the optional slides if not needed in your context	
All	Review the instructions and answer keys for all activities	
1	Prepare a *Course Agenda* handout with detailed information on the course units, subtopics, and schedule	
1,10	Print copies of the knowledge *Pre-Test* and *Post-Test*	
1	Prepare flip charts following instructions in unit	
2	Download short videos: □ *Iraqi Refugees in Jordan: Gender-based Violence*.[3] www.youtube.com/watch?v=InpAY1zsFdM □ *Violence against women: Strengthening the health sector response*.[4] www.youtube.com/watch?v=Qc_GHITvTmI	
2	Print *In Her Shoes Character Cards* and *Blanketed By Blame Character Cards*	
5	Find and print site-specific GBV standard operating procedures (SOPs)	
6	Create name tag stickers on colored Post-it notes	
7	SOP	
8	Download short video: □ *Reproductive Health Kits Shelving*.[5] www.unfpa.org/video/reproductive-health-kits-shelving	
10	Fill out participants' names on the certificates of completion	
10	Print copies of course evaluation form	

3. Women's Refugee Commission, 2009, 6:03 minutes
4. World Health Organization, 2016, 3:27 minutes
5. United Nations Population Fund, 2012, 5:38 minutes

CHARACTERISTICS OF EFFECTIVE TRAINING[6]

The following recommendations are necessary to ensure effective transfer of information during adult learning:

- Clearly communicate the purpose of the training to both facilitators and learners.
- State exactly what learners are expected to do at the end of the course.
- Use training methods that build on participants' existing skills and experience, enabling them to meet the objectives. Present new knowledge and skills in a relevant context.
- Actively engage learners in the process.
- Use an effective mix of training methods to meet the needs of different learning styles.
- Offer learners the opportunity to practice applying new knowledge and skills.
- Provide learners with constructive feedback on their performance.
- Allow enough time for learners to meet the training objectives.
- Offer facilitators and learners the opportunity to evaluate the course, which includes measuring the extent to which facilitators and learners met the training objectives, and accepting feedback from learners to make improvements to the course.

ALERT: IMPORTANT RECOMMENDATIONS FOR BEFORE AND AFTER THE TRAINING

This module is designed to be a minimum 3-day clinical refresher training for health care service providers caring for survivors of sexual violence in crisis-affected contexts. The IAWG Training Partnership Initiative conducted research about the barriers and facilitators to its implementation during the pilot phase, and have the following recommendations **for trainers and program managers**.

Before the training:

- Limit the selection of participants to those who meet the specified pre-requisite qualifications in the facilitator's guide.
- Assess qualified participants' learning needs to prepare for how best to address knowledge gaps. To do so, use the pre-test included in the *Clinical Management of Survivors of Sexual Violence in Crisis Settings* module or interview participants.
- Based on identified trainees' needs, provide additional training resources to expand the training as needed.
- Ensure that participants become certified in the *MISP for Sexual and Reproductive Health Distance Learning Module* (available at www.iawg.net/misp-dlm) as a foundation prior to the training.

After the training:

- Discuss and possibly organize a logbook and a calendar of opportunities for trainees to continue practicing updated skills and behaviors at their institution.
- Regularly schedule ongoing support and post-training follow up for the providers as soon as the security situation allows. Also encourage participants to use the learning materials and continue to work with their peers (on models if available) as they build their competence and confidence.

ADDITIONAL RECOMMENDATIONS FOR AFTER THE TRAINING

- Encourage participants to use the learning materials and continue to work with their peers and facility managers to consider ways in which all staff providing post-assault care achieve and expand competencies via an ongoing capacity-building plan with short, targeted skill-builders, regular team meetings, and other activities, and are supported on a personal level in this work. Example activities may include:
  - Mock interviews to simulate patient interactions and receive feedback regarding patient communication and safety
  - Peer-led case review sessions
  - Monthly supervision meetings to discuss challenging cases, address any secondary trauma experienced by providers, and receive mentored feedback on the spectrum of post-assault services provided
- It is strongly encouraged that facilities where providers practice have mechanisms in place to support and promote self-care for providers who experience secondary trauma as a result of providing post-violence care. For example, access to counseling services and periodic supervision meetings for debriefing.
- This training covers aspects of best practices in forensic evidence collection and clinical management for child survivors. It is not, however, a substitute for in-depth training on these specialty areas. Additional, comprehensive trainings on these and other topics should be organized as needed.

SENSITIVITY AND FLEXIBILITY IN A CRISIS SETTING

Sensitivity and flexibility are crucial in a crisis setting. When planning this training, keep the following points in mind:

6. Adapted from Ipas. (2014). *Woman-centered, comprehensive abortion care: Trainer's manual* (second ed.) K.L. Turner & A. Huber (Eds.), Chapel Hill, NC: Ipas.

- Minimize the time providers spend away from their duty stations. This can be addressed by conducting the training at the facility, if possible.
- Be sensitive to long hours and double shifts health care providers may be working.
- Remember that some participants may have long travel times or have competing priorities at home that may prevent them from completing advanced reading or other assignments.
- Be prepared for participants with a range of abilities and experiences – some participants may be very new to the setting.
- Attendees will most likely be a range of nurses, midwives, physicians, and clinical officers.
- Be sensitive to the emotional needs of health care providers/participants in a crisis setting.
- **Be aware that providers themselves may be survivors and ensure you have resources available to support any providers/participants who may be at risk for being triggered or in need of services themselves.**
- Some providers may be experienced in providing care to sexual violence survivors but inexperienced doing so in a crisis setting with limited resources and a different legal structure.

FEEDBACK ON THE TRAINING MATERIALS

The IAWG Training Partnership Initiative is interested in hearing from you. Please share any questions or feedback to info.iawg@wrcommission.org regarding the training materials and their use in your context.

UNIT 1 COURSE OVERVIEW

Time:
45 minutes

Unit Objectives:

By the end of this unit, participants will:

- Reflect on their expectations for the training.
- Agree on ground rules (norms) for the training.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 15 minutes: Ice-breakers/Introductions
- 15 minutes: Housekeeping, Ground Rules, Expectations, and Agenda
- 15 minutes: Knowledge Assessment*

*Note: Participants can begin the knowledge assessment during registration and finish during this session to save time.

PREPARATION

- Print, download, and gather materials as listed below
- Prepare two sheets of flip chart paper:
  - One titled: *Ground Rules*
  - One titled: *Garden*
- Prepare a *Course Agenda* handout with detailed information on the course units, subtopics, and schedule
- Prepare small pieces of paper with written numbers, one for each participant
- Place the *Course Agenda*, *Learning Objectives*, *Pre-Test*, markers, and Post-it notes on the tables for the participants prior to the start of the day

PRINT:
Handouts, one per participant:
- ☐ *Course Agenda*
- ☐ *Pre-Test*

Participant Workbook:
- ☐ *Learning Objectives*

DOWNLOAD:
Presentation:
- ☐ Slides 1 and 2

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart papers
- ☐ Markers, pens, or crayons in various colors
- ☐ Post-it notes in various colors

DETAILED SESSION GUIDE

INTRODUCTION/ICEBREAKER

Greet participants warmly. There may be some formal opening requests from national dignitaries. Please try to **accommodate** such requests in the shortest time possible. **Introduce** yourself and **give** a brief summary of your qualifications. **Thank** participants for attending the course despite hectic schedules, exhaustion, and difficult circumstances.

Show slide 2: *What is Your Superpower*? As an icebreaker, **invite** participants to share their name and one superpower they will bring to their efforts to deliver high quality clinical care to survivors of sexual violence. **Explain** that all of us have certain strengths that we bring to our work and lives. For example, some people are extremely good at staying calm and thinking clearly under severe stress. Others may be particularly good at demonstrating empathy and concern for strangers, or at motivating their colleagues to maintain strong team morale. What is one of your strengths that you will draw from to be an exceptional health care provider for survivors?

GROUP DISCUSSION: HOUSEKEEPING, GROUND RULES, EXPECTATIONS, AND AGENDA

Tell participants where the restrooms are and encourage them to leave the training room quietly if needed. **Mention** when you will start and finish each day and what arrangements are made for morning and afternoon breaks and lunch. **Note** any relevant safety and security information, such as safe areas.

Note: Consider setting up a WhatsApp group or similar group platform for communication for all participants. This will help with sharing key training and security information.

Present the flip chart sheet entitled "Ground Rules":

- **Explain** that ground rules are mutually agreed-upon guidelines to help the group work together, create a safe and respectful learning environment, and accomplish tasks efficiently.
- **Ask** participants to suggest ground rules. Write their suggestions on the flip chart. Possible ground rules may include participating, listening respectfully, speaking one at a time, turning off cell phones and pagers, maintaining confidentiality, and being on time.
- **Acknowledge that gender-based violence is widespread and some participants in this training may be survivors themselves**. Establish a ground rule that it is acceptable if someone needs to excuse themselves to take a break from content that may be triggering, and that you, as the facilitator, are available to speak with anyone privately about getting connected to resources, as needed.

Ask participants to write at least one to three expectations each on a colored Post-it note about what they hope to learn from the course. **Have** participants put the notes on the wall or a flip chart that you have placed in the front of the room. Next, **ask** participants to write on separate Post-it notes:

- One thing that makes them fearful of working with survivors (for example, "I am worried I may not know what to say"), and
- One thing that excites them about being able to deliver high quality services to survivors (for example, "this work is very meaningful").

Group the Post-its and **review** participant's expectations for the training, along with their fears and why they look forward to this work and training. Go through the *Learning Objectives* in the *Participant Workbook* and **identify** the expectations likely to be met. **Point out** any expectations that may be beyond the scope of the course. **Note** that this training covers aspects of best practices in forensic evidence collection and clinical management for child survivors, however it is not a substitute for in-depth training on these specialty areas. Keep the list of expectations to **review** with participants at the end of the course to ensure that those within the scope of the training were met.

Briefly **review** the *Course Agenda* with the participants.

Post a blank flip chart sheet and **draw** a flower at the top. **Explain** that during the course, any questions that cannot be addressed at that time will be put in the "garden" where they can grow. Throughout the course, the facilitator will refer to these questions and address them when most relevant.

KNOWLEDGE ASSESSMENT

Note: To save time, you can distribute the *Pre-test* during registration. Participants can begin answering the questions and finish once the activities above have been completed.

Tell participants that they have about 15 minutes to complete the *Pre-test* questions. **Prepare** small pieces of paper with numbers on them. **Ask** each participant to pick a number. **Explain** that this number will be used for tests and other assessments throughout the training. **Note for yourself** the participants' names and numbers, then **ask** participants to write their numbers on their tests. **Collect** all *Pre-tests* at the end of the allotted time.

UNIT 2 CORE CONCEPTS: GENDER-BASED VIOLENCE

Time:
270 minutes (4 hours 30 minutes)

Unit Objectives:

By the end of this unit, participants will be able to:

- Explain the link between gender-based violence and violations of human rights.
- Define gender-based violence.
- Describe the guiding principles for working with survivors of sexual violence.
- Increase awareness of and empathy for the difficulties survivors who experience violence face when seeing support.
- Highlight how social norms can affect survivors' abilities to seek help and access care, including special populations.*
- Encourage participants to consider what they can do as providers to provide an empathetic response to survivors of sexual violence.
- Critically reflect on participants' own perceptions and beliefs that may affect the quality of care survivors receive, including members of special populations.*

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 20 minutes: Video and Group Discussion
- 40 minutes: Facilitator Presentation and Video
- 90 minutes: Group Activity: In Her Shoes
- 60 minutes: Group Activity: Blanketed by Blame
- 60 minutes: Values Clarification Activity: Vote With Your Feet

This unit begins with a video and is followed by a slide presentation and interactive learning activities. The beginning of the session introduces the topic of sexual violence with a documentary clip. The session highlights the guiding principles for working with survivors of gender-based violence: **safety**, **confidentiality**, **respect**, and **non-discrimination**. The activities *In Her Shoes* and *Blanketed in Blame* provide a critically important opportunity to explore how social norms and discrimination affect survivors' abilities to seek help and access care, and encourage participants to consider what they can do as providers to provide an empathetic response to survivors of violence. The final activity, *Vote With Your Feet*, is a values clarification exercise. It challenges participants to critically reflect on their own perceptions and beliefs that affect the quality and type of care provided to survivors, including survivors from vulnerable populations.

