CLINICAL MANAGEMENT OF SEXUAL VIOLENCE SURVIVORS IN CRISIS SETTINGS

PARTICIPANT WORKBOOK

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

ACKNOWLEDGEMENTS

These training materials were developed in 2017 through an ongoing collaboration among the membership of the Inter-Agency Working Group (IAWG) on Reproductive Health in Crises through the efforts of the Training Partnership Initiative. The project was first made possible thanks to generous funding provided by USAID's Office of Foreign Disaster Assistance (OFDA). In 2020, funding from the Netherlands Ministry of Foreign Affairs allowed for this module to be updated to align with the 2018 revised *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*.

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.

The authors are also grateful to UNFPA and UNHCR for their extensive piloting of and technical contributions to the module's content. The authors would also like to thank the International Rescue Committee, Jhpiego, and the Women's Refugee Commission for their support of the project, and to the agencies which offered pilot sites: Family Planning Association of Nepal, Institut Africain de Santé Publique and the Ministry of Health in Burkina Faso, and Juba College of Nursing and Midwifery in South Sudan.

LIST OF ABBREVIATIONS

3TC	Lamuvidine
ARV	Antiretrovirals
ATV	Atazanavir
AZT	Zidovudine
BP	Blood pressure
EC	Emergency contraception
GBV	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 protocols
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

TABLE OF CONTENTS

INTRODUCTION

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

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 crisis 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.

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

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.

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 persons living with disabilities in the communities they serve and in particular the interpretation, mobility, and other accessibility needs of participants in these trainings.

- **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 participants should keep these inclusive considerations of gender, age, disability, and diversity in mind when attending 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 (i.e. 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 characteristics, or the circumstances in which they live, which should not define who they are and how health staff treats 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.

OBJECTIVE

This training includes presentation slides, case studies, and interactive activities. It provides information on the necessary skills and professional behaviors for the provision of survivor-centered medical care, and includes resources for further study. The content is based on most recent guidelines by the World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR), and IAWG, namely the *Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings* (2019) and *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings* (2018). The pre- and post-tests serve as knowledge assessments. The skills checklists and other resources are used to assess participants' performance during role-plays, activities, or in a clinical practicum.

TRAINING OVERVIEW

The *Clinical Management of Sexual Violence Survivors in Crisis Settings* is an introductory or refresher course for health care providers, including midwives, nurses, general practice physicians, obstetricians/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 (IARH) Kit, or similar medical supplies to manage cases of sexual violence are available. Course components include discussion and activities to promote sustainability of services for survivors of sexual violence. The course also provides ways to address ongoing training needs in crisis settings that have high staff turnover. This course is intended for in-person workshops in crisis settings with limited resources.

HOW TO USE THIS WORKBOOK

This workbook is designed to serve as a learning tool during the training session and as a reference guide and job aid for your clinical work post-training. In addition to offering you a centralized location to keep your notes and plans for caring for sexual violence survivors in crisis settings, it also provides contextual information, skills checklists, and recommendations for additional resources. You can access this participant workbook in addition to the presentations, facilitator's guidance, and links to supplemental resources on the IAWG website at www.iawg.net/scorts.

SUPPLEMENTARY MATERIALS FOR THIS TRAINING

In addition to the materials included in this workbook, you may receive the following job aids and materials from your workshop facilitator, or you can download them at any time from the IAWG website at www.iawg.net/scorts.

- → *The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
- → Video: Women's Refugee Commission. *Iraqi Refugees in Jordan: Gender-Based Violence*, 2009, 6:03 minutes.
- → Video: World Health Organization (WHO). *Violence against Women: Strengthening the Health System Response*, 2016, 3:27 minutes.
- → Video: United Nations Population Fund. *Reproductive Health Kits Shelving*, www.unfpa.org/video/reproductive-health-kits-shelving, 2012, 5:38 minutes.

Many of the tools and protocols included in this workbook are adapted from the WHO, UNFPA, and UNHCR open-source *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. The authors recommend closer review of the above resource, with particular attention to the following tools not included in but relevant to this training.

- → Annex 7: Protocols for emergency contraception
- → Annex 8: Protocols for prevention and treatment of sexually transmitted infections
- → Annex 9: Protocols for post-exposure prophylaxis of HIV infection
- → Annex 10: Assessment and Management of Mental Health Conditions

FURTHER READING/RESOURCES:

- Jhpiego, United States Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) (2018). *Gender-based violence quality assurance tool*. Baltimore (MD): Jhpiego
- Inter-Agency Standing Committee, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Promoting resiliency and aiding recovery*. (Geneva. 2015)
- Internal Rescue Committee and UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, first edition. (New York. 2012)
- United National Population Fund, *Manual: Inter-Agency Emergency Reproductive Health Kits for Crisis Situations*, 6th Edition (UNFPA. 2019)
- World Health Organization (WHO). United Nations Population Fund (UNFPA). United Nations High Commissioner for Refugees (UNHCR). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. Geneva: WHO; 2019.
- 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 (November 30, 2017): 103–13. doi.org/10.1080/09688080.2017.1405678.

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

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 WELCOME AND INTRODUCTION

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

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

MY EXPECTATIONS FOR THIS TRAINING

TOPICS I WANT TO REVISIT

LEARNING OBJECTIVES

INTRODUCTION

Unit 1. Welcome

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

Unit 2. Core concepts: Sexual and gender-based violence

- Explain the link between sexual and 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 seeking support
- Highlight how social norms can affect survivors' abilities to seek help and access care, including special populations (LGBTQIA, adolescents, disabled persons, 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 sexual violence
- Critically reflect on participants' own perceptions and beliefs that may affect the quality of care survivors receive, including members of special populations

CLINICAL MANAGEMENT OF RAPE SURVIVORS

Unit 3. Preparing the clinical site, identifying survivors, offering first-line support (LIVES)

- Describe the elements that must be in place in the health system for providing clinical services
- 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 4. Informed consent, collecting a medical history, and conducting a physical examination

- 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 purpose and composition of a medical certificate

Unit 5. Providing treatment and related counseling

- 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 6. Enhancing safety and referrals, mental health & psychosocial supports, follow-up care

- 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

PROGRAMMING FOR CLINICAL MANAGEMENT OF RAPE SURVIVORS

Unit 7. Standard Operating Procedures (SOPs)

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

Unit 8. Monitoring & evaluation for health care providers

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

Unit 9. 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

Unit 10. Care for the caregivers, evaluation, and closing

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

UNIT 2 CORE CONCEPTS: GENDER-BASED VIOLENCE

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 seeking support.
- 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.
- Critically reflect on participants' own perceptions and beliefs that may affect the quality of care survivors receive, including members of special populations.*

NOTES:

* 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.

MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of reproductive health services

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

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

IARH Kit 3 IARH Kit 5 IARH Kit 8 IARH Kit 9

OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE AS SOON AS POSSIBLE. WORK WITH THE HEALTH SECTOR/CLUSTER PARTNERS TO ADDRESS THE SIX HEALTH SYSTEM BUILDING BLOCKS:

- Service Delivery
- Health Workforce
- Health Information System
- Medical Commodities
- Financing
- Governance and Leadership

GOAL

PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

IARH Kit 1 IARH Kit 3 IARH Kit 5 IARH Kit 12 Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary health care facilities to meet demand
- Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

IARH Kit 1 IARH Kit 3 IARH Kit 4

OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
  - At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)
  - At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of life-saving, post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

IARH Kit 2 IARH Kit 6 IARH Kit 8 IARH Kit 9 IARH Kit 10 IARH Kit 11 IARH Kit 12

IARH Kit 8 **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.

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

- Work in respectful partnership with people receiving care, providers, and local and international partners
- Ensure equality by meeting people's varied sexual and reproductive health needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality
- Provide comprehensive, evidence-based, and accessible information and choice about the supplies and services available
- Ensure effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities
- Ensure privacy and confidentiality for everyone and treat people with dignity and respect
- Promote equity, with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g. rural/urban), disability, race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth, or other characteristics
- Recognize and address gender and power dynamics in healthcare facilities to ensure that people do not experience coercion, discrimination, or violence/mistreatment/disrespect/abuse in receiving or providing health services
- Engage and mobilize the community, including often marginalized populations such as adolescents, in community outreach to inform the community about the availability and location of MISP services and commodities
- Monitor services and supplies, and share information and results with the aim of improving quality of care

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEmONC): Primary Health Care Facility Level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmONC): Referral Hospital Level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

**** The new kit structure will only be available late 2019***

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEmONC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level - CEmONC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

- where providers are trained to use the special supply;
- where the supplies were accepted and used prior to the emergency;
- after the rapid first order of SRH supplies in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels); and,
- where the use of the supplies is allowed to the fullest extent of the national law.

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpaprocurement.org

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

Source: Inter-Agency Working Group on Reproductive Health in Crises. "Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)," 2018. iawg.net/resources/misp-reference.

