Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

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Session 0.

Welcome and introductions


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Welcome

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Introductions

Turn to your neighbour:

- What is your name?
- What does your name mean or signify in your culture?
- What is your institutional affiliation?

Why is this curriculum specific to humanitarian settings?

In 2013, the Inter-Agency Standing Committee adopted its statement on the "Centrality of Protection"

Addressing gender-based violence (GBV) is among the core concerns of humanitarian policy

Caring for survivors of sexual violence is part of the minimum initial services package (MISP) for sexual and reproductive health (SRH)

The MISP for SRH comprises a priority set of life-saving activities to be implemented at the onset of every humanitarian crisis and should be sustained and built upon throughout protracted crises and recovery

The MISP for SRH

The MISP for SRH covers 4 core areas of service delivery:

1. Preventing excess maternal and newborn morbidity and mortality
2. **Preventing sexual violence and responding to the needs of survivors**
3. Preventing unintended pregnancies
4. Preventing the transmission of and reducing morbidity and mortality due to HIV and other sexually transmitted infections (STIs)

Supporting implementation of the MISP for SRH

MISP for SRH Objective 2

- Ensure health facilities and points of care offer services for those affected by sexual violence
- Make clinical care and appropriate referrals available for survivors
- Ensure health facilities have confidential, private spaces where survivors can disclose and receive care

Inter-agency emergency reproductive health (IARH) kits are available through UNFPA

Intimate partner violence (IPV)

38%
of female victims of homicide were killed by their intimate partners

IPV increases
during times of stress and conflict

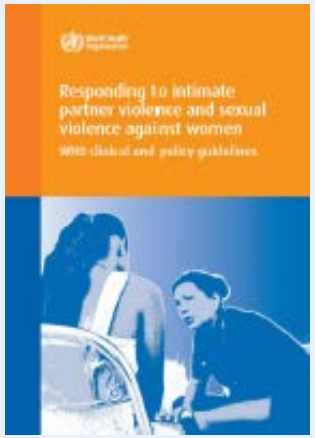
1 in 3 women
will experience physical or sexual IPV in their lifetime

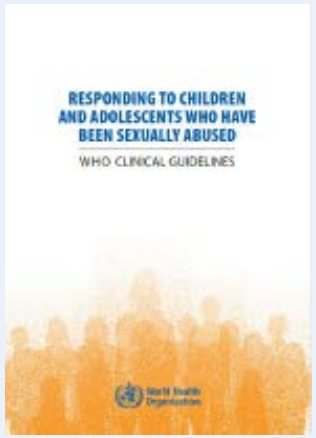
IPV refers to ongoing or past violence by a current intimate partner or ex-partner (husband, boyfriend or lover)

Women may suffer several types of IPV, including physical violence, sexual violence and emotional/psychological abuse

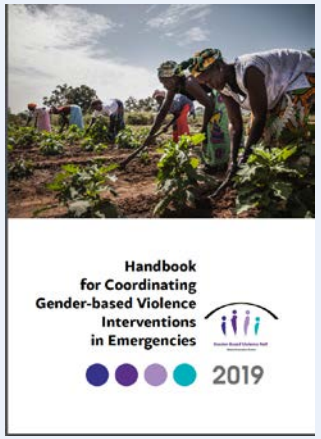
This training builds off a wealth of global guidelines and evidence

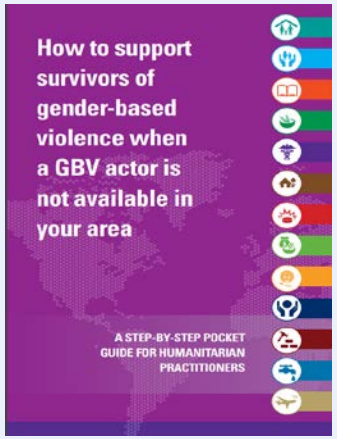
Guidelines on WHAT to do





Handbooks and tools for HOW to intervene





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Why a humanitarian-specific curriculum?

Scenario 1.

You've been trained to provide first-line support for GBV in the course of your work as an SRH clinical officer. You are well acquainted with the LIVES approach to providing first-line support and are comfortable making referrals to the One Stop Centre housed within the district hospital. However, the facility manager has called an all-staff meeting this morning to share the news that there was significant damage to the district hospital from flash flooding and mudslides over the past 2 days. The One Stop Centre, pharmacy, registration building and one inpatient ward are all unusable. The hospital is only receiving critical care referrals.

Why a humanitarian-specific curriculum?

Scenario 2.

As the physician at the local health centre, you are accustomed to treating rape survivors and feel confident in your knowledge of when to offer post-exposure prophylaxis (PEP) for HIV and emergency contraception, and how to treat any lacerations or other physical injuries.

You are summoned to a briefing by the district health coordinator to discuss the conflict that is taking place just over the border, and the increasing number of refugees who have been showing up at the health centre. As part of the briefing, the district coordinator shares that he has received a report that a wave of refugees is expected to arrive in the district in the next 2–3 days. There are many injured individuals and some of the most acutely sick and injured are being transported ahead by aid vehicles. Aid worker reports note that there are indications of mass rape among survivors, including men and children.

At the end of this training, participants will have achieved the following objectives

1. Demonstrate general knowledge of sexual violence and IPV as a public health problem
2. Demonstrate behaviours and understand values contributing to safe and supportive services
3. Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV
4. Demonstrate knowledge of how to access resources and support for patients and for oneself in crisis

Keeping ourselves and each other safe

- The topics we will cover may trigger uncomfortable emotions or memories
- If you experience this, you are welcome to step out of the training for some time
- Let the organizers know if you need support to access more services or if we can refer you to local resources

Contact numbers

Facilitators

-
-

Local mental health and psychosocial support (MHPSS) resources

-
-

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Exercise 0.1

Fears and motivations in a hat

Instructions

- Write down one fear or worry you have about providing care to survivors
- Write down one thing that motivates you to provide high-quality, survivor-centred care
- Place the pieces of paper in the respective hats being passed around

Group rules and norms

- Timeliness – both in attendance and in expressing your point of view
- Learn and work together
- Participate actively
- Respect each other
- Listen with an open mind
- Let everyone participate
- Be present
- Express disagreements respectfully
- Give feedback in a constructive way (starting with the positive)
- Do not interrupt when people are talking
- Respect confidentiality – any personal information shared stays in the room
- Only use electronic devices such as mobile phones or laptops for emergencies

Key points

- Many health workers have concerns about talking about GBV, particularly IPV, with their patients. They may feel inadequate to respond to violence.
- Many of us are passionate about providing care and ensuring health and justice for our clients. This positive energy can fuel how we apply this training in our clinical practice.
- Providing survivor-centred, first-line sexual violence and IPV support is an essential service during humanitarian emergencies.

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Session 1.

Understanding sexual violence and IPV as a public health problem

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Session objectives

Objective 1: Demonstrate general knowledge of sexual violence and IPV as a public health problem

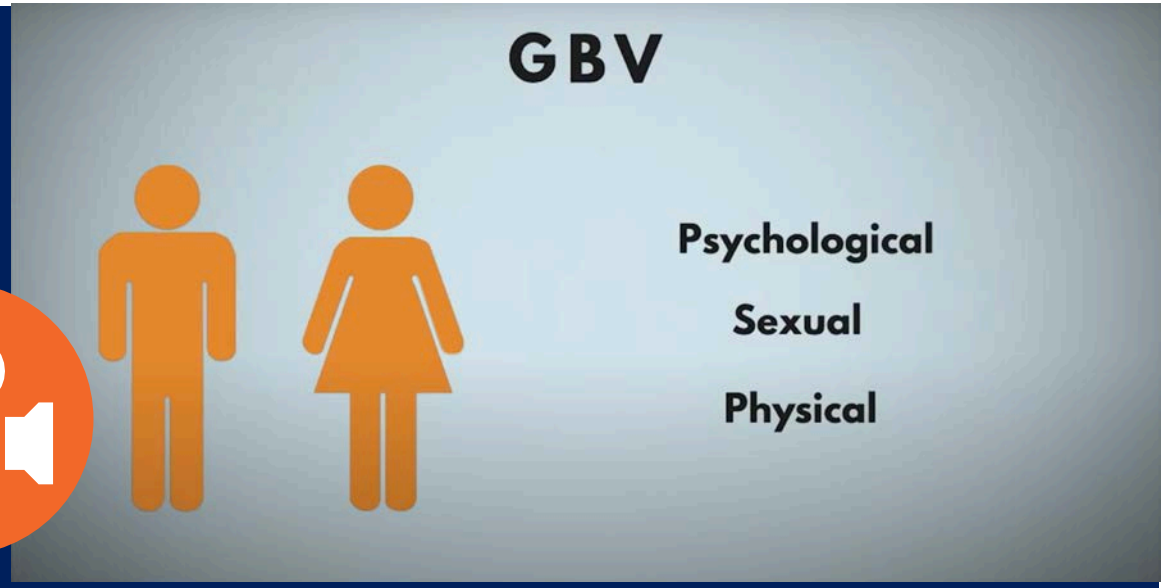
Competencies:

- Know the epidemiology of the different forms of GBV at global and local levels, including in humanitarian contexts
- Know the health consequences of sexual violence and IPV for different populations
- Understand the role and limitations of health workers in responding to sexual assault and IPV in humanitarian emergencies, including minimum essential sexual violence response services that are part of the MISP for SRH

What is gender-based violence (GBV)?

"[A]ny act that results in physical, sexual, or mental harm, including threats, coercion or arbitrary deprivation of liberty, whether occurring in public or private life, and based on an individual's gender identity, gender roles or norms" – *United Nations definition*

GBV disproportionately affects women and girls, and in situations of displacement, the risk of exposure to GBV increases for people of all genders



https://youtu.be/3AF9Rjki0DE?si=nmGJuolWW8Vtev9W

Forms of gender-based violence

Sexual

- Forced marriage
- Sexual exploitation / forced prostitution
- Rape
- Sexual harassment

Physical

- Hitting, beating, burning, cutting
- Trafficking
- Acid attacks, “honour” killings
- Female genital mutilation (FGM)

Emotional / psychological

- Insults, humiliation
- Confinement / isolation
- Intimidation / threats
- Blame for uncontrollable outcomes

Social

- Discrimination and/or denial of opportunities
- Denial of education
- Denial of inheritance and/or property rights

Rape and sexual assault

Rape is any non-consensual penetration – even if slight – of the vulva, mouth or anus, using a penis, other body part or an object

The attempt to do so is known as “attempted rape”

Sexual assault is a common term used to refer to both attempted rape and rape

Note: Legal definitions of rape vary from country to country and may or may not encompass non-consensual penetration between two people when those individuals are married

Essential service focus on sexual violence and IPV

- Prioritization of essential services in times of crisis demands hard choices.
- Sexual violence and IPV are the most prevalent forms of GBV worldwide, in both stable and emergency contexts.
- This session will discuss root causes of GBV, as they influence all its forms. Later sessions will focus on provision of health care for survivors of sexual violence and IPV.

Understanding the difference between sex and gender

Gender	Sex
Socially constructed roles, responsibilities and attitudes (e.g. division of labour)	Physically, biologically defined
Gender rules and regulations are learned/imposed; we build them in our own minds	Determined by birth; we are born with it
Expressed by differences in dress and behaviour	Determines our physical functions
Differences between and within cultures include variables identifying differences in roles, responsibilities, attitudes, opportunities, expectations, needs and constraints	Same throughout the world
Changeable over time	Generally unchangeable

Let’s try a gender quiz

Please read each statement below carefully.

Does this issue relate to sex or gender?

	Tick the correct box	
	Gender	Sex
Women must consume extra calories and safe water during lactation		
It is a man’s responsibility to protect the honour of his family		
Female-bodied people will need resources and space to enable optimal menstrual hygiene		
Women and girls have a responsibility to ensure they don’t get pregnant or have sex before they are married		

Scenario 1: Flora

Flora is the eldest of four children (three girls, and a 4-year-old brother). At age 15, attacks by a local militia group start to occur closer and closer to her village. One of her teachers is abducted and her parents insist the children stop going to school. When five of the girls from the village are also abducted, Flora's father announces they are leaving and will seek safety over the border in another country. It will take a week of walking.

On the second day, Flora and her family come over the top of a hill to see a blockade across the road and members of the militia group – all heavily armed. Flora's father tells the family to stay silent and let him do all the talking. The militia men look at Flora's family and tell her father that with so many daughters he can spare one, and they tell him to decide who he will give to them. Her father tries to offer them money instead, but one of the soldiers hits her father in the head with his gun. Her mother screams and kneels by his side.

Then Flora sees one of the soldiers grabbing her 11-year-old sister. She starts to yell at the soldiers even though she is terrified, and even tries to hold on to her sister. The soldiers just laugh. One of them says, "This one has fire". The others say, "She will be too much trouble". The first soldier slaps Flora hard across the face. Everything goes dark and blurry for a moment and when her vision returns, she sees her sister being tied up in the back of a truck as it drives off.

Scenario 1: Flora

Turn to your neighbours and discuss the following questions

- How does gender influence the power of the people in the story?
- Where do you see power contributing to and/or shaping violence?
- What forms of violence do you see?

Understanding men and boys as the primary perpetrators of GBV

Any action, threat or exercise of control that uses gender roles and norms to decrease a person's power is GBV

Intersectional factors increase or decrease a person's vulnerability

The greater the power an individual or institution holds, the easier it is for them to perpetrate GBV

Prevalence and consequences

Global prevalence of violence against women (age 15–49)

13% of ever-married/ partnered women have experienced physical or sexual IPV in the past 12 months[1]

27% of ever-married/ partnered women have experienced physical or sexual IPV in their lifetime[1]

133 women are victims of femicide every day[2]

Globally, **19%** of girls have experienced child or forced marriage[1]

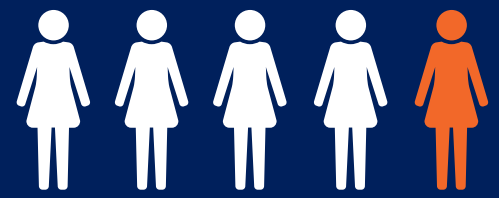
6% of women have experienced non-partner sexual violence[3]

38% of femicides are committed by the woman's current or a past intimate partner[2]

IPV is the most prevalent form of GBV regardless of country or context

Population groups at increased risk

- Pregnant women
- People living with HIV
- People with disabilities
- People who sell or exchange sex
- Persons with diverse sexual orientation, gender identity, gender expression (SOGIE)
- Women and girls living in or displaced by humanitarian emergencies
- Refugees and internally displaced persons (IDPs)
- Female heads of household
- Women and children migrating alone



At least **1 in 5** female refugees and IDPs experience sexual violence[4]

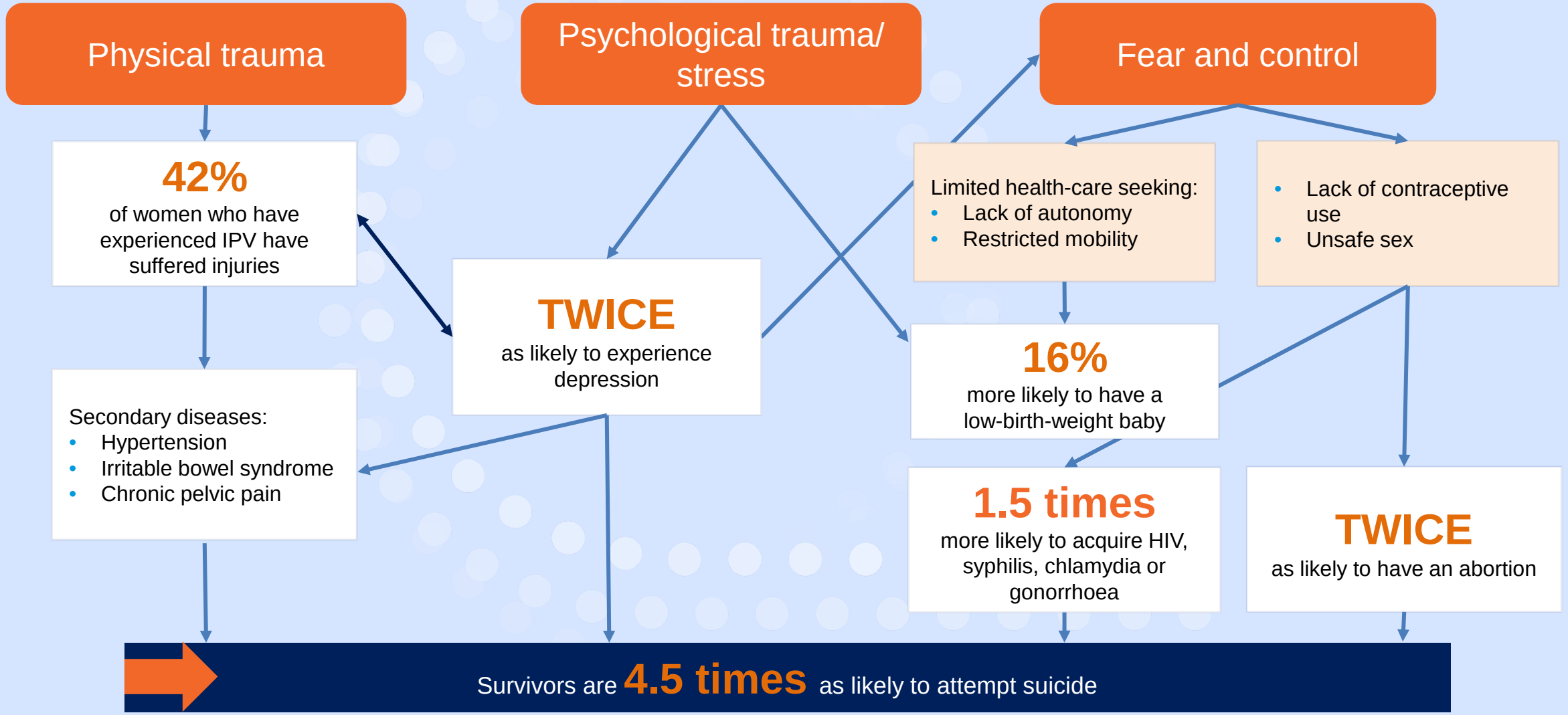
GBV prevalence in Mozambique

According to the UN Women Global Database:[5]

- **54%** of women have experience of physical and/or sexual violence in their lifetime.
- **21.7%** of women have experience of physical and/or sexual IPV in their lifetime.
- **15.5%** of women report physical and/or sexual IPV in the last 12 months.
- **52.9%** of girls are married before the age of 18.

All prevalence data are estimates. GBV is routinely underreported, and data are rarely available at hyperlocal level.

How sexual violence and IPV impacts health



The role of health workers

Why a health system response?

- Health workers are often women's only point of contact outside of where they are living
- The sexual and reproductive health (SRH) needs of women, such as family planning, antenatal care and assistance with childbirth, create natural opportunities for women living with violence to develop trust with a health worker
- Health workers can be less intimidating to survivors than response workers in other sectors, such as police or judiciary personnel

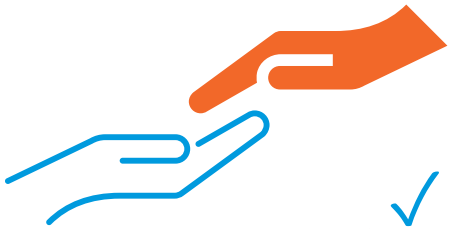
Health workers and health systems play a critical role in supporting survivors, mitigating the impact of violence and preventing violence

Care needs

Survivors' care needs are complex, but may include:

- Emotional support
- Reassurance
- Physical health care
- Safety may be an ongoing concern
- Referrals for other resources that you cannot provide
- Help to feel more in control and able to make their own decisions

Health worker responsibilities



- ✓ Do no harm
- ✓ Identify violence
- ✓ Empathic response
- ✓ Clinical care

- ✓ Referrals as needed
- ✓ Documentation
- ✓ Medico-legal evidence
- ✓ Advocacy as community role models

Health workers are NOT responsible for:

- ✗ Solving violence and related social issues
- ✗ Addressing all violence-related needs
- ✗ Addressing all aspects of treatment, care and support in one consultation

Do No Harm

Health worker behaviour

- Blames or disrespects women or girls
- Does not recognize violence as a contributor to chronic or recurring conditions
- Fails to provide post-rape care or address violence against women in family planning or STI/HIV care
- Breaches privacy or confidentiality
- Ignores signs of fear or emotional distress

Possible consequences

- Inflicts additional emotional distress or trauma
- Woman receives inappropriate or inadequate medical care
- Unwanted pregnancy, STIs, HIV, unsafe abortion, more violence
- Partner or family member becomes violent after overhearing information
- Woman is later injured, killed or commits suicide

Session 1: That's a wrap

- GBV affects survivors' physical and mental health
- Health services for survivors of sexual violence and IPV are essential during any emergency, and are essential components of implementing the MISP for SRH
- Health workers have an important role to play in providing support and care to survivors

References

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2. Gender-related killings of women and girls (femicide/feminicide): global estimates of female intimate partner/family-related homicides in 2022. Vienna: UNODC; 2023.
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Session 2.

Increasing awareness and understanding of the survivor experience

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Session objectives

Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive services

Competencies:

- Demonstrate awareness of one's own beliefs, assumptions, potential biases and emotional responses, which can affect interactions with survivors
- Understand the circumstances and the barriers that survivors face in seeking support
- Recognize the importance of having empathy with survivors

Exercise 2.1a

Myth or fact?