PREPARATION

- Print, download, and gather materials as listed below
- Update the slide presentation with:
  - Any existing statistics regarding sexual violence prevalence in the context of the region on slide 8
  - Add the legal definition of rape in the setting on slide 20
- Flip chart: Draw a blank GBV tree (see example on the following page)
- *In Her Shoes Activity*:
  - Print one full set of each of the *Character Story Cards* (Amina, Carol, Mazuba, and Kemi)
  - Write out one copy of each of the 15 location signs (Religion, Friends & Neighbors, Violence Strikes, Police, Medical Care, Family, NGO, Work, Return Home, Chance, Cultural Leader, Traditional Healer, Carry On, Education, and Camp) and tape them to walls around the room. Be sure that they are well spread out to facilitate movement of participants
  - Distribute the *Character Story Cards* across each location in advance
- *Blanketed by Blame Activity*:
  - Procure 11 shawls / scarves or newspaper sheets
  - Print character script and cut into separate cards to give to participants, or create character cards by writing the character name on one side of an index card and the script for that character on the opposite side
- *Vote With Your Feet Values Clarification Activity*:
  - Select 5 to 6 statements

Note: Additional background guidance about the original *In Her Shoes* toolkit is included for those who are not familiar with facilitating this exercise.

* For this training, the term "special populations" should be read to refer to groups who are excluded or marginalized based on their identities or characteristics, including but not limited to lesbian, gay, bisexual, transgender, queer, intersex, and asexual (LGBTQIA) people; adolescents; persons living with disabilities; sex workers; and religious or ethnic minorities.

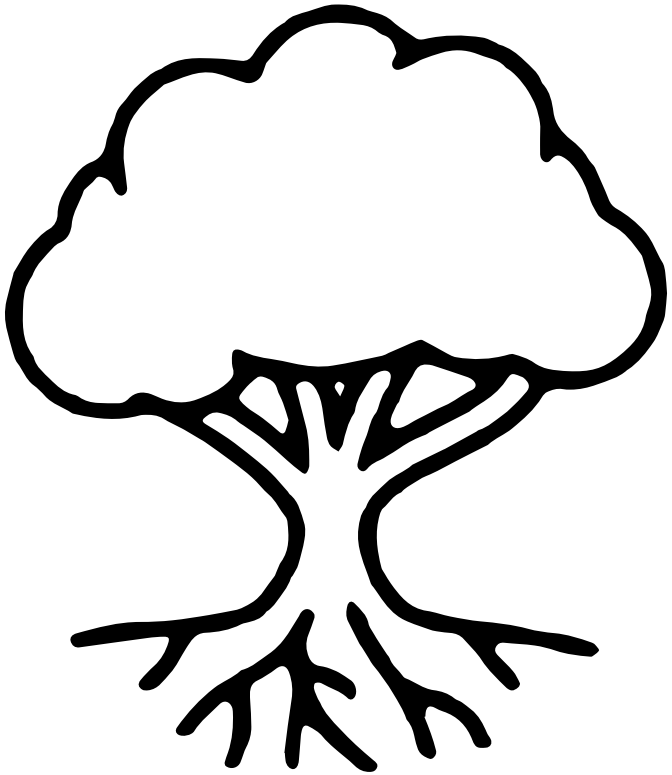
PRINT:
- ☐ *In Her Shoes Character Cards*, Raising Voices, and Program for Appropriate Technology in Health (PATH). *In Her Shoes Toolkit,* 2011
- ☐ *Blanketed By Blame Character Cards*

Participant Workbook:
- ☐ *MISP Reference*
- ☐ *Foundational Terms & Definitions*

DOWNLOAD:
Videos:
- ☐ *Iraqi Refugees in Jordan: Gender-based Violence*, 6:03 minutes
- ☐ *Violence against women: Strengthening the health sector response*, 3:27 minutes

Presentation:
- ☐ Slides 3 through 34

GATHER:
- ☐ Projector and computer with sound
- ☐ Markers, pens, or crayons
- ☐ Tape
- ☐ 11 shawls/scarves or newspaper sheets



DETAILED SESSION GUIDE

VIDEO AND GROUP DISCUSSION

After **warning the audience** that some of the scenes may trigger strong emotional responses, **show** the *Iraqi Refugees in Jordan* video from the beginning and **stop** it at 2 minutes, 20 seconds. Take 10 minutes to **facilitate** a group discussion using the following prompts:

- What do you feel?
- Do you think all survivors can access medical care?
- (People will likely say no, then ask:) Why not? What are the barriers?

Stay focused on the questions and do not let the discussion stray off topic. The purpose of this discussion is to introduce the guiding principles and how adherence to these principles will improve access for survivors to health care. **Showing** slide 5, **guide** the discussion to elicit some of the barriers to accessing medical care after an assault, which include:

- Survivors are stigmatized and blamed for the violence.
- Health care providers consulted by survivors should respect confidentiality. Nobody should find out that the survivor came to seek health care services. If confidentiality is not respected, survivors will not seek care.
- The perpetrator may threaten to harm the survivor if she or he talks about the sexual violence to anyone. It is important to ensure the survivor's safety.
- Survivors may be reluctant to seek health care services if they feel the provider shows no respect and blames them for what happened.
- Survivors may be unable to access care if they are unmarried, male, LGBTQIA, from a different ethnic or religious group, or for many other reasons, including fear and stigma.

Conclude the discussion by introducing the guiding principles for the care of survivors of sexual violence.

Write the guiding principles on a flip chart: **safety**, **confidentiality**, **respect**, and **non-discrimination**. **Explain** that if these guiding principles are integrated into participants' services, access to post-assault care for survivors will be improved. **Post** the written guiding principles in a prominent place on the wall and **refer** to them throughout the sessions that follow.

FACILITATOR PRESENTATION AND VIDEO

Show slides 6-8 and **discuss** using the presentation notes on *GBV and Human Rights*.

Note: Slide 8: *Scope of the Problem: Statistics* is optional. Hide it prior to the beginning of the presentation if it will not be used and has not been updated with context-specific information. Find any existing statistics, if possible, regarding sexual violence prevalence in the context of the region to include on the slide.

Discuss and **pause** at slide 9 before moving to slide 10: *GBV Tree*. **Do not show this slide until the following activity is completed**. **Move** the flip chart with the tree drawing in front of the participants.

Ask: Why does GBV occur? **Explain** that this is the GBV tree. It has roots, a trunk, and branches. The branches represent examples of GBV, the trunk represents contributing factors, and roots represent underlying or root causes. Let us think of some examples of GBV. **Stop** the discussion when you have 5-8 examples. **Write** the examples on the branches of the tree. For example:

- **Female genital cutting**: The practice of removing all or part of a girl's or woman's genitalia.
- **Dowry abuse**: A "dowry killing" occurs when a new wife is murdered by her husband or in-laws if they are unhappy with her, rather than returning her to her family and returning the dowry.
- **Isolation**: A married woman is not allowed to go out of the house or given money of her own.

Explain that these are all examples of GBV, but there are many others we can think of. Different forms of GBV are examples of different types of abuse: sexual/physical (including harmful traditional practices), emotional, and economic.

Write the following types of violence on the tree trunk: sexual, physical, emotional/mental/social, economic, harmful traditional practices. Point out where the earlier examples fall. **Explain** that in order to design effective GBV programming for emergencies, we must understand both the contributing factors and underlying causes of GBV.

- **Contributing factors** are factors that either perpetuate or increase the risk of GBV and influence the type and extent of GBV in any setting. Contributing factors do not cause GBV, but they are associated with some acts of GBV. For example, alcohol/drug abuse is a contributing factor, but not everyone who has substance abuse issues harms their partners or commit acts of sexual violence towards others. War, displacement, and the presence of armed combatants are all contributing factors, but not all soldiers

sexually assault civilians. Poverty is a contributing factor, but not all people experiencing poverty will experience sexually exploitation or will engage in sex work. Note that many contributing factors can be eliminated or significantly reduced through prevention activities.

- **The underlying causes** of all forms of GBV lie in a society's attitudes towards gender and practices of gender discrimination, as well as the roles, responsibilities, limitations, privileges, and opportunities afforded to an individual according to gender. Addressing the root causes through prevention activities requires sustained, long-term action with change occurring slowly over a long period of time.

Ask for examples of root causes and fill them in on the roots. When the flip chart drawing has been filled in and the discussion is complete, **show** slide 10 with all the associated bullets as a summary.

Depending on the context and relevancy you may **ask**, "How might a global emergency, such as the Covid-19 pandemic or Ebola, affect the risks for violence that an individual may experience?" For example, reports of survivors being forced to shelter in place with their abusers, reduced household incomes and economic impacts in communities, etc. After **calling** on a few volunteers, **point out** that during the Covid-19 pandemic incidents of gender-based violence, including domestic violence, increased dramatically.

Show and slides 11-29 and **discuss** using notes and activities in the presentation.

Note: Slide 20: *Legal Definition of Rape* should be updated in advance with the legal definition of rape in the setting prior to the training.

Conclude the presentation after slide 30 by reviewing the *Foundational Terms & Definitions* in the *Participant Workbook*. Then play the WHO animated video *Violence against women: Strengthening the health sector response* (3 minutes, 26 seconds).

GROUP ACTIVITY: IN HER SHOES[7]

Direct participants' attention to the 15 location signs taped to the walls around the room. **Explain**: "We will have the chance to walk in the shoes of a survivor who has experienced sexual violence. We will make the kind of decisions a survivor is faced with and discuss those decisions." **Break** the group up into small groups of 3-6 participants each.

Explain that this is a guided experience and decisions will be made through discussion and group consensus.

Assign each group a story card of a different character. If there are more groups than story cards, assign the same story to multiple groups. In this scenario, let the groups start staggered (after 5 minutes of the first group's starting) to avoid many groups being at the same station. (See character cards and situation cards for *In Her Shoes*.)

The card will have instructions at the bottom. **Ask** participants in each group to follow these instructions. At each station, participants will find a card that is relevant to their character. **Ask** participants to read that card and make decisions based on the information provided.

Participants have 60 minutes for this activity. At the end of the activity, the facilitator should **facilitate** a 30-minute discussion in plenary using the following questions:

- How did it feel to walk through the story of this person? Were you able to put yourselves 'in her shoes'?
- How do you feel about the survivor's options for help and about the choices she was able to make?
  - Probe: Was she always free to make the decision and access the services?
  - Probe: How much power did she have and how did others use power?
- What made it difficult for the woman to leave violent situations?
- Do you think there were instances of violence which were provoked or justified? What made you feel that way?
  - Probe: Why do we blame some women and not others?
  - Probe: Should we ever blame a person for the violence perpetrated against them?
- How did service providers and others respond to the survivor?
  - Probe: What happens when we do not believe survivors who seek support when they are experiencing violence?
  - Probe: How could they have done this better?
- What are your thoughts in response to the activity and these questions if the person in the story was a male, LGBTQIA, living with a disability, a sex worker, of another background?

7. Activity is adapted from Raising Voices, and Program for Appropriate Technology in Health (PATH). *In Her Shoes Toolkit*, 2011.

GROUP ACTIVITY: BLANKETED BY BLAME[8]

Ask 12 participants to volunteer to participate in the activity. Invite the others to be observers. **Ask** for one volunteer to play the role of Maya – a woman who has experienced violence. **Provide** each of the other 11 participants with a character card and a shawl or newspaper sheet.

Instruct Maya to sit in the middle. She sits in a chair in front of and facing the audience. The other participants **stand** around her in a circle, facing outwards (away from Maya). Each participant holds a shawl or newspaper sheet.

As the facilitator, stand outside of the circle and **read** the script of Maya's story. Then, in the order of characters provided below, **explain** whom Maya approaches first. **Invite** the first character to respond by reading the statement on the character card. After doing so, the participant should step forward and **place** a shawl/newspaper over Maya.