MISP FOR SEXUAL AND REPRODUCTIVE HEALTH: OBJECTIVE 2

The MISP for Sexual and Reproductive Health is part of the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings*, which was revised in 2018. Objective 2 of the MISP is to "Prevent Sexual Violence and Respond to the Needs of Survivors." Activities under this this objective include:

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

FOUNDATIONAL TERMS AND DEFINITIONS[2]

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between women and men. It includes acts that inflict physical, sexual, or mental harm or suffering, threats of such acts, coercion, and other deprivations of liberty. These acts can occur in public or in private.

The term "gender-based violence" (sometimes referred to as "sexual and gender-based violence") highlights the gendered dimension of these types of acts. In other words, this term highlights the relationship between females' subordinate status in society and their increased vulnerability to violence. Women and girls are the most affected by GBV and thus the term "gender-based violence" is often used interchangeably with the term "violence against women." However, violence against men and boys may also be gendered and/or sexual in nature, particularly when they are subjected to torture, detainment, or forced participation as child soldiers. Additionally, the term GBV may also be used to refer to violence targeting lesbian, gay, bisexual, transgender, queer, questioning, intersex, and asexual (LGBTQIA) persons who face risks as a result of being seen as defying a society's established sexual and gender norms, otherwise referred to as gender non-conforming.

GBV includes: sexual violence (including rape, sexual abuse, sexual exploitation, and forced prostitution); domestic and intimate partner violence; child, early, and forced marriage; harmful traditional practices such as female genital cutting, so-called 'honor' crimes, and widow inheritance; human trafficking; denial of resources and lack of opportunities based on gender, sexual orientation, and/or gender identity; and harmful acts based on sexual orientation and/or gender identity.

SEXUAL VIOLENCE (SV)

Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic a person's sexuality, using coercion, threats of harm, or physical force, by any person regardless of relationship to the victim, in any setting, including but not limited to home and work. Sexual violence includes:

- **Rape/attempted rape**
  Rape is an act of non-consensual sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force, and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape.
- **Sexual abuse**
  Actual or threatened physicel intrusion of a sexual nature, whether by force or under unequal or coercive conditions.
- **Sexual exploitation**
  Any actual or attempted abuse of a position of vulnerability, differential power or trust, for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another.

DOMESTIC VIOLENCE AND INTIMATE PARTNER VIOLENCE (IPV)

Domestic violence takes place between current or former intimate partners (spouses, boyfriend/girlfriend) as well as between family members (e.g. mothers-in-law and daughters-in-law). Domestic violence may include sexual, physical, and psychological abuse. Other terms used to refer to domestic violence perpetrated by an intimate partner include "spousal abuse" and "wife battering".

FEMALE GENITAL CUTTING (FGC)

FGC consititutes all procedures involving partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. These practices are sometimes referred to as "female circumcision" or "female genital mutilation".

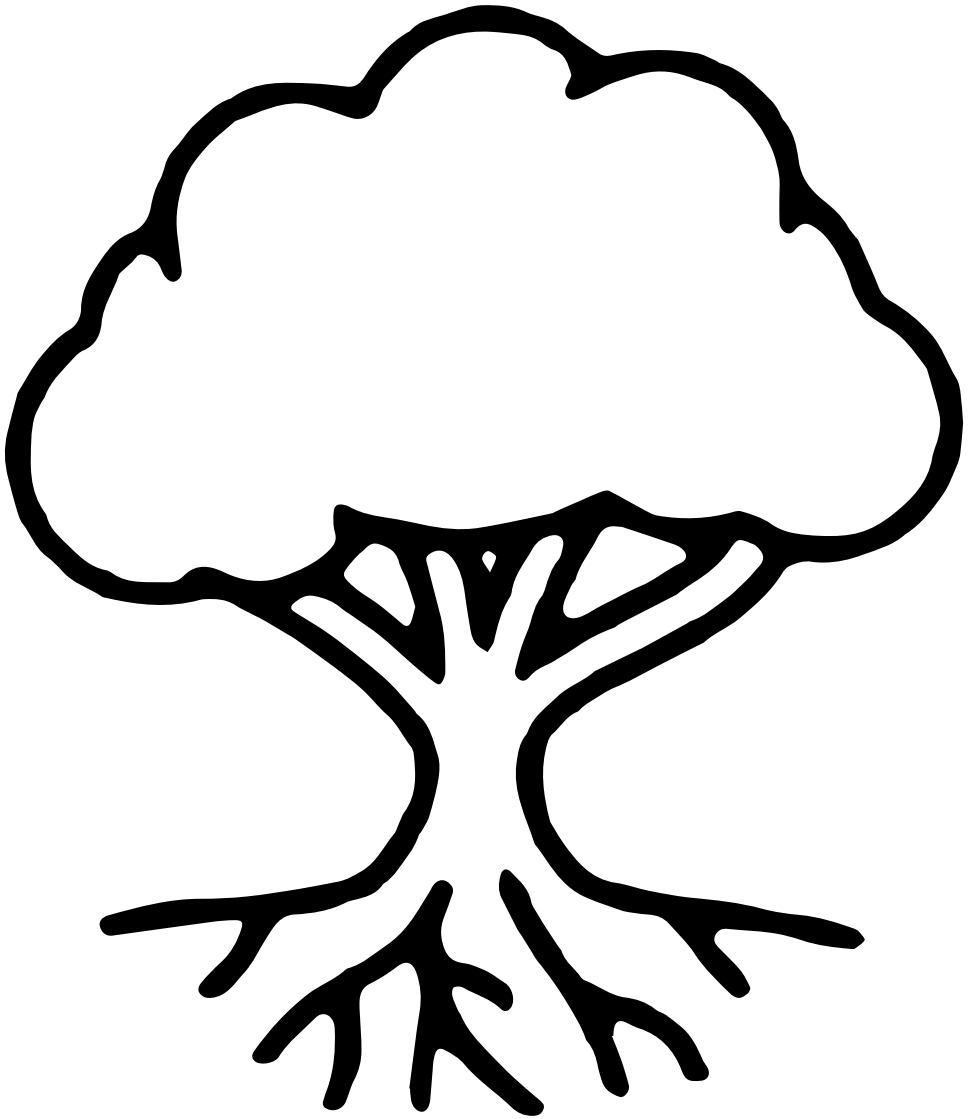
FORCED EARLY MARRIAGE

This occurs when parents or others arrange for and force a minor to marry someone. Force may occur by exerting pressure or by ordering a minor to get married and may be for dowry-related or other reasons. Forced marriage is a form of GBV because the minor is not allowed to, or is not old enough to, make an informed choice.

GUIDING PRINCIPLES FOR CARE OF SURVIVORS OF GENDER-BASED VIOLENCE:

Safety, **confidentiality**, **respect**, *and* **non-discrimination**

2. Source: Inter-Agency Working Group on Reproductive Health in Crises. Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings, 2018. iawgfieldmanual.com.



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

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.

CLINICAL CARE

Prepare to offer clinical care

Identification of survivors

Clinical Management of sexual violence survivors:

- Step 1: Offer first-line support (LIVES, Part 1)
- Step 2: Obtaining informed consent
- Step 3: Taking the history
- Step 4: Performing the physical examination
- Step 5: Providing treatment
- Step 6: Enhancing safety and referring for support (LIVES, Part 2)
- Step 7: Assessing mental health and psychosocial support
- Step 8: Providing follow up care

1. SURVIVOR-CENTERED APPROACH

2. SURVIVOR-CENTERED CLINIC SET-UP

3. PREPARATION OF STAFF

STEP 1. OFFER FIRST-LINE SUPPORT (LIVES)[3]

Listening	Listen to the woman closely, with empathy, and without judging
Inquiring about needs and concerns	Assess and respond to her various needs and concerns – emotional, physical, social, and practical (e.g. child care)
Validating	Show her that you understand and believe her. Assure her that she is not to blame
Enhancing safety	Discuss a plan to protect herself from further harm if violence occurs again
Supporting	Support her by helping her to access information, services, and social support

NOTES:

3. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 10. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

UNIT 4 INFORMED CONSENT, MEDICAL HISTORY, AND PHYSICAL EXAMINATION

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.