GBV can be prevented. The survivor could have done something or behaved differently to stop the violence from occurring.

Myth or fact?

GBV can be prevented. The survivor could have done something or behaved differently to stop the violence from occurring.

This is a myth!

GBV is inherently rooted in power imbalance

Those experiencing violence are never at fault

Myth or fact?

Survivors who choose not to leave a living situation in which they are experiencing GBV don’t mind the violence. It can’t be that bad.

Myth or fact?

Survivors who choose not to leave a living situation in which they are experiencing GBV don't mind the violence. It can't be that bad.

This is a myth!

There are many reasons an individual stays in a violent household

It may be the safest option for her at that moment in time

Long-term domestic or intimate partner violence can be severe

Myth or fact?

Men are naturally violent. Fighting increases sexual urges, and soldiers can’t stop themselves from forcing women to fill these needs.

Myth or fact?

Men are naturally violent. Fighting increases sexual urges, and soldiers can't stop themselves from forcing women to fill these needs.

This is a myth!

Violent tendencies and sexual control are not biologically rooted in genetic sex

Myth or fact?

How GBV responders speak with and talk to survivors makes a difference in short- and long-term recovery as well as the mental health sequelae a survivor may experience.

Myth or fact?

How GBV responders speak with and talk to survivors makes a difference in short- and long-term recovery as well as the mental health sequelae a survivor may experience.

This is a fact!

The response a survivor gets when disclosing what has happened to them will significantly impact their psychological recovery and will influence whether they continue to seek services and support.

Exercise 2.1b

Vote with your feet

- Be honest with yourself. Remember that this training is a safe space to reflect on and discuss difficult topics and ideas.
- It is OK to be somewhere in the middle.
- Remember our ground rules. Be respectful of other participants' points of view. Do not interrupt.

Learning points

- Our beliefs and attitudes often reflect the norms and values of the societies we live in. It is important to reflect on these norms and whether they might harm survivors.
- Your job as a health worker is to provide care and treatment. It is NOT your job to share or preach your values to clients.
- Changing mindsets takes time. However, it is possible to change our beliefs and attitudes, and it is healthy to examine and adjust them if necessary.

Exercise 2.2

Blanketed by blame

- Empathy requires understanding. This exercise helps us witness how responses to a disclosure of violence can impact the survivor's experience and well-being.
- Observers will be asked to share reflections following the exercise. You will still participate even if you choose not to volunteer for one of the active roles.
- Please be quiet throughout the exercise. We'll have time to discuss and debrief afterward.

Session 2: That's a wrap!

- By putting ourselves in the shoes of the survivor, we can empathize and better understand their situations.
- As providers, it is important to reflect on our own values and beliefs and how we may convey these to our patients. It is important NEVER to place any kind of blame on the survivor.
- Safety is the long-term goal. Disclosing abuse or leaving an abusive partner may not be right for every survivor.
- Always encourage survivors to look for options in their lives and support them to choose what they believe is right for them.

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Session 3.

Guiding principles for health response to sexual assault and IPV in emergencies

Session objectives

Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive services

Competencies:

- Know the guiding principles of providing survivor-centred care in a culturally appropriate way
- Understand how to apply the guiding principles for survivor-centred care in your practice
- Understand how first-line support, or LIVES, supports survivor-centred care

Guiding principles I

- **Dignity and respect** – the right to be treated with dignity and respect, and not to be blamed for the violence perpetrated against them
- **Privacy and confidentiality** – survivors always have the right to choose to whom they will or will not tell their story; any information should only be shared with the survivor's informed consent
- **Self-determination** – the right to make one's own decisions, including sexual and reproductive decisions; to refuse medical procedures and/or take legal action; and to choose the course of action
- **Non-discrimination** – survivors should receive equal and fair treatment regardless of their age, impairments, gender identity, sexual orientation, religion, nationality, ethnicity, employment or any other characteristic

Guiding principles II

Survivor-centred care further promotes the following

- **Life** – the right to a life free from fear and violence
- **The highest attainable standard of health** – the right to health-care services of good quality, that are available, accessible and acceptable
- **Information** – the right to know what information has been collected about one's health and to have access to this information, including medical records

Guiding principles in practice

- A survivor's wishes determine the care that you give
- Do not blame or judge
- Do no harm by:
  - **limiting actions to a context**-appropriate scope
  - respecting **human rights**
  - promoting **gender equality**
  - always ensuring **confidentiality**

Promoting gender equality

Health workers must promote women's autonomy and dignity

- Be aware of the power dynamics and norms that perpetuate GBV and how these may affect a survivor's ability to safely access and continue to receive health care
- Be careful not to put the survivor at further risk through your actions or recommendations
- Provide information and counselling that helps the survivor make their own decisions

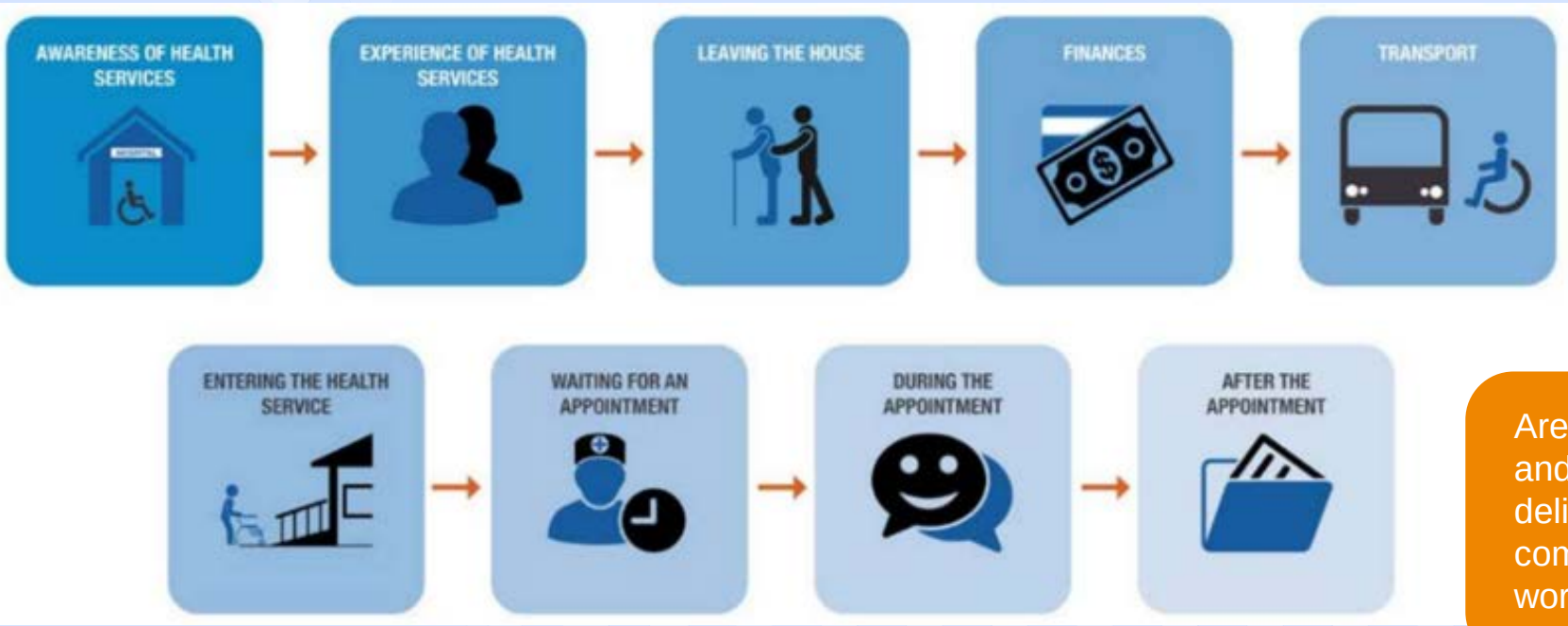
Equity in access and care

- Never assume you know what a patient needs or wants. Instead, empower the patient to be part of their care by asking first.
- Remember, a **survivor's wishes** determine the care that you give.

Equity in access and care[1]

Does the person have access to information they can understand and relate to?

Does the patient need additional support to access services?



Do signage, entryways and facility flow welcome and accommodate the patient's needs?

Are treatment guidance and referral options delivered in a communication style that works for the patient?

Guiding principles for caring for children and adolescents

- All core principles apply to survivors of any age.
- Pay attention to the best interests of children and adolescents. There may not be another adult looking out for the child's best interest.
- Provide information and offer choices that are appropriate for their age: use communication tools and history-taking aids that are appropriate to the age and developmental stage of the survivor.
- Respect young people's autonomy and agency even when they are younger than the legal age of consent; ensure the participation of children or adolescents in decisions that have implications for their lives.

Ensure survivor-centred, evidence-based responses regardless of the person's initial reason for seeking care

Health workers are likely to encounter survivors of sexual assault or IPV in a range of clinical settings, including:

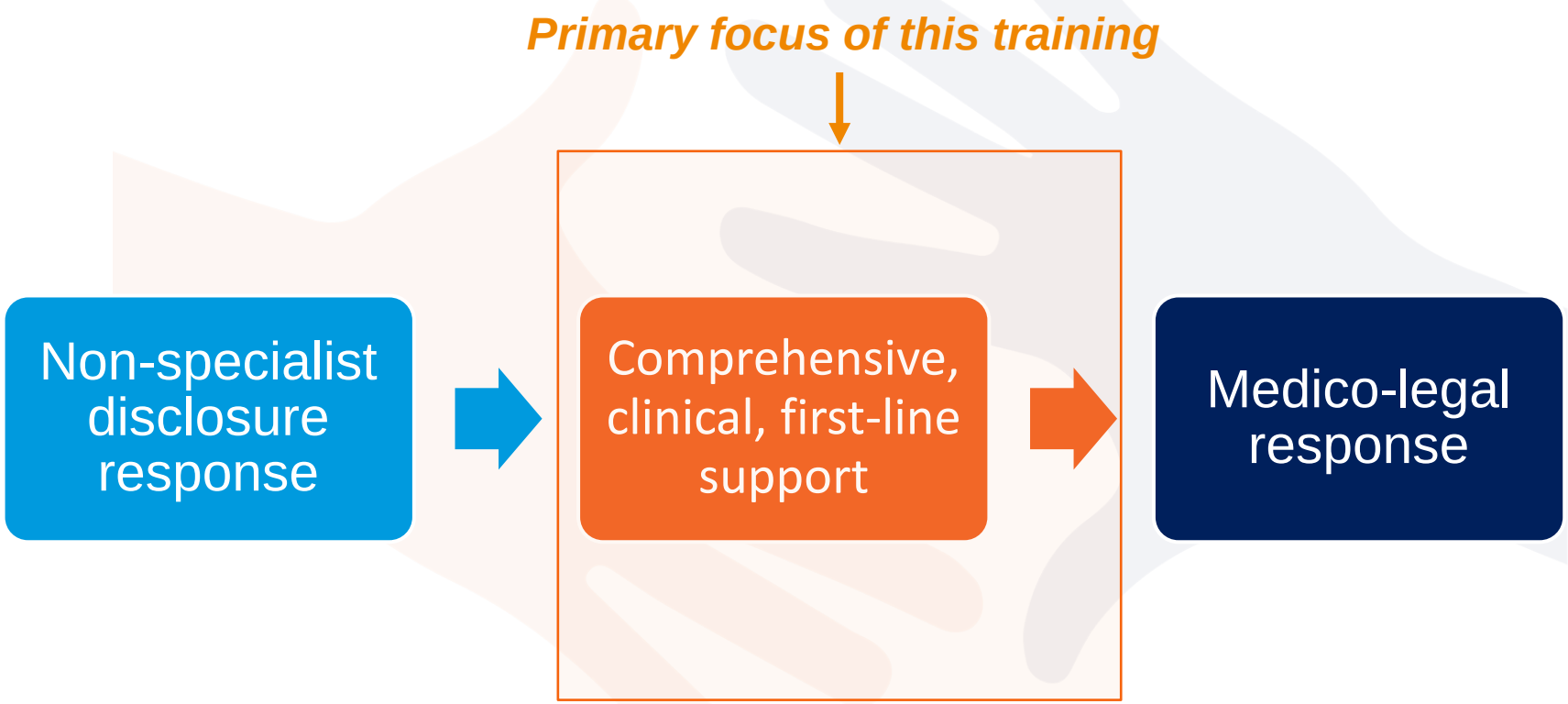
- STI or HIV care
- Child immunization
- Child feeding programmes
- Adolescent health
- Mental health
- Abortion or post-abortion care
- Maternal health (antenatal or postnatal)
- Family planning services
- Mobile outreach
- Emergency departments

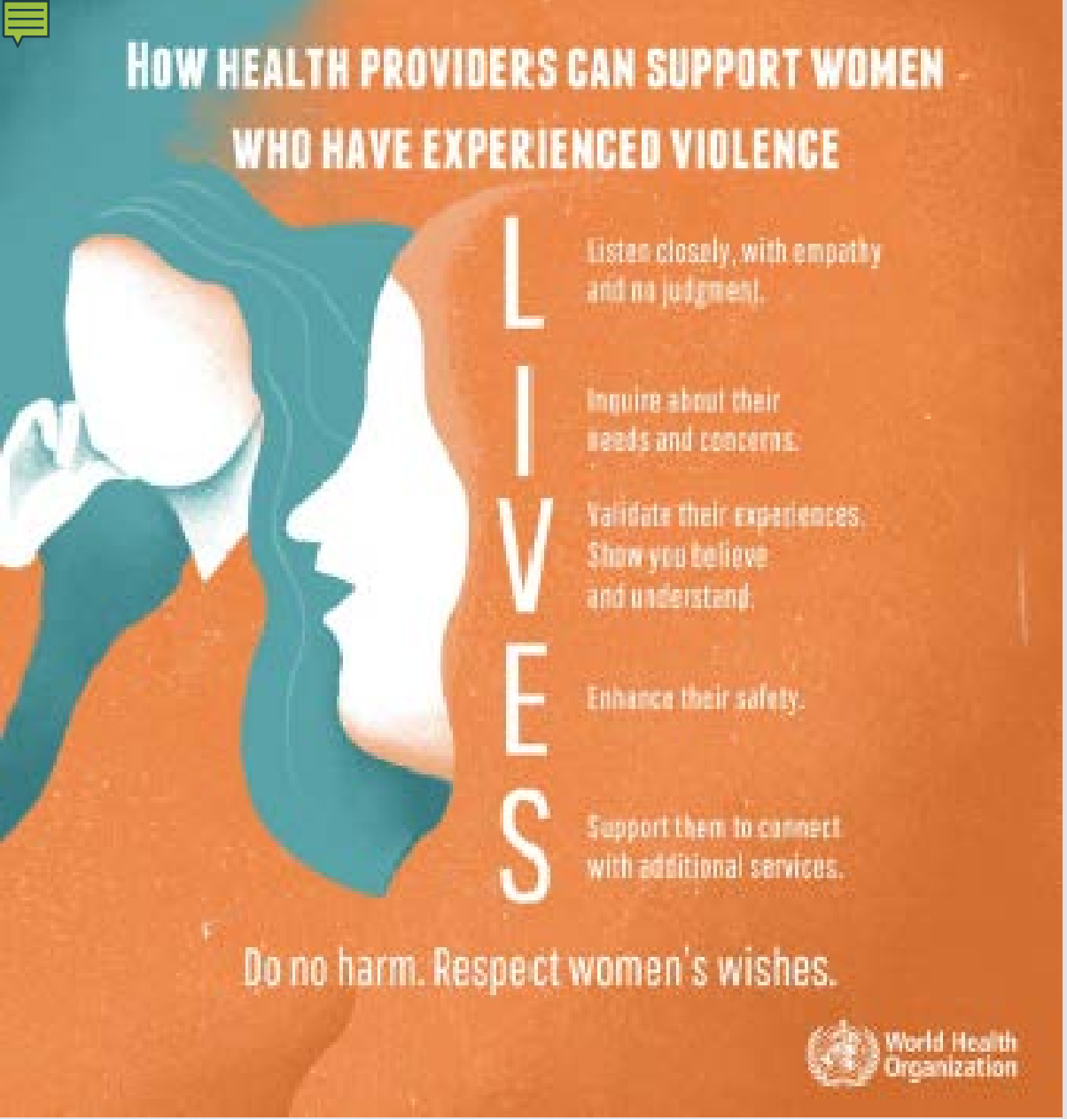
Why not universal screening?

- It is rare for a health system to have capacity to respond to all people who have experienced violence. It can be harmful to bring up GBV without full-scope referral options in place.
- If given space, compassion and safe opportunity, survivors who want to disclose will do so.
- General messages about how GBV is never the survivor's fault, available resources for survivors, and the provider's availability to listen and offer support can be provided without a disclosure of violence.

First-line support

A continuum of health-sector services

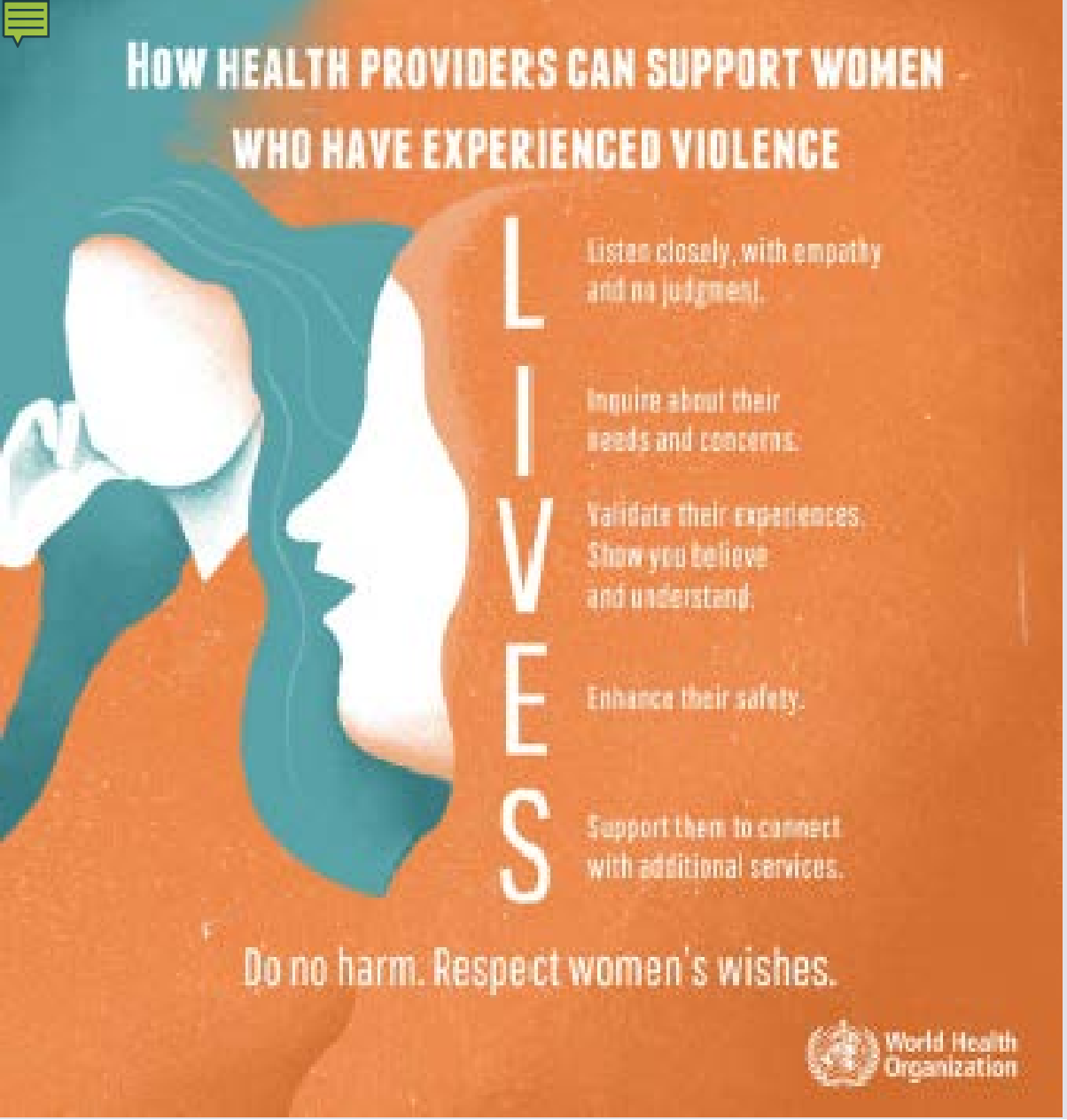




First-line support

Learn to listen with your:

- Eyes – giving her your undivided attention
- Ears – truly hearing her concerns and questions
- Heart – hearing with caring and respect



First-line support

Supporting with basic psychosocial care means to:

- Help strengthen **positive coping methods**
- Explore availability of **social support**
- Teach **stress-reduction** exercises
- Make regular **follow-up** appointments
- Assess for moderate-to-severe **depression or post-traumatic stress disorder (PTSD)**

Session 3: That's a wrap!