PROCESS OF BLANKETING (COVER WITH SHAWL OR NEWSPAPER):

Characters:

- friend
- HER mother
- neighbor
- HIS mother
- community health worker (female)
- priest/religious leader (male)
- daughter
- police
- social worker
- lawyer
- doctor

Ask each character to read the statement on their character card after which that character steps forward and places a shawl or newspaper over Maya. After all 11 characters have placed a shawl or newspaper on Maya, **ask** Maya why she did not leave. **Wait** for her response.

Next, **ask** each character to reverse this process by reading the statement on their character card on the *reverse side* and removing one shawl/newspaper from Maya. This time the characters should face inwards towards Maya and read their statements in the reverse order (beginning with the doctor and finishing with the friend).

SCRIPT: MAYA'S STORY

Maya is thirty-five years old. She has been married for 10 years. She has two children ages seven and nine. Maya works in her host community at a garment factory sewing clothes for a big foreign company. Her husband, Lee, works for an automobile manufacturing factory. Soon after their younger child was born, Lee started beating her and eventually forcing her to have sex. This has continued for many years and has gotten worse. Lee's drinking has also gotten worse. One day when she had to stay late to sew clothes for a big order, the garment factory manager dropped her off at home. Lee saw them together and became jealous and very angry. He beat and raped her so badly that her arm got fractured, she had a big gash on her forehead, bruises everywhere, and a swollen black eye. Her children saw this and became very scared that something would happen to their mother. Maya could not take it anymore as she was afraid for her life and decided to take action. She approached her friends, family, a social worker in an NGO, a doctor, and the police.

Participants have 45 minutes for this activity. After, the facilitator should **facilitate** a 15-minute discussion in plenary using the following questions:

- Ask the:
  - Survivor how she felt.
  - Other characters how they felt.
  - Observers how they felt.
- How do you feel about the survivor's options for help and about the choices she was able to make?
  - Probe: Was she always free to make the decision and access the services?
  - Probe: How much power did she have and how did others use power?
  - Probe: How might tensions within host communities against refugees like Maya and Lee affect survivors' ability or willingness to seek help?
- What made it difficult for a survivor to leave a violent situation?
- Do you think there were instances when violence against the survivor was justified?
- How did service providers and others respond to the survivor?
  - Probe: What happens when we do not believe survivors who seek support when they are experiencing violence?
  - Probe: How could they have done this better?

8. Activity is adapted from World Health Organization. *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*. World Health Organization, 2019. www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en

Wrap up *In Her Shoes* and *Blanketed by Blame* by **sharing** the following key messages:

- *In Her Shoes* and *Blanketed by Blame* illustrate the challenging decisions that survivors face in handling violence and how they are responded to.
- Survivors are making important safety decisions all the time, and they are the experts on their situations.
- Survivors often have very few, if any, options for seeking support or escaping from violent situations. Many factors may prevent a survivor from getting help, including economic barriers, social stigma, legal obstacles, and physical threats.
- Perpetrators of violence often cause survivors to think that the violence is their own fault rather than the perpetrators', making it difficult for them to seek help.
- Many survivors feel compelled to stay in violent situations because they will not be accepted or supported if they leave.
- When violence is considered normal, survivors often feel that they must simply accept and bear it. Many survivors are not believed or are dismissed as over-reacting, especially when violence is normalized. These are examples of unequal norms in our communities.
- Gender-based violence is never justified. It does not matter whether a survivor is married, what they wear, how they act, what their religion is, or any other factor.
- Using violence is a choice that perpetrators make. It is not acceptable for husbands to discipline their wives.
- Survivors are not to blame for what has happened to them. It is important to NEVER place any kind of blame on the survivor. We can remind others as well not to blame survivors for violence they experienced.
- We often think of violence only as physical violence and/or random acts committed by strangers. Hence, we do not recognize other types of violence when we see them. This includes intimate partner sexual or emotional violence, or exploitation.
- Health care providers can help survivors in several ways in the path to healing.
  - They can reach out to survivors who they suspect are experiencing violence and ask them about it.
  - They can listen to survivors' stories and shown empathy for their feelings.
  - They can believe survivors' experiences and not blame them for the violence.
  - They can ask them about their needs and concerns, encourage them to look for options, support them to make decisions that are right for them, and respect survivors' wishes and choices.
- These exercises help us understand that survivors need empathy and non-judgmental responses. We will come back to these themes throughout the training.

VALUES CLARIFICATION ACTIVITY: VOTE WITH YOUR FEET[9]

Find a space where participants can easily move around. If the group is too big, split into 2-3 groups and conduct the exercise in 2-3 different spaces (e.g., breakaway room or different ends of the room).

Label/Designate one side of the space as **"Agree"** and the opposite side as **"Disagree." Ask** the participants in each group to stand in the middle in a straight line.

Read one of the statements listed in the *Values Clarification: Vote With Your Feet Statements* out loud.

Ask participants to respond by moving closest to the sign/side designated as "agree" or "disagree," depending on whether they agree or disagree with the statement. **Ask** the participants to choose where they stand based on how strongly they agree or disagree with the statement.

After each statement, **facilitate** a discussion about why people chose the response they did. This will help dig deeper into their underlying belief systems. **Allow** some time for debate between people of differing viewpoints by **asking** each side to explain their view to the other side. After a short debate, **ask** people if they would like to change their position.

Repeat this by **reading** about 4-5 more statements, depending on how much time is available.

Note: There are facts about GBV included with the statements for you to use as part of the discussion if needed. This exercise can be intensely personal and uncomfortable for some participants. It can result in some participants feeling isolated if their values do not align with other group members' values or create feelings of negativity towards their peers. If you find that this is being expressed, intersperse the statements on GBV with those that are under the miscellaneous category to create a non-threatening atmosphere.

It is important to **maintain** a non-judgmental atmosphere during this exercise. **Allow** each person to express her or his thoughts without making a judgment about who is right or wrong. These are complicated, emotional issues, and some participants may react strongly to the statement and others' views. **Remember**, everyone brings their own personal perspective to this exercise.

9. Activity is adapted from World Health Organization. *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*. World Health Organization, 2019. www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en

VALUES CLARIFICATION: VOTE WITH YOUR FEET STATEMENTS

Statement	Optional Talking Points
Men sometimes have a good reason to use violence against their partners.	There is never any excuse or justification for any type of violence. It should never be used as a form of power or control.
Women are just as violent as men in relationships.	The few population-based studies that have examined women's perpetration of violence have found that violence experienced by men at the hands of their female partners is less frequent than violence experienced by women at the hands of their male partners. Exploratory studies have found that the violence perpetrated by women is not as severe in terms of the resulting physical injuries, and that oftentimes the violence is in response to violence perpetrated by the men.
A sex worker cannot be raped.	The fact that a person sells sex for a living does not mean s/he is always ready and willing to have sex with anyone. Rape is the act of forcing someone to have sex. Sex workers are often forced to have sex because of a stigma that they are always available for sex. It is rape if clients and potential clients force sex workers to have sex. If someone has sex with you, even when paid for, this person does not have the right to have sex with you again without your consent.
Most women are abused by strangers. Women are safe when they are home.	Studies show that in most settings the majority of the perpetrators of sexual abuse are known to the survivors. Moreover, intimate partner violence – that is physical and/or sexual violence – is the most common form of violence experienced by women. Therefore, unfortunately for many women, home is not necessarily a safe space.
Men who have sex with men do not experience gender-based violence.	Gender-based violence is defined as "An umbrella term for any act, omission, or conduct that is perpetuated against a person's will and that is based on socially ascribed differences (gender) between males and females." Men who have sex with men defy the socially ascribed roles for males and females, and experience abuse and violence as a result. This is considered a form of gender-based violence.
Women who wear revealing clothing are asking to be raped or survivors of gender-based violence provoke the abuse through their inappropriate behavior.	There is never any excuse or justification for rape or any type of violence. Women and others who are abused should never be blamed or told that it is their fault.
A woman can say "no" if she does not want to have sex with her husband.	Every person has the right to bodily integrity and the right to refuse sex or say no to sex. In many settings, however, gender norms socialize women and men into believing that once you are married, the man is entitled to have sex with his wife whenever he wants. In many countries, forced sex with your spouse is not considered to be rape. However, all people have the right to control their own bodies and sexuality. This means that women can say no to sex with their husbands.
Men cannot control themselves. Violence is simply a part of their nature.	Perpetrating violence is always a choice for the perpetrators. It is not part of nature nor inevitable. Violence is often a learned behavior. Data shows that children who are either subjected to violence themselves or witnessed violence in their homes, are more likely to perpetrate or experience intimate partner violence when they grow up.
Gender-based violence is a private matter and should not be discussed publicly or Intimate partner violence is a private matter and outsiders should not interfere.	Gender-based violence is a public health issue with grave effects on the health of women and families. Additionally, there are economic impacts that result from the need to treat and respond to health impacts as well as the negative impact on survivors' economic productivity. It also has compounding effects on children/witnesses of violence who may become violent themselves, drop out of school, and be unable to lead productive lives due to the violence to which they were exposed.
As a health worker, how I respond to a survivor who has suffered violence from a partner or sexual abuse is very important.	Individuals subjected to violence often do not disclose their experience to anyone because of the fear of being blamed or stigmatized, or that no one will believe them. As a health care provider, you will likely encounter survivors. Even if a client does not disclose his or her exposure to violence to you, studies show that such clients are more likely to seek health care for a range of related conditions. Survivors indicate that an empathetic response from a health care provider can gain their trust in disclosing their experience. Therefore, an empathetic, validating, and non-judgmental response is very important to survivors and to putting them on a path to healing.

Statement	Optional Talking Points
If a woman stays with a violent partner, it is her fault.	There are many reasons why a person might stay with a violent partner. It is not our place to judge these individuals. In fact, leaving a violent relationship can also result in an increased risk of violence from a controlling, violent partner. Other reasons, such as economic dependence and social pressures to not break up the family, can also prevent a survivor from leaving a violent partner.
If a drunk person is sexually assaulted, it is partially their fault because they chose to drink.	There is never any excuse or justification for sexual or any type of violence. Although we may encourage people to stay aware of their surroundings and potential risks for being in vulnerable or potentially abusive situations, not doing so does not mean that a person is at fault for experiencing violence.
MISCELLANEOUS STATEMENTS (to be used if tensions arise within the group)	
I would rather ride a bike a mile than walk a mile.	
I love to cook.	
I am a good dancer.	
It makes me feel proud when someone thinks I have done a good job.	
Babies are cute.	

After the exercise is complete, **facilitate** a group discussion using the following questions as a starting point.

- How did it feel to confront values that you do not share?
- What did you learn from this experience?
- Did you change your opinion about any of the issues?

Encourage debate within the group. Be ready to spend some time **discussing** the issues that arise. **Wrap up** by reinforcing the following key messages:

- The purpose of this exercise was to reflect on our personal beliefs about survivors to see how our perceptions and beliefs might affect the care that we, as health care providers, offer to survivors.
- All of us hold attitudes and beliefs that reflect the norms and values of the societies we live in. Often our attitudes may be in conflict with those of others. In the earlier exercises – *In Her Shoes* and *Blanketed by Blame* – we saw how these norms affect the survivors' experiences and access to care. In this exercise, we are taking this further to reflect on how we, as providers, might mirror societal values and beliefs, and perceptions about violence in how we provide care to survivors.
- It is important to respect others' beliefs and attitudes about acceptability of violence, but to also challenge those attitudes and values or beliefs that can be harmful to others.
- Even though we may be familiar with gender-based violence and the importance of addressing it, some of the issues may be difficult for us to work on. Looking at our socialization and how our cultures feel about violence, especially toward women and girls, may influence the way we address this issue in our work or whether we even address it at all.
- It is important to challenge our own values and beliefs and reflect on if they can harm others or affect how we treat survivors. Changing mindsets takes time. However, it is possible to change our beliefs and it is healthy to examine our attitudes and adjust them, if necessary.
- Survivors of sexual violence are often acutely aware of their surroundings and can sense when someone has a negative opinion about them. Therefore, it is important to be conscious of our beliefs. The main purpose of doing so is to minimize trauma, establish trust with the survivor, and express the fact that you trust their choices and decisions. This is one way to restore power and control back to the survivor who has experienced violence.

UNIT 3 PREPARING THE CLINICAL SITE, IDENTIFYING SURVIVORS, OFFERING FIRST-LINE SUPPORT (LIVES)

Time:
60 minutes (1 hour)

Unit Objectives:

By the end of this unit, participants will be able to:

- Describe the elements that must be in place in the health system for providing clinical services to survivors.
- Discuss common signs and symptoms of sexual violence and intimate partner violence.
- Summarize the basic principles of supportive communication and first line response (LIVES) for survivors.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 40 minutes: Facilitator Presentation and Group Discussion
- 20 minutes: Demonstration: First-Line Support using LIVES

PREPARATION

- Print, download, and gather materials as listed below

PRINT:
Participant Workbook:
□ *First Line Response using LIVES*

DOWNLOAD:
Presentation:
□ Slides 35 through 65

GATHER:
□ Projector and computer with sound

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND CASE STUDIES

Part 1: Show slides 36-54 and discuss using notes and activities included in the presentation on how to prepare the health care setting in order to ensure medical care is available and accessible for sexual violence survivors, and how to identify survivors of violence.

Part 2: Show slides 55-63 and discuss using notes and activities included in the presentation which introduce the principles of supportive communication, including offering a first line response.

DEMONSTRATION: FIRST-LINE SUPPORT USING LIVES

Pause the presentation on slide 64. **Invite** a volunteer to join you at the front of the group to demonstrate a supportive interaction between a survivor and a provider, using the *Demonstration of LIVES Script*. The facilitator plays the role of the provider and the volunteer **plays the role** of the survivor. This is the facilitator's opportunity to **demonstrate** effective active listening techniques and supportive communication principles of LIVES.

DEMONSTRATION OF LIVES SCRIPT

Patient (volunteer participant) and Health Care Provider (facilitator) are both sitting in chairs facing one another. The provider is making eye contact, and not writing in a medical record.

Provider: We've spoken about your concerns regarding your health. You said that you have repeated headaches. Headaches could be related to stress. Are you experiencing any stress?
Patient: I don't know. Sometimes I feel overwhelmed at home.

Provider: Is there anything specific at home that could be causing you to feel like this? Talking about this may help us understand your health better.
Patient: OK, if you think it will help.

Provider: I do think it is important and might help. I have seen Patients with health problems like yours who have been experiencing trouble at home. Problems in your relationship can affect your health. Could we speak more about your relationship?
Patient: OK.

Provider: Before we continue, I want you to know what you tell me is confidential, and that means I won't tell anyone not involved with your care about what you share with me.
Patient: OK.

Provider: Is everything ok with your partner?
Patient: I am not sure. He has been under a lot of stress.

Provider: I see. What happens when he has a lot of stress?
Patient: He gets very angry at me and sometimes he does not calm down easily.

Provider: OK. Has he threatened to hurt you or physically harmed you in some way when he gets angry?
Patient: It has happened. He hit me a few times last year, but then it stopped. Now he has threatened me a few times in the last couple of months. *The Patient pauses, looks down, and appears uncomfortable*.

Provider: *Nods head and waits a few seconds*. This can be hard to talk about.
Patient: *Is silent, nods the head, and then looks up again*.

Provider: *Provider leans in slightly towards the Patient, looking concerned*. Can you tell me about the last time it happened?
Patient: *Pauses*. Well, when he came home yesterday he was really mad about something, and he threatened to hit me when I asked him why he was so mad.

Provider: *Pauses, giving Patient time to think*. How do you feel about that?
Patient: It makes me sad and afraid. I'm not sure what to do when he gets mad. It makes me anxious just thinking about it. *About to cry, but then recovers*.

Provider: *Pauses*. Feeling anxious is common when you feel threatened at home. It's important to know that it's not your fault. Everybody deserves to feel safe at home.
Patient: I am anxious, but I don't think he would hit me again like he did last year.

Provider: Is there anything you need or want to feel less anxious?
Patient: No, I think this is fine.

Provider: There are specific exercises that can be helpful to feel calmer when you are feeling anxious. Would you like me to share a method with you to help you with this?
Patient: Yes, that would be great, thank you.

Conclude the unit with a group discussion and summary of key messages on slide 65 about communicating with survivors and raising the sensitive issue of violence.

UNIT 4 INFORMED CONSENT, MEDICAL HISTORY, AND PHYSICAL EXAMINATION

Time:
150 minutes (2 hours 30 minutes)

Unit Objectives:

By the end of this unit, participants will be able to:

- Summarize key elements of informed consent.
- Describe how to conduct and collect a comprehensive patient history pertaining to sexual violence, and document findings appropriately.
- Explain components of a physical examination of survivors of sexual violence, including internal and external genital examination.
- Describe principles of collecting forensic evidence during the physical examination.
- Discuss the purpose and composition of a medical certificate.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 60 minutes: Facilitator Presentation and Group Discussion
- 60 minutes: Small Group Activity: Case Study
- 30 minutes: Facilitator Presentation and Group Discussion

PREPARATION

- Print, download, and gather materials as listed below
- Summarize the responsibility of the health care provider in reporting medical findings in a court of law in the setting. Ask a legal expert to write a short briefing about the local court proceeding in cases of sexual violence and what to expect to be asked when giving testimony in court
- Confirm what the lab capabilities are for testing specimens prior to the training
- Research the medical certificate legal requirements in the country of the training, where to get a sample of the medical certificate, and who is allowed to fill this document out

PRINT:
Participant Workbook:
- ☐ *Topics to Cover When Taking a History*
- ☐ *Sample Informed Consent Form*
- ☐ *Sample History and Physical Examination Form*
- ☐ *Case Study: Elizabeth's Story*
- ☐ *Forensic Evidence Collection Guidance*
- ☐ *Sample Medical Certificate*

DOWNLOAD:
Presentation:
- ☐ Slides 66 through 109

GATHER:
- ☐ Flip chart paper
- ☐ Markers, pens, or crayons
- ☐ Tape

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

The first part of the presentation discusses how to prepare the health care setting in order to make medical care for sexual violence survivors available and accessible.

Show slides 66-69 and **discuss** using notes and activities in the presentation. **Pause** on slide 69: *Obtaining Informed Consent* and **direct** participants to the *Sample Informed Consent Form* included in their workbooks for reference. **Continue** the presentation to slide 72: *Taking the Medical History*. **Explain** that preprinted history and examination forms should guide the process and all findings should be thoroughly documented. The primary purpose of the history and examination is to determine the clinical care that is needed. History-taking and the examination are to be done at the survivor's own pace. **Direct** participants to the *Sample History and Examination Form* included in their workbooks, which will be used for the activity at the end of this session.

Show slides 73-98 and **discuss** using notes and activities in the presentation before moving to the *Case Study Activity*.

SMALL GROUP ACTIVITY: HISTORY AND EXAMINATION CASE STUDY

The objective of the group case study exercise is to practice filling in the *Sample History and Examination Form* appropriately and becoming aware of the detailed and careful questioning and examination that is required when working with survivors of rape.

Divide the participants into groups of 4 or 5 people. **Ask** participants to reference the *Case study: Elizabeth's Story* and use the *Sample History and Examination Form*. **Ask** participants to read the case study and to complete Boxes 1 (General Information) to 7 (Evidence Taken) in the medical intake form, and to complete the pictograms, based on Elizabeth's story.

CASE STUDY: ELIZABETH'S STORY

The patient is Elizabeth S., 25 years old, who arrives at the health care center 2 days after escaping from her abusers.

Interviewer: Thank you for being here. To help me understand how I can best help, can you begin by telling me what happened that brings you in today?

Elizabeth: There were a lot of other people also seeking shelter from the rain – there were about 18 of us, mostly neighbors and many old people.

Interviewer: I see, and who were the people?

Elizabeth: There was the old man in the village..., my mother, my sister... but the soldiers came and they were all around.

Interviewer: How many soldiers were there?

Elizabeth: There were a lot of them – I can't say how many, I could only hear their voices and see their guns.

Interviewer: What were the soldiers saying?

Elizabeth: I don't know, they were yelling at us, they told us they would kill us if we did not do what they said.

Interviewer: That sounds very frightening. I'm sorry to hear this happened. What happened next...

Elizabeth: I saw that everything in the house was stolen. Our food, our clothing, we had nothing left. My baby was on my back. Four soldiers entered the house.

Interviewer: [Pause, nods]

Elizabeth: [Elizabeth tearful] They were all armed. They took my baby away from me. I tried to resist, but they kept hitting my forearms with the butts of their guns.

Interviewer: You did nothing wrong and no one deserves to be treated this way. Can you show me where they hit your arms?

Elizabeth: The four soldiers made me carry the things they had stolen on my back.

Interviewer: Where did you go with the things on your back?

Elizabeth: We walked in the forest at night for several hours. It was very dark and I fell many times.

Interviewer: And where did you finally stop?
Elizabeth: I don't know where we finally stopped.

Interviewer: It sounds very scary. Can you tell me what happened when you stopped?
Elizabeth: I was raped three times by the one soldier.

Interviewer: [Pause] I'm sorry to hear this happened, Elizabeth. It is difficult and brave to talk about these things. I am glad you are here now. [Pause] So that I can offer you the best medical care, it is important for me to understand details of what happened to your body and where. Can you tell me what the soldier did to you when he raped you?
Elizabeth: He put his thing in me.

Interviewer: And by 'thing' you mean his penis, is that right?
Elizabeth: [Avoiding eye contact, looking down] Yes

Interviewer: And did he ejaculate?
Elizabeth: Yes, he did.

Interviewer: We will talk more about medicine to prevent pregnancy and sexually transmitted infections during today's visit. Did his penis enter any other parts of your body?
Elizabeth: No

Interviewer: And did he touch or hurt other parts of your body?
Elizabeth: I could see he had a long gun and a knife. When I cried, he threatened to rape me with his knife. It was long and had a jagged edge.

Interviewer: What exactly did he say to you?
Elizabeth: He said, "Shut up and stop crying or I'll put this knife inside you where it will hurt more." That's when he cut my thigh, the inside part.

Interviewer: Which leg did he cut?
Elizabeth: My right leg. I stopped crying.

Interviewer: What happened then?
Elizabeth: I tried to stop the bleeding. This cut still hurts me and it won't close.

For any information asked in the *Sample History and Examination Form* that is not described in this case study, participants can **imagine** the answer this patient would have given and any signs that would have been found upon examination. **Reassure** them that they cannot make a mistake and they can think of anything to add to have sufficient information to fill out the form. To document the incident history in detail, the form does not have enough space. In this case, participants should **focus** on **writing** only the information that could relate to findings in the physical examination.

All the groups will do the entire exercise. However, each group will report back only on part of the exercise in the interest of time. **Give** the participants 45 minutes to 1 hour to work through the form and **ask** the groups to report back as follows:

- **Group One**:
  - Boxes 1 (General Information) and 2 (The Incident)
- **Group Two**:
  - Box 3 (Medical History)
  - Ask participants why it is necessary to know the things that are asked in this step.
- **Group Three**:
  - Boxes 4 (Medical Examination) and 5 (Anal and Genital Examination)
  - Ask participants to show how they have filled out the pictograms.
- **Group Four**:
  - Boxes 6 (Investigations Done) and 7 (Evidence Taken)
  - If there are a lot of participants, Group Four can be split into 2 groups.

After each presentation, **ask** the other groups if they have any brief additions or comments on the reporting group's efforts. The **debriefing** discussion after the activity should include reminders that:

- This survivor is providing very important information in her interview. It is important for health care providers to document this history in an accurate manner while they are listening actively to the survivor.
- The history should be documented in the words of the patient ("*I was raped three times by the one soldier,"* or *"patient stated she was raped by..."*), not of the provider (*"patient was raped by…"*).
- Physical exam should be documented using objective medical terminology.
- The most important points to remember when documenting are to keep notes:
  - Legible.
  - Accurate.
  - As complete as possible.

- **Boxes 1 and 2**: The case history includes information that can be elicited through follow-up questions. Therefore, it is important to follow a standardized form, so as not to forget anything. Acknowledge that some providers may feel uncomfortable asking such personal questions at first (for example, around ejaculation) and location of penetration. However, this information is critical to guide the physical examination and clinical care.
- **Box 3**: Information obtained in this step will help inform decisions on what treatment to offer and may help in interpreting physical examination findings (a multiparous patient may have vulvar scars, for example).
- **Boxes 4 and 5**: Detailed descriptions of injuries are required. Make sure that any visible injuries are marked on the pictograms (including detailed description, color, size, and depth of injuries).
- **Boxes 6 and 7**: Explain the differences between these two steps.
  - **Box 6**: Investigations are done to aid in treatment decisions (e.g., X-rays, a urine test to determine pregnancy, with urine to be collected before the examination).
  - **Box 7**: Forensic evidence taken can include items of clothing, a sample of fluid from the vagina, etc. Remind participants that at this stage STI screening tests are not needed; neither for medical investigation (all STIs are treated presumptively as addressed in the next session), nor for evidence (finding a preexisting STI could even be used against the survivor in court). The only exception may be in young children when repeated abuse is suspected and a positive rapid plasma reagin (RPR) or HIV test can be used as evidence.

FACILITATOR PRESENTATION AND GROUP DISCUSSION

The second part of the presentation covers informed consent, taking a medical history, completing a physical examination, and collecting forensic evidence.

Begin with slide 100: *Physical Exam: Forensics*. **Explain** that the main purpose of the examination of a survivor is to determine what medical care is needed. Forensic evidence may also be collected to help the survivor to pursue legal redress where this is possible and if they wish to do so. However, in many settings, the ability to process forensic evidence or for it to be used for legal action is extremely limited or non-existent. This is particularly true in crisis-affected contexts. Furthermore, the survivor may choose not to have evidence collected. Respect this choice.

The clinical management of survivors of sexual violence takes priority over the medico-legal (forensic) process. **Collection of forensic evidence should ONLY occur IF that evidence can be safely secured, tested, analyzed, and used**. Evidence collected during an examination may help prove or disprove a connection between individuals and/or between individuals and objects or places.

Note: Find out what the responsibility of the health care provider is in reporting medical findings in a court of law in the setting. Ask a legal expert to write a short briefing about the local court proceeding in cases of sexual violence and what to expect to be asked when giving testimony in court.

Show slides 101-104 and **discuss** using the notes in the presentation. **Tell** participants they may refer to the *Forensic Evidence Collection* handout for additional reading around considerations for forensic evidence collection, if relevant at their sites.

Note: Slides 102 and 104 on *Forensic Evidence* are hidden. Only show these slides if the setting has the ability to safely implement forensic evidence collection for use in court proceedings and there is a protocol for STI testing in the facility.

Pause on slide 105: *Medical Certificate*. Have a discussion with the participants on how best to have a survivor-centered approach and make the certificate available with the person's consent. A *Sample Medical Certificate* is included in the workbook for participants to reference.

Note: As the facilitator, you need to know:

- The legal requirements for medical certificates in the country of the training.
- Where to get a sample of the medical certificate, sometimes called a police form.
- Who is allowed to fill this document out.

Move through slides 106-109 using the notes and activities to conclude the presentation.

UNIT 5 PROVIDING TREATMENT AND RELATED COUNSELING

Time:
210 minutes (3 hours 30 minutes)

Unit Objectives:

By the end of this unit, participants will be able to:

- Provide appropriate treatment for adult and children survivors of sexual violence, including:
  - Emergency contraception.
  - Pregnancy testing, pregnancy options information, and safe abortion care/referral to the full extent of the law.
  - Presumptive treatment of STIs.
  - Post-exposure prophylaxis (PEP) to prevent HIV transmission.
  - Prevention of hepatitis B and HPV.
  - Care of wounds and prevention of tetanus.
- Demonstrate supportive, accurate counseling to survivors.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 20 minutes: Small Group Work: Case Study
- 40 minutes: Facilitator Presentation and Group Discussion
- 45 minutes: Group Activity: Treatment Decisions Case Studies
- 30 minutes: Facilitator Presentation and Group Discussion
- 75 minutes: Group Activity: Counseling Role Play

PREPARATION

- Print, download, and gather materials as listed below
- Research the PEP protocol used in the setting and update slides 115-116
- Research the local STI treatment protocols before the training and update slide 124

PRINT:
Participant Workbook:
- ☐ *Case Study: Elizabeth's Story* (See Unit 4)
- ☐ *Sample History and Examination Form* (See Unit 4)
- ☐ *Case Studies: Treatment and Counseling*

DOWNLOAD:
Presentation:
- ☐ Slides 110 through 139

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

SMALL GROUP WORK: CASE STUDY

Provide an overview of the unit by moving through slides 110-113. **Start** this session by **asking** participants to return to the same groups from the last session. Using the *Case Study: Elizabeth's Story* and *Sample History and Examination Form* from Unit 4, **fill in Box 8**: Treatments Prescribed. **Give** the groups 15 minutes to decide whether or not they would treat the patient for a given issue and which treatment they would give. Each group will report on one of the treatments:

- **Group One** – STIs and hepatitis B
- **Group Two** – Emergency contraception
- **Group Three** – Wound treatment and tetanus
- **Group Four** – PEP

Do not spend a lot of time discussing this activity. Instead, **move** into the presentation below to explain and clarify.

FACILITATOR PRESENTATION AND GROUP DISCUSSION

The activity is followed by a slide presentation reviewing treatment in detail. **Show** slides 114-130 and **discuss** using notes and activities in the presentation.

Note:
- Slides 115-116 on *Provide treatment: PEP* should be adapted based on the PEP protocol used in the setting.
- Slides 119-120 are hidden. They can be used if there are concerns with providing PEP without knowing the result of an HIV test and if there are questions about the risk of HIV transmission.
- Slide 124: *Provide treatment: Prevent STIs* should be updated accordingly. Find out the local STI treatment protocols before the training. Discuss either the national treatment protocol or the antibiotics in IARH Kit 3. The WHO guidance for STI treatment may change – adapt the slide as appropriate.

GROUP ACTIVITY: TREATMENT DECISIONS CASE STUDIES

The case studies pertaining to treatment that are included on the *Treatment Worksheet* are an opportunity for the participants to address clinical scenarios with various complexities.

Assign participants to four groups. Each group works either on Case Studies 1 and 2, or on Case Studies 3 and 4. This means that each group has a fairly easy and a more challenging case. **Ask** participants to **fill out** the matrix regarding treatment decisions for each of their cases. After 30 minutes, have the group **report** back. **Utilize** the facilitation notes to guide the discussion toward points that need emphasis.

The **key points** to address for all case studies are as follows:

- The purpose of this exercise is to understand that treatment decisions need to be made based on careful considerations in each individual case.
- HIV transmission occurs through either blood or semen that has an entry point into the survivor's body (through the vaginal or anal mucosa, or through oral and other open wounds).
- No tests are required before providing treatment.
- Post-exposure prophylaxis (PEP) can be started without knowing the HIV status of the survivor. Voluntary counseling and testing (VCT) for HIV is recommended for all patients but PEP should not be delayed for test results, and VCT should never be forced. Providing PEP will do no harm even if the survivor is HIV positive, and it will not create viral resistance in the community.
- It is also unnecessary to test for STIs prior to presumptive STI treatment. Because of incubation times, STIs will not show up in a survivor of a recent incident (less than two weeks) of sexual violence. If there is an STI detected, then it will be from a previous contact and documenting this STI could be used against the survivor in court.
- A pregnancy test may be done before providing treatment if the history indicates the survivor may have an early pregnancy, but it is not required. If a pregnancy test is positive, then emergency contraception should not be prescribed because it has no treatment value. However, if emergency contraception is given to a pregnant patient, then it will not have an effect on the pregnancy.

CASE STUDIES: TREATMENT DECISIONS ANSWER KEY

Case Study 1:
An adult woman survivor comes to the clinic 36 hours after being sexually assaulted with penile penetration into her vagina. She states she wants all available treatment. She states she has no allergies that she knows of. The woman feels emotionally numb, and does feel supported by her husband.

The treatment offered to the woman should include:

To prevent/manage	Give treatment
Pregnancy	Levonorgestrel 1.5 mg orally, or other emergency contraception Reason: Survivor presents within 5 days
Chlamydia	Azithromycin 1g orally **or** Doxycycline 100 mg twice daily for 7 days (note this is contraindicated in pregnancy)
Syphilis	Azithromycin 1 g orally (note this will also cover against chlamydia and is safe if any allergies to penicillin) **or** Benzathine penicillin 240 million international units intramuscularly
Gonorrhea	According to local STI protocol Preferably stat oral dose (e.g., cefixime 400 mg stat)
Trichomonas	Metronidazole 2 g orally
Other STIs according to your setting	Azithromycin (1 g) also gives good coverage for chancroid Syndromic treatment for STIs is indicated. The survivor was presumably exposed to STIs.
HIV/AIDS	Tenofovir (TDF) + lamivudine (3TC) or tenofovir (TDF) + emtricitabine (FTC) **plus** dolutegravir* or atazanavir /ritonavir (ATV/r) or lopinavir/ritonavir (LPV/r) *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 for PEP. Once per day for 28 days. PEP is indicated because she presents within 72 hours and has an exposure risk to HIV.
Wound care if necessary	Clean and dress wounds Tetanus vaccination

Case Study 2:
A girl, 13, was brutally raped vaginally by five soldiers four days ago. Her mother is very concerned about HIV and wants all possible treatment. On examination, you note multiple bruises on her breasts, healing lacerations around the introitus, and anal tears. When she takes off her skirt, you see that she has wet herself.

Treatment offered to the girl should include:

To prevent/manage	Give treatment
Pain	Paracetamol 500 mg
Pregnancy	Levonorgestrel 1.5 mg orally, or other emergency contraception Discussion: She presents within 5 days of the incident. This girl is old enough to have periods, so she is at risk of pregnancy. Note that it is mentioned that she has breasts. A prepubertal girl can ovulate even before having her first menstrual period.
Chlamydia	Azithromycin 1 g stat **or** Erythromycin 500 mg, 4 times daily for 7 days
Syphilis	Azithromycin 1 g orally (note this will also cover against chlamydia and is safe if any allergies to penicillin) **or** Benzathine penicillin 240 million international units
Gonorrhoea	According to local STI protocol. Preferably oral dose.
Trichomonas	Metronidazole 2g stat
Other STIs according to your setting	Azithromycin (1g) also gives good coverage for chancroid We treat for all relevant STIs, as the survivor is presumed to have been exposed to STIs. Note, she is under 26 and therefore may also be a strong candidate for HPV vaccine, if available.
HIV/AIDS	Most experts agree that it is too late for PEP since she presents after 72 hours.
Complications of fistula	**DO NOT DO PELVIC SPECULUM EXAMINATION** Urgent referral to gynecology
Wound care	Clean and dress wounds Tetanus vaccination

Case Study 3:
A 5-year-old boy comes to the clinic 70 hours after being sexually assaulted. His mother states she wants all available treatment. She states he has no allergies that she knows of.

Therefore, the treatment offered to the boy should include:

To prevent/manage	Give treatment
Pain	Paracetamol 250 mg It may be necessary to prescribe paracetamol for the pain in order to do the examination
STIs	He has presumably been exposed to STIs and this can lead chlamydia, gonorrhea, or syphilis of the rectum
Chlamydia	Azithromycin 20 mg/kg orally **or** Doxycycline 50 mg/kg orally (up to a maximum of 2 g) divided into 4 doses, for 7 days
Syphilis	Nothing if azithromycin given **or** Benzathine penicillin 50 000 international units/kg intramuscularly (IM) (up to a maximum of 2.4 million international units) **or** Erythromycin 50 mg/kg of body weight daily orally (up to a maximum of 2 g) divided into 4 doses for 14 days
Gonorrhea	According to local protocol if greater than 45 kg (unlikely since he is 5 years old). If less than 45 kg, give ceftriaxone 125 mg IM single dose, or spectinomycin 40 mg/kg IM, or cefixine 8 mg/kg of body weight. An oral dose may be preferable to a child over an IM route.
Trichomonas	According to local protocol. Preventive treatment is typically offered for all STIs except for trichomonas vaginalis. Although men can harbor and theoretically transmit trichomonas vaginalis during anal sex, it is unlikely that this would happen.
Other STIs according to your setting	Azithromycin (20 mg/kg) also gives good coverage for chancroid.
HIV/AIDS	The boy presents within 72 hours and there is a risk of HIV exposure (anal abuse in a boy is likely) Example: Zidovudine (AZT) / Lamivudine (3TC), fixed dose combination twice per day **plus** Dolutegravir* is recommended as the third medication for HIV PEP. Dolutegravir 50 mg can be used once daily from 20 kg **or** lopinavir /ritonavir (LPV/r) 100 mg/25 mg – 2 tablets twice per day. * When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options for PEP.
Wound care if necessary	Clean and dress

Case Study 4:
A woman, 42, states she was severely beaten and sexually abused by a soldier 2 days ago. The perpetrator was unable to achieve sufficient erection for vaginal penetration. The survivor was forced to perform oral sex on the perpetrator who neither achieved erection nor ejaculated. On examination, there are multiple bruises around her face, legs, and abdomen. There is a laceration on her forehead and abrasions on her elbows. She is very emotional and very concerned about HIV. She wants all possible treatment.

The treatment offered the woman should include:

To prevent/manage	Give treatment
Pregnancy	Not indicated
STIs	Has presumably been exposed to STIs, which can lead to chlamydia, gonorrhea, or syphilis of the throat. Azithromycin (1g) gives good coverage for chlamydia, chancroid, and incubating syphilis. There is no need to treat for trichomonas vaginalis. Although men can harbor and theoretically transmit trichomonas vaginalis during oral sex, the odds of this happening are very low.
Chlamydia	Azithromycin 1 g stat **or** Doxycycline 100 mg twice daily for 7 days
Syphilis	Nothing if given azithromycin Benzathine penicillin 240 million international units
Gonorrhea	According to local STI protocol. Preferably stat oral dose. For example, cefixime 400 mg stat.
HIV/AIDS	Most experts agree that there is no obvious exposure to HIV in this story. There was no ejaculation (no semen), no erection, and no pre-seminal fluid. HIV exposure in the mouth in the presence of semen is highly unlikely to lead to transmission. However, a case can be made for providing PEP if there is trauma or gingivitis in the survivor's mouth, which can be an entry point for HIV. The combination of an entry point and a perpetrator with a presumed symptomatic STI (for example, with urethral discharge or penile ulcer), is a potential exposure to HIV and an indication for PEP. There is an activity later in this unit that focuses on counseling regarding PEP. Encourage participants to hold off on discussion on counseling until the following unit.
Wound infection	Clean and dress wounds Tetanus vaccination

FACILITATOR PRESENTATION AND GROUP DISCUSSION

After **discussing** treatment decisions, **continue** the presentation around related counseling for survivors. **Show** slides 132-138 and **discuss** using notes and activities.

GROUP ACTIVITY: COUNSELING ROLE PLAYS

Divide participants into groups of three or four and **assign** each group one of the case studies from the last activity. **Provide** them with the new information for each case study. Each group should **develop** a role play scenario to demonstrate the appropriate related counseling for the survivor for 30 minutes. Have each group **present** to the larger group with one participant **acting** as the survivor and two participants **providing** related counseling together. The groups should present in numerical order of the case studies. **Give** each group five minutes to **present** with a five-minute discussion following each presentation. It is important to keep to time in this exercise. **Remind** participants to **demonstrate** principles of first-line response and supportive communication throughout their interactions with survivors.

CASE STUDIES: COUNSELING ANSWER KEY

Case Study 1:

New information: After you have counseled her on emergency contraception, the woman tells you that she is not as sure about the date of her last normal period as she indicated in her medical history. You do a pregnancy test and it is positive. What additional counseling does she need?

Note: This case study highlights the importance of understanding that a rape puts a pre-existing pregnancy at risk. Instruct this group to focus its five-minute presentation on counseling on PEP and the positive pregnancy test.

The counseling offered to the woman should include:

Treatment	Counseling
Emergency contraception	Explain treatment (not abortion) Explain side effects (nausea, normal period irregularities) Does not prevent future pregnancy (use condoms and other preferred methods of contraception, or desire for pregnancy) Explain failure rate, next menses, when to return
STIs	Medication administration and side effects Return if STI symptoms despite treatment
PEP	Medication administration and side effects Adherence counseling Recommend VCT Advise the use of condoms for 6 months
Mental health	Explain that it is common to experience negative emotions or numbness. Encourage her to continue to get support from her family and friends. Offer referral to psychosocial support, if desired by the survivor.
Follow-up	Agree on the date and time of the next visit Return at any time with physical or increasing emotional symptoms Offer referral to social and/or legal support Discuss whether she would like to report to the police
Positive pregnancy test	This pregnancy is not the result of the sexual assault. A pregnancy test becomes positive approximately two weeks after conception. If she has already taken emergency contraception, then it will not cause a miscarriage or harm the baby. This pregnancy is at increased risk for infection or miscarriage. Discuss the risks and the danger signs. Refer her to antenatal care.* *Depending on her gestational age and the legal content of the setting, she may be eligible to receive safe abortion care, if desired. If so, comprehensive pregnancy options counseling should be provided.

Case Study 2:

New information: The girl returns to the clinic two weeks later for follow-up. She has a positive pregnancy test. What counseling does she need now?

Note: This counseling case study highlights the need for providing comprehensive information on all options available to the survivor after a rape that results in a pregnancy. Instruct this group to focus its five-minute counseling presentation on emergency contraception and the subsequent pregnancy.

Counseling offered to the girl should include:

Treatment	Counseling
Pain medication	Medication administration and side effects
Emergency contraception	**At first visit**: Explain treatment (not abortion) Explain side effects (nausea) Explain risk of pregnancy, failure rate, next menses, when to return for second pregnancy test **At follow-up**: Counsel survivor on all options available in the setting, including safe abortion care to the full extent of the law, and support her to make an informed decision. Refer to appropriate services. Discuss the risk of unsafe abortions
STIs	Medication administration and side effects Symptoms of STI Return if any symptoms of STIs despite treatment
PEP	It is unfortunately too late to take PEP Risk of transmission Recommend testing now and in three months' time because there is a high risk of exposure
Complications of fistula	Explanation of risk of fistula, the need for referral for further examination, and treatment if needed.
Wound care	Clean and dress wounds Tetanus vaccination
Mental health	Referral to psychosocial services
Follow-up	Discuss referral to protection/police. In most countries there is mandatory reporting of sexual abuse in minors. Inform the mother and the girl at the start of the appointment that you have to report to the police. It is important to keep the best of interest of the girl at the heart of your decision-making. Agree on date and time of next visit.

Case Study 3:

New information: You have finished your examination and are making a treatment plan for the child. The mother tells you that the perpetrator of the rape is their adult male neighbor who is a police officer.

Note: Instruct this group to focus its five-minute counseling presentation on mandatory reporting of sexual assault in children.

Counseling offered to the boy's mother should include:

Treatment	Counseling
Pain medication	Reason for medication administration and side effects
STIs	Risk of STIs Medication administration and side effects Return to clinic with symptoms of STI
PEP	Recommend HIV testing and counseling Importance of taking all drugs for 28 days, side effects, and how to manage them
Wound care if necessary	When to return or to seek emergency care
Mental health	Referral to psychosocial support
Other	Risk of repeated abuse. In most countries, there is mandatory reporting of sexual abuse in minors. In this case, inform the mother at the start of the appointment that you may have to report to the police. Keep the best interest of the boy at the heart of your decisions. If he is a refugee, then refer to UNHCR for protection.
Follow-up	Agree on date and time of next visit.

Case Study 4:

New information: During your counseling, you explain that the risk of HIV transmission in this situation is very low and PEP is not indicated. The patient becomes increasingly distressed as you discuss the low risk of HIV transmission. She is unable to sit still to speak with you or have a discussion. She is pacing the room, shaking, and crying. She says she wants to go home and get back to her family. Her son is waiting in the waiting room. It is getting late and it is not possible to get a referral for psychological support before tomorrow.

Note: Instruct this group to focus its five-minute counseling presentation on how to approach voluntary testing and counseling for HIV and mental health.

Counseling offered should include:

Treatment	Counseling
Emergency contraception	Why emergency contraception is not indicated
STI Prophylaxis	Indicated because the throat is vulnerable to STIs Instructions on how to take all medications Information on side effects of medications Symptoms of STIs and when to return
PEP	PEP is not indicated. Explain the extremely low chance of transmission. Recommend VCT. PEP may be started at patient insistence if resources allow.
Wound care/Infection	Medication information and side effects When to seek emergency care
Mental health	**Remember first-line response (LIVES).** Do **not** routinely prescribe benzodiazepines for insomnia. Do **not** prescribe benzodiazepines or antidepressants for acute distress. Referral for higher-level mental health support if symptoms are disabling and do not disappear over time. Agree on follow-up visit date and time.

UNIT 6 ENHANCING SAFETY AND REFERRALS, MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT, FOLLOW-UP CARE

Time:
120 minutes (2 hours)

Unit Objectives:

By the end of this unit, participants will be able to:

- Describe how to assess for immediate safety risks and develop a safety plan with a survivor.
- Identify key types of referral service needs for survivors.
- Explore the survivor experience of a referral through an interactive, empathy-building activity.
- Discuss strategies to counsel survivors around mental health and psychosocial support.
- Discuss patient follow-up care guidelines and timing.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 45 minutes: Facilitator Presentation and Group Discussion
- 45 minutes: Group Activity: Referrals
- 30 minutes: Facilitator Presentation and Group Discussion

PREPARATION

- Print, download, and gather materials as listed below
- Write out name tag stickers for: Survivor, Mother, Community Leader, Traditional Birth Attendant, Midwife, Doctor, Community Services Worker, UNHCR Community Services Officer, UNHCR Protection Officer, Police, Lawyer, Prosecutor, and Social Worker. For larger groups, you can also include Judge and Journalist
- Research referral mechanisms for psychological counselling, psychiatric care, or psychosocial support in the context and/or invite the GBV coordinator to facilitate the presentations for this unit and Unit 7

PRINT:
Participant Workbook:
- ☐ *Follow-up Visit Schedule*

DOWNLOAD:
Presentation:
- ☐ Slides 140 through 167

GATHER:
- ☐ Projector and computer with sound
- ☐ Ball of string or twine
- ☐ Name tag stickers

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Start the Unit with a presentation on LIVES Part 2 (enhancing safety and referring for support). **Show** slides 140-154 and **discuss** using notes and activities in the presentation. Pause to **move on** to the *Referral Group Activity*.

GROUP ACTIVITY: REFERRALS

The objective of this activity is to show a survivor's experience of referral and the need for collaboration among different humanitarian actors for clear protocols. **Let** the activity speak for itself, unfolding before participants' eyes. **Do not** describe it or explain its purposes before completing the activity.

Ask for volunteers and distribute the name tags to the appropriate number of people. **Tell** them that they will be in the role of the person noted on their name tag.

Seat the volunteers in a circle, chairs fairly close together. **Ask** the remaining participants to stand outside the circle so that they can easily see the activity. Alternatively, **ask** the volunteers to stand in a circle.

Explain that the ball of yarn represents the process experienced by a 20-year-old woman who was raped.

Standing outside the circle, **give** the ball to Mother and **explain** that the woman told her mother about the incident.

Instruct Mother to hold the end of the string firmly, do not let go, and **toss** the ball to the person you tell her.

Tell the story below of what happens to this woman. Each time an Actor is involved, the ball of string is tossed across the circle to that Actor. Each Actor who receives the ball will wrap it around a finger and then toss the ball to the next Actor, as instructed.

STORY

A 20-year-old woman was raped and tells her mother.

- Mother takes her daughter to the Community Leader
- The Community Leader refers her to the TBA
- The TBA helps, but the Survivor needs more health interventions and TBA refers her to the Midwife
- The Midwife calls in the Doctor
- The Doctor administers treatment and sends the survivor back to the Midwife
- The Midwife refers her to the Community Services Worker
- The Community Services Worker provides emotional support and contacts the UNHCR Community Services Officer for assistance
- The UNHCR Community Services Officer speaks with the Survivor and discovers she wants to involve the Police, then refers her to the UNHCR Protection Officer
- The UNHCR Protection Officer meets the Survivor, takes her back to the Doctor for a few more questions
- The Doctor sends her back to the UNHCR Protection Officer
- The UNHCR Protection Officer refers her to the Police
- The Police contact the Doctor
- The Doctor contacts her Mother
- The Mother takes her daughter to a UNHCR Protection Officer
- The UNHCR Protection Officer refers her to a Lawyer
- The Lawyer contacts the Police
- The Police contact a Prosecutor to speak with the Survivor
- The Prosecutor discusses with the Lawyer
- The Lawyer discusses with the Prosecutor
- The Prosecutor calls the Doctor about the Survivor to get information about the medical exam; the Doctor forgot to examine something and asks to see the Survivor again
- The Doctor refers her to a Social Worker
- The Social Worker then contacts the Police to provide new information
- The Police contact the UNHCR Protection Officer to report the incident
- The UNHCR Protection Officer contacts the Mother to ask questions
- The Mother asks her daughter, the Survivor, additional questions
- The Survivor goes to talk with the Community Leader because she is confused about the process
- A Journalist has heard of the case and is at the Community Leader's house, and wants to speak with the Survivor (Optional)
- The Survivor speaks with the Journalist and with the Community Leader (Optional)

- The Community Leader contacts the Prosecutor and the Judge to find out the status of the case
- The Prosecutor and the Judge refer the Community Leader to the Police
- The Police refer the Community Leader to the UNHCR Protection Officer

Stop the game when every actor has taken part in at least two communication exchanges regarding the case. There will be a large web in the center of the circle, with each actor holding parts of the string.

Pause to **look** at the web. **Ask** some questions to generate discussion:

- What do you see in the middle of this circle?
- Was this helpful for the survivor? Traumatic?
- Might a situation like this happen in your setting?
- What could have been done to avoid making this web of string?
- To observers: How many times did the woman have to repeat her story?
- To actors: How many times did you speak with the survivor or with others about her? Do you remember the details?

Actors should **let go** of the string and let it drop to the floor. Leave the stringy chaotic mass sitting on the floor for all to see.

Explain that in the next unit we will take a closer look at standard operating procedures (SOPs), which help define referral pathways and partner agency roles and coordination. **Debrief**, making sure to highlight the following points:

- The sexual violence survivor must navigate a complex system with many contacts or resources that are not well established or coordinated. A confusing system may discourage survivors from seeking care. Options to set up a clear response system include having someone act as a case manager for the survivor and provide support with navigating the system or setting up a "one-stop shop" where all relevant response actors (police, social worker, legal advisor, etc.) are available to support the survivor, as needed.
- Referrals should be clearly defined to prevent unnecessary "back and forth" with the survivor, which may delay medical attention and worsen her or his situation (as shown in the string activity).
- Include affected community members in the creation of the SOPs (which will be further discussed shortly), so that they are aware of the response mechanisms in place. The community can be involved in peer-to-peer awareness on human rights, especially women's rights; establishing committees; facilitating support groups for survivors; and engaging women's and other groups (LGBTQIA, adolescents, persons living with disabilities, and others) in the identification of and support for survivors. Survivors of sexual violence should know where they can go to receive necessary attention, assistance, support, and care.

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Resume the presentation. **Show** slides 156-167 and **discuss** using notes and activities in the presentation on the topics of assessing mental health and psychosocial support and guidelines for follow-up care.

Note: The facilitator needs to know referral mechanisms for psychological counseling, psychiatric care, or psychosocial support in the context. Consider inviting the local GBV coordinator to facilitate or assist with facilitating this unit (about referrals) and the next unit, which is specific to standard operating procedures (SOPs).

UNIT 7 STANDARD OPERATING PROCEDURES (SOPs)

Time:
30 minutes

Unit Objectives:

By the end of this unit, participants will be able to:

- Describe the health care provider's role in the implementation of SOPs.
- Discuss how SOPs can improve access to care.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 30 minutes: Facilitator Presentation and Group Discussion

PREPARATION

- Print, download, and gather materials as listed below
- Find out if standard operating procedures (SOPs) are already in place. Print copies of the site SOPs and adapt the presentation to match. If no SOPs exist, then go through this presentation and brainstorm on how to initiate discussions on the process with the GBV coordinator

PRINT:
- ☐ *Example of an SOP*

DOWNLOAD:
Presentation:
- ☐ Slides 168-175

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

This unit builds on the introduction to referrals from Unit 6, to guide participants in understanding the health care provider's role in the implementation of SOPs and how SOPs can improve access to care.

Note: Find out if SOPs are already in place and adapt the presentation based on the SOPs. If no SOPs exist, then go through this presentation and brainstorm on how to initiate discussions on the process with the GBV coordinator. If SOPs are in place in the setting, remind the participants that they should be aware of the referral pathways.

Note: Consider inviting the local GBV Coordinator to facilitate or assist with facilitating this unit.

Show slides 168-175 and discuss using notes and activities in the presentation.

Pause on slide 171: *Standard Operating Procedures (SOPs)* to review and **discuss** the example of an SOP with participants. **Explain** that standard operating procedures are an agreement among agencies outlining roles and responsibilities to prevent and respond to sexual violence. Because of the importance of multi-sectoral collaboration in GBV programming, SRH Coordinators and health program managers must actively participate in a process to clarify roles and responsibilities and collaboration within and among sectors to prevent and respond to GBV. The outcome of this process is sometimes referred to as standard operating procedures (SOPs) for GBV. Developing agreed-upon SOPs must be a collaborative process that occurs through a series of consultations with key stakeholders and actors in the setting.

UNIT 8 MONITORING AND EVALUATION FOR HEALTH CARE PROVIDERS

Time:
60 minutes (1 hour)

Unit Objectives:

By the end of this unit, participants will be able to:

- Explain the role of the health care provider in monitoring and evaluation.
- Explain the role of the health care provider in stock management.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 45 minutes: Facilitator Presentation and Group Discussion
- 15 minutes: Video and Discussion

PREPARATION

- Print, download, and gather materials as listed below

PRINT:
Participant Workbook:
- ☐ *Sample History and Examination Form* (See Unit 5)
- ☐ *Audit Tool*
- ☐ *Sample Health Facility Checklist*

DOWNLOAD:
Video:
- ☐ *Reproductive Health Kits Shelving*, 5:37 minutes.

Presentation:
- ☐ Slides 176 through 197

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

This unit includes a slide presentation related to monitoring and evaluation activities. **Show** slides 176-189 and **discuss** using notes and activities in the presentation.

Pause on slide 190: *Discussion* and **ask** participants:

- Do you currently collect any of this data in your clinical setting?
- Does the Ministry of Health (MoH) have a set of indicators that they use? The MoH may use a set of indicators that is different than the indicators of the agency managing the clinic. It is important to respect the confidentiality and safety of data if there are parallel systems in place. For example, if data is being collected for two different agencies, then is that data still collected in a way that protects the identity of the survivor?

Show and **discuss** slides 191-193, which are examples of tools that are used in the project cycle approach. These include the *Audit Tool* and *Health Facility Checklist* in the *Participant Workbook*.

Conclude the presentation by **summarizing** the key points on slides 194-195.

VIDEO AND DISCUSSION

Show the UNFPA video clip *Reproductive Health Kits Shelving* on the management of supplies within a clinic. The key point of the video is that supplies must be stored and tracked in an organized way. **Ask**: What is the role of the health care provider in addressing the management of supplies? **Facilitate** a discussion for 5 to 10 minutes on the topic.

Conclude the unit with slide 197: *Medical Supplies Management*. **Ask** participants for information about the set-up of supplies in their own workplace. **Highlight** key points as noted on the slide.

UNIT 9

ASSESSING AND STRENGTHENING CLINICAL SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE

Time:
120 minutes (2 hours)

Unit Objectives:

By the end of this unit, participants will be able to:

- Discuss key requirements of delivering quality clinical care for survivors of sexual violence and intimate partner violence.
- Develop a list of initial actions to strengthen clinical services for survivors.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 60 minutes: Group Work
- 60 minutes: Group Presentations and Discussion

PREPARATION

- Print, download, and gather materials as listed below

PRINT:
Participant Workbook:
- ☐ *Assessing and Strengthening Clinical Services: Group Work Guidance and Tools*
- ☐ *WHO Checklist for Providing Quality Clinical Care* (See Unit 8)
- ☐ *Action Plan*

DOWNLOAD:
Presentation:
- ☐ Slides 198 through 201

GATHER:
- ☐ Projector and computer with sound

DETAILED SESSION GUIDE

GROUP WORK

Explain that in this session, participants will discuss key requirements of delivering quality clinical care for survivors of rape and intimate partner violence and develop a list of initial actions to strengthen clinical services for survivors.

Divide participants into groups, ideally based on the clinical site in which they work. If more than five participants are from one clinical site, create more groups. **Refer** participants to the *Assessing and Strengthening Clinical Services—Group Work Guidance and Tools*, *WHO Checklist for Providing Quality Clinical Care*, and *Action Plan* resources. Review the instructions for small group work together.

Ask participants to use the *Action Plan* handout to capture their thinking around any gaps/challenges identified, action item needed, person(s) responsible, support needed, and deadlines for completion. Participants should focus first on the gaps and interventions that are easy to achieve (the "low hanging fruit") early results and create momentum for change.

GROUP PRESENTATIONS AND DISCUSSION

After 60 minutes, **take** a 15-minute break. After the break, **bring the group back together**. Each group should be given an opportunity to **present** its discussion to the broader audience. **Guide** the discussion toward practical solutions and ongoing identification of ways to improve clinical care.

Ask the participants to present on the following questions:

- What elements of clinical care for sexual violence survivors are currently in place?
- What are your facility's greatest strengths in providing post-assault care services? What are you most proud of?
- What elements can be improved? Where are the current gaps/resources needed? What are the key next steps for action?

UNIT 10 CARE FOR THE CAREGIVERS, EVALUATION, AND CLOSING

Time:
60 minutes (1 hour)

Unit Objectives:

By the end of this unit, participants will be able to:

- Discuss strategies to identify and prevent burnout.
- Reflect on the training in relation to meeting participant expectations and course objectives.

UNIT OVERVIEW

TIMING AND METHODOLOGY

- 25 minutes: Facilitator Presentation and Group Discussion
- 10 minutes: Course Evaluation
- 15 minutes: Knowledge Assessment
- 10 minutes: Closing Ceremony

PREPARATION

- Print, download, and gather materials as listed below
- Fill out participants' names on certificates of completion

PRINT:
- ☐ *Course Evaluation*
- ☐ *Post-Test*
- ☐ *Certificates of Completion*

DOWNLOAD:
Presentation:
- ☐ Slides 202 through 209

GATHER:
- ☐ Projector and computer with sound
- ☐ Flip chart papers

DETAILED SESSION GUIDE

FACILITATOR PRESENTATION AND GROUP DISCUSSION

Begin this final Unit by **reminding** participants that their needs as providers are as important as those of the survivors they are caring for. Health workers can develop stress-related conditions, such as burnout, compassion fatigue, or vicarious trauma. If you are working with survivors, be aware of these risks and take action to maintain your well-being in the face of work-related stress.

Showing slide 204: *Care for Caregivers: Activity*, **instruct** participants to break into pairs. **Discuss** a difficult experience they encountered during their work as providers. What was it that made this experience particularly challenging? After 10 minutes, bring the participants back to plenary and **invite** participants to share their own responses, if they feel comfortable.

Before advancing to the next slide, **ask** participants:

- What is burnout?
- Have you ever felt 'burnt out' or worked with someone else who was 'burnt out'?
- How did you know? How was this different from 'just a bad day'? How did you feel in your body?
- How did your/your colleague's behavior change?

After a few volunteers share their ideas, **advance** to the animation and explain the bullets on slide 205. **Move** through the remainder of the presentation.

End the training by first reviewing the course objectives and revisiting the participant expectations. Ensure that all expectations have been addressed.

COURSE EVALUATION

Thank participants for their attention and their participation in the short course. **Distribute** *Course Evaluation Form*. **Ask** participants to take 10 minutes to complete the *Course Evaluation* and **provide** feedback on which areas of the training went well and which areas could be improved. **Remind** participants that their input is critical in improving the course.

KNOWLEDGE ASSESSMENT

Distribute and ask participants to complete the knowledge *Post-test*, which covers content from the entire course. **Ask** participants to take 15 minutes to complete the test. Participants should use the same number they selected at the beginning of the training instead of writing their names.

CLOSING CEREMONY

Present each participant with their prepared *Certificate of Completion* and congratulate them.

ANNEX 1: SAMPLE COURSE AGENDA

This is an example of an agenda for the refresher training on clinical management of sexual violence survivors. Facilitators may need to adjust some content and the time allowed based on the setting and the experience level of the participants. There is an adaptable soft copy of the *Course Agenda* available in the training materials.

Unit	Timing	Session Title	Objectives (At the end of the unit, participants will be able to:)	Methodology
DAY 1				
	8:00-8:30	Registration of Participants		
Introduction				
1	8:30-9:15	Welcome and Introduction • Icebreaker • Expectations and ground rules • Pre-test	• Reflect on their expectations of the training • Agree on the ground rules of the training	• Discussion
2	9:15-10:15	Core Concepts: Presentation • Sexual Violence: Barriers to care and support • Core concepts of gender-based violence (GBV)	• Explain the link between gender-based violence (GBV) and violations of human rights • Define GBV • Describe the guiding principles when working with sexual violence survivors	• Video • Presentation
10.15-10.30 (15 min) Break				
2	10:30- 12:00	Core Concepts: In Her Shoes	• Increase awareness of and empathy for the difficulties survivors who experience violence face when seeking support	• Participatory Activity
2	12:00-1:00	Core Concepts: Blanketed by Blame	• Highlight how social norms can affect survivors' abilities to seek help and access care, including special populations (LGBTQIA, adolescents, persons living with disabilities, sex workers, and religious or ethnicity minorities) • Encourage participants to consider what they can do as providers to provide an empathetic response to survivors of violence	• Participatory Activity
13.00-14.00 (60 min) Lunch				
2	2:00-3:00	• Core Concepts: Vote With Your Feet	• Critically reflect on participants' own perceptions and beliefs that may affect the quality of care survivors receive, including members of vulnerable populations.	• Participatory Activity

Unit	Timing	Session Title	Objectives (At the end of the unit, participants will be able to:)	Methodology
Clinical management of survivors of sexual violence				
3	3:00-4:00	• Preparing the Clinical Site, Identifying Survivors, Offering First-Line Support (Step 1)	• Describe the elements that must be in place in the health system for providing clinical services to survivors • Discuss common signs and symptoms of sexual violence and intimate partner violence • Summarize the basic principles of supportive communication and first line response (LIVES) for survivors	• Presentation • Demonstration
DAY 2				
	8:30-8:45	Recap of Day 1		
4	8:45-11:15	Informed Consent, Medical History, and Physical Examination (Steps 2-4)	• Summarize key elements of informed consent • Describe how to conduct and collect a comprehensive patient history pertaining to sexual violence, and document findings appropriately • Explain components of a physical examination of survivors of sexual violence, including internal and external genital examination • Describe principles of collecting forensic evidence during the physical examination • Discuss the purpose and composition of a medical certificate	• Presentation • Group Activity
11.15-11.30 (15 min) Break				
5	11:30-12:30	Providing treatment and related counseling (Step 5)	• Provide appropriate treatment for adult and children survivors of sexual violence, including: · Emergency contraception · Pregnancy testing, pregnancy options information, and safe abortion care/referral to the full extent of the law · Presumptive treatment of sexually transmitted infections (STIs) · Post-exposure prophylaxis (PEP) to prevent HIV transmission · Prevention of hepatitis B and HPV · Care of wounds and prevention of tetanus	• Activity • Presentation
12.30-13.30 (60 min) Lunch				
5	1:30-2:45	Providing treatment and related counseling (Step 5) *continued*	• Provide appropriate treatment for adult and children survivors of sexual violence, including: · Emergency contraception · Pregnancy testing, pregnancy options information, and safe abortion care/referral to the full extent of the law · Presumptive treatment of STIs · PEP to prevent HIV transmission · Prevention of hepatitis B and HPV · Care of wounds and prevention of tetanus	• Group Activity • Presentation
5	2:45-4:00	Providing treatment and related counseling (Step 5) *continued*	• Demonstrate supportive, accurate counseling to survivors	• Group Activity

Unit	Timing	Session Title	Objectives (At the end of the unit, participants will be able to:)	Methodology
DAY 3				
	8:30-8:45	Recap Day 2		
6	8:45-10:45	Enhancing Safety and Referrals, Mental Health and Psychosocial Support, Follow Up Care (Steps 6-8)	• Describe how to assess for immediate safety risks and develop a safety plan with a survivor • Identify key types of referral service needs for survivors • Explore the survivor experience of a referral through an interactive, empathy-building activity • Discuss strategies to counsel survivors around mental health and psychosocial support • Discuss patient follow-up care guidelines and timing.	• Presentation • Group Activity
10.45-11.00 (15 min) Break				
7	11:00-11:30	Standard Operating Procedures (SOPs)	• Describe the health care provider's role in the implementation of SOPs • Discuss how SOPs can improve access to care	• Presentation
8	11:30-12:30	Monitoring & Evaluation	• Explain the role of the health care provider in monitoring and evaluation • Explain the role of the health care provider in stock management	• Presentation • Video
12.30-13.30 (60 min) Lunch				
9	1:30-3:30	Assessing and Strengthening Clinical Services for Survivors of Sexual Violence	• Discuss key requirements of delivering quality clinical care for survivors of sexual violence and intimate partner violence • Develop a list of initial actions to strengthen clinical services for survivors	• Group work
Closing				
10	3:30-4:30	Care for The Caregivers, Evaluation and Closing • Certificate of Completion • Post-Test • Training Evaluation	• Discuss strategies to identify and prevent burnout • Reflect on the training in relation to meeting participant expectations and course objectives	• Presentation • Discussion

ANNEX 2: PARTICIPANT PRE- AND POST-TEST ANSWER KEY

1. Which of the following are forms of gender-based violence? Select all that apply.
   - **a. Any unwanted sexual comments**
   - **b. Forced penetration of the anus with the penis or foreign object**
   - **c. Forced marriage**
   - **d. Female genital cutting**
   - **e. Honor killing**

2. Is it possible for a sexual violence survivor to have no visible injuries?
   - **a. Yes**
   - b. No

3. The health care provider should communicate with the survivor by:
   - **a. Asking open-ended questions and empathizing with them**
   - b. Giving them a short lecture about human rights
   - c. Probing about the perpetrator who is known to the provider
   - d. Listing the negative consequences of sexual violence

4. If a husband has sex with his wife when she does not want to, that is:
   - a. His right, since they are married
   - b. Not the concern of a medical professional
   - c. Only illegal if she is a minor
   - **d. Considered sexual violence**

5. A sexual violence survivor's medical and health information can be discussed without consent with: (Select all that apply.)
   - a. The survivor's family members
   - b. A police officer who requests the medical certificate
   - c. A legal advisor
   - d. A psychologist
   - **e. No one**

6. What should be done in the preliminary assessment of a patient presenting after a sexual assault? Select all that apply.
   - **a. Assess for medical stability**
   - **b. Assess whether or not needed treatment can be given at your facility or referral is needed**
   - c. Decide whether or not the patient has been sexually assaulted
   - **d. Give first-line response (LIVES)**

7. What is the purpose of informed consent?
   - a. To provide the sexual violence survivor with an explanation of all examination and treatment procedures
   - b. To ensure the sexual violence survivor understands all examination and treatment procedures
   - c. To give the sexual violence survivor a choice of which examination and treatment procedures to receive
   - **d. All of the above**

8. What should you do if a sexual violence survivor refuses to give consent for the examination?
   - **a. Explain the purpose and procedures of the examination and treatment in detail, and accept the patient's decision**
   - b. Explain that without the exam, no one will believe him/her
   - c. Proceed with the exam and treatment, since it is within the best interest of the patient
   - d. Ask the survivor to bring a family member so that you can explain it to the family member instead

9. While you are talking to the survivor, he becomes teary-eyed and quiet. What is the best response? Select all that apply.
   - a. Avoid eye contact and quickly move on to another question
   - **b. Ask the patient if he needs to take a break**
   - c. Reassure the patient by saying, "I know how you feel"
   - d. Encourage him to respond by telling him you have another patient waiting

10. During the safety assessment, a client discloses that her partner choked her, threatened to kill her, and follows her every move. Which is the appropriate action?
    a. Counsel the client to try not to provoke her partner in order to maintain her safety
    b. Provide first line support, offer referrals to shelter or safe housing, or work with her to identify a safe plan she can go to (such as a friend's home or place of worship)
    c. Take no further action, since the client responded yes to fewer than three safety assessment questions and is not in immediate danger

11. The purpose of a physical examination of a sexual violence survivor is to: (Select all that apply.)
    a. Determine virginity
    b. Determine conclusively whether or not a sexual assault occurred
    c. Assess and document injuries

12. When performing a physical examination of a sexual violence survivor, I should: (Select all that apply.)
    a. Avoid explaining what I am doing so as not to frighten the patient
    b. Encourage the patient to ask questions if she or he wants
    c. Ask for the patient's permission before touching her or him
    d. Stop the examination at any time the patient says so

13. Vaginal speculum exam is indicated for:
    a. All women sexual violence survivors
    b. Forensic evidence collection in pre-pubertal girls
    c. If a woman reports vaginal penetration and shows signs of unusual bleeding

14. Examination findings which may indicate a need for referral to a higher level of surgical care include:
    a. Foreign body embedded in the vaginal wall
    b. Heavy bleeding from the rectum
    c. Loss of control over urine or feces
    d. All of the above

15. To prevent unwanted pregnancy, emergency contraception must be administered within **120 hours**. (Fill in the blank)

16. HIV post-exposure prophylaxis (PEP) may be indicated for: (Select all that apply.)
    a. Pregnant women and children survivors of sexual violence
    b. Sexual violence survivors presenting within 72 hours of exposure
    c. Sexual violence survivors presenting within 120 hours of exposure
    d. Survivors of penile penetration of the anus within 72 hours of exposure

17. HIV PEP medication must be taken for **28** or 30 days. (Circle the correct answer.)

18. HIV testing is required before starting PEP.
    a. True
    b. False

19. A 16-year-old female presents to your health facility six months after being sexually assaulted. She reports no vaginal discharge, pain, or bleeding. What services should you offer? (Select all that apply.)
    a. Antibiotics to treat chlamydia and gonorrhea
    b. Syphilis screening, if available
    c. Emergency contraception
    d. HIV PEP
    e. Referral for psychological counseling and community support services

20. List four common emotional reactions to sexual assault which a survivor may experience:
    a. **Sadness/depression/anxiety**
    b. **Shame/embarrassment**
    c. **Guilt**
    d. **Fear**
    e. **Isolation**

21. Male survivors of sexual assault may experience an erection or orgasm during an assault and should be reassured that this is a normal reflex they could not control.
    a. True
    b. False

22. Fecal incontinence noted during an exam of a 5-year-old boy survivor may indicate: (Select all that apply.)
    a. Need for a digital rectal exam
    b. Need for higher level surgical care
    c. Rectal sphincter muscle tear
    d. All of the above

23. Emergency contraception is indicated for young female survivors who have not started menstruation but have developed breast buds or other signs of puberty.
    a. True
    b. False

ANNEX 3: REFERENCES AND RECOMMENDED RESOURCES

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