

Clinical Care for Sexual Assault Survivors

A Multimedia Training Tool

Facilitator's Guide



Presented by the International Rescue Committee
with production by the UCLA Center for International Medicine



UCLA
Center for International Medicine

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Disclaimer

Great effort has been made to ensure that all information and recommendations in this DVD and all accompanying materials are in accord with international standards of care at the time of publication, August 2008. Practitioners and other users of this DVD should be advised that new research might affect clinical guidance (e.g., concerning drug dosages, procedures, and other topics pertinent to the material contained herein). The authors, editors, producers, experts, and others who participated in developing this DVD are not responsible for errors or omissions of information, or for any consequences of the application of this information. Many actions and procedures described in the DVD require additional training that is beyond the scope of this DVD. Users are advised that application of all information contained in this DVD remains the sole responsibility of the individual. We urge practitioners to check treatment procedures and drug dosages before application, and we urge all individuals to obtain training appropriate to their professional qualification.

Due to some sensitive material the DVD is password protected. To obtain a password, or for further information, contact the IRC. The DVD is available online: www.iawg.net/ccsas

E-mail: clinicalcare@iawg.net

Telephone: + 1 212 551-3000

Mailing Address: International Rescue Committee
122 East 42nd Street, New York, NY 10168-1289, USA
Website: www.theirc.org

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Introduction

CHAPTER

1

Introduction to the Training Tool

The goal of this multimedia educational program is to improve clinical care for and general treatment of sexual assault survivors by providing medical instruction and encouraging competent, compassionate, confidential care. The training is not meant to teach basic medical information; it is a skills based training designed to help medical professionals and clinic staff better communicate with and serve survivors of sexual assault.

The program is intended for both clinical care providers and non-clinician health facility staff. It is designed to be delivered in a group setting with facilitators guiding participants through the material and directing discussions and group participation as appropriate. It is divided into five sections:

1. What Every Clinic Worker Needs to Know
2. Responsibilities of Non-Medical Staff
3. Direct Patient Care
4. Preparing Your Clinic
5. Forensic Examination

The first two are intended for a general (non-clinician) audience. Section 3 and Section 5 are intended for clinical care providers and contain graphic images inappropriate for untrained personnel. Section 4: *Preparing Your Clinic* is intended to guide participants through the process of assessing the current situation and developing an action plan for the improvement of services for sexual assault survivors.

The CCSAS Psychosocial Toolkit: A new module has been created with greater detail on how clinicians can provide survivor centered-care. We recommend trainers review the material as it will help answer some of participants' questions. It also includes a section on self-care for providers dealing with the stress of working with survivors. This updated facilitators' guide will refer to this new module where relevant throughout the training. However, the module is not part of the DVD. It can be found on-line at: www.iawg.net/ccsas

Other resources: At the end of the DVD there is a section that contains key resources in PDF format, including the major source documents for this training as well as a copy of this facilitator's guide.

IRC Protocol: Clinical Care for Sexual Assault Survivors (English, French)

Facilitator's Guide

Knowledge Assessments* (Pre & Post Tests)

Pictograms & Forms

*The pre/post tests have been revised. The version on the DVD is the old one.

Reference Resources

WHO Clinical Management of Rape Survivors (2004) (English, French, Arabic)

UNHCR Guidelines for Sexual & Gender Based Violence (2003)

IASC GBV Guidelines (2005) (English, French, Arabic)

RHRC Emergency Contraception (2004) (English, French)

WHO Sexually Transmitted and other Reproductive Tract Infections (2005)

IASC Guidelines on Mental Health & Psychosocial Support (2007)

Learning Objectives

Section 1: What Every Clinic Worker Needs to Know

Participants will be able to:

- Explain why sexual assault is underreported.
- Name the universal human rights which are particularly important for sexual assault survivors.
- Give an example of how these rights can be realized in their work.
- Define the terms “sexual assault” and “rape” and explain why the term sexual assault is used in this training.

Section 2: Responsibilities of Non-Medical Clinic Staff

Participants will be able to:

- Name the public health consequences of sexual assault.
- Describe how compassion, competence and confidentiality can help the survivor begin to heal.
- Demonstrate appropriate ways to protect survivors’ human rights.

Section 3: Direct Patient Care

Section 3a: Receiving the patient and preliminary assessment

Participants will be able to:

- Describe the purpose of the preliminary assessment.
- Describe what treatment you would offer to a patient who is being referred to a higher level facility before she leaves your care.
- Follow the clinical pathway to ensure that the key elements of care are provided.