- The health system response should be based on respect for human rights and promotion of gender equality
- Children and adolescents will need additional considerations based on the principles of best interest and evolving capacities
- The training prepares qualified health workers to provide first-line support and clinical care for survivors of sexual violence and IPV

Reference

1. Adapted from: Disability-inclusive health services toolkit: a resource for health facilities in the Western Pacific Region. Manila: World Health Organization Regional Office for the Western Pacific. 2020;11.

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Session 4.

Provider–survivor communication skills

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Session objectives

Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive services

Competencies:

- Communicate empathically and effectively with patients and survivors
- Understand how discrimination faced by survivors (based on language, ethnicity an/or gender identity, among others) can shape their access to and experience of care

Why communication matters

- Communication helps the provider give the best and most appropriate care possible
- It allows the patient to understand what is happening and why
- It is essential for true informed consent
- It facilitates active participation in care by the patient

Active listening

Use verbal and nonverbal means to show support and communicate understanding

Ask questions that are:

- Open-ended
- Focused
- Closed (i.e. require yes/no responses)

Use good body language involving:

- Posture
- Eye contact

AVOID leading questions and compound questions

Body language of active listening

S – Sitting position

O – Open posture

L – Leaning forward

E – Eye contact

R – Relaxed

Exercise 4.1

Practice

- Turn to your neighbour
- Invite your neighbour to take 3–4 minutes to tell you about a recent bad day they have had
- Practise active listening
- Switch roles

Session 4: That's a wrap!

- Survivors of violence are often silenced by perpetrators, family – and even health-care providers. By contrast, active and supportive listening allows survivors to feel heard, enables disclosure of violence, and invites survivors to be an active participant in their own care and recovery.
- Active listening uses both verbal and nonverbal skills.

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Session 5.

Know your setting

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Session objectives

Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies:

- Understand the role of referral services in caring for survivors of sexual assault and IPV
- Know the legal and policy context, including health workers' legal obligations

Provider responsibilities in a multisectoral response

Health workers cannot do it all, but they…

- Have an obligation to know about the referral services in their area
- Should understand the range of referral services available under the current legal, regulatory and safety contexts
- Must be able to protect the confidentiality and safety of clients when making referrals
- Must uphold client self-determination and agency when offering referrals

Referrals in emergencies

Make every effort regardless of the emergency

- Mental health care
- Sexual and reproductive health care
- Child protection services
- Shelter/housing
- Police protective services

Core principles for referral pathways

- Respect self-determination
- Minimize points of care and the need for retelling of violent experiences
- Maintain safety of the survivor and confidentiality of her information
- Include protocols for confirming referral completion
- Maintain and update lists of known quality referrals
- Enable bi-directional communication between referring and referred to providers

Providing a warm referral

Warm referral practices help survivors reach further care and increase the likelihood of referral completion

✓ DO

- ✓ Ask: “What would help most if we could do it now?”
- ✓ Help her identify and consider referral and social support options. Explain how the referral service can meet her need.
- ✓ Give her contact details – location, how to get there, names.
- ✓ Help her identify solutions to practical barriers (e.g. childcare).
- ✓ Offer to help make an appointment.

✗ DON’T

- ✗ Simply hand over a sheet of all possible referrals.
- ✗ Suggest that she needs every referral service available.
- ✗ Assume the same referral service is appropriate for every survivor.
- ✗ Assume the survivor knows how to access the referral service.

Spotlight on known referrals

- Known referrals prevent sending a survivor to a point of service that is no longer functional and/or where they might receive poor-quality or harmful services
- Ensure referral directories are updated regularly
- Persons responsible for updating referral directories should have frequent contact and communication with referral service points

Need	Name of agency &/or contact person	Contact	Responsible for follow-up
Victim advocate/Family protection unit/Social worker		Phone: E-mail:	
Counselling/Crisis centre/		Phone: E-mail:	
Support groups		Phone: E-mail:	
Mental health care		Phone: E-mail:	
Reproductive health care		Phone: E-mail:	
Laboratory services		Phone: E-mail:	
Child care		Phone: E-mail:	
Child protection		Phone: E-mail:	
Police		Phone: E-mail:	
Need	**Name of agency &/or contact person**	**Contact**	**Responsible for follow-up**
Forensics		Phone E-mail:	
Shelter/housing		Phone E-mail:	
Financial aid		Phone E-mail:	
Legal aid		Phone E-mail:	
Livelihood/ employment		Phone E-mail:	
[Other]		Phone E-mail:	
[Other]		Phone E-mail:	

International legal and policy context

In cross-border emergencies, the international body of law may be the prevailing jurisprudence

International Humanitarian Law (1949 Geneva Conventions + 1977 addendum protocols)	• Protects any person who is not or is no longer actively participating in hostilities and regulates means of warfare. • Affords protection on the basis of sex or gender discrimination; rape as an act of war; and special protections for pregnant and postpartum women.[1]
Rome Statute of the International Criminal Law (2002)	• Prohibits war crimes and defines rape, forced pregnancy or any other form of sexual violence as a crime against humanity when committed in a widespread or systematic way.[2]
International Refugee Law, including the Convention and Protocol Relating to the Status of Refugees and the Cartagena Declaration on Refugees	• Includes rape and other forms of GBV (including IPV, FGM and reproductive coercion) as grounds for claiming refugee status. • Further allows for asylum claims based on persecution due to sexual orientation, gender identity or forced prostitution.

National and local legal and policy context

Know the law and policy that affects the care you give:

- Laws around intimate partner violence, marital rape, age of consent, and other facets of IPV or sexual violence
- Laws about abortion services for survivors of violence
- Limits or spousal/parental consent constraints to providing emergency contraception
- Age of parental consent requirements for adolescents

National and local legal and policy context (continued)

Know the law and policy that affects the care you give:

Legal or policy obligations around the following:

- Is there mandatory reporting to police?
- Is there mandatory notification of a parent or guardian?
- Is there mandatory forensic exam and/or medico-legal certificates in cases of sexual violence?
- Who is authorized to perform forensic exams?
- Who is authorized to testify in court proceedings?
- What are the regulations around records or data-sharing?

Caution regarding mandatory reporting

- **WHO does not** recommend mandatory reporting for adult survivors of sexual assault or IPV.
- Mandatory reporting imposes barriers in access to time-sensitive health care for survivors and can deter them from coming forward to disclose. It violates the principles of self-determination.

Temporary legal and policy context

Know the changes to scope of practice, recommended treatment protocols, and signatory authority that may be temporarily imposed during times of crisis or emergency

Exercise 5.2

Understanding how policies impact the care provided

Instructions

- ☑ Read the case summary in your assigned group
- ☑ Discuss and answer the provided questions as a group
- ☑ Choose a group member to report in plenary

Exercise 5.3

When referral networks break down

Instructions for each group

- Choose a note-taker
- Review the assigned case study
- Record group reflections on the provided flip chart/poster paper
- Choose a rapporteur who will give a summary of the reflections

Session 5: That's a wrap!

- Active and up-to-date referral networks and warm referral practices can help women more easily access the care that is available
- When emergencies disrupt referral services and pathways, provision of health care and facilitating the safety of survivors are critical
- Self-determination is at the core of the referral process
- Providers are responsible for knowing the legal and policy context that affects the care they provide

References

1. Handbook for coordinating gender-based violence interventions in emergencies. Geneva: Gender-Based Violence Area of Responsibility. UNFPA; 2019.
2. United Nations Office of the Special Representative on Sexual Violence in Conflict. Sexual violence: a tool of war – background note. 2014.

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Session 6.

Identifying and responding to IPV

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Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

Competencies:

- Understand the minimum requirements that need to be in place for a health worker to be able to identify and respond appropriately to IPV
- Recognize the signs and symptoms that suggest IPV in a variety of care encounters, including in reproductive health and mental health consultations
- Demonstrate appropriate ways to ask about IPV

When to ask about IPV

WHO does **not** recommend universal screening for IPV

- Only where visual and auditory privacy are assured
- Only when a system for providing first-line support is in place
- Only if you have been trained and have competency in disclosure response and psychological first aid
- Only in tandem with sharing any limits on confidentiality or mandatory reporting obligations

Identifying partner violence

- **Clinical inquiry is recommended**
- Providers are advised to hold a low threshold for inquiry as answers can improve diagnosis and treatment of a range of issues
- Printed information on partner violence and resources for the survivor to take home can be helpful

Clinical inquiry: signs and symptoms

- Injuries that are recurrent and/or not well explained
- Repeat STIs and/or unwanted pregnancies
- Unexplained, ongoing anxiety, insomnia or depression
- Partner is intrusive or dominating during appointments
- Repeated health consultations with no clear diagnosis; common somatic issues such as chronic headaches or gastrointestinal distress without other cause
- Often misses health-care appointments
- Emotional and/or behavioural problems

When to ask about IPV in the midst of crisis

Remember!

Do no harm

- Asking about IPV and inviting disclosures when neither you nor nearby resources have the ability to provide first-line support can do more harm than good
- **But**, asking about suspected IPV and providing the first three steps of LIV(ES) only requires 5–10 extra minutes

Asking about violence

Raise the topic indirectly…

- Is everything OK at home?
- Do you feel safe where you are staying?

Asking about violence

If the client gives an indication that it is OK to proceed, ask direct questions, such as:

- Are you afraid of your intimate partner?
- Has your intimate partner ever threatened to hurt you or your children?
- Has your intimate partner forced you to have sex?
- Has your intimate partner forced you to have sex without contraception (e.g. condom or birth control)?
- Does your intimate partner prevent you from having money or going places?
- Has your intimate partner ever threatened to kill you?

Asking about violence

Remember!

Never pressure someone into disclosing violence

If you suspect violence, but the patient denies any trouble, move the visit along:

- Treat the reasons the patient came to the clinic
- Offer general information about IPV and local resources
- Offer a follow-up visit related to her primary complaint

Special considerations for accompanied patient

- Patients experiencing IPV may be accompanied by the partner who is perpetrating violence
- Be alert to body language
- Create opportunities for the patient to share information without the knowledge of the person accompanying them

For additional information and guidance see:
Responding to children and adolescents who have been sexually abused: WHO clinical guidelines (2017).[1]

Tips and tricks for creating privacy with accompanied patients

- Request a urine sample and ask the accompanying adult to fetch some drinking water
- Ask the accompanying adult to go to registration, the pharmacy or another auxiliary service
- What are some tips and tricks from your own professional experience?

Summary protocol

Job aids can be found in:

- WHO VAW Clinical Handbook (IPV specific),[2] p. 38
- Web Annex B. Participant job aids (Job aid 6a)

1. Identify partner violence
2. First-line support: Listen, Inquire, Validate
3. Assess mental/emotional state
4. Care for health conditions that brought her to health facility
5. First-line support continued: enhance safety; support and refer for other services needed
6. Plan for follow-up care

Exercise 6.1a

Demonstration: Asking about IPV

Exercise 6.1b

Role play on identification of IPV

- Ensure each person in your group has an opportunity to play the role of the provider
- When not actively involved in the role play, observe closely and share constructive feedback with your colleagues
- Practise active listening

Session 6: That's a wrap!

- Partner violence is identified by staying attentive to possible clinical cues
- First, ask general questions
- Ask about violence compassionately, without judgement
- Many survivors will not disclose; even so, providers play an important role in providing information and building trust
- Skills for identifying or asking will improve with practice

Reference

1. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259270). Licence: CC BY-NC-SA 3.0 IGO.
2. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/136101).

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Session 7.

First-line support using LIV(ES), part 1: Listen, Inquire, Validate

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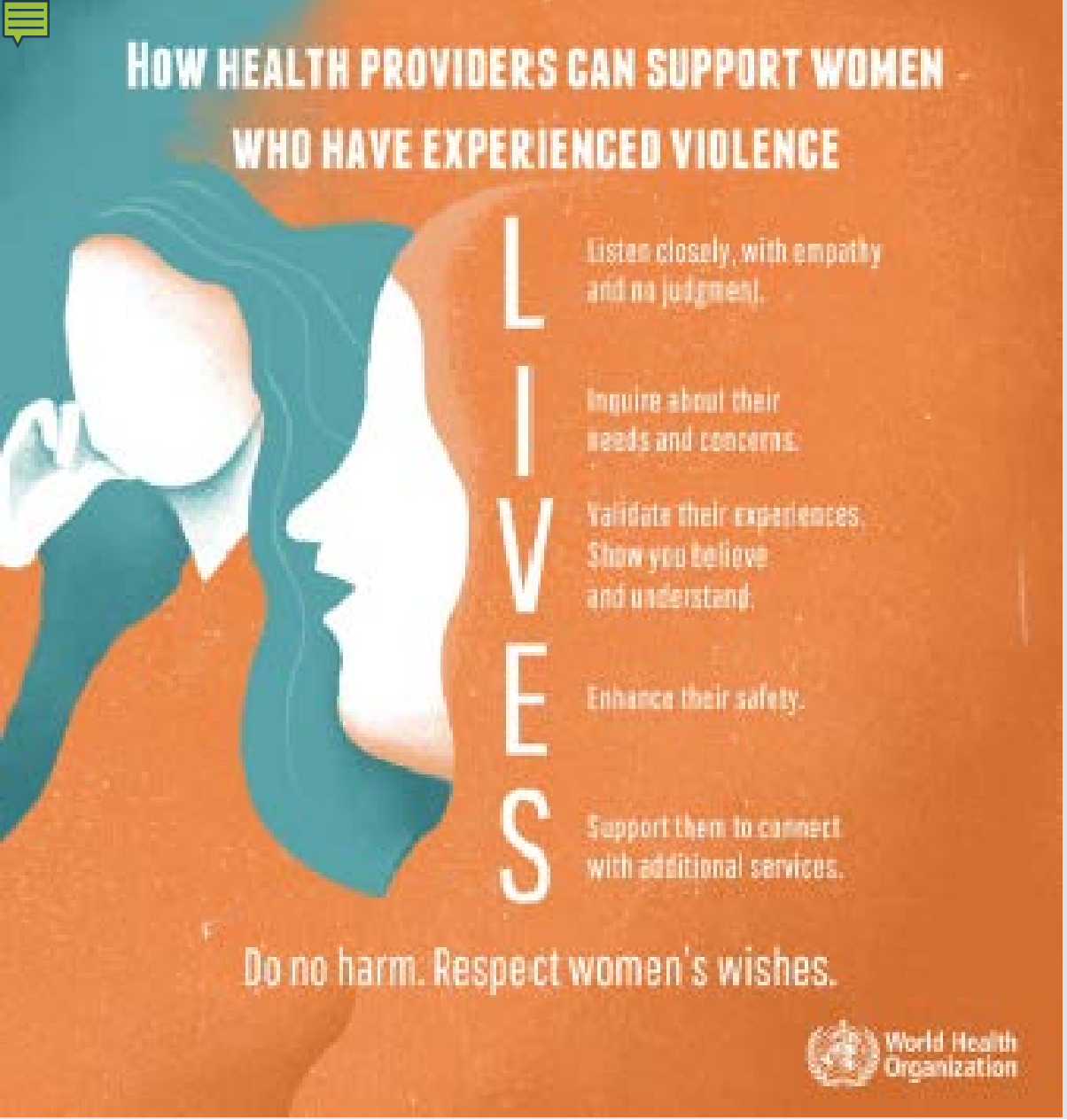
Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

Competencies:

- Know the content of first-line support (LIVES)
- Demonstrate skills in offering the first three elements (listening, inquiring and validating) of first-line support to survivors who disclose abuse



First-line support

Learn to listen with your:

- Eyes – giving her your undivided attention
- Ears – truly hearing her concerns and questions
- Heart – hearing with caring and respect

First-line support for children and adolescents

The 2 Cs, "CC"

Child- and adolescent-friendly environment

Provide age-appropriate information in an age and life-stage tailored manner and environment

Respect the survivor's opinions, beliefs, thoughts and choices – regardless of their age

Caregiver support

Involve a non-offending caregiver in all aspects of first-line support

Empower non-offending caregivers with information about care, referral resources and ongoing support, and healing

Special considerations for inquiry

- Know and follow mandatory reporting laws and protocols regarding child abuse
- Know the national and local laws regarding consent for minors for medical care and treatment
- Be mindful that the adult who has brought the child to the health centre may be the perpetrator or complicit in the abuse

What is first-line support?

✓ DO

- ✓ Identify needs and concerns
- ✓ Respond to emotional, physical, safety and support needs
- ✓ Listen to and validate experiences and concerns
- ✓ Help her feel connected to others, calm and hopeful
- ✓ Empower her to feel able to help herself and to seek help
- ✓ Explore options
- ✓ Respect her wishes

Do's for LIVES + CC

✓ DO

- ✓ Speak in a way the child understands
- ✓ Help the child to feel safe
- ✓ Pay extra attention to non-verbal communication
- ✓ Reassure the child or adolescent that they are not at fault
- ✓ Make extra time to explain and help the child understand why you are talking about these things
- ✓ Refer to or bring in a child advocate or social worker if a non-offending family caregiver is unavailable

What is first-line support?

✗ DON'T

- ✗ Try to solve her problems
- ✗ Try to convince her to leave a violent relationship
- ✗ Try to convince her to go to the police or courts
- ✗ Try to figure out why something happened

Don’ts for LIVES + CC

✗ DON’T

- ✗ Assume a young person cannot be in an intimate relationship
- ✗ Force a child or adolescent to answer questions
- ✗ Expect children to be able to convey all information verbally
- ✗ Assume the adult accompanying the child is a non-offending caregiver

Listen

✓ DO

- ✓ Be patient and calm. Allow for silence.
- ✓ Look at her, nod your head, and make acknowledging sounds (“mmm”).
- ✓ Have open, relaxed expressions.
- ✓ Encourage her to keep talking. Ask: “Would you like to tell me more?”
- ✓ Invite disclosure. Ask: “How can I help you?”

Listen

✗ DON'T

- ✗ Don't hurry or pressure her into telling her story.
- ✗ Don't look at your phone or watch. Don't answer the phone. Limit note-taking. Decline interruptions or other patients unless critical to save a life.
- ✗ Don't judge what she is telling you or try to figure out the why behind actions.
- ✗ Don't assume you know how she should feel. **AVOID** saying: "You should feel lucky to be alive!" or "Don't feel like that!"
- ✗ Don't tell her about someone else's story

Inquire about needs and concerns (1)

Inquiry principles

- Phrase your questions as invitations to speak
- Ask open-ended questions
- Check your understanding
- Reflect her feelings

Sample questions

- “What would you like to talk about first?”
- “What would you like to do now?”
- “You mentioned that you are worried you could be pregnant, did I understand that correctly?”
- “It sounds as if you are having a hard time feeling relaxed …”

Inquire about needs and concerns (2)

Inquiry principles

- Ask for clarification when needed
- Help the survivor to identify and express her needs and concerns
- Explore events further as needed

Sample questions

- “Could you clarify that for me?”
- “What are your biggest worries right now?”
- “Could you tell me more about that?”

Validate

Important things you can say:

You may be the first or only person to say these things!

- “It’s not your fault.”
- “It’s okay to talk about this.”
- “No one deserves to be hit by their partner.”
- “You are of value. Your life and your health matters.”
- “You are not alone. Sadly, many others have faced this.”
- “The way you are feeling and coping will change over time. It’s OK to be struggling right now.”
- “Help is available.” (Only say this if it is true.)

Exercise 7.1

Video “Responding to intimate partner violence – LIV”

- Watch as the doctor demonstrates the techniques for the first three steps: **L – I – V**
- Reflect on how you might provide this care in your own words and style
- Watch for active listening techniques

Exercise 7.2

Role play to practise LIV(ES), part 1

- Practise the first three steps: **L**isten – **I**nquire – **V**alidate
- Resist the urge to follow pathways of physical examination or treatment counselling
- Remember your active listening techniques

Job aid 7a
in Web Annex B. Participant job aids

Session 7: That's a wrap!

- Effective listening and LIVES can be powerful healing tools for survivors. For some, first-line response alone can be what they need to move forward.
- Remember to minimize distractions and focus on your patient for the most effective communication.
- When providing first-line support to younger survivors, ensure a **C**hild- and adolescent-friendly environment, and **C**aregiver support.
- Take the time to continue practising the LIV portions of LIVES, and think about how you can provide first-line support using your own words.

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Session 8.

First-line support using LIV(ES), part 2: Enhancing safety and providing Support

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Session objectives

Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies:

- Demonstrate the skills to assess immediate risk/safety and to support safety planning, including for child and adolescent sexual abuse survivors
- Know what resources are available in the community and through coordinated humanitarian response
- Know how to collaborate with partners to help survivors access other services and to provide referrals
- Demonstrate skills to provide warm referrals, where possible

First-line support

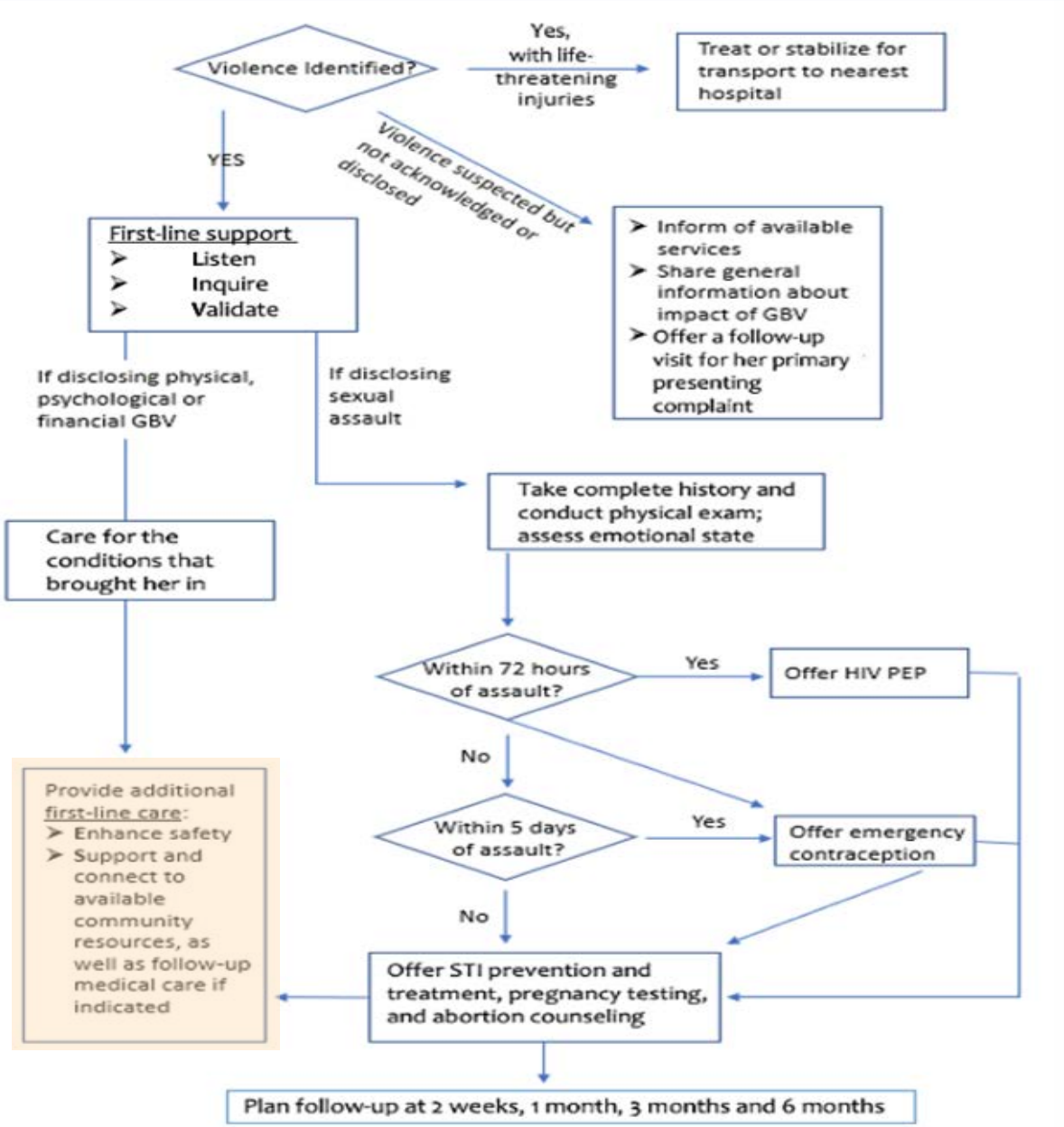
Listen

Inquire about needs and concerns

Validate

Enhance safety

Support



Job aid 8a
in the CMRIPV guidelines[1]

IPV safety risk assessment

After a violent incident (physical or sexual assault), it is important to discuss and help the survivor assess whether it is safe to go home.

Affirmative ("yes") responses to at least 3 of these questions indicates high immediate risk of severe harm

- ✓ Has the violence happened more often or become worse over the past 6 months?
- ✓ Has he ever used a weapon or threatened you with a weapon?
- ✓ Has he ever tried to strangle you?
- ✓ Do you believe he could kill you?
- ✓ Has he ever beaten you when you were pregnant?
- ✓ Is he violently and constantly jealous of you?

Enhancing safety

When elevated safety risks are identified in the survivor's home environment, make time to:

- Encourage and support development of a safety plan
- Provide warm referrals to protection and/or shelter services, as well as social work or case-management services, if available
- Always offer a follow-up visit to continue discussing ways to protect her, her well-being and her children

Making a risk mitigation plan

Avoid putting her at additional risk

- Talk about abuse only when you and she are alone
- Maintain confidentiality of health records
- Discuss how she will explain where she has been and what to do with any paperwork that she will take home
- The survivor knows the most effective way to reduce her exposure to harm. Support her decision-making process and choices.

Facilitating social Support

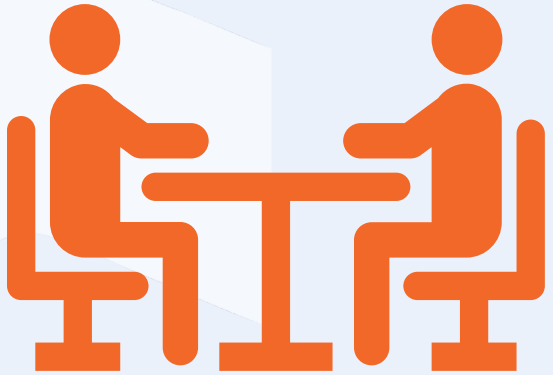
- Help her identify and consider her options, and what is most important to her
- Discuss her social support – she may prefer to rely on her informal network
- Connect her to resources through warm referrals

Exercise 8.1

Facilitator demonstration, (LIV)ES

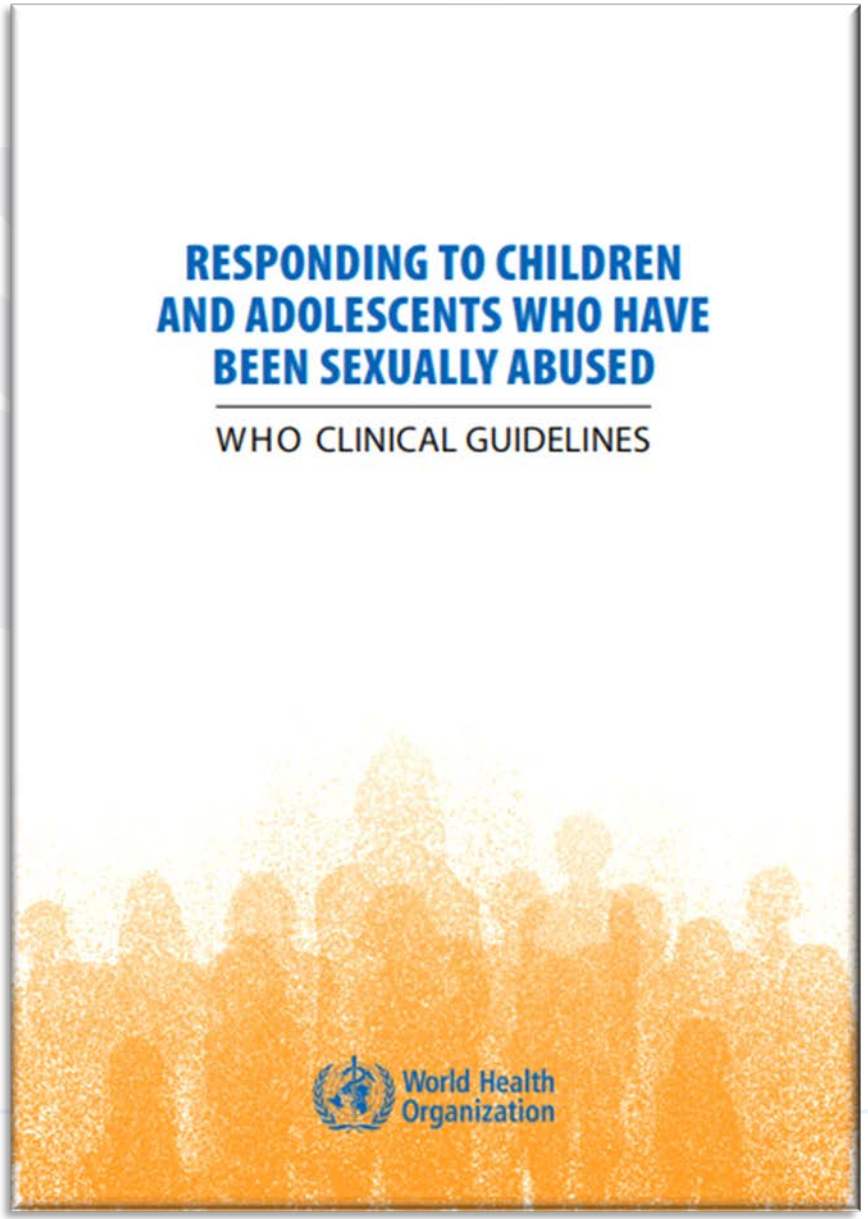
Learning objective for this exercise:

Develop skills for providing
the **E** and **S** elements of LIVES first-line support



Special considerations for children and adolescents

For more information see:
Responding to children and adolescents who have been sexually abused: WHO clinical guidelines[2]



Guiding principles

- Be mindful of the evolving capacities of children and adolescents
- Provide information, seek informed consent, and encourage their agency and autonomy in a manner appropriate to their age and developmental stage
- All service providers have a duty of care to promote the best interests of children and adolescents, especially if the child's parents or guardians are not able to do so
- Whenever possible, bring in a provider with paediatric experience when child survivors of sexual violence are identified

Special considerations for (LIV)ES + CC

- Help the child feel safe
- Strive to offer children and adolescents a choice of gender of their provider
- Be mindful of word choice and use simple vocabulary:
  use Child-centred communication throughout
- Young children may communicate best through drawing pictures or pointing at body diagrams
- Frequently reinforce that the child has done nothing wrong
- Include a trusted, non-offending Caregiver in risk assessment, safety planning and linkages to social support and referral services

Age-appropriate involvement in decision-making

- Understanding the evolving capacities of children and adolescents is critical to providing age-appropriate care
- Intersectional factors affecting the survivor's maturity, their capacity to give informed consent and local regulatory requirements, all need to be taken into account
- A child's or adolescent's capacity to be involved in decision-making can be diminished by their response to the violence they have experienced and/or other impairments, and this can make assessment difficult; in these cases, make every effort to bring in a child specialist

Exercise 8.2

Role play to practise (LIV)ES, part 2

- **Patient:**
  Read the scenario to yourself. Don't tell the others the details. When asked, read aloud the section entitled "explain to provider". Describe your situation and answer the provider's questions.
- **Health-care provider:**
  Listen to the patient's disclosure and provide first-line support – Enhance safety and access Support.
- **Observer:**
  Provide feedback to the provider.

Session 8: That's a wrap!

- Risk assessment can help you understand a woman's immediate safety needs
- Trust your patient when she tells you she is in severe danger
- Providing linkages to support services is a core activity in the response to violence
- Always provide referrals that respond to her stated needs
- Engage children and adolescents in identifying their own support needs as much as possible

References

1. World Health Organization, United Nations Population Fund, United Nations High Commissioner for Refugees. Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331535). Licence: CC BY-NC-SA 3.0 IGO.
2. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259270). Licence: CC BY-NC-SA 3.0 IGO.

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Session 9.

Clinical care for survivors of sexual assault, part 1: Informed consent and history-taking

World Health Organization

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Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual violence and IPV

Competencies:

- Understand the 4-step process for informed consent
- Demonstrate skills to take a clinical history, including for a child or adolescent survivor of sexual abuse

Steps for clinical management of rape

Step 1	Listen, inquire about needs/concerns, and validate the survivor
Step 2	**Obtain informed consent and prepare the survivor**
Step 3	**Take the history**
Step 4	Perform the physical and genito-anal exam
Step 5	Provide treatment
Step 6	Enhance safety and refer for additional support
Step 7	Assess mental health and provide psychosocial support
Step 8	Provide follow-up care

Informed consent… an ongoing process

Considerations

- Giving informed consent requires the survivor to know the consequences of their choices
- Frequent and ongoing verbal informed assent is critical when caring for survivors of sexual violence
- Written informed consent is recommended and usually required prior to:
  - physical examination
  - collection of physical evidence
  - sharing of records in the course of referral

Information to include when seeking consent to proceed with clinical management of rape

Certain types of information should also be provided to a client when seeking consent to proceed, including:

- What will happen during the visit
- The survivor's right to pause, skip or stop any step
- Options for physical examination and physical evidence collection
- Any applicable mandatory reporting
- The survivor's degree of control over who has access to documentation and prosecution
- Whether forensic services are available/functioning

Informed consent with child and adolescent survivors

- ☑ Know and explain any mandatory reporting laws
- ☑ Seek informed assent from the survivor, even if legal consent must come from a guardian or caregiver
- ☑ Help solicit the survivor's preferences, questions and wishes in an age-appropriate manner, to inform the parent's or guardian's decisions around consent
- ☑ Be alert to body language that suggests intimidation or coercion by the accompanying adult when seeking a child or adolescent's assent

When to offer a forensic examination

Only when:

- A certified forensic science lab is available
- The woman has presented within 5 days of the assault
- She wants to report the case to the police or reporting is mandatory
- A trained provider is available

Under no circumstance should physical evidence be gathered if the resources needed to store and analyse samples are not available

Exercise 9.1

Whether and when to offer forensic examination and evidence collection

- Listen to the brief scenarios
- Consider if the context meets the following **4** minimum requirements for offering forensic evidence collection:
  - Are forensic evidence storage and analysis processes and facilities available and functioning?
  - Does the time elapsed since assault allow for collection of physical evidence?
  - Is there a legal obligation to prepare a medico-legal certificate?
  - Does the provider have the ability and authorization to complete a forensic exam and medico-legal reporting forms?

Exercise 9.1

Scenario 1

Fatima is a maternal, newborn and child health nurse working at the district hospital in Anywhere Town, Nationville. Nationville has mandatory reporting for any suspected case of sexual violence against a child under age 16. Fatima has been trained in first-line response to GBV. Her normal work focuses on family planning/reproductive health services, including provision of long-acting contraception, post-abortion care, and antenatal and postpartum care. There are no GBV specialists in her hospital. There is a One-Stop Centre at the national hospital located 3 hours away. Currently, there is a travel advisory for the road between Anywhere Town and the capital due to seizure by militia forces and an armed blockade of the road.

Fatima calls in her next patient and sees two adolescent girls walk in. Bernice is a 13-year-old girl. She was brought in by her older sister (age 17), who found her crying at home. For several months – ever since their father was killed in a militia raid – their uncle has been staying with them for increased protection, and has been sexually abusing Bernice. It started as touching, then he kissed her and forced her to watch him masturbate. He threatened to harm her if she told her mother or siblings. A few weeks ago, he raped her vaginally. She has been facing sleepless nights, anxiety and nightmares, but has been terrified to say anything, fearing he would hurt her. Finally, the previous evening, she told her sister, because she is experiencing pain in her vagina and there is yellow-green discharge. Her sister brought her to the doctor first thing in the morning. She did not say anything to their mother because the man is their mother's favourite brother.

Exercise 9.1

Scenario 2

Princess is a physician trained in GBV response and usually works at the One-Stop Centre at the hospital in Banda Aceh, Sumatra. She was up-country with her family for Christmas when the 2004 tsunami devasted the city. She raced back to help with the response. A week after the tsunami, Princess is working at the massively damaged hospital, providing general practitioner (GP) services in the section of the hospital that has been cleared of debris. The One-Stop Centre was completely destroyed and there are no forensic labs in the province.

Cham is a 36-year-old woman. There had been renovation work at her house, which has now been completed. Five days ago, on the last day of the renovation work, one of the workers entered her bedroom and forced her to have sex while the children were playing outside. Then, two days later, the tsunami hit. She has not found her husband and believes he was killed in the initial wave.

She finally made it to the clinic today because she is scared of becoming pregnant or contracting HIV. She has no interest in going to the police and just wants to be able to take care of her surviving children and figure out where they will now live.

Preparing to take the clinical history

- ☑ Remember to provide the first three steps of LIV(ES) early and often
- ☑ Active listening and care with verbal and body language are important throughout the entire exam
- ☑ Ensure a second person is in the room to support the survivor
- ☑ Ensure auditory and visual privacy

History-taking

The survivor may sit or be in any position that is most comfortable for this conversation

- Create a climate of trust
- Plan for a lot of time and go at the survivor's pace
- Make time for silence, breaks, crying or other pauses
- Document findings in official client records

History-taking with child survivors

The survivor may sit or be in any position that is most comfortable for this conversation

- Younger children may remain on their parent's/caregiver's lap, or in any position that makes them most comfortable
- Gather and document the history of the survivor's timing, onset and stage of puberty
- Gather information about the environment in which the survivor lives and the caregivers and adults/older adolescents they spend time with
- Offer the child options for using pictures or toys to enact aspects of their experience/history

History-taking with child survivors

Remember!

- Experiencing maltreatment is a potentially traumatic event
- Health workers should seek to minimize additional distress by minimizing the number of assessments the survivor undergoes, including asking them the same questions more than once
- Asking a child repeatedly to tell their history can be re-traumatizing

Clinical history for clinical management of rape

History component	Information sought
General assault events	• Date, time, location • Known or unknown suspect • How the violence unfolded: injuries, penetration – what type and with what body part or object – loss of consciousness, intake of drugs or toxic substances • Subsequent activities that may impact evidence such as bathing, douching or changing clothing
Survivor's general medical history or conditions	• Unexplained symptoms of concern • Known chronic medical conditions • Current medications or supplements • Current use/abuse of alcohol or drugs

Clinical history for clinical management of rape (continued)

History component	Information sought
Survivor's obstetric/ gynecological history	• Currently pregnant? • First day of last menstrual period • Current use of contraception and the method of contraception • Any pain and/or blood with urination, defecation or in the genital area
Mental health assessment	• Current ability to recall events • Current ability to understand what is happening • Degree of distress/capacity to sleep and rest • Any self-harm or suicide ideation

Skills in action – history-taking

Allow the survivor to tell you what happened in their own way

Exercise 9.2

Clinical history role play

- **Patient:**
  Read the scenario to yourself.
  Don’t tell the others the details. When asked, read aloud the part entitled “explain to provider”. Describe your situation and answer the provider's questions.
- **Health worker:**
  Gather a complete history, using Job aid 9a to document findings.

“Sample history and examination form” in Women IPV and sexual violence clinical handbook[1]

Session 9: That's a wrap!

- Ensure the counselling for informed consent includes information about applicable laws and regulations that will impact what happens with information that is shared and/or documentation that is completed
- Obtain informed consent separately for the four steps of clinical management of rape: history taking, physical examination, forensic evidence collection and documentation
- History informs and shapes the examination and treatment
- Thorough clinical history and examination should be offered and provided even in cases where the minimum requirements for forensic examination are not met
- Obtain consent separately for each aspect of the exam; informal verbal consent should be sought throughout the physical and recto-genital exam

Reference

1. World Health Organization, United Nations Women, United Nations Population Fund (UNFPA). Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: WHO; 2014 (https://iris.who.int/handle/10665/136101).

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

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Session 10.

Clinical care for survivors of sexual assault, part 2: physical examination and documentation

World Health Organization

HEALTH CLUSTER

Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

Competencies:

- Know how to conduct an examination of a female or male survivor of sexual assault, including awareness of special considerations for different age groups
- Know how to document sexual assault in a safe and confidential manner

Steps for clinical management of rape

Step 1	Listen, inquire about needs/concerns, and validate the survivor
Step 2	Obtain informed consent and prepare the survivor
Step 3	Take the history
Step 4	**Perform the physical and genito-anal exam**
Step 5	Provide treatment
Step 6	Enhance safety and refer for additional support
Step 7	Assess mental health and provide psychosocial support
Step 8	Provide follow-up care

Performing the physical examination

- Begin by reminding the survivor that the physical exam is to help you identify all injuries or health issues that can be treated.
- Say at the beginning and repeat throughout that the survivor is in control and can pause or stop the exam at any time.
- Proceed in a systematic fashion: Record all your findings and observations as clearly and completely as possible on a standard examination form, using pictograms.
- Keep the survivor as covered as possible at each stage. Drapes allow you to easily uncover a single part of the body at a time.
- At each step, tell her what you are going to do, and ask permission before you do it.
- Always look at the survivor before you touch her and pay attention to her appearance and emotional state.
- Only ask the survivor to endure a single examination. Health providers designated to collect forensic evidence should minimize stress by collecting evidence during the physical examination, ensuring beforehand that survivor consent has been obtained.

Performing the physical examination

If any of the following complications are identified, pause the exam and admit the person to hospital:

- ☑ Extensive injury (to genital and/or anal region, head, chest or abdomen)
- ☑ Neurological deficits (e.g. cannot speak, problems walking)
- ☑ Respiratory distress
- ☑ Swelling of joints on one side of the body
- ☑ Fever and sepsis

Performing the physical examination

- Be sure to assess and record standard vitals including pulse, temperature, respiratory rate and blood pressure
- Take note of the survivor's mental and emotional state (e.g. withdrawn, crying, calm, partial memory recall)
- Measure any observed injuries:
  Document location, size, type and depth as precisely as possible using pictograms;
  Include notation of coloration of observed contusions

If a survivor presents **more** than 72 hours after an assault

A thorough physical examination remains important for documenting and treating injuries. Assess for:

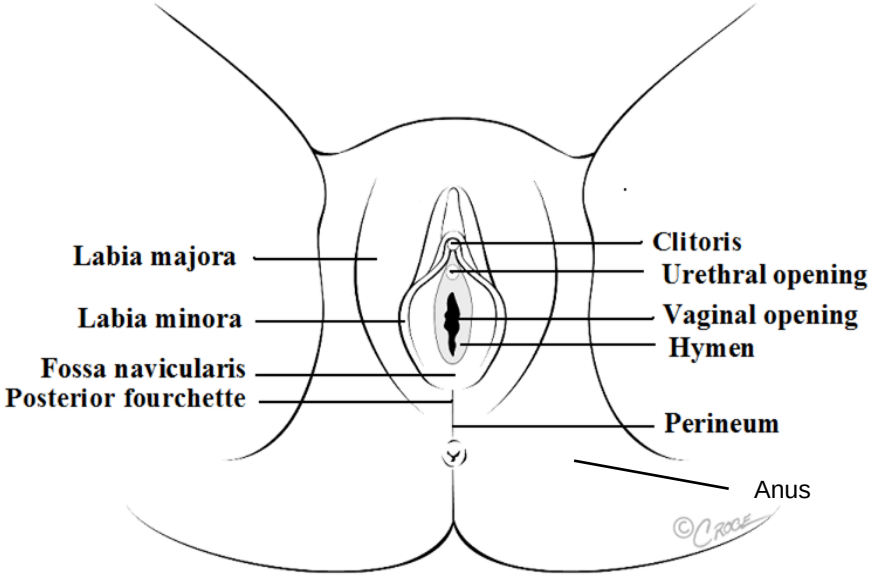
- size and colour of any bruises or scars
- evidence of loss of hearing, partially healed fractures, abscesses, etc.
- signs of pregnancy
- signs of mental illness (PTSD, depression, suicidal thoughts)

Skills in action – physical examination

Allow the survivor's account of events to guide your examination

Physical examination of the genitals

- Matted, sticky pubic hair may be seminal or body fluid
- Be aware of injuries from blunt trauma to the external and internal genitalia, including abrasions, bruising and lacerations
- Posterior fourchette is a common site of injury (acute mounting injury)
- Vaginal bleeding, other than menses, is an indication for further evaluation and possible specialist consultation



Note: Moderate to severe genital lacerations can cause lasting and serious complications; evaluate for 3rd or 4th degree lacerations, fistula and/or anal injuries as clinical history and findings indicate

Physical examination of the genitals

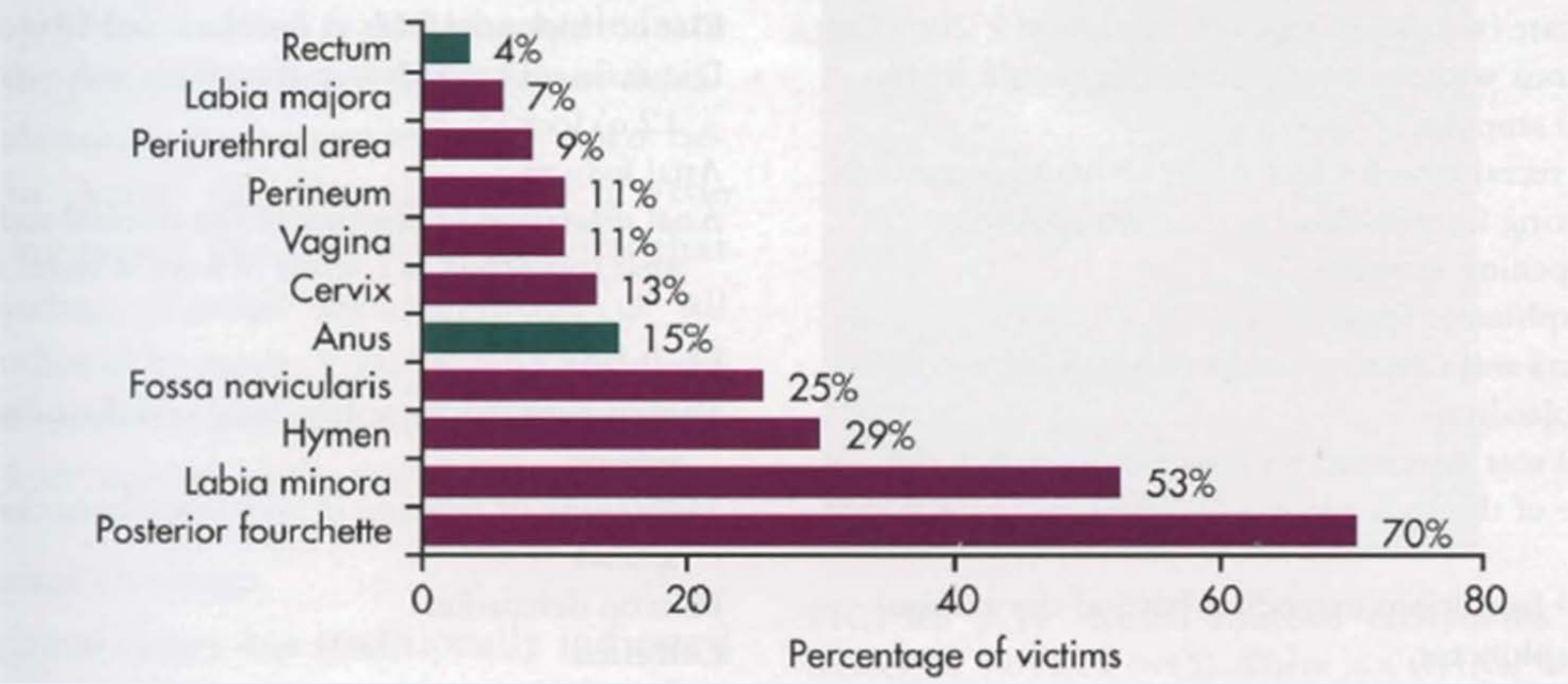
Steps for vagino-cervical examination

1. Following visual examination of external genitalia, repeat information about what an internal examination will entail and verbally reconfirm consent to proceed. Remind the survivor they can request a pause or stop at any time.
2. Gently insert a speculum, preferably warm, lubricated with water or normal saline. Lubricants are not recommended as they may interfere when collecting samples.
3. Under good lighting, inspect the cervix, then the posterior fornix and the vaginal mucosa for trauma, bleeding and signs of infection.
4. If collecting forensic evidence, take swabs and collect vaginal secretions according to the local evidence collection protocol.
5. If indicated by the history and the examination findings thus far, do a bimanual examination and palpate the cervix, uterus and adnexa, looking for signs of abdominal trauma, pregnancy or infection.

IMPORTANT!

An internal, speculum examination is very sensitive and should be done only if there has been vaginal penetration with the following indications: bleeding, pain, foul-smelling discharge and/or survivor request

Relative frequency of injury by location in genitalia in female assault survivors[1]



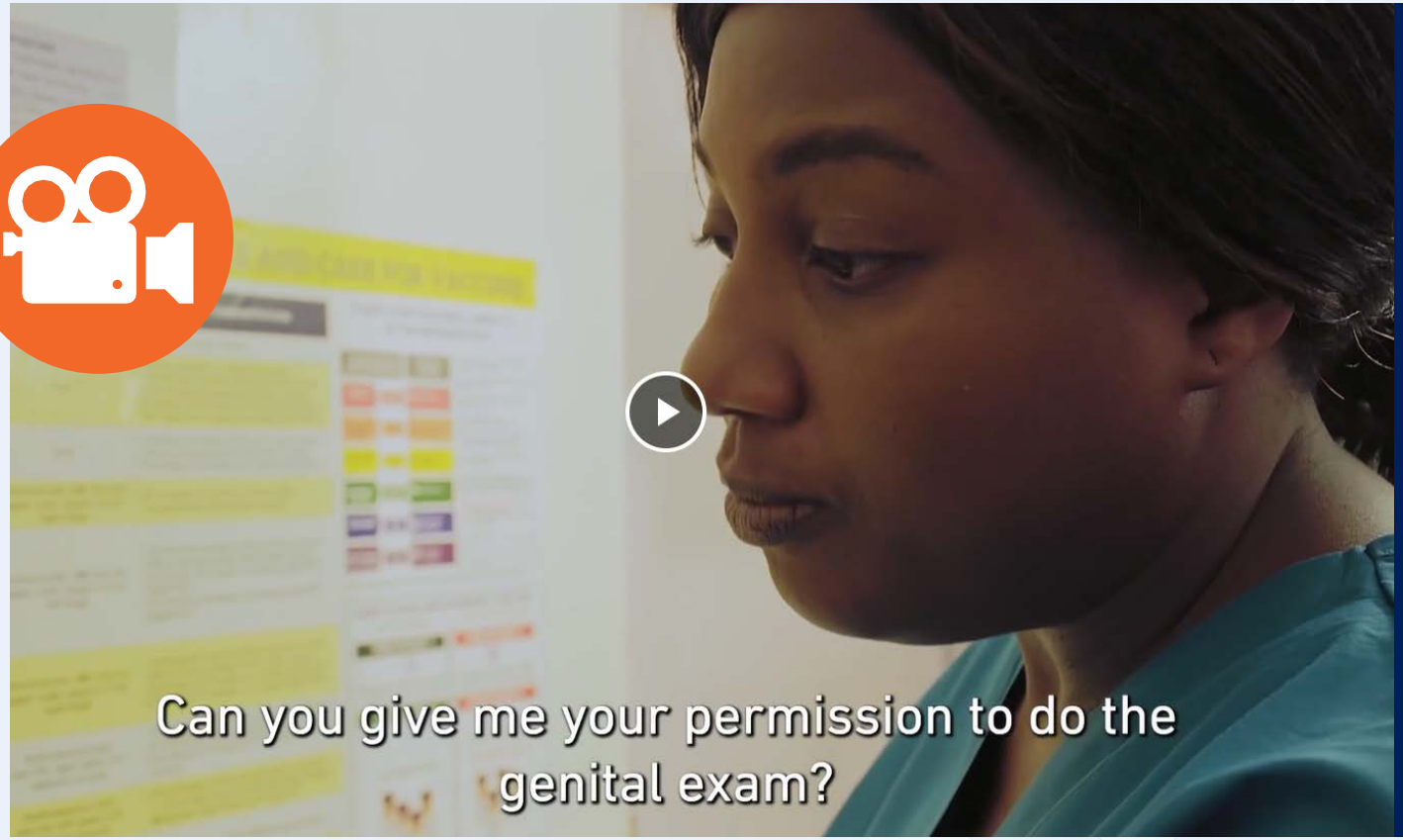
Many survivors of sexual assault have no genital injuries

Possible reasons include:

- Delayed examination – healing of injuries occurs quickly
- Injury is very small and/or cannot be seen with the naked eye
- Tissue fragility (young versus old woman)

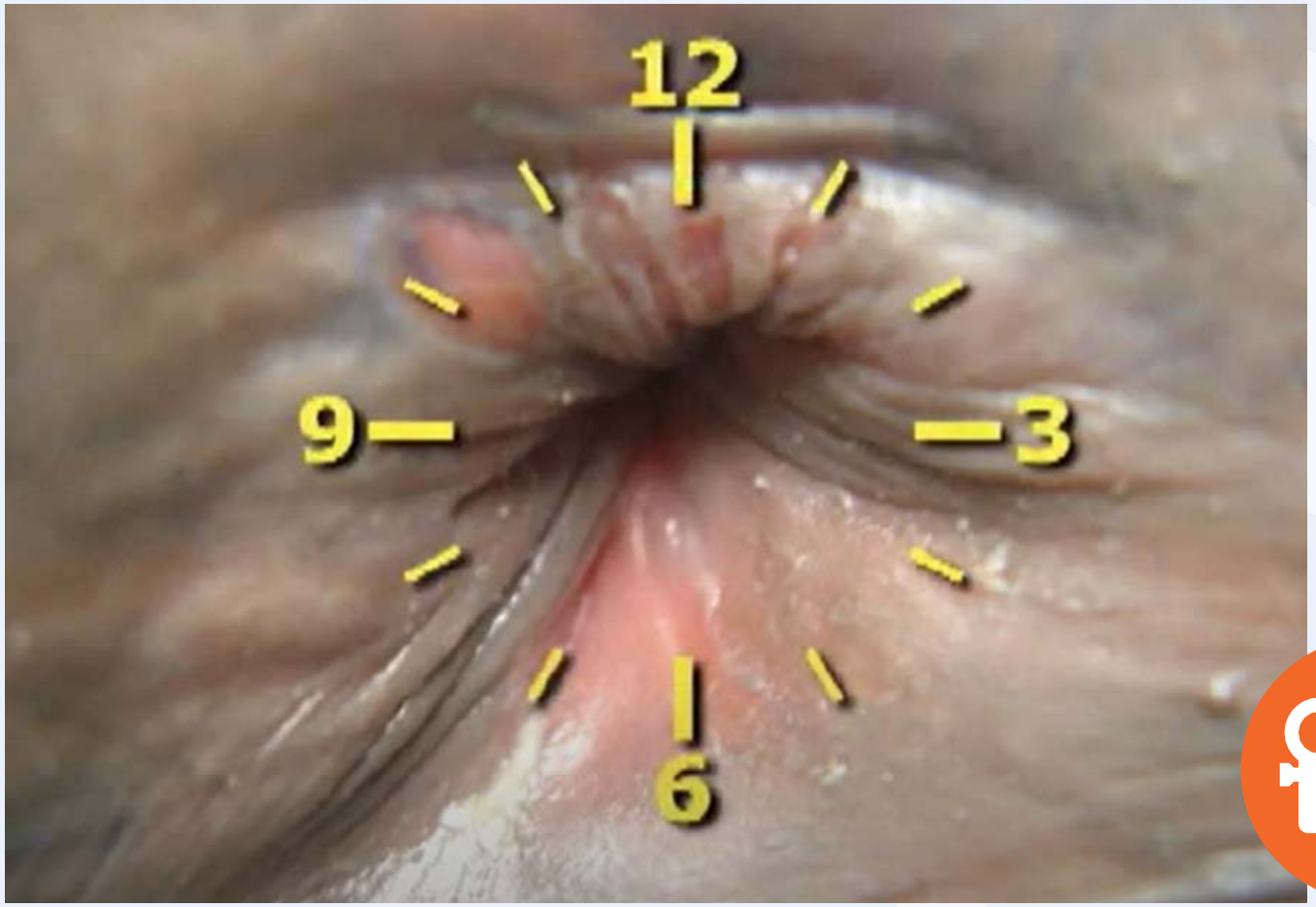
The reason does <u>not</u> matter.
Ensure the survivor knows you still believe her.

Physical examination of the genitals



If a sexual assault occurred more than 7 days ago and there are no visible injuries on the external genitalia and no client complaints, there is NO indication for internal examination

Skills in action: anal examination



Survivors may not always know if anal penetration occurred and may not be aware of injuries that are present

Documenting wounds and injuries

Feature	Notes
Classification	Clinical wound type: abrasion, contusion, laceration, gunshot, incised wound, etc.
Site	Anatomical position and location
Size	Measure and record dimensions (length, height, width)
Shape	Describe the shape in geometric terms (linear, curved, irregular, semicircular, etc.)
Surrounds	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen)

Documenting wounds and injuries (continued)

Feature	Notes
Colour	Particularly relevant when describing bruises as can give indication of age
Contents	Note the presence of any foreign material in the wound (e.g. grass, glass, dirt, fingernails)
Age	Comment on any evidence of healing; never try to estimate or record a quantitative age as this is impossible to determine from physical exam, even by advanced providers
Borders	Note the characteristics of the edges of wound(s) (e.g. jagged, angled, vertical)
Depth	Give an indication of the depth of the wound; if measurement is not possible, provide an estimate and note that it is an estimate

Wound classification

Classification	Characteristics	Common cause
Abrasion	• Scraping or removal of the outer layers of skin	• Dragging against a rough surface: ground, rope, cement, gravel, etc.
Contusion	• Bruising, swelling, discolouration	• Blunt force impacts such as slamming against an object, being hit or punched
Laceration	• Separation wound extending through the epidermis	• Extreme force where skin is already stretched • Intentional cuts with a blade or sharp-edged object (incised laceration)
Avulsion	• Tear-based wound in which extreme force removes skin and/or muscle from its attachments	• May leave skin and/or tissue flaps • Often inflicted during physical struggles
Puncture wound	• Small visible opening in the dermis; damage below the skin varies widely; depth varies widely and may be difficult to determine	• Vertically oriented objects with a sharp end or tip: teeth, screwdrivers, metal nails, glass shards, bullets

Exercise 10.1

Injury description

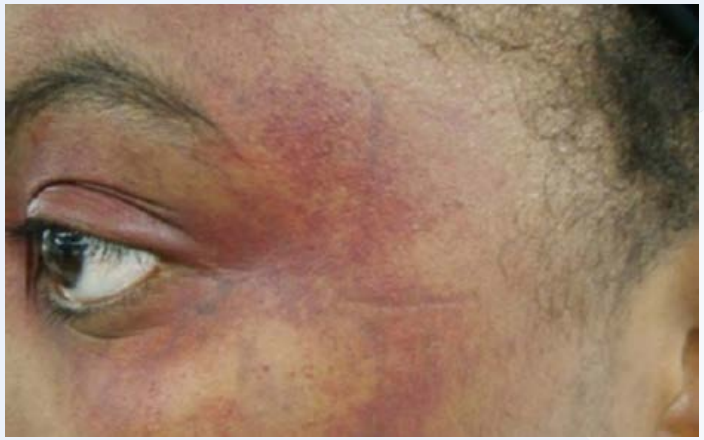
- Detailed accurate description of physical examination findings is valuable for many reasons
- Your examination documentation may be the best record available for the survivor to submit should they choose to pursue judicial procedures

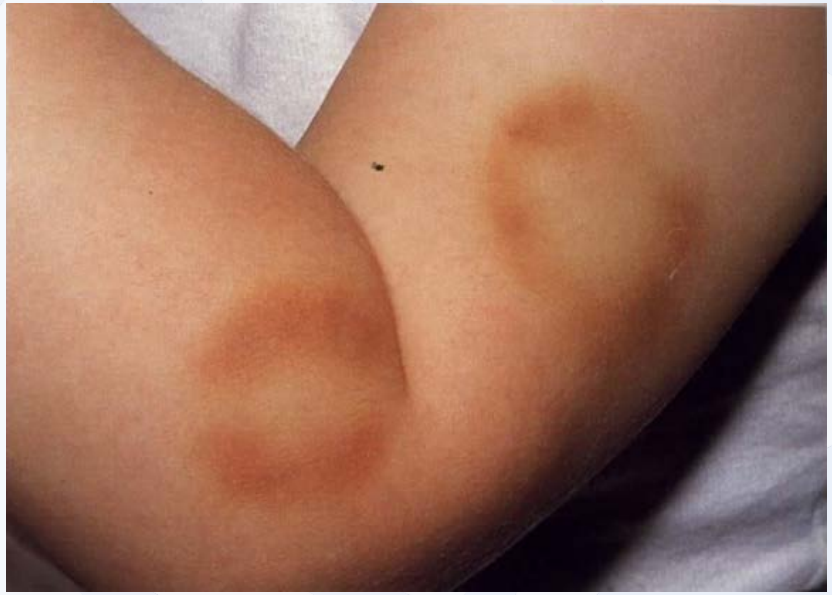
Self-care:

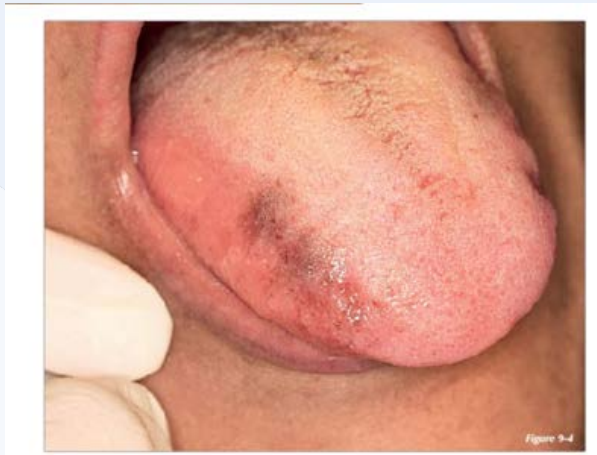
The following slides contain close-up images of injuries sustained during sexual violence or IPV

Exercise 10.1

Injury description

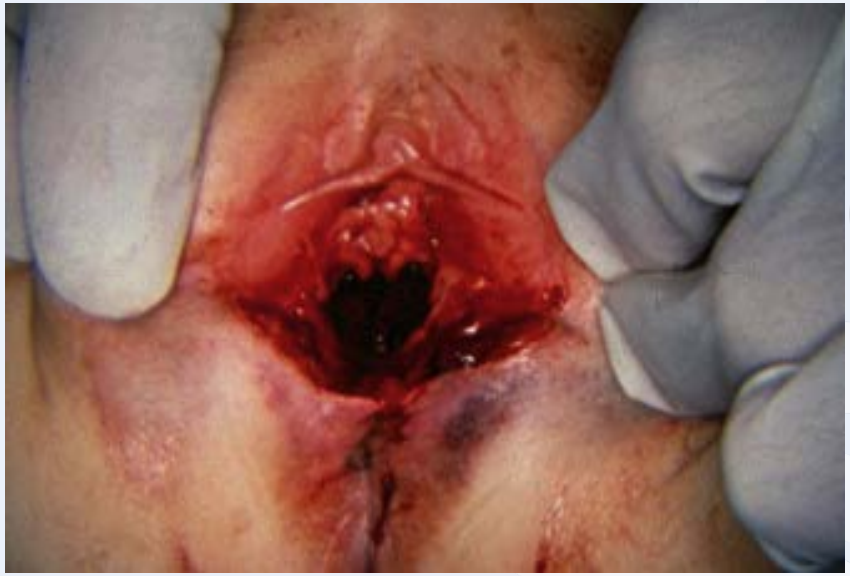


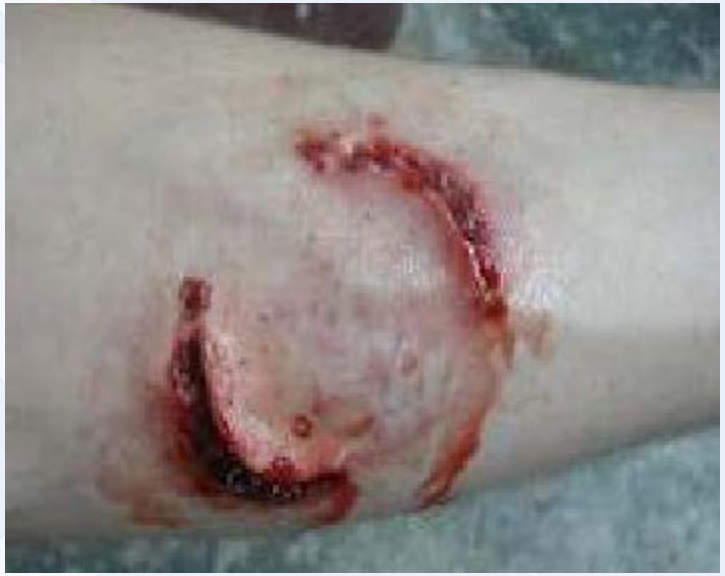




Exercise 10.1

Injury description

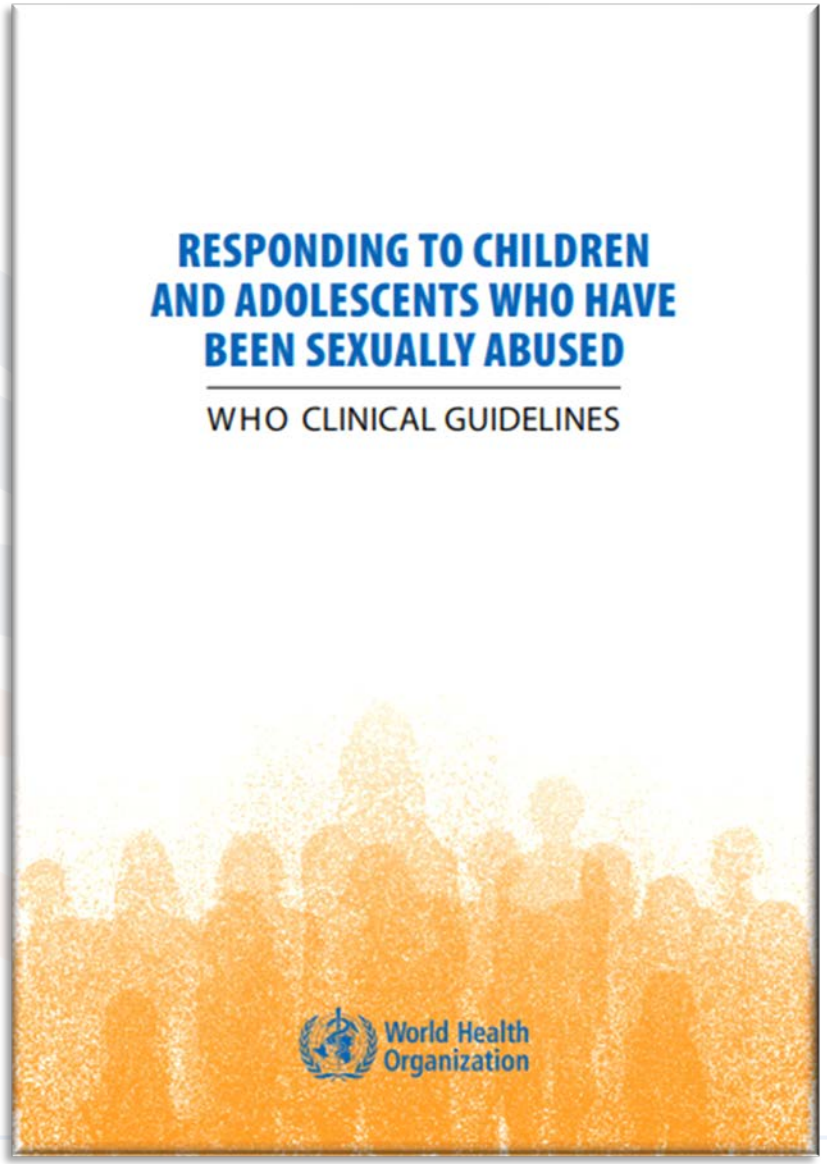




A moment of calm

Special population considerations – history and physical examination

For more information see WHO clinical guidelines[2]



Caring for child and adolescent survivors of sexual violence[2]

Physical examination

- ☑ Have a second trusted/safe adult present for the entirety of the exam
- ☑ Use age-appropriate visuals to help explain each step before you proceed
- ☑ Offer alternative positioning for the child, including remaining in a chair, sitting on the exam table or lying on their side
- ☑ Use drapes and medical gowns to allow the child to remain as dressed/covered as possible through each stage of the exam
- ☑ The so-called “virginity” or hymenal intactness test has no scientific validity and is a violation of the survivor’s human rights

Caring for child and adolescent survivors of sexual violence

Genital examination

- Use paediatric examination instruments and adapted body postures to minimize physical discomfort
- Supine positioning **without lithotomy** is most commonly appropriate when conducting genital exams in preadolescent children
- Avoid digital or bimanual examination to evaluate anal sphincter tone and/or vaginal tone
- Internal pelvic examination should be reserved only for specific clinical necessity in the paediatric survivor

Only if medically necessary

Male survivors of sexual violence

Special considerations

- Most perpetrators of sexual violence against men and boys are men
- Be aware that any laws criminalizing sodomy or homosexuality may make survivors even more fearful about seeking help
- Sexual violence (especially conflict-related sexual violence) may be used as a means to undermine traditional masculinity among perceived enemy communities, e.g. forced witnessing

Male survivors of sexual violence (continued)

Providing first-line response

- Know the importance of understanding and separating physical from sexual orientation, attraction or identity acts: male physiology can result in erection and ejaculation during sexual assault
- Remember confidentiality, the concept of "do no harm" and other guiding principles; unless required to do so by local laws, you should only report sexual violence against men and boys to police if the survivor chooses that path
- Recto-genital examination is still important for male survivors; bleeding from the anus that does not resolve in a few hours may require specialist evaluation and treatment

Note:
Torsion of the testes is a medical emergency requiring immediate surgical referral

Skills in action: caring for male survivors

Special considerations for older women

- Post-menopausal women who have been vaginally raped are at increased risk of vaginal tears and injury, and transmission of STIs and HIV
- Decreased hormonal levels following menopause result in reduced vaginal lubrication and a thinner and more friable vaginal wall
- Use a thin speculum for genital examination
- If the only reason for the examination is to collect evidence or to screen for STIs, consider inserting swabs only without using a speculum

Exercise 10.2

Documenting examination findings

- Use active listening and age-appropriate communication to “conduct” a physical examination
- At each stage of the exam, the “survivor” will tell you their findings
- Be sure to document appropriately in Job aid 10c

Sessions 10: That's a wrap!

- Clinical history informs and shapes the examination and treatment
- Obtain consent separately for each aspect of the exam, and verbal permission to proceed at each step of the physical and recto-genital exam
- The absence of physical evidence does not mean that violence did not occur
- Collect forensic evidence only when minimum requirements are met, and if you have the legal authority to do so in your setting
- Men experience sexual violence too; the incidence increases in conflict settings
- There are specific considerations for examination of children and adolescents who have experienced sexual violence

References

1. Slaughter L, Brown CR, Crowley S, Peck R. Patterns of genital injury in female sexual assault victims. Am J Obstet Gynecol. 1997;176(3):609–16 (https://doi.org/10.1016/s0002-9378(97)70556-8).
2. Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (https://iris.who.int/handle/10665/259270). Licence: CC BY-NC-SA 3.0 IGO.

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

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Session 11.

Clinical care for survivors of sexual assault, part 3: treatment and care

World Health Organization

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Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual violence and IPV

Competencies:

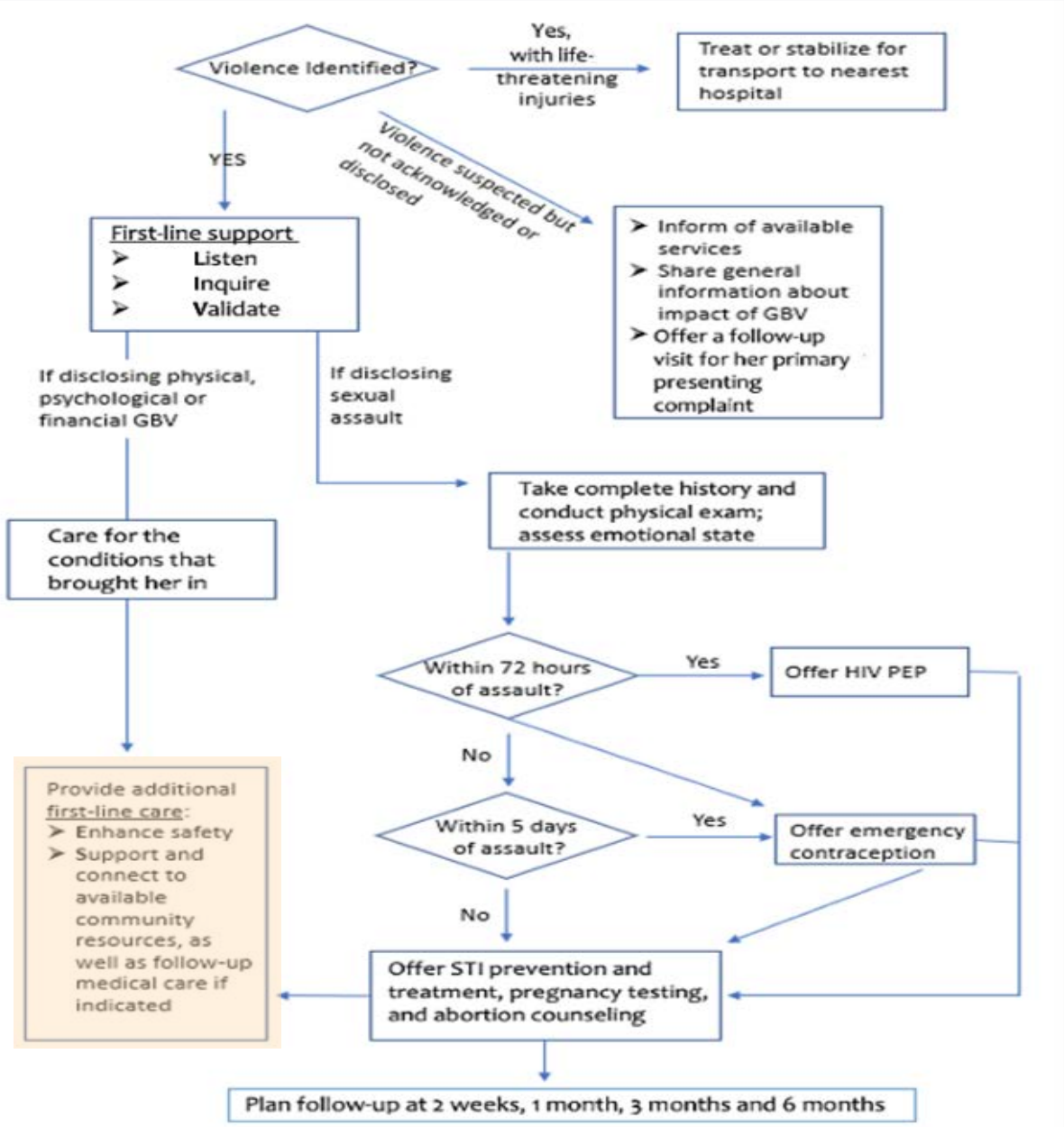
- Know how to provide appropriate treatment/care to survivors of sexual assault, including child and adolescent survivors

Treating injuries

Urgent hospitalization is required if there is:

- Extensive injury
- Neurological deficits
- Respiratory distress
- Swelling of joints on one side of the body (septic arthritis)

Less severe injuries can usually be treated on site



Treating injuries

Tetanus

- It has an incubation period of 3–21 days but can be many months
- Refer the survivor to the appropriate level of care if you see signs of a tetanus infection
- If the person has not been fully vaccinated, vaccinate immediately, no matter how long it has been since the incident
- If there remain major, dirty, unhealed wounds, or the survivor is HIV-positive, consider giving tetanus immunoglobulin* if it is available

* Tetanus immunoglobulin requires cold chain without freezing, which is rarely available in low-resource or crisis settings

Oral emergency contraception pills (ECPs)

See CMRIPV Annex 7

- Offer an ECP to all women who have been raped
- ECPs will not harm girls. They can be offered to girls who have attained menarche (i.e. post-menarche), as well as those in the beginning stages of puberty (i.e. Tanner stage 2 or 3; see Job aid 11a)
- There is no need to screen for health conditions or test for pregnancy
- Say: “Return if your next menstrual period is more than 1 week late”
- **ECPs are effective for up to 5 days after sexual assault**
- Spotting or bleeding a few days after taking an ECP is normal
- ECPs can be taken at the same time as antibiotics for STIs and PEP for HIV prevention

Counselling on oral ECPs

- ECPs will not cause abortion. If she is already pregnant, ECPs will not harm the pregnancy.
- ECPs will not prevent pregnancy the next time she has sex.
- ECPs are not meant for regular use. More effective continuing contraceptive methods are available.
- A pregnancy test may show if she was already pregnant. She can have a test if she wishes, but it is not necessary before taking an ECP.
- For those who are already pregnant as a result of rape, discuss options including for accessing safe abortion to the full extent of the law.

Emergency contraception (EC) regimen options

Available from IARH Kit 3A or 4

Oral ECP – No need to test for pregnancy prior to administration

Ulipristal acetate or levonorgestrel recommended 1.5 mg single dose

or

combined estrogen–progestogen – 2 doses of 100 µg ethinyl estradiol plus 0.5 mg levonorgestrel, 12 hours apart

Copper intrauterine device (IUD) – Rule out pregnancy before insertion

- Do no use hormonal intrauterine system (IUS) for EC
- Active STIs are a contraindication
- Also effective for up to 5 days (120 hours) post-incident
- Requires a trained provider to perform the insertion, which requires use of a speculum

Offer PEP for HIV prevention

- Test for HIV. Do not give PEP to those who test positive for HIV.
- PEP should be started as soon as possible, up to 72 hours after possible exposure to HIV.
- Choose drugs based on national guidelines/current WHO antiretroviral (ARV) guidelines.
- A 28-day prescription of ARVs should be provided.

Available from IARH Kit 3B

When to test and when to give PEP

Situation	Recommended procedure
Perpetrator is HIV-positive or status unknown	▶ Give PEP
Survivor's HIV status is unknown	▶ Offer HIV testing and counselling
Survivor is unwilling to test	▶ Give PEP; plan follow-up
Survivor is HIV-positive	▶ Do **not** give PEP
Survivor has been exposed to blood or semen	▶ Give PEP
Survivor was unconscious and cannot remember what happened	▶ Give PEP
Survivor was gang-raped	▶ Give PEP

Counselling for PEP

Discuss

- Whether HIV is common in that setting
- Whether she knows if the perpetrator is HIV-positive
- That PEP lowers the chances of HIV infection but is not 100% effective
- That half of people who take PEP have side-effects (nausea, tiredness, headaches); for most, these decrease after a few days

Also:

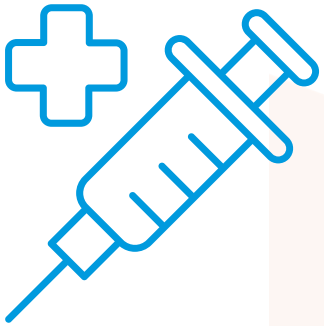
- Tell her that the medicine must be taken daily for 28 days
- Encourage retesting for HIV at 3 or 6 months, or both
- If the test result is positive:
  - Refer her for HIV treatment and care
  - Ensure follow-up at regular intervals

Offer STI prophylaxis/treatment

- Test if a lab is available, even if treating for STIs
- Give antibiotics to prevent or treat these STIs: chlamydia, gonorrhea, trichomonas and, if common in the area, syphilis
- Also give preventive treatment for other STIs common in the area (such as chancroid)
- Give the shortest courses available in the national protocol

Available from IARH Kit 5

Prevent hepatitis B and offer human papillomavirus (HPV) vaccination if age-appropriate



Has she been vaccinated against HPV?	
No or does **not** know, age 9–14	1- or 2-dose schedule
No or does **not** know, age 15–20	1- or 2-dose schedule
No or does **not** know, immunocompromised, any age, including HIV-positive	2- or 3-dose schedule
Yes	No need to re-vaccinate

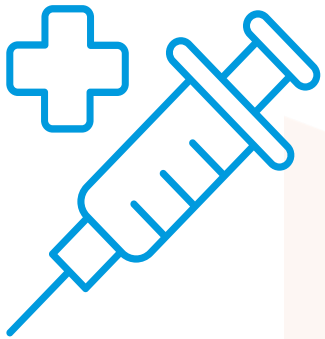
Follow local protocols based on vaccines available in your country/setting. WHO recommendations (December 2022) provide alternate reduced dose options.[1]

Special considerations for STI prophylaxis/treatment and PEP for children

Tolerance of side-effects and completion of treatment regimens may be more challenging for children and adolescents

- Involve a safe and trusted adult in treatment
- Be mindful of whether crushing or chewing a medication is contraindicated
- For adolescents with mobile phones, encourage the use of reminder alarms
- Offer a follow-up in a few days to discuss the management of side-effects
- Ensure they understand the instructions for missed doses

HPV vaccination



- Offer HPV vaccination to children and adolescents aged 9–14, if they were not previously vaccinated
- HPV and hepatitis B vaccinations can be administered at the same visit, ensuring that different injection sites are chosen and different syringes are used

Discuss self-care and plan follow-up care

Explain the summary of examination findings and given or agreed-upon treatments

- Invite her to voice questions and concerns
- Explain the importance of completing the course of medication
- Discuss likely side-effects and what to do about them

Care of injuries

- Show how to care for any injuries
- Describe signs and symptoms of wound infection; ask her to return if these signs develop

Treatment of STIs

- Discuss signs and symptoms of STIs; advise her to return if they occur
- Advise her to avoid sexual intercourse until STI treatments are finished

Plan follow-up care

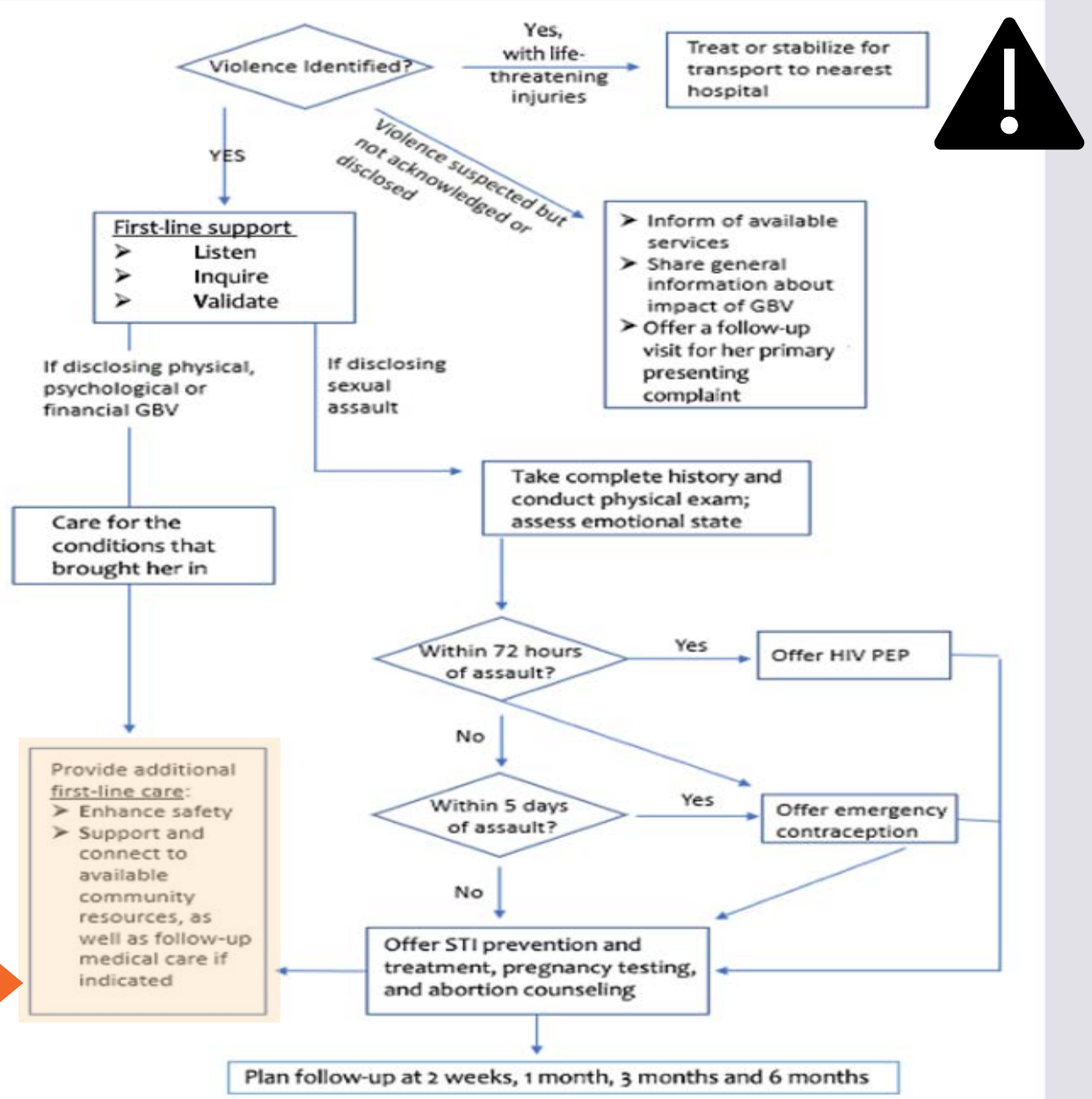
Encourage follow-up visits

- Important to check progress of wound healing
- Re-test for STI and HIV
- Rule out unintended pregnancy
- Monitor emotional/psychological recovery

Safe abortion care

- In many restrictive legal environments, induced abortion is permissible in cases of rape
- Know your local laws
- If a survivor learns during an initial visit that she is pregnant as a result of sexual violence, offer a follow-up visit sooner than 2 weeks

Available from IARH Kit 8



Accessing essential medications in emergencies[2]

- This is primarily a responsibility of the crisis response coordinator, health-zone manager or other health system administrators
- Your first-line medications and protocols may change; be on the lookout for adapted guidance
- Commodities may be procured through humanitarian response mechanisms and arrive as kits from UNFPA as part of the MISP for SRH

Exercise 11.1

Sexual assault treatment decisions – case studies

- Each group should select a rapporteur to present back to plenary
- Groups have 7 minutes per case study to discuss and fill out tables describing treatments to prescribe, tests to do and referrals to make and why
- After groups reconvene in plenary, rapporteurs will present one of their case studies (in 3–4 minutes) and explain their decisions

Session 11: That's a wrap!

- Immediate treatment includes first-line support and, as needed, referral to other mental health services, treatment of injuries, EC, HIV PEP, STI prophylaxis, hepatitis B and HPV prevention, and comprehensive abortion care to the fullest extent of applicable law
- Treatment for rape/sexual assault depends on whether the survivor presents within the first 72–120 hours
- Many elements of first-line support can and should still be provided after this critical window; offer LIVES, including appropriate referrals even after 5 days have elapsed
- Providers need to determine the history of the assault and what has happened since then, to arrive at a decision about which tests to run and treatments to offer

References

1. Human papillomavirus vaccines: WHO position paper (2022 update). Weekly epidemiological record, no. 5. Geneva: World Health Organization; 2022 (https://iris.who.int/bitstream/handle/10665/365350/WER9750-eng-fre.pdf).
2. Minimum initial service package for sexual and reproductive health: Interagency field manual of reproductive health in humanitarian settings. New York: United Nations Population Fund; 2020 (www.unfpa.org/sites/default/files/resource-pdf/MISP-Reference-English.pdf).

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

World Health Organization

HEALTH CLUSTER

Session 12.

Mental health and psychosocial support (MHPSS)

World Health Organization

HEALTH CLUSTER

Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

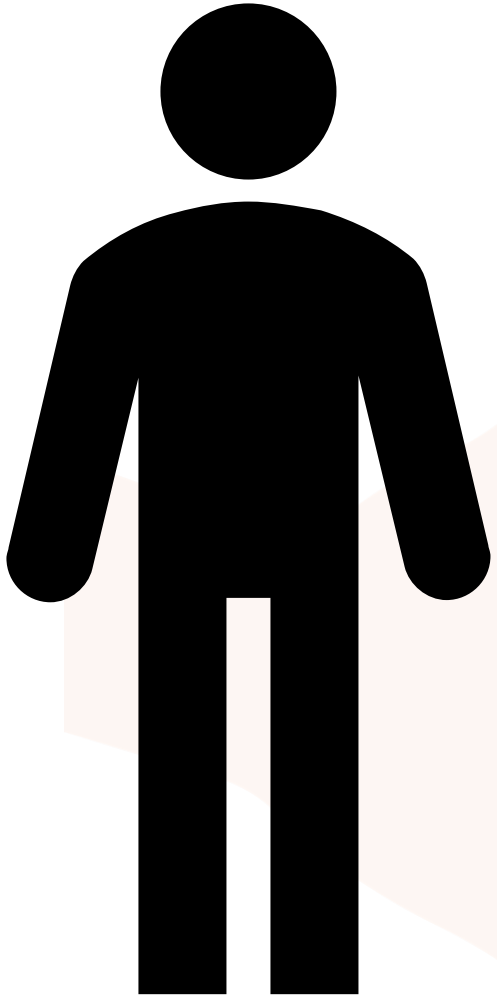
Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies:

- Know how to provide basic mental health and psychosocial support (MHPSS)
- Know about available referrals for MHPSS

MHPSS as a core need for survivors

- Most survivors who have experienced sexual assault and/or IPV experience symptoms of emotional distress
- Human stress responses can begin as functional, healthy coping responses, but under prolonged and/or extreme stress, reactions may negatively impact health and well-being
- In most cases, transient signs of distress will improve over time if the survivor has and is receiving practical and emotional support



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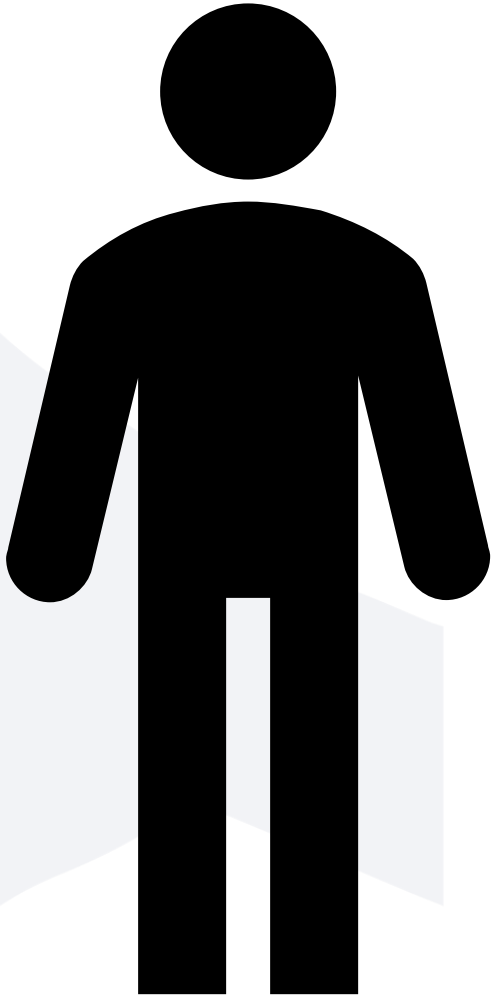


BACK

Stress reactions

Functional

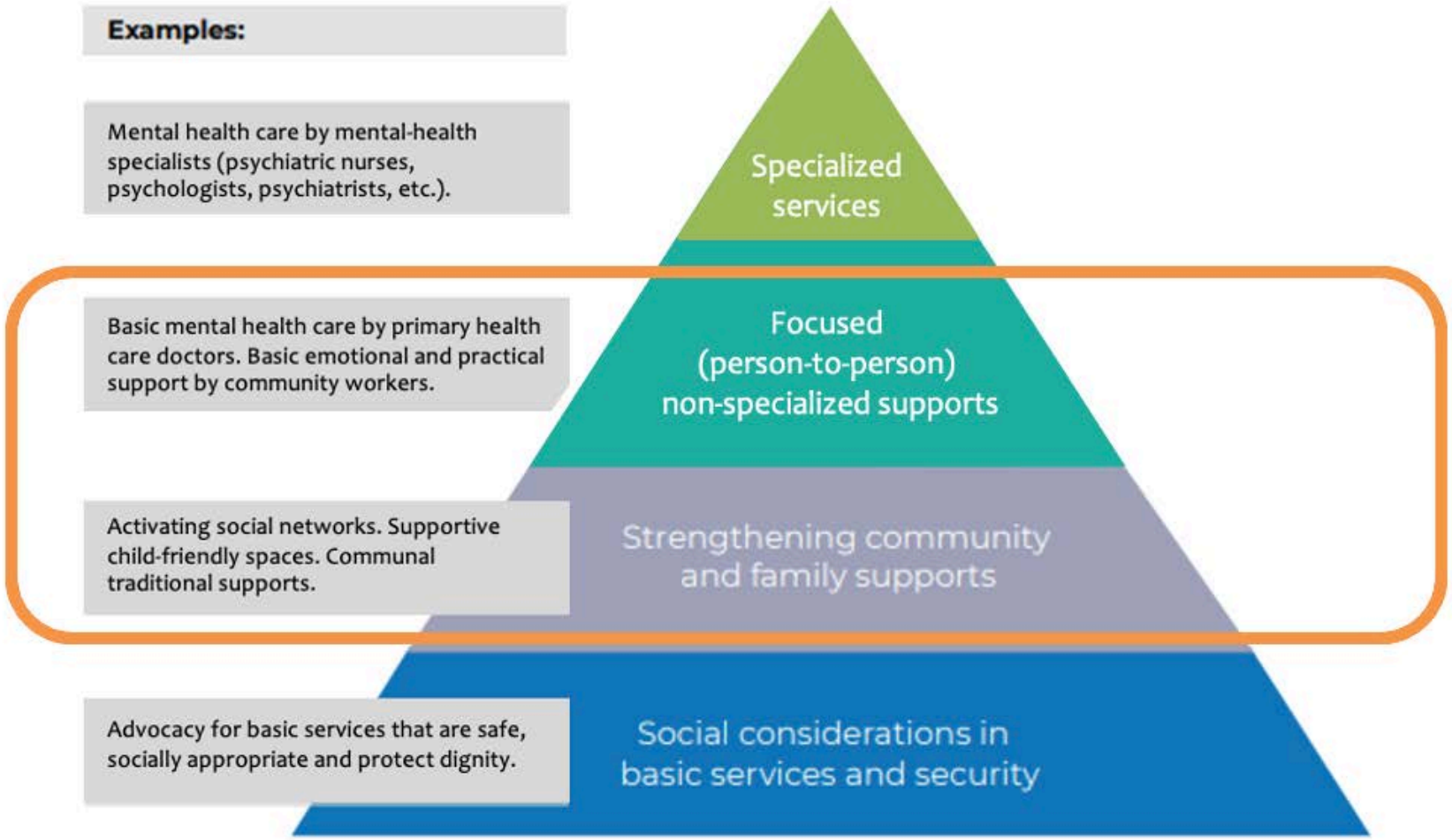
- Improved focus, alertness and reaction times
- Increased oxygen to the brain and large muscle groups
- More awake hours to mitigate the source of stress

Dysfunctional

- Hooks and triggers
- Insomnia
- Hypertension
- Increased risk of pre-term and low-birth-weight pregnancy outcomes
- Depression
- Suicidal thoughts or actions

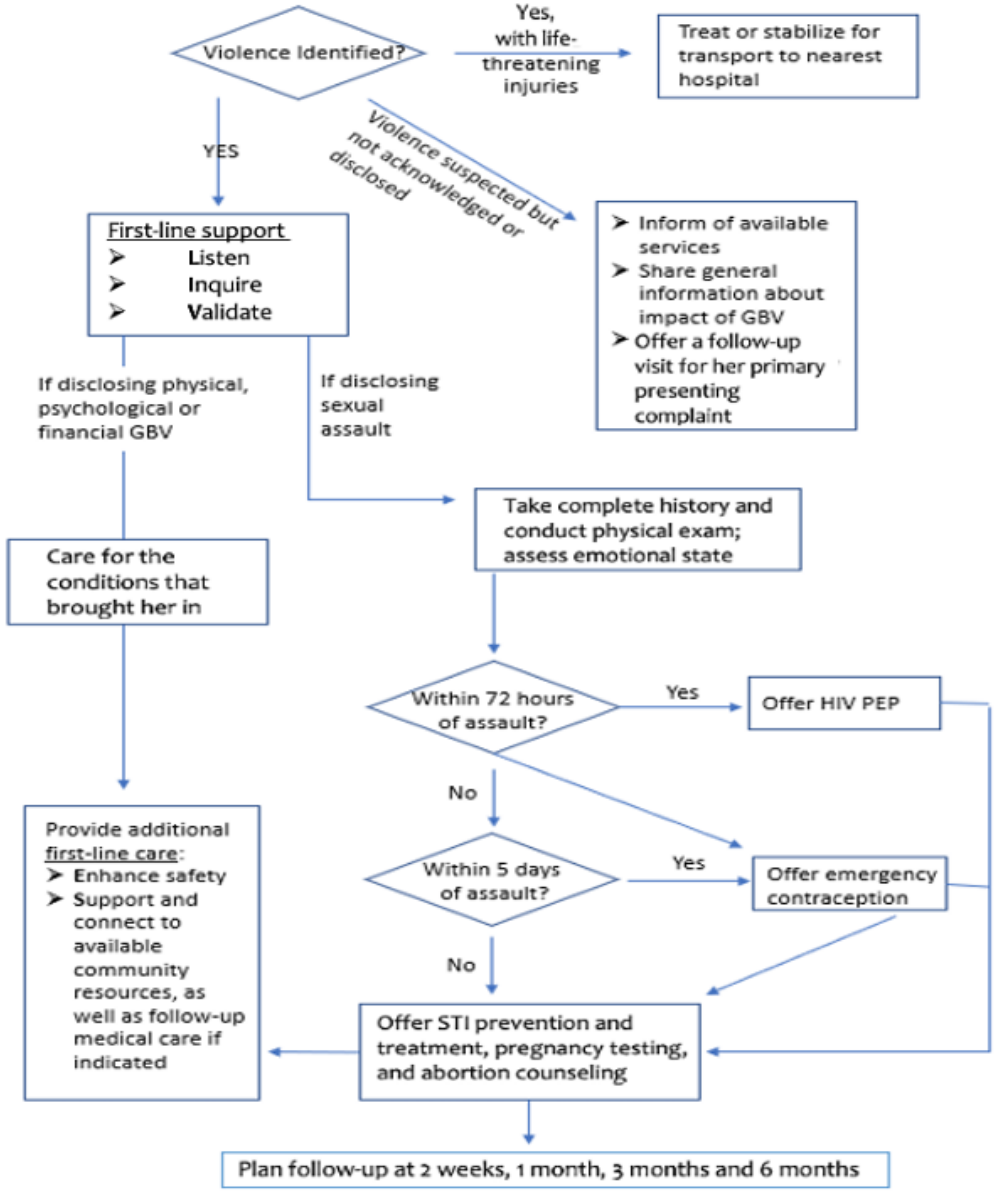
Everyone deserves support in times of chronic or severe stress

Intervention pyramid for mental health and psychosocial support in emergencies[1]



Providing MHPSS in first-line support

The clinical history, provision of LIVES, and follow-up visits should all include assessment of mental health, provision of basic mental care, and referral for more serious conditions when needed



Basic mental health care and psychosocial support

- Help strengthen their positive coping methods
- Explore the availability of social support
- Teach and demonstrate stress-reduction exercises
- Make regular follow-up appointments for further support

More pronounced coping reactions are normal and OK until the person is in a place and time of relative safety

Strengthen positive coping

Encourage and help the survivor to:

- Take small, simple steps
- Build on their own strengths and abilities
- Continue usual activities
- Engage in relaxing activities and stress-reduction exercises
- Keep a regular sleep schedule
- Engage in regular physical activity
- **Avoid** self-prescribed medications, alcohol or drugs
- Return if she has thoughts of self-harm or suicide
- Return if these suggestions are not helping

Encourage and link to social support

Encourage and help the survivor to:

- Connect with family and friends; if the survivor has been separated from family and friends, link to community support groups or other more formal social networks
- Identify people who she trusts and likes – spending time with them can help her feel connected and supported
- Participate in community and religious activities or other activities where she feels supported
- Collaborate with social workers, community organizations or other known referrals when available

Observe, reflect back and support

- It is important not to jump to giving advice or trying to solve every problem. Survivors are facing many challenges outside their control.
- Focus on identifying the survivor's biggest mental health and psychosocial challenges.

Exercise 12.1

Stress reduction techniques

Stress-reduction exercises offer basic psychosocial support and mental health care and can be taught to patients or used by health workers themselves

Exercise 12.1

Stress reduction techniques

- Try to keep your eyes closed. Sit with your feet flat on the floor.
- First, relax your body. Shake your arms and legs, and let them go loose. Roll your shoulders back, and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about 2 minutes. As you breathe, feel the tension leave your body.

Assessing for mental health conditions that necessitate a referral

Imminent risk of suicide or self-harm

- Some health workers fear that asking about suicide may provoke the survivor to self-harm
- On the contrary, talking about suicide often reduces the survivor's anxiety around suicidal thoughts and helps her feel understood

If she has:

- Current thoughts or a plan to commit suicide or to harm herself **or**
- A history of thoughts or plans for self-harm in the past month or acts of self-harm in the past year, and she is now extremely agitated, violent, distressed or uncommunicative …
  then there is immediate risk of self-harm or suicide, and **she should not be left alone**

Refer her immediately to a specialist or emergency health facility

Assessing for mental health conditions

Depression

- Depression is a common mental health condition. As health workers, you have an important role to play in overcoming the stigma and misinformation many people have about mental health disorders.
- There are many management options front-line health and care workers can offer patients.
- If a survivor is interested in medication, referral to a specialist is recommended.

Assessing for mental health conditions

Depression

Assess if she has experienced the following for at least 2 weeks:

- ☑ Persistent depressed mood
- ☑ Marked diminished interest in or pleasure from activities previously enjoyed
- ☑ Sleep disturbances
- ☑ Changes in appetite
- ☑ Sense of worthlessness or guilt
- ☑ Fatigue, loss of energy
- ☑ Reduced ability to concentrate or sustain attention on tasks
- ☑ Indecisiveness
- ☑ Observable agitation or restlessness
- ☑ Talking and/or moving slower than usual
- ☑ Hopelessness about the future
- ☑ Suicidal thoughts or acts
- ☑ Difficulty functioning in daily life

Assessing for mental health conditions

Cautions

Do not routinely prescribe benzodiazepines for insomnia

Do not prescribe benzodiazepines or antidepressants for acute distress

Assessing for mental health conditions
Post-traumatic stress disorder (PTSD)

Characteristic PTSD symptoms are:

- Re-experiencing
- Avoidance
- Heightened sense of current threat

Only a fraction of sexual violence and IPV survivors will develop PTSD

Many survivors will experience these symptoms, but they will improve on their own in the weeks following an assault

PTSD cannot be assessed or diagnosed in the first month following an incident

Follow-up visits are important!

Treating and managing PTSD

- Educate the survivor about PTSD, including about common feelings, fears, recollections, physical problems, the role of treatment, etc.
- Strengthen her social support and teach stress management
- Consult a specialist
- Offer regular follow-up: a second appointment within 2–4 weeks and subsequent appointments depending on the course of the disorder

Exercise 12.2

Role play on provision of basic mental health care

A five-step approach to offering basic mental health care

Support the survivor to:

1. Name or identify the stress reaction or coping manifestation that is bothering them
2. Describe the context of the problem
3. Brainstorm solutions
4. Prioritize solutions
5. Make an action plan

➢➢➢ **Repeat for additional problems**

Exercise 12.2

Role play on provision of basic mental health care

- **Form pairs**
- **“Provider”:** Use the five-step problem-solving approach
  - Practise teaching stress-reduction techniques if identified in the solution brainstorm
  - Help the person determine how they will remember and seek support for following up on their action plan
- **“Patient”:** Seek support for a real-life stress reaction that is difficult for you to manage or disrupting your well-being

Session 12: That's a wrap!

- Even in emergencies, front-line providers can offer basic mental health and psychosocial support (MHPSS)
- Basic psychosocial support includes stress-reduction exercises
- Assess survivors with continuing mental health symptoms for suicide or self-harm risk, moderate-to-severe depression and PTSD
- Manage conditions or refer survivors to mental health specialists

Reference

1. IASC Reference Group on Mental Health And Psychosocial Support in Emergency Settings. IASC guidelines on mental health and psychosocial support in emergency settings. Geneva: Inter-Agency Standing Committee; 2007 (https://interagencystandingcommittee.org/sites/default/files/migrated/2020-11/IASC%20Guidelines%20on%20Mental%20Health%20and%20Psychosocial%20Support%20in%20Emergency%20Settings%20%28English%29.pdf).

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

World Health Organization

HEALTH CLUSTER

Session 13.

Self-care and preventing burnout

World Health Organization

HEALTH CLUSTER

Session objectives

Objective 4: Demonstrate knowledge of how to access resources and support for patients and for oneself

Competencies:

- Know how to access and practise self-care in a crisis setting
- Know how to support health worker colleagues who may be facing vicarious trauma from working with survivors or emergency-related stress in their own lives

Self- and collective care for providers

- Your emotional health is important, too
- You may have strong reactions or emotions when listening to or talking with survivors about sexual violence and IPV...
  …especially if you have experienced it yourself
- Be aware of your own emotions
- Get the help and support you need for yourself
- Support colleagues in taking care of themselves, too

Work culture risks

The pressure to respond to the overwhelming needs of the population you are caring for can lead to harmful social norms among health-care professionals.

Common results of such norms include:

- Working through breaks
- One-upmanship among colleagues in relation to who has slept the least
- Minimizing personal stress or ill health in comparison to patients
- Feeling guilt or shame over engaging in pleasurable rest time and/or activities

Protective habits

- Rejuvenating physical/sensory activities – exercise, listening to or playing music, bathing, massage or other bodywork
- Social recreation – spending time with loved ones, shopping, playing with children, laughing
- Expression of difficult experiences – talking, drawing, collaging or writing
- Spiritual meaning-making – prayer, personal ritual, study of scripture or philosophic texts
- Cognitive support – mantras, self-talk, visible affirmation in your home, office or exam room

Signs of work stress

- Disengagement
- Blunted emotions, overly detached
- Hopelessness
- Loss of motivation
- Anxiety disorders
- Extreme urgency and hyperactivity
- Depression

Responding when dysfunctional stress and/or coping emerges

- **Ask for time off.** A well-timed shift trade or long weekend can go a long way towards reversing early stages of dysfunctional stress reactions.
- **Speak up.** If you notice signs of dysfunctional stress or burnout in a colleague, don't be afraid to approach them with compassion. Ask if they are okay. Offer some social time away from work.
- **Reach out for help.** Many organizations working in or coordinating emergency response will have in-person or tele-health mental health and psychosocial support services available for providers.

Exercise 13.1

Making a collective care plan

Session 13: That's a wrap!

- Be aware of your own emotional needs
- Practise self-care through stress-reduction exercises, and seek professional help when needed
- Look out for your colleagues and invite them to look out for you

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

World Health Organization

HEALTH CLUSTER

Session 14.

Clinical simulation

Session objectives

Objective 2: Demonstrate behaviours and understand values contributing to safe and supportive services

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

Competencies:

- Demonstrate clinical judgement to respond to survivor wishes and needs
- Demonstrate understanding of limitations to services offered to survivors in specific contexts

Session 14: That's a wrap!

- Developing clinical skills requires practice
- The more you practise, the more comfortable and skilled you will become
- It is important to continue practising and obtaining feedback from colleagues and supervisors

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

World Health Organization

HEALTH CLUSTER

Session 15.

Forensic examination (optional)

World Health Organization

HEALTH CLUSTER

Session objectives

Objective 3: Demonstrate clinical skills appropriate to one's scope of practice to respond to sexual assault and IPV

Competencies:

- Know-how and when to collect forensic evidence

Foundations in forensics

The importance of clinical examination

- Medical evidence is a bridge that links the health and criminal justice systems in the care and management of survivors
- Obtain separate consent for collecting forensic evidence, including any photographs
- The head-to-toe physical exam is primarily for medical care, but it is also useful for documentation of forensic evidence
- Documentation of injuries can provide important evidence regardless of forensic evidence

** This session provides basic information about forensic evidence and documentation only. It does not qualify a provider as a forensic specialist. **

Foundations in forensics

- If a survivor chooses to go to the police or seek legal action, **or may want to do so in the future**, it can be important to collect forensic evidence. Also, the law may require it.
- The survivor's health and emotional well-being and safety should be the primary consideration.
- A good medical history and detailed description of the sexual assault will guide the physical and forensic examination and evidence collection.
- Minimize distress and trauma by combining the physical examination and evidence collection.

Laws and regulations guiding medico-legal services for clinical management of rape

- Who can serve as an expert witness in court?
- What is the minimum training required for a provider's report and specimens to be upheld in a court of law?
- What are the storage and chain of evidence requirements?

Laws and regulations guiding medico-legal services for clinical management of rape

- What forms and labels must be completed for documentation?
- At what age can a survivor consent to forensic evidence collection?
- Are there laws governing marital rape?

Why collect forensic evidence?

The importance of clinical examination

- Medical evidence is a bridge that links the health and criminal justice systems in the care and management of survivors
- However, if there are no means to analyse this evidence, then it is **not** recommended to routinely collect forensic evidence

Guiding principles

- The survivor's health and emotional well-being and safety should be the primary consideration. In many emergency contexts, forensic evidence collection will not be appropriate.
- The account of the assault and the activities and time elapsed since then will determine the specimens to collect.
- Careful labelling, documentation and storage (to avoid contamination) are essential for medico-legal evidence.
- It is important to **not** conclude whether evidence of sexual activity indicates rape or whether it does not. That is for courts to establish.

Types of evidence

- Clothing (especially underwear)
- Blood and urine samples (e.g. to assess covert or non-consenting drug administration)
- Hair, if suspicion of drug administration
- Specimens where biological material containing DNA may have been deposited: skin, hair, mouth, vagina and anus
- Photographs – to document injuries
- Visible foreign objects
- Visible foreign biological material (e.g. skin scrapings under the survivor's nails)

Forensic analysis

- The provider's job is to collect, document and store evidence thoroughly and without contamination, to enable a credible chain of evidence and forensic analysis/report. Forensic samples are transferred to specialty laboratories for analysis.
- Forensic lab reports are forwarded to the investigating officer(s) and/or legal teams and brought before a court during judicial proceedings.
- Evidence is **not** collected for the police but for the court as a means to access justice for the victims.

When to collect

Maximum times for collecting evidence after assault:

- Skin, including bite marks – 72 hours
- Mouth – 12 hours
- Vagina – up to 5 days
- Anus – 48 hours
- Urine (toxicology) 50 ml – up to 5 days
- Blood (toxicology) 2 × 5 ml samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate

Remember:

- ✓ Only medico-legal evidence that can be collected, stored and analysed should be gathered
- ✓ Analysis of forensic evidence requires specialist laboratories and technicians and is not available in many contexts

Skills in action: forensic examination

Collection

Deciding whether to proceed with forensic sample collection prior to beginning the examination will enable you to preserve as much evidence as possible

- Use sterile or very clean drop cloths, table drapes and absorbent sheets to ensure capture of any and all debris from the survivor's hair or clothing
- Store all evidence in paper bags, not plastic, to preserve biological evidence
- Collect samples such as skin or nail scrapings over a clean cloth and place collection swabs or scrapers as well as the cloth in the evidence bag with that sample
- Always follow laboratory guidance and protocols regarding specific specimen collection tubes and procedures

Handling and preservation of evidence

The following practices must be followed when handling/storing forensic specimens:

- Protect the exhibit from weather and contamination (i.e. a room or cupboard/closet with minimal or no human or animal traffic, humidity control, etc.)
- Use sterile instruments and containers
- Wear gloves (powder-free and sterilized) and protective gear when appropriate
- Change gloves when handling/collecting different specimens
- Package, transport and store exhibits safely and securely
- Take special care with fragile and perishable specimens
- Call on an expert if you lack adequate training to handle a particular type of specimen

Storage and documentation

- Each unique specimen and specimen site must be placed in a unique evidence bag
- Biological samples should be completely dry before closing and sealing the evidence bag
- Each bag must be marked with specimen information – time, date, patient name/ID number, nature and site of collection
- Document in the examination record:
  - any limitations to the examination (e.g. poor lighting)
  - each body site or injury from which a specimen was collected, and whether or not a photograph was taken
  - detailed descriptions of all wounds and injuries

Chain of custody

- This refers to the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the community, health facility and finally to the police
- It also refers to a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation

Video

Preparation, storage and dissemination of evidence

© International Rescue Committee and University of California – Los Angeles (2008)

Documenting wounds and injuries

Feature	Notes
Classification	Clinical wound type: abrasion, contusion, laceration, gunshot, incised wound, etc.
Site	Anatomical position and location
Size	Measure and record dimensions (length, height, width)
Shape	Describe the shape in geometric terms (linear, curved, irregular, semicircular, etc.)
Surrounds	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen)
Colour	Particularly relevant when describing bruises, as can give indication of age
Contents	Note the presence of any foreign material in the wound (e.g. grass, glass, dirt, fingernails)
Course	Note indications of impact or infliction directionality, if trained to do so. If not, inclusion of photographs and/or careful documentation of changes in depth and borders along the length of an injury will help review by the forensic laboratory.
Age	Comment on any evidence of healing. Never try to estimate or record a quantitative age, as this is impossible to determine from physical examination by even advanced providers.
Borders	Note the characteristics of the edges of wounds (e.g. jagged, angled, vertical)
Depth	Give an indication of depth of the wound. If measurement is not possible, provide an estimate and note that it is an estimate.

Types of injuries

Blunt force trauma

- Laceration-tissue bridge
- Contusion-haematoma, petechiae, bite marks
- Abrasions/glazes
- Bruises, e.g. tramline injuries, scratch, ligature marks, finger imprints
- Fracture

Sharp force trauma

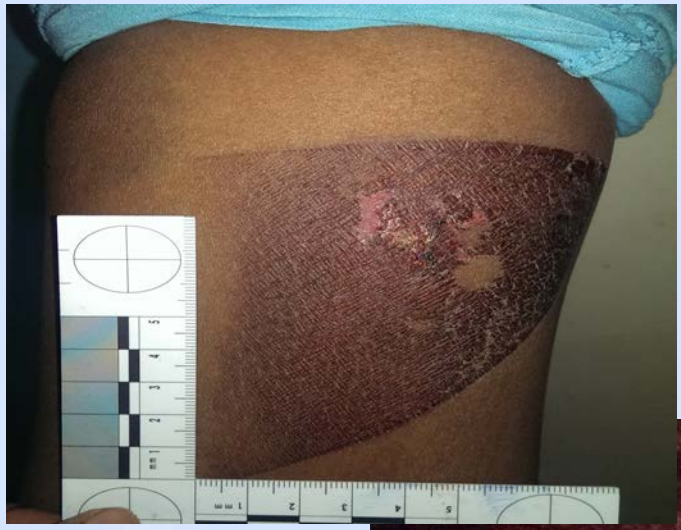
- Incisional wound (cut), e.g. by use of a knife; can be superficial or deep
- Penetrating incised wound (stab)
- Chop wounds – heavy instrument with at least one cutting edge

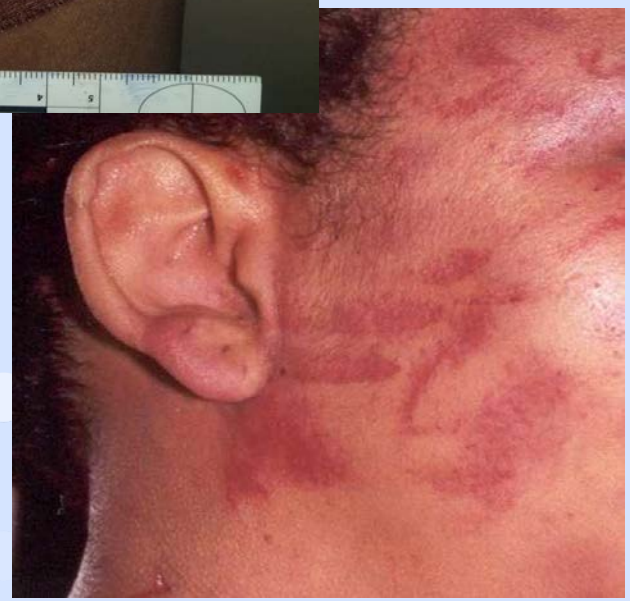
Types of injuries

Thermal injuries could be caused by hot objects or hot liquids, radiators or irons

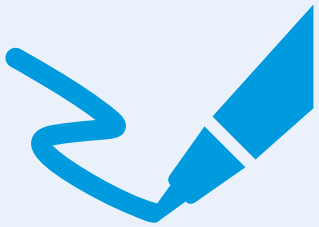
Corrosive injuries could be caused by chemicals

Imprint contusions could be caused by prolonged restraint or gripping with fingers, ropes or other objects



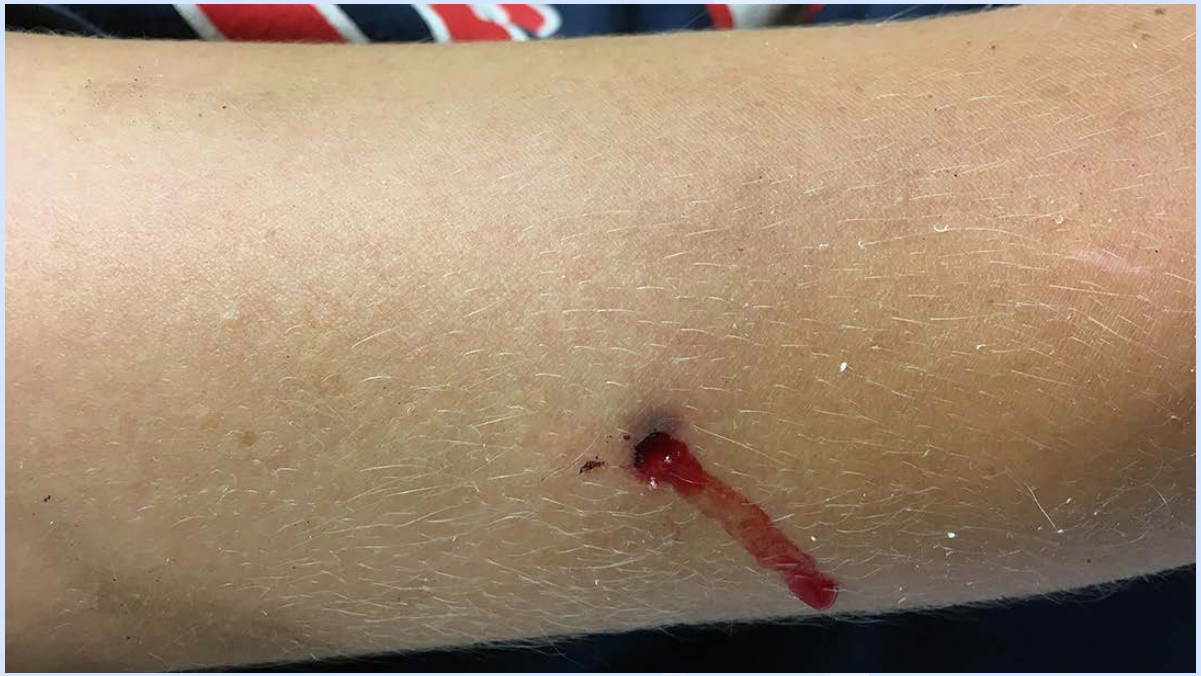


A note on penetration injuries



- Penetrative sexual activity of the vagina, anus or mouth rarely produces any objective signs of injury.
- The hymen may not appear injured even after penetration has occurred. Hence, the absence of injury does not exclude penetration. The health practitioner cannot make any comment on whether the activity was consensual or otherwise.

Documenting wounds and injuries



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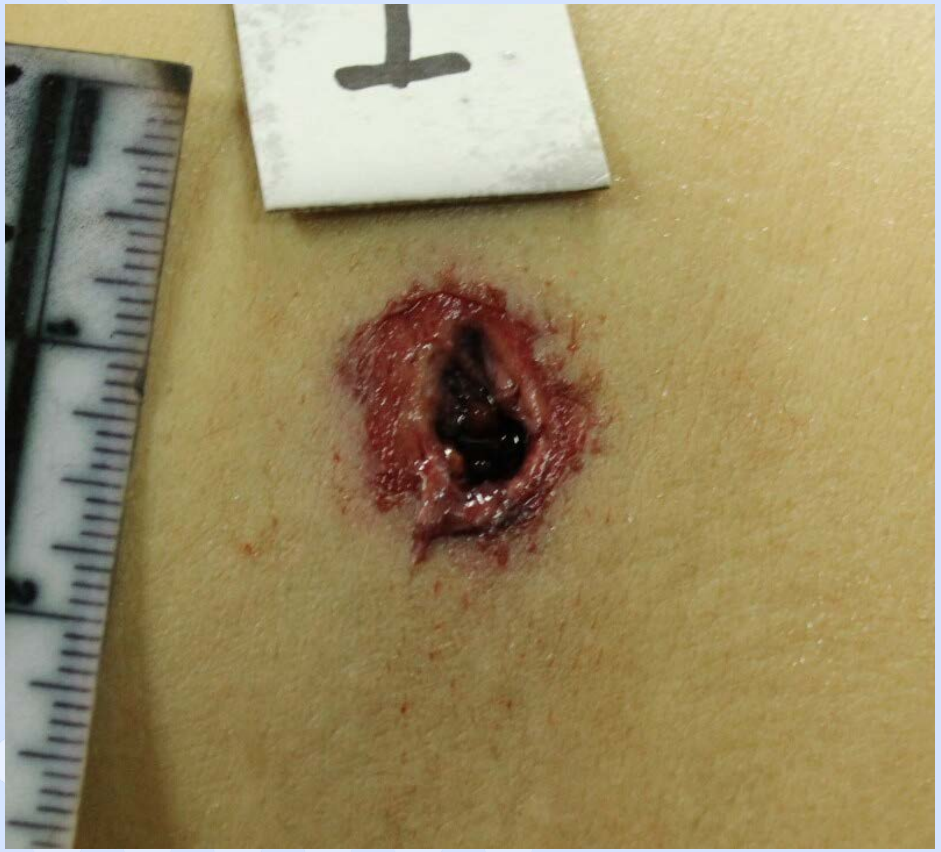

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Documentation type

Medical record

- Not forensic evidence
- May still be submitted into judicial proceedings
- Consists of the history, observed/diagnosed injuries and pathologies, and any treatment provided

Photo-documentation

Ensure photographs do not allow direct identification of the individual. Use a confidential code system to allow authorized staff to identify the individual and note when photographs were taken.

- May be considered forensic evidence
- Record details of any photos obtained (including date, time, location of photo subject) and any subsequent editing or cropping of digital images
- Make certain that notes, photographs and other records are held securely and only accessed by authorized individuals

Documentation type

Medical certificate

- It is a legal requirement for some countries
- It is a confidential medical document
- It is often the only material evidence available
- It is completed by a clinical service provider
- One copy is offered to the survivor, and one copy is locked with the file depending on the country's law
- Hand it over with the consent of the survivor to legal services or organizations with a protection mandate

Role of health-care professionals in evidence presentation in court

Two types of witnesses:

1. A fact witness may be compelled to testify if they have some knowledge due to direct observation. A treating doctor may be compelled to testify about their contact with a patient regardless of forensic training or skill. A treating doctor usually has more credibility than a non-treating doctor.

2. Expert witnesses are persons who have facts directly related to some science or profession beyond the scope of the average lay-person (e.g. blood-spatter expert).

In court

"If the law has made you a witness, remain a man of science. You have no victim to avenge, or guilty or innocent person to ruin or save. You must bear testimony within the limits of science."

– Paul Brouardel

If called to testify in court

✓ DO

- ✓ Trust your clinical notes and experience
- ✓ Remain calm and project confidence
- ✓ Take time to consider your answers
- ✓ Fully explain the clinical facts that you heard, saw and treated
- ✓ Stick to the science

✗ DON'T

- ✗ Lose your temper
- ✗ Answer questions you don't fully understand
- ✗ Speak beyond the facts of the case you evaluated and treated
- ✗ Allow a zealous attorney to manipulate you
- ✗ Share your feelings or speculation

Session 15: That's a wrap!

- Collect forensic evidence ONLY when:
  - The survivor wants to go to the police **or** it is mandatory by law
  - The survivor is being examined within 5 days of the assault
  - The provider is trained in forensic examination **and**
  - A qualified forensic science laboratory is available
- Separate consent is needed for a forensic examination
- The assault history guides forensic evidence collection
- Time elapsed and activities undertaken after the incident will determine whether evidence can be found
- Storage that avoids contamination, labelling and detailed documentation are essential
- Health workers may need to provide testimony; they cannot conclude whether evidence points to rape – that is for the courts to establish

Reference

1. Shrestha R, Kanchan T, Krishan K. Gunshot wounds forensic pathology. In: StatPearls [Internet]. Treasure Island: StatPearls Publishing; 2023 (https://www.ncbi.nlm.nih.gov/books/NBK556119/). Licence: CC BY-NC-ND 4.0.

Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

PRESENTATION SLIDES

World Health Organization

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Session 16.

Conclusion

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- As front-line health workers, you have a critical role to play in responding to GBV and beginning to restore power to survivors
- This training is just a beginning. Learning and skill-building is an ongoing process. Look for opportunities to:
  - Take refresher training on challenging skills and topics
  - Participate in clinical case reviews
  - Use job aids as references and reminders
  - Continue self-directed study
  - Seek experienced clinicians as mentors

Final thoughts

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- Do not underestimate the importance of LIV(ES) in survivor recovery and healing. It is an essential component of the clinical care package.
- WHO and IASC guidelines, national protocols and agency job aids are frequently updated to reflect the latest evidence and treatment standards. They are valuable resources.

Exercise 16.1

Action planning

Instructions

1. Identify specific goals that will strengthen your personal response and/or care for survivors of sexual assault and IPV.
2. Use Job aid16a (Post-training action plan) to record your goals. These may be the same as for other members of your group, and/or you may record goals unique to yourself.
3. Focus on goals for which you can take actions that are within your control.

Session 16: That’s a wrap!

Thank you !