CONSIDERATIONS FOR SPECIFIC POPULATIONS:

_____

_____

_____

_____

_____

TOPICS TO COVER WHEN TAKING THE HISTORY WITH A RAPE SURVIVOR[4]

Topics to Cover	Purpose	What to Cover
General information	• Recording and monitoring	• Identifier/name, address, sex, date of birth or age • Date and time of examination and staff or support person present
Prior medical history	• To understand examination findings • To inform most appropriate treatment to provide, counselling needed and follow-up health care	• Current or past health problems • Allergies • Use of medications • Vaccinations • HIV status
Rape incident	• To guide the examination so that all injuries can be found and trated • To assess the risk of pregnancy, sexually transmitted infections (STIs), HIV, tetanus and hepatitis B • To guide specimen collection and documentation • To determine most appropriate tratment, counselling and follow-up health care	• Timing of the incident (how recent) • General description of incident • Has she bathed, urinated, vomited, used a vaginal douche or changed her clothes after the incident (relevant if collecting forensic evidence)?
Gynaecological history	• To identify whether there is a risk of pregnancy and/or STIs • To check whether any examination findings coould result from previous traumatic events, pregnancy or delivery	• Evaluation for possible pregnancy • Details of contraceptive use • Date of last menstrual period
Mental health	• To assess mental health status and need for referral • To help her identify possible coping strategies • To access her sources of support	• How she is feeling, what are her emotions: see Part 4, Step 5 (Assess mental health and provide psychosocial support) and further information in Part 5

4. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Job Aid 3: Topics to Cover When Taking the History with a Rape Survivor." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 17. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

SAMPLE INFORMED CONSENT FORM[5]

NOTES ON COMPLETING THE CONSENT FORM

Consent for an examination is a central issue in medico-legal practice. Consent is often called "informed consent" because it is expected that the survivor (or their parent(s) or guardian) will receive information on all the relevant issues, to help the survivor to make a decision about what is best for them at the time. It is important to make sure that the survivor understands that their consent or lack of consent to any aspect of the examination will not affect their access to treatment and care. The health-care provider must provide information in a language that is readily understood by the survivor or their parent/ guardian to ensure that they understand:

- → What the history-taking process will involve;
- → The type of questions that will be asked and the reason they will be asked;
- → What the physical examination will involve;
- → What the examination of genital and anal areas will involve;
- → That the physical examination and the examination of genital and anal areas will be conducted in privacy and in a dignified manner;
- → That during part of the physical examination, the survivor will lie on an examination couch;
- → That the health-care provider will need to touch him/her for the physical examination and the examination of genital and anal areas;
- → That an examination of genital and anal areas will require the patient to lie in a position where their genitals can be adequately seen with the correct lighting;
- → That specimen collection (where needed) involves touching the body with swabs and collecting body materials such as head hair, pubic hair, genital secretions, blood, urine and saliva; that clothing may be collected; and that not all of the results of the forensic analysis may be made available to the patient and why;
- → That they can refuse any aspect of the examination they do not wish to undergo; and
- → Examination they do not wish to undergo; and
- → That they will be asked to sign a form that indicates that they have been provided with the information and that documents what procedures they have agreed to.

Inform the survivor that if, and only if, they decide to pursue legal action, and only with their consent, the information told to the health-care provider during the examination will be conveyed to relevant authorities for use in the pursuit of criminal justice.

NOTES:

5. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Annex 2: Sample Consent Form." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 44–45. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

SAMPLE CONSENT FORM[6]

Name of facility:

_____

NOTE TO THE HEALTH WORKER:

After providing the relevant information to the patient as explained above, read the entire form to the patient (or their parent/guardian), explaining that they can choose to refuse any (or none) of the items listed. Obtain the signature of the survivor, or the thumb print of the survivor and the signature of a witness.

I, _____ (print NAME of survivor), authorize the above-named health-care facility to perform the following (tick the appropriate boxes):

	YES	NO
Conduct a physical examination	☐	☐
Conduct a genital examination	☐	☐
Collect evidence, such as body fluid samples, clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of these examinations and any relevant follow-up care provided.	☐	☐

I understand that I can refuse any aspect of the examinations I do not wish to undergo.

Signature:

_____

Date:

_____

Witness:

_____

6. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Annex 2: Sample Consent Form." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 44–45. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

SAMPLE HISTORY AND EXAMINATION FORM[7]

CONFIDENTIAL CODE: _____

MEDICAL HISTORY AND EXAMINATION FORM - SEXUAL VIOLENCE

1. GENERAL INFORMATION

First Name: _____ Last Name: _____
Address: _____
Sex: _____ Date of birth (dd/MM/yy): _____ Age: _____
Date/Time of Examination: _____ / _____

In the presence of: _____

(In case of a child, include: name of school, name of parents or guardian)

2. THE INCIDENT

Date of incident: _____ Time of incident: _____

Physical violence	Yes	No	Describe type and location on body
Type (beating, biting, pulling hair, etc.)	☐	☐	
Use of restraints	☐	☐	
Use of weapon(s)	☐	☐	
Drugs/alcohol involved	☐	☐	

Penetration	Yes	No	Not sure	Describe (oral, vaginal, anal, type of object)
Penis	☐	☐	☐	
Finger	☐	☐	☐	
Other (describe)	☐	☐	☐	

	Yes	No	Not sure	Location (oral, vaginal, anal, other)
Ejaculation	☐	☐	☐	
Condom used	☐	☐	☐	

(If the survivor is a child, also ask: Has this happened before? When was the first time? How long has it been happening? Who did it? Is the person still a threat? Also ask about bleeding froM the vagina or the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, any other sign or symptom.)

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?	☐	☐	Rinse mouth?	☐	☐
Urinate?	☐	☐	Change clothing?	☐	☐
Defecate?	☐	☐	Wash or bath?	☐	☐
Brush teeth?	☐	☐	Use tampon or pad?	☐	☐

7. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Annex 4: Sample History and Physical Examination Form." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 49–60. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

Contraception use	Yes	No		Yes	No
Pill	☐	☐	Condom	☐	☐
Injectable	☐	☐	Sterilization	☐	☐
Intrauterine device	☐	☐	Other	☐	☐

Menstrual/obstetric history	Yes	No		Yes	No
Last menstrual period (dd/MM/yy) _____			Menstruation at time of event	☐	☐
Evidence of pregnancy	☐	☐	Number of weeks pregnant _____		

Obstetric history _____

_____

_____

History of consenting intercourse (only if samples have been taken for DNA analysis)

Last consenting intercourse within a week prior to the assault _____ Date (dd/MM/yy) _____

Name of individual: _____

Other health-related conditions

History of female genital mutilation, type _____

Allergies _____

Current Medication _____

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus	☐	☐	☐	_____
Hepatitis B	☐	☐	☐	_____

HIV/AIDS status Known _____ Unknown _____

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)

_____

_____

_____

_____

Mental state (calm, crying, anxious, cooperative, depressed, detached, other)

_____

_____

_____

_____

Weight: _____ Height: _____ Pubertal stage: Prepubertal ☐ Pubertal ☐ Mature ☐

Pulse rate: _____ Blood pressure: _____ Respiratory rate: _____ Temperature: _____

Physical findings

Describe systematically, and draw on the body pictograms (below), the exact location of all wounds, bruises, petechiae, marks, and so on. DOCUMENT type, size, colour, form and other particulars. Be descriptive but do not interpret the findings.

Head and face _____ Mouth and nose _____

Eyes and ears _____ Neck _____

Chest _____ Back _____

Abdomen _____ Buttocks _____

Arms and hands _____ Legs and feet _____

5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum _____ Introitus _____ Anus _____
Vagina/penis _____ Cervix _____ Bimanual/rectovaginal examination _____

Position of patient (supine, prone, knee-chest, lateral, mother's lap) _____
For genital examination: _____ For anal examination: _____

6. INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result
_____	_____	_____
_____	_____	_____
_____	_____	_____

7. EVIDENCE TAKEN

Type and location	Sent to…/stored	Collected by/date
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and comments
Wound treatment	☐	☐	_____
Emergency contraception	☐	☐	_____
Sexually transmitted infection	☐	☐	_____
prevention/treatment	☐	☐	_____
Post-exposure prophylaxis for HIV	☐	☐	_____
Tetanus prophylaxis	☐	☐	_____
Hepatitis B vaccination	☐	☐	_____

Other _____

9. COUNSELLING, REFERRALS, FOLLOW-UP

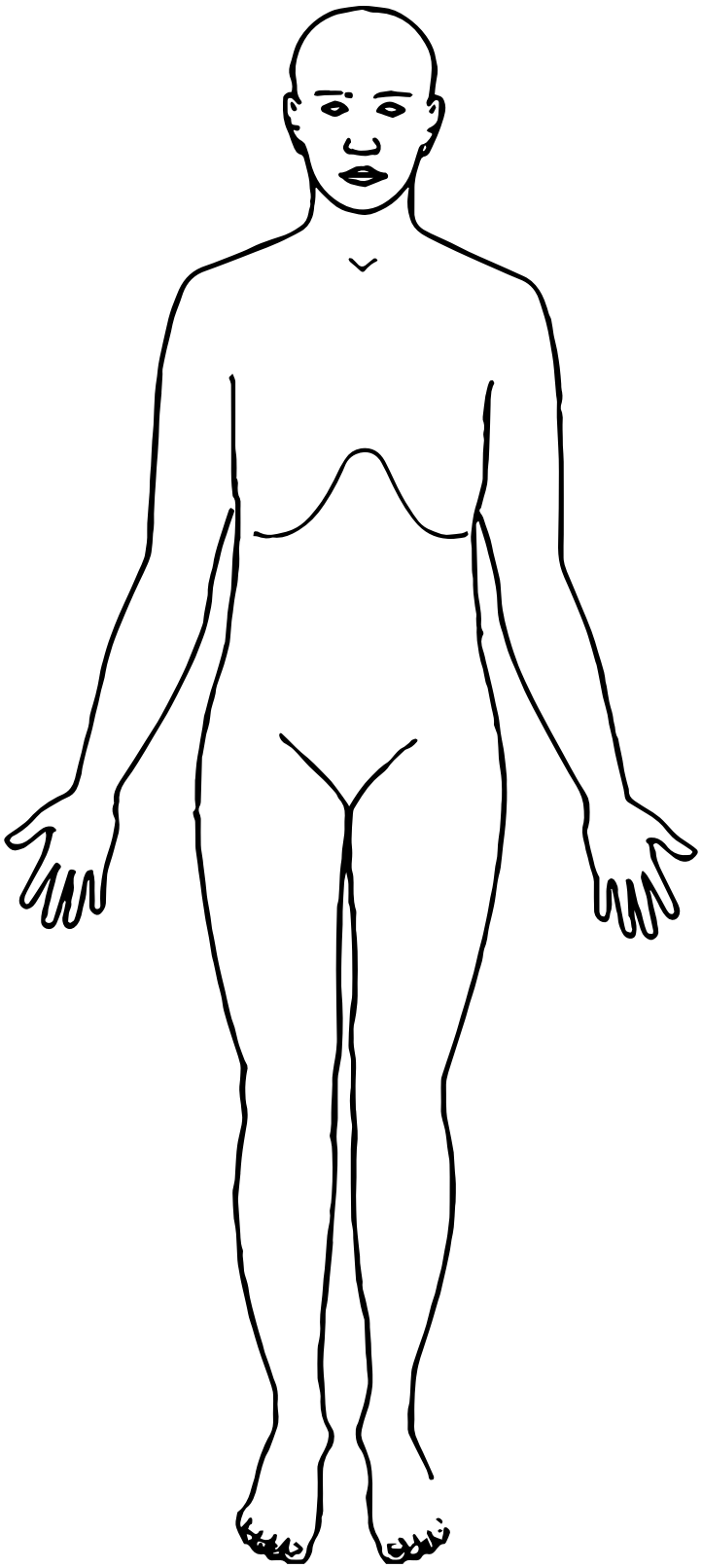
General psychological status	Yes	No
Survivor plans to report to police OR has already made report	☐	☐
Survivor has a safe place to go to	☐	☐
Survivor has someone to accompany them	☐	☐
Counselling or psychological intervention provided:nated	☐	☐

Referrals:
Case management/psychosocial services: ☐ Mental health services: ☐ Legal Services: ☐ Police: ☐
Other: _____

Follow-up required: _____
Date of next visit: _____

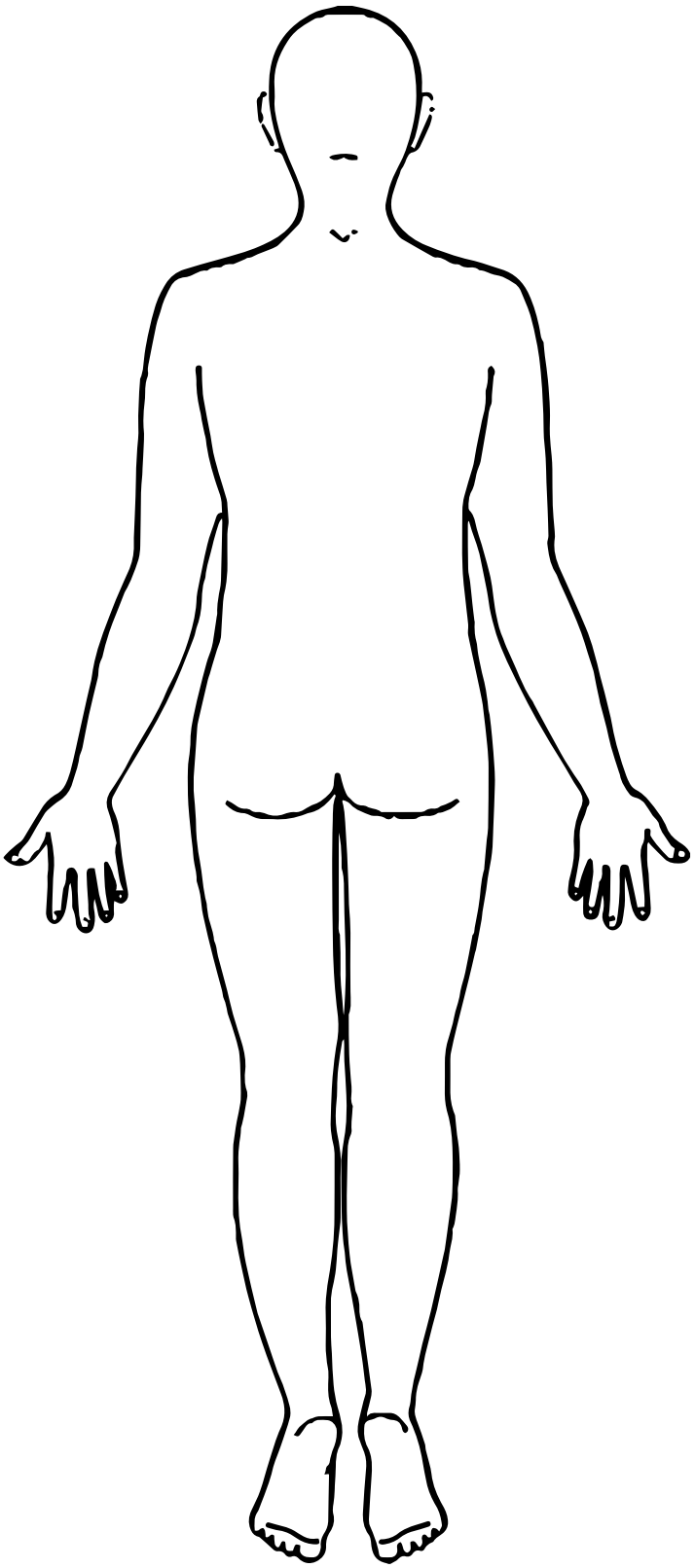
Name of health worker conducting examination/interview: _____

Title: _____ Signature: _____ Date: _____



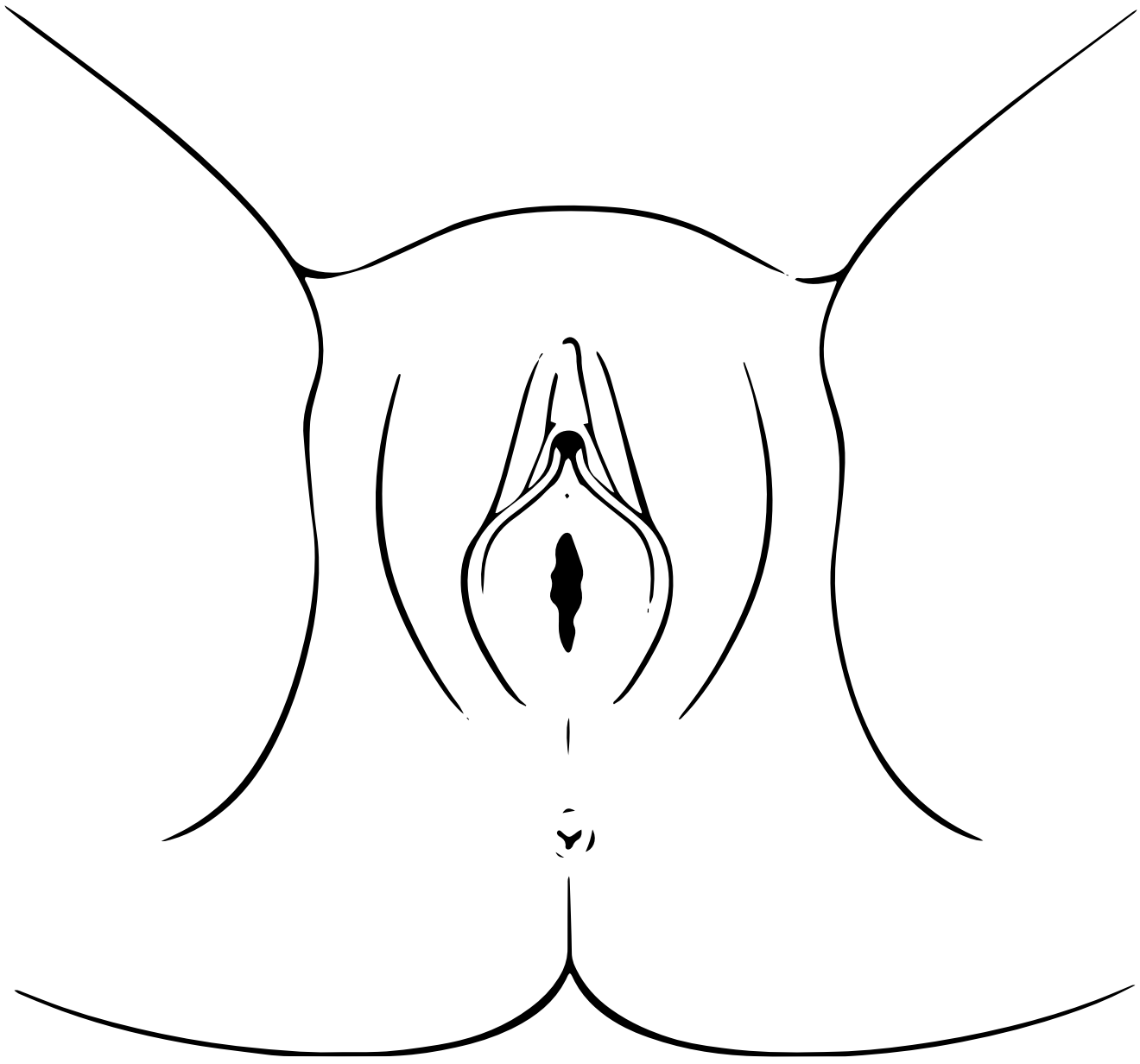
RIGHT

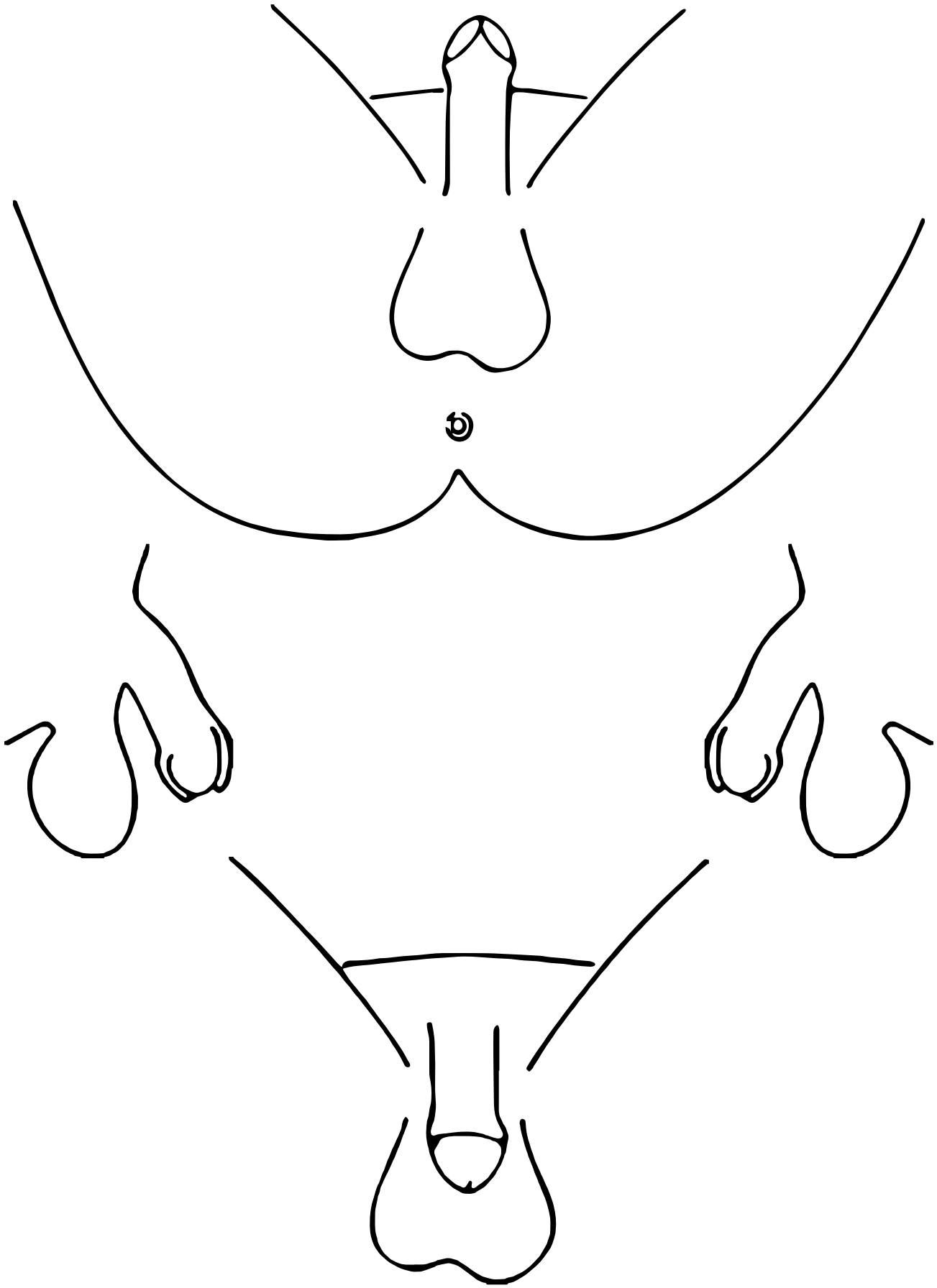
LEFT



LEFT

RIGHT





CASE STUDY: ELIZABETH'S STORY[8]

Instructions: Divide into groups of four or five participants. Use the information in the following story to fill out boxes 1-7 on the *History and Examination Form* and the associated pictograms. For any information asked in the *History and Examination Form* that is not described in this case study, imagine the answer this patient would have given and any signs that would have been found upon examination.

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.

8. Adapted from 'The War Within The War: Sexual Violence against Women and Girls in Eastern Congo,' by Human Rights Watch; Copyright © June 2002

FORENSIC EVIDENCE COLLECTION[9]

The capacity of laboratories to analyse forensic evidence varies considerably, and in humanitarian contexts is extremely limited. This annex describes the different types of forensic evidence that can be collected, and outlines procedures for doing so. Health-care providers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence. Do not collect evidence that cannot be processed.

IMPORTANT CONSIDERATIONS

- Health-care providers should familiarize themselves with national and local protocols and resources. Different countries and locations have different laws about rape and different guidelines on what is accepted as evidence.
- The survivor should be informed that some injuries might become more visible after some days and that, if this happens, they should return for examination and documentation.
- Only those who have had specialized training and experience in working with children (e.g. child-friendly communication, specialized examination techniques, evidence collection) should provide medico-legal services to children.
- Medico-legal evaluations (history taking, examination, specimen collection and medico-legal report) should be conducted on children only if child-specific health and other services are accessible for referral.
- All medico-legal practitioners working with children should be aware of the relevant laws and policies in place in the setting, including those related to consent, mandatory reporting, definitions of sexual violence against children, and who can collect and provide medico-legal evidence in court.

BEFORE BEGINNING

- A careful explanation should be provided to the survivor. This should include the reasons for, and the extent of, the proposed examination, any procedures that might be conducted, the collection of specimens, and photography.
- A sensitive and specific explanation of any genital or anal examination is needed.
- Consent to undertake the examination should be obtained from the individual or their guardian. The consent should be specific to each procedure (particularly the genital examination), to the release of findings and specimens, and to any photography. The victim may consent to some aspects and not others and may withdraw consent. The consent should be documented by signature or fingerprint.
- Photographs are a useful adjunct to injury documentation. Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital photographs are taken) need to be addressed and agreed with the victim.
- Consent for the collection and release of the specimens (to investigators) should be obtained from the victim. The impact on the victim (both physically and psychologically) of the collection of specimens should be carefully considered.

INSPECTION OF THE BODY

- Examine the survivor's clothing under good light before they undress. Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, foreign hairs). Ask the person to undress while standing on a sheet of paper to collect any debris that falls. Do not ask them to uncover fully. Examine the upper half of their body first, then the lower half, or provide a gown for them to cover themselves. Collect torn and stained items of clothing only if you can give replacement clothes. Clothes will need to be air dried before storage.
- Document all injuries in as much detail as possible.
- Collect samples for DNA analysis from all places where there could be saliva (where the attacker licked or kissed or bit the survivor) or semen on the skin, with the aid of a sterile cotton-tipped swab, lightly moistened with sterile water if the skin is dry.
- The survivor's pubic hair may be combed for foreign hairs.
- If ejaculation took place in the mouth, take samples and swab the oral cavity for direct examination for sperm and for DNA and acid phosphatase analysis. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there.
- Take blood and/or urine for toxicology testing if indicated (e.g. if the survivor was drugged).

INSPECTION OF THE ANUS, PERINEUM AND VULVA

Inspect and collect samples for DNA analysis from the skin around the anus, perineum and vulva/ penis using separate cotton-tipped swabs moistened with sterile water. For children, always examine both the anus and the vulva/ penis.

EXAMINATION OF THE VAGINA AND RECTUM

Depending on the site of penetration or attempted penetration, examine the vagina and/ or the rectum.

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis). Do not use a speculum to examine prepubertal girls. It is painful and may cause injury.

9. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Annex 3: Forensic Evidence Collection." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 46–48. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

- Using a cotton-tipped swab, collect fluid from the posterior fornix for examination for sperm. Put a drop of the fluid collected on a slide, if necessary with a drop of normal saline (wet-mount), and examine it for sperm under a microscope. Note the motility of any sperm. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage.
- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature.
- Collect separate samples from the cervix and the vagina for acid phosphatase analysis.
- Obtain samples from the rectum, if indicated, for examination for sperm, and for DNA and acid phosphatase analysis.

MAINTAINING THE CHAIN OF EVIDENCE

It is important to maintain the chain of evidence at all times, to ensure that the evidence will be admissible in court. This means that the evidence must be collected, labelled, stored and transported properly.

Documentation must include the signature of everyone who has had possession of the evidence at any time, from the individual who collects it to the one who takes it to the courtroom, to keep track of the location of the evidence since collection.

Take precautions against contamination: restrict access to examination facilities, ensure facilities are cleaned between cases and change gloves frequently. If it is not possible to take the samples immediately to a laboratory, precautions must be taken.

- All clothing, cloths, swabs, gauze and other objects to be analysed need to be well dried at room temperature and packed in paper (not plastic) bags. Samples can be tested for DNA many years after the incident, provided the material is well dried.
- Blood and urine samples can be stored in the refrigerator for five days. To keep the samples longer they need to be stored in a freezer.

Follow the instructions of the local laboratory.

- All samples should be clearly labelled with a confidential identifying code (not the name or initials of the survivor), date, time, and type of samples (what it is, from where it was taken), and put in a container.
- Seal the bag or container with paper tape across the closure. Write the identifying code and the date and sign your initials across the tape. In the adapted protocol, clearly write down the local laboratory's instructions for collection, storage and transportation of samples.
- Evidence should be released to the authorities only if the survivor decides to proceed with a legal case.

The survivor may consent to have evidence collected but not to have it released to the authorities at time of the examination. In this case, advise her of the laws and procedures around maintaining evidence and whether there is a time frame for the storage of evidence before it is destroyed. If she changes her mind during this period, she can advise the authorities where to collect the evidence.

REPORTING MEDICAL FINDINGS IN A COURT OF LAW

If the survivor wishes to pursue legal redress and the case comes to trial, the health-care provider who examined them after the incident may be asked to report on the findings in a court of law. Only a small percentage of cases actually go to trial. Many health workers may be anxious about appearing in court or feel that they do not have enough time to do this. Nevertheless, providing such evidence is an extension of the health worker's role in caring for the survivor.

In most settings, the health-care provider is expected to give evidence as a factual witness (that means reiterating the findings as they recorded them), not as an expert witness. The health-care provider should meet with the prosecutor prior to the court session to prepare their testimony and obtain information about the significant issues involved in the case.

When giving evidence as a factual witness, the health-care provider should conduct themselves professionally and confidently in the courtroom.

- Dress appropriately.
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whomever you are speaking to.
- Use precise medical terminology.
- Answer questions as thoroughly and professionally as possible.
- If you do not know the answer to a question, say so. Do not make an answer up and do not testify about matters that are outside your area of expertise.
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions.

The notes written during the initial interview and examination of the survivor are the mainstay of the findings to be reported. It is difficult to remember things that are not written down. This underscores the need to record all statements, procedures and actions in sufficient detail, accurately, completely, and legibly. This is the best preparation for an appearance in court.

SAMPLE MEDICAL CERTIFICATE[10]

MEDICAL CERTIFICATE FOR AN ADULT

I, the undersigned: (last NAME, first NAME)
_____

title (indicate the function): _____

on this date and time (day / MONTH/ year; HH:MM) _____

certify having examined at her/his request Mrs, Miss, Ms, Mr: (last NAME, first NAME)
_____

date of birth: (day / MONTH /year) _____

address: (exact address of the WOMAN or MAN)
_____
_____
_____

She/He declared that she/he was the VICTIM of a sexual attack
on (day / MONTH / year) _____ at (HH:MM) _____
at (place) _____
by: ☐ known person: (NAME) _____
☐ unknown person

Mrs, Miss, Ms, Mr _____ presents the following signs:
_____
_____
_____
_____
_____
_____
_____
_____

Descriptions should include:

- General examination (behaviour: prostrate, excited, calm, afraid, mute, crying, etc.)
- Physical examination (detailed description of lesions, the site, extent, pre-existing or recent, severity)
- Genital examination (bruises, abrasions, tears, etc.)
- Anal examination (bruises, abrasions, tears, etc.)
- Other examinations carried out and SAMPLES taken
- Evaluation of the risk of pregnancy

THE ABSENCE OF LESIONS SHOULD NOT LEAD TO THE CONCLUSION THAT NO SEXUAL ATTACK TOOK PLACE

Certificate prepared on this day and handed over to: _____
(NAME OF PARENT, CAREGIVER, GUARDIAN) AS PROOF OF EVIDENCE

Signature of the clinician: _____

The MEDICAL certificate should be filled in duplicate with one copy for patient or caregiver and one to be kept in clinic, stored safely in a locked cabinet or cupboard.

10. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Annex 6: Sample Medical Certificates." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 57–60. Geneva, Switzerland: World Health Organization, 2019. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

SAMPLE MEDICAL CERTIFICATE

MEDICAL CERTIFICATE FOR A CHILD

I, the undersigned: (last NAME, first NAME)
_____

title (indicate the function): _____

on this date and time (day / MONTH/ year; HH:MM) _____

certify having examined at her/his request Mrs, Miss, Ms, Mr: (last NAME, first NAME)
_____

child: Miss, Mr (last NAME, first NAME)
_____

date of birth: (day / MONTH /year) _____

address: (exact address of the WOMAN or MAN)
_____
_____
_____

During the meeting, the child told me (repeat the child's own words as closely as possible):
_____
_____
_____
_____

During the meeting, Mrs, Miss, Ms, Mr (NAME of the person ACCOMPANYING the child) _____
_____ stated (repeat the words of the ACCOMPANYING person as closely as possible):

The child presents the following signs:
_____
_____
_____
_____

Descriptions should include:

- General examination (behaviour: prostrate, excited, calm, afraid, mute, crying, etc.)
- Physical examination (detailed description of lesions, the site, extent, pre-existing or recent, severity)
- Genital examination (bruises, abrasions, tears, etc.)
- Anal examination (bruises, abrasions, tears, etc.)
- Other examinations carried out and SAMPLES taken

THE ABSENCE OF LESIONS SHOULD NOT LEAD TO THE CONCLUSION THAT NO SEXUAL ATTACK TOOK PLACE

Certificate prepared on this day and handed over to: _____
(NAME OF PARENT, CAREGIVER, GUARDIAN) AS PROOF OF EVIDENCE

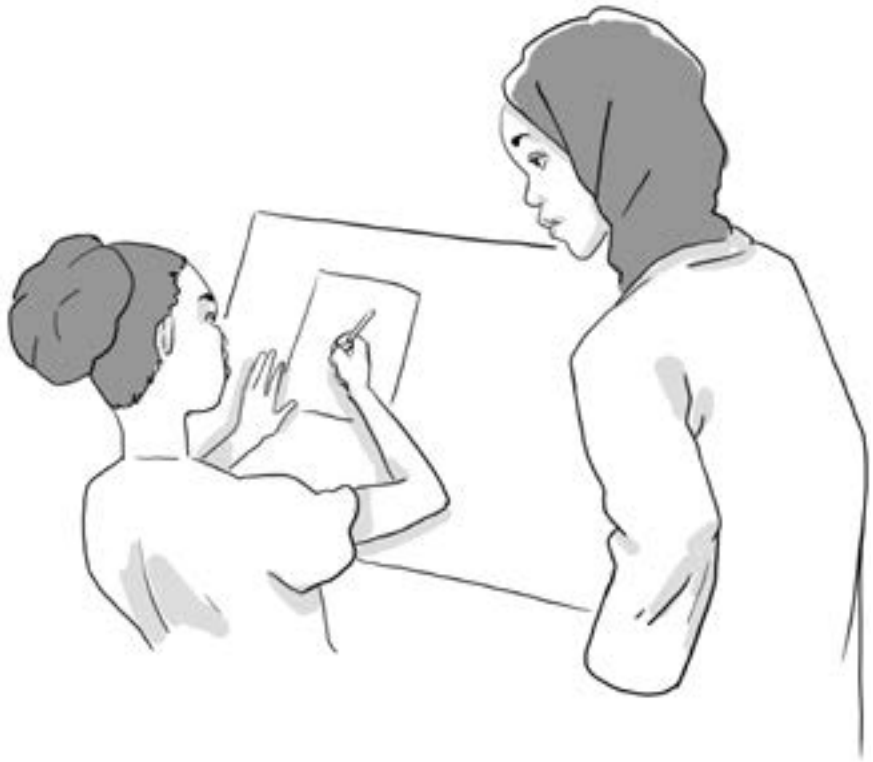
Signature of the clinician: _____

The MEDICAL certificate should be filled in duplicate with one copy for patient or caregiver and one to be kept in clinic, stored safely in a locked cabinet or cupboard.

UNIT 5 PROVIDING TREATMENT AND RELATED COUNSELING

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.



TREATMENT

NOTES

CASE STUDIES

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.

Step 1: The treatment offered to the woman should include:

New Information:

_____

_____

_____

Step 2: Fill in the initial counselling that should be offered to the woman in the table:

To prevent/manage	Give treatment	Counseling

Which tests are *required* before you prescribe treatment?

_____

_____

_____

_____

_____

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.

Step 1: The treatment offered to the girl should include:

New Information:

_____
_____
_____
_____
_____

Step 2: What important counselling does she need at this visit?

To prevent/manage	Give treatment	Counseling

Which tests are *required* before you prescribe treatment?

_____
_____
_____
_____
_____

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.

Step 1: Therefore, the treatment offered to the boy should include:

New Information:

_____
_____
_____
_____
_____
_____

Step 2: What additional counseling do you offer the boy's mother?

To prevent/manage	Give treatment	Counseling

Which tests are *required* before you prescribe treatment?

_____
_____
_____
_____
_____

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 achieve 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.

Step 1: Treatment offered the woman should include:

New Information:

_____

_____

_____

_____

Step 2: What counseling should you offer?

To prevent/manage	Give treatment	Counseling

Which tests are *required* before you prescribe treatment?

_____

_____

_____

_____

_____

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

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.

FOLLOW-UP VISIT SCHEDULE[11]

Two-week follow-up visit	
Injury	• Check that any injuries are healing properly.
STIs	• Check that the survivor has taken the full course of any medication given for sexually transmitted infections (STIs). • Check adherence to post-exposure prophylaxis (PEP), if she is taking it. • Discuss any test results.
Pregnancy	• Test the woman for pregnancy if she was at risk. If she is pregnant, explain and discuss the available options. If abortion is legally available, and she chooses this option, refer her for safe abortion.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status.
Planning	• REMIND her to return for further hepatitis B vaccinations in 1 MONTH and 6 MONTHS, and for HIV testing at 3 MONTHS and 6 MONTHS, or else to follow up with her usual health-care provider. • Ask her to return for follow-up care if emotional or physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by 1 MONTH after the incident. • Make the next routine follow-up APPOINTMENT for 1 MONTH after the initial visit.

One-month follow-up visit	
STIs	• Give the second hepatitis B vaccination, if needed. REMIND her of the 6-MONTH dose. • Test for syphilis, gonorrhoea, chlamydia and trichomoniasis (if available), even if presumptive treatment (and testing) was provided near the time of exposure. • Ask the survivor about symptoms of STIs and examine for genital and/or anal lesions or other signs of STIs.*
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status.
Planning	• Make next routine follow-up appointment for 3 MONTHS after the initial visit.

Three-month follow-up visit	
STIs	• Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care. • If laboratory testing is available, retest for syphilis. • If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status.
Planning	• Make next follow-up appointment for 6 MONTHS after the sexual violence incident. Also, remind her of the 6-MONTH dose of hepatitis B vaccine, if needed.

Six-month follow-up visit	
STIs	• Offer HIV counselling and testing if not done before. Make sure that pre- and post-test counselling are available and refer for HIV prevention, treatment and care, as needed. • Give the third dose of hepatitis B vaccine, if needed. • If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.
Mental health	• Continue first-line support and assess the survivor's emotional state and mental health status.

* When genital ulcers suspicious for syphilis are present on physical exam and a syphilis test is negative, repeat testing may be required to exclude syphilis due to delayed antibody response. A negative treponemal or non-treponemal test at three months after sexual exposure excludes the diagnosis of syphilis. Presumptive treatment with benzathine penicillin doxycycline (non-pregnant women only) should be provided if suspicious lesions are present. Similarly, testing for chlamydia and gonorrhoea may be negative if provided less than one week after exposure. Repeat testing is needed.

11. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Table 3.4: Checklist for Follow-up Visits with a Rape Survivor." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 29. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO.
www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

UNIT 7 STANDARD OPERATING PROCEDURES (SOPs)

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.

PREPARE FOR SURVIVOR-CENTERED* SOP

- What are the laws and policies?
- What laboratory facilities are available?
- What are the existing protocols (post-rape medical care, incident reporting, etc)?
- Where to provide care and support?
- Where and how to refer?
- How to coordinate between responders?
- What should the community know?

* Respect the rights, needs, choices, wishes, and dignity of the survivor at all times

NOTES:

UNIT 8 MONITORING & EVALUATION FOR HEALTH CARE PROVIDERS

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.

WHY DO YOU MONITOR AND EVALUATE SEXUAL VIOLENCE INTERVENTIONS IN YOUR PROGRAM?

HOW DO YOU MONITOR AND EVALUATE?

WHAT DATA DO YOU COLLECT?

WHEN DO YOU COLLECT IT?

WHAT DO YOU DO WITH THE DATA THAT YOU COLLECT?

EXAMPLE MEDICAL RECORD AUDIT TOOL

CHECKLIST	
Date of exam:	Time of exam:
Date of incident:	Time of incident:
Sexual assault survivor sex:	Sexual assault survivor age:

Indicate whether or not the following were recorded on the medical record of the sexual assault survivor:

Consent Availability	**Yes**	**No**
General consent for examination		
The incident	**Yes**	**No**
Description of incident		
Physical violence		
Penetration		
Current signs and symptoms	**Yes**	**No**
Pain		
Bleeding and discharge		
Medical history	**Yes**	**No**
Menstrual/obstetric history		
Existing health problems		
Vaccination status		
HIV/AIDS status		
Physical exam	**Yes**	**No**
Body pictogram of findings		
Written description of findings		
Genital exam		

Investigations	**Yes**	**No**
Pregnancy test		
HIV test		
Other		
Treatment prescribed	**Yes**	**No**
STI prevention/treatment		
Emergency contraception		
HIV PEP		
Wound treatment		
Tetanus prophylaxis		
Hepatitis B vaccination		
Counseling, referral, and follow-up	**Yes**	**No**
Referral for psychosocial support		
Follow-up visit scheduled		

EXAMPLE HEALTH FACILITY CHECKLIST[12]

Checklist of requirements for providing quality clinical care for survivors of rape and intimate partner violence (IPV)

1. Protocol	**Available?**
Written medical protocol in the language of the provider	
2. Personnel	**Available?**
Trained (local) health-care professionals (where possible, it is ideal to have an on-call system 24 hours a day, seven days a week)*	
A female health-care provider who speaks the same language as the survivor is optimal; if this is not possible, a companion of choice or another female health/social worker should be in the room during the examination*	
3. Furniture/setting	**Available?**
A clean, quiet, child-friendly, accessible consultation room, with access to a toilet or latrine, and with a door, curtain or screen for visual privacy*	
An examination table*	
Light, preferably fixed (a torch may be threatening for children)*	
A magnifying glass (or colposcope)	
Access to an autoclave to sterilize equipment*	
Access to laboratory facilities/microscope with a trained technician	
Weighing scales and a height chart for children	
4. Supplies	**Available?**
Speculums* (only adult sizes)	
Tape measure for measuring the size of bruises, lacerations, etc.*	
Syringes/needles* (butterfly type for children) and tubes for collecting blood	
Supplies for universal precautions (gloves, box for safe disposal of contaminated and sharp materials, soap)*	
Resuscitation equipment*	
Sterile medical instruments (kit) for repair of tears, and suture material*	
Tongue depressor (for inspection of oral frenulum and injury)	
Cover (gown, cloth, sheet) to cover the survivor during the examination*	
Spare items of clothing to replace those that are torn or taken for evidence	

12. Source: World Health Organization, United Nations Population Fund, and United Nations High Commissioner for Refugees. "Job Aid 1: Checklist of Requirements for Providing Quality Clinical Care for Survivors of Rape and Intimate Partner Violence (IPV)." In *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for Use in Humanitarian Settings*, 8–9. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en.

Sanitary supplies (disposable or cloth pads)*	
Pregnancy tests	
Pregnancy calculator disk to determine the age of a pregnancy	
Additional supplies that may be needed for forensic evidence collection/documentation • Comb for collecting foreign matter in pubic hair • Cotton-tipped swabs/applicators/gauze compresses for collecting samples • Glass slides for preparing wet and/or dry mounts (for sperm) • Laboratory containers for transporting swabs • Paper sheet for collecting debris as the survivor undresses • Paper bags for collection of evidence • Paper tape for sealing and labelling containers/bags	
5. Medications (with age-appropriate dosages)	**Available?**
For treatment of STIs as per country protocol*	
For post-exposure prophylaxis (PEP) of HIV transmission*	
Emergency contraceptive (EC) pills* and/or copper-bearing intrauterine device (IUD)	
Tetanus toxoid, tetanus immunoglobulin*	
Hepatitis B vaccine*	
Pain relief* (e.g. paracetamol)	
Anxiolytic (e.g. diazepam)	
Sedative for children (e.g. diazepam)	
Local anaesthetic for use when suturing*	
Antibiotics for wound care*	
6. Administrative supplies	**Available?**
Medical history and examination form including chart with pictograms*	
Medical certificate/medico-legal forms	
Referral directory	
Job aids in the language of the provider (e.g. care/treatment algorithm, referral flow chart)	
Consent forms*	
Information pamphlets for post-rape care (for the survivor)	
Safe and locked filing space to keep records confidential, or password-protected computer for electronic files*	

* Items marked with an asterisk are the minimum requirements for examination and treatment of a rape survivor

UNIT 9 ASSESSING AND STRENGTHENING CLINICAL SERVICES FOR SURVIVORS OF SEXUAL VIOLENCE

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.

ASSESSING AND STRENGTHENING CLINICAL SERVICES: GROUP WORK GUIDANCE AND TOOLS[13]

INSTRUCTIONS

For this activity, divide into groups, ideally based on the clinical site in which participants work. Review the *Health Facility Checklist* from the previous unit, along with the list of Additional Key Questions (below) for consideration. This activity provides time for reflect on how your facility is currently delivering post-assault services.

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

At the end of this activity, participants will report back to the larger group on their high-level summary of key points discussed, including:

- 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? What are the key next steps for action?

Note: *It is likely you will need more time after this training session to complete a comprehensive facility* Action Plan. *After the training, it is suggested that you work with your facility management team to continue the discussion, share ideas discussed today, and generate buy-in for changes.*

STEP 1: DISCUSS CURRENT SERVICES FOR SURVIVORS AT YOUR SETTINGS

Review the *WHO Checklist of Requirements for Providing Quality Clinical Care* and consider which of the standards your facility meets and/or still needs improvement to meet. Then consider the additional key questions below and discuss whether your facility does or not does meet these standards.

Additional Key Questions for Consideration

Availability and Appropriateness of Services:

- Facility maintains patient privacy during triage/intake process?
- Facility priorities patients who have experienced sexual assault to ensure they receive care and support as soon as possible?
- Facility ensures all patients have equal access to care, regardless of sex, gender identity, sexual orientation, marital status, age, disability, race, religion, ethnicity? Have you ever heard of any patient being turned away from the facility due to the ethnical group they were from, because they were unmarried, because they were male, or for any other reason?

Facility Readiness and Infrastructure

- Facility has visible gender-based violence (GBV) information, education, and communication materials in the lobby, waiting areas, restrooms, etc.?
- Facility ensures that signs inside and outside the facility are discreet (e.g., signs could say "Wellness Center" or "One-Stop Center," instead of "Rape Center") to increase the safety and privacy of patients and providers?
- Rooms/areas where GBV counseling and clinical services are provided are private (patient cannot be seen or heard from the outside), clean, and comfortable?
- Facility has all essential infrastructure, furniture, equipment, supplies, documents, and commodities available?
- A system is in place to check on a regular (e.g., quarterly) basis whether medicines, vaccines, and tests are within validity/expiration date, and safely discard those that have expired?
- Identification of patients who have experienced sexual violence / intimate partner violence (IPV)

13. Adapted from: World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*. Geneva: WHO; 2019. Licence: CC BY-NC-SA 3.0 IGO. Jhpiego, United States Centers for Disease Control and Prevention (CDC), World Health Organization (WHO) (2018). *Gender-based violence quality assurance tool*. Baltimore (MD): Jhpiego (resources.jhpiego.org/resources GBV-QA-tool).

- Facility has a standard process to ask about sexual violence/ IPV (e.g., job aid, algorithm, etc.) which aligns with national or local guidelines?
- Providers at the facility counsel about sexual violence / IPV in an appropriate manner?
  - Never asks about violence unless the patient is alone;
  - Brings up the topic carefully by making some general statements about violence before asking the patient directly about her/his situation;
  - Does not require the patient to talk about his/her experience if s/he does not want;
  - Assess and addresses any risk of immediate violence or harm when violence is disclosed;
  - Helps patients make a safety plan.

Survivor-Centered Clinical Care and Communication

- Providers obtain informed consent from adult patients and informed assent from minors?
- Providers collect detailed medical history and manage injuries appropriately?
- Providers respect and maintain patient privacy and confidentiality?
  - Does not share information with anyone who is not involved in patient's care;
  - Keeps patient files, forms, and any other documents surely locked in cupboard, locker, or locked room, according to written policy in place to govern who can access these files.
- Providers offer HIV counseling, testing, and PEP within 72 hours to sexual assault survivors?
- For female survivors, providers offer emergency contraception if within 120 hours?
- Providers offer relevant medications and/or vaccinations for prevention and treatment of other sexually transmitted infections?

Referral System and Follow Up of Patients

- Facility has a referral system in place to ensure patient is connected to all necessary services?
- Providers discuss and offer follow-up services (2 weeks, 1 month, 3 months, 6 months)?

Training and Quality Improvement

- All providers who deliver post-assault care have received training relevant to their roles and responsibilities in the care of patients?
- Facility has systems in place to ensure continuous quality improvement of post-GBV care services?
  - Providers receive verbal or written feedback from a supervisor about the care they deliver to survivors.
  - Facility ensures that all staff providing post-assault care achieve and expand competencies via ongoing capacity-building plan with short, targeted skills-builders, regular team meetings, and other activities, and are supported on a personal level on this work.
    - → 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.
  - Facility has mechanisms in place to support and promote self-care for providers who experience secondary trauma resulting from providing post-violence care.

Outreach

- Facility integrates awareness raising and referrals into other health programs and outreach activities? (E.g., Facility has a community liaison to raise awareness of GBV and the services that are available.

Reporting and Information Systems

- Facility has secured intake forms, chart forms, or registers that collect information about a patient's experience of GBV and the post-GBV care s/he received?
- An evaluation system is in place to collect and analyze GBV program data to understand trends and improve health services and systems?

STEP 2: DEVELOP AN ACTION PLAN TO GUIDE PRIORITIZED IMPROVEMENTS

Use the template *Action Plan* to begin to outline next steps for changes. In addressing the identified gaps and challenges, the teams should remember that there are three main categories of gaps that may need to be addressed:

1. **Internal Gaps** that do not require a significant cause analysis because the solution is obvious and simple. (E.g., Designation of a person in charge of a task, minor purchases to replace broken pieces of equipment, minor relocation of supplies and equipment to make them more available at point of use.)
2. **Resource Gaps** that are likely to be caused by factors that are under local/facility control and could be eliminated with the mobilization of local resources. (E.g., Modification of some internal procedures, redistribution of workload within the facility, internal reallocation of resources, some types of training, implementation of some types of incentives.)
3. **External Gaps** that are likely to be caused by factors that are outside local/facility control and that usually require the mobilization of significant external resources (e.g., changes in policies, salary increases, increases in the number of staff, provision of additional budgets, remodeling/construction).

Remember: *It is likely you will need more time after this training session to complete a comprehensive facility* Action Plan. *After the training, it is suggested that you work with your facility management team to continue the discussion, share ideas discussed today, and generate buy-in for changes.*

STEP 3: PRESENT HIGH-LEVEL RESULTS BACK TO THE WIDER GROUP

Prepare a brief presentation for the wider group focused on the following key 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? What are the key next steps for action?

NOTES:

ACTION PLAN[14]

GAP/CHALLENGE	TYPE OF GAP	ACTION ITEM			PERSON RESPONSIBLE	SUPPORT NEEDED	DEADLINE
		INTERNAL	RESOURCE	EXTERNAL			
1.							
2.							
3.							
4.							
5.							
6.							

14. Source: Jhpiego and U.S. Centers for Disease Control and Prevention (CDC). "Appendix V. Sample Action Plan." In *Gender-Based Violence Quality Assurance Tool: Facilitation Guide*, 2018. resources.jhpiego.org/resources/GBV-QA-tool.

UNIT 10 CARE FOR THE CAREGIVERS, EVALUATION, AND CLOSING

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.

STRATEGIES TO USE FOR SELF-CARE AND TO AVOID BURN OUT

THREE THINGS I HAVE LEARNED AND WILL BRING BACK TO MY WORKPLACE TO IMPROVE CARE FOR SURVIVORS OF SEXUAL VIOLENCE:

1.

2.

3.

Suggested citation:
Inter-Agency Working Group (IAWG) on Reproductive Health in Crises and Jhpiego. Clinical Management of Sexual Violence Survivors in Crisis Settings: A Training Course for Health Care Providers. New York: 2021.

Jhpiego
1615 Thames St. #200
Baltimore, MD 21231
www.jhpiego.org

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises
Training Partnership Initiative
Women's Refugee Commission
15 West 37th Street, New York, NY 10018
info.iawg@wrcommission.org
www.iawg.net

IAWG Inter-Agency Working Group on **Reproductive Health in Crises**

jhpiego