Section 3b: Obtaining informed consent and taking the history

Participants will be able to:

- Describe the purpose of obtaining informed consent.
- Demonstrate how to properly obtain informed consent and fill out the form.
- Explain what to do if a survivor refuses to give consent.
- List the elements of the health history.
- Demonstrate active listening skills.

Section 3c: Performing a physical exam

Participants will be able to:

- Describe how to give the survivor control over the examination.
- Describe how to use information from the history to guide the exam.
- Determine when a speculum exam is needed.
- Describe the cause and the signs and symptoms of fistula.
- Explain the importance of correct documentation.
- Demonstrate how to correctly fill out the medical exam form.

Section 3d: Treatment and disease prevention

Participants will be able to:

- List the elements of treatment for survivors.
- Describe the use of emergency contraception.
- Describe which patients should be offered PEP and list the patient teaching messages.
- Describe how you would approach a survivor who came to you 6 months after a sexual assault.
- Describe common reactions to sexual assault and demonstrate the ability to express compassion for what the survivor is feeling.
- Describe when the survivor should come back for follow up and what should be addressed at each follow up visit.

Section 3e: Caring for male survivors

Participants will be able to:

- Describe how male survivors may react to a sexual assault.
- Describe how to communicate with a male survivor.
- Explain what physical response men can experience during an assault and how this may make them feel.
- Describe signs to look for during the male genital exam.

Section 3f: Caring for child survivors

Participants will be able to:

- Describe the issues involved in getting consent for the examination of a child.
- List the information you need to gather from a child survivor.
- Discuss what it means to always put the best interest of the child first.
- Describe under what conditions it would be inappropriate to perform a genital exam on a child.
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP if vaginal penetration has occurred.
- Describe what treatment you would offer for a child survivor.
- Demonstrate how to advise parents/guardians on a child's possible reactions to sexual assault.

Section 4: Preparing Your Clinic

Participants will be able to:

- Map out current patient flow and response to sexual assault survivors and identify areas for improvement.
- Describe the information needed to adapt the protocol to your local setting.
- Describe what referral resources are needed for sexual assault survivors.
- Determine what resources are currently missing in your referral network and develop a plan for filling gaps and improving communication between the various organizations.
- Describe what resources are available at the country and TU level to support CCSAS.
- Use the checklist to develop a draft work plan improving facility practices to meet standards for CCSAS and the adaptation and implementation of the CCSAS protocol.

Section 5: Collecting Forensic Evidence

Participants will be able to:

- Describe the reasons for collecting forensic evidence.
- Describe the types of forensic evidence that can be collected.
- Describe proper packaging of samples.
- Explain why evidence collection should be done as soon as possible after the assault and what activities in particular reduce the quality of the evidence.
- Describe the process of consent for a survivor wishing to have evidence collected.

Using the Facilitator's Guide

This facilitator's guide is intended for use with the accompanying interactive DVD to provide a complete training program on the clinical care for sexual assault survivors as outlined in IRC's Clinical Care for Sexual Assault Survivors: a prototype protocol for IRC health programs. Chapter 1 provides general information for users, such as technical requirements, an overview of the DVD, time requirements, instructional options and user tips. Chapter 2 presents information on preparing for and presenting the training including a training agenda, materials and equipment, a facilitator's checklist, and suggestions for how to introduce the participants to the training and each other. Chapter 3 contains content notes which take the facilitator through the training, elaborating on issues or questions that may arise and suggesting content for discussion. Facilitators should use these notes to follow along with the DVD. They provide cues for exercises, discussions, breaks, etc. Chapter 4 provides detailed descriptions of the exercises along with participant handouts. Chapter 5 presents tools for assessing the participants' learning and their experience of the training. The pre/post-test and training evaluation are included here. A glossary can be found at the end of this guide.

It is recommended that you review the DVD and read through the guide completely before beginning the presentation to the group. Although we have tried to present issues in the order in which they will arise during the presentation, it is likely that questions will come up at different times for different groups or even several times over the course of the training. In order to keep the training running smoothly, the facilitator needs to think through how to respond to both common and difficult questions.

Who should facilitate

Facilitators should have basic clinical knowledge of how to care for sexual assault survivors. They should feel comfortable talking about the sensitive issues that will be discussed during the training and they should also feel comfortable facilitating group discussions. Most of all, they need to understand and adhere to the basic principles of respect and confidentiality which will apply to the group being trained as well as to the survivors they serve. Some brief training tips are provided in the next chapter.

The maximum size of a training group should be 15 persons. It is recommended that 2 facilitators present the training module, particularly for groups larger than 8 - 10 persons. Ideally, one person from the health program and one person from a counseling or gender based violence prevention and response background should co-facilitate so that participants can benefit from both kinds of experience and expertise.

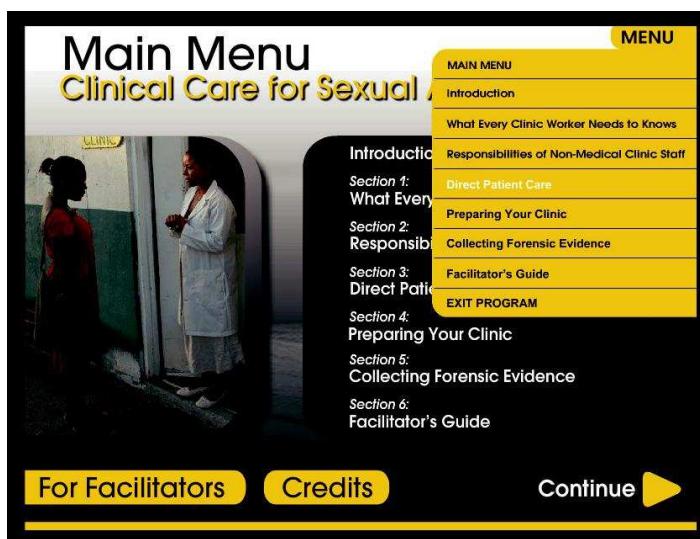
Technical Information

To present the training you need a computer. The multimedia tool will not play in a DVD player intended for movies. Each time you start the DVD, you will be prompted to enter a password. The training program is password protected due to the graphic material contained in the *Direct Patient Care* and *Collecting Forensic Evidence* sections. A password can be obtained by contacting the IRC via email: clinicalcare@iawg.net

After you have opened the presentation you can go to full screen by typing **ctrl+F** or by clicking on Full Screen in the View drop down menu in the upper left corner. To get out of full screen just hit escape.

Subtitles are included for viewers who may have some difficulty understanding the pronunciation of the different speakers. These subtitles can be turned on and off using the button on the bottom left corner.

We do not recommend skipping sections or changing the order of the presentation (except as noted in the Content Notes in Chapter 3 of this guide), with the following exception: Section 5: *Collecting Forensic Evidence* should be presented prior to Section 4: *Preparing Your Clinic*. The reasons for this, as well as various options for structuring the training, are explained below in “Structuring the Course.”



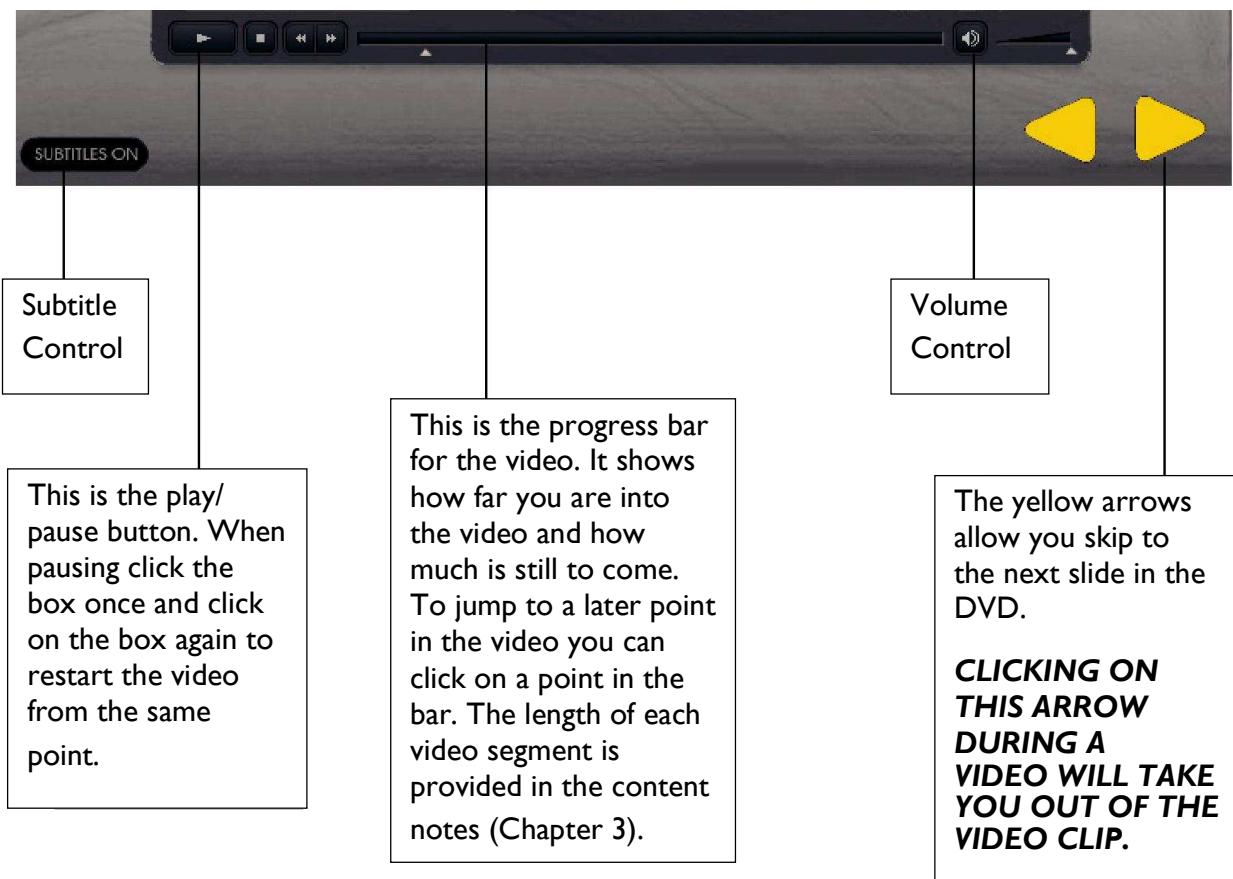
The Main Menu is accessible as its own screen at the beginning of the DVD and subsequently by clicking on the Menu button at the top right hand corner of the screen.

Navigate forward or backward from screen to screen by clicking on the yellow arrows at the bottom right hand corner of the screen.



The *Direct Patient Care* section contains a sub-menu with several sub-sections. You can navigate to any of these from the *Direct Patient Care* menu.

During the presentation, the facilitator or an assistant will click from screen to screen. As you click through the DVD you will notice a series of different media formats: video, text cards, discussion cards, and case studies. In the video screen you can pause, rewind or fast forward using the controls at the bottom of the screen. There is also a volume control button, but the volume will be determined by your computer's volume level or your speakers. The built in speakers in your computer will not be adequate.



Video elements

Video is used in a variety of ways to convey information that is both accessible and compelling. Documentary style videos are used to discuss and depict concepts and subject matter such as the impact of sexual assault and the treatment needs of survivors.

Direct Patient Care (Section 3) is largely built around the interaction between one survivor, Alisha, and the physician who treats her, Dr. Ngozi, both played by actors. The scene is set somewhere in sub-Saharan Africa. The narrative follows Alisha from arrival through discharge. Four other short scenarios supplement the training material provided by the Alisha story.

These include:

- Speculum Examination: Maksoud and Dr. Semira: Patient requiring a speculum examination, somewhere in Asia.
- Suspected fistula or other serious injury: Dhakira and Dr. Ngozi: Patient with suspected severe internal injury requiring higher level care, Dr. Ngozi's clinic in Sub-Saharan Africa. *Parts of this scenario are omitted during the training because they are not medically accurate.
- Male survivor: Thomas and Dr. Masiolo: Male patient reports after being raped, somewhere in sub-Saharan Africa.
- Young survivor: Lawan, Tida, and Dr. Kaya: Young woman is brought to the clinic by her mother three days after being assaulted, somewhere in Southeast Asia.
- Forensic Evidence Collection: Linda, Dr. Otieno and Nurse Nelly: A sexual assault survivor presents at a clinic in Sub-Saharan Africa where she is examined and has forensic evidence collected.

Discussion Cards

Discussion cards are included to allow the group to share their reactions to what they are learning and to share their experiences. Each discussion card lists talking points, with more included in the Content Notes section of this guide, along with important points that the facilitators should emphasize or explain to the group. Facilitators should encourage discussion among the group, but should also keep the discussions focused and on track. The recommended time to spend on each activity is included for each section of the training.

Case Studies

Case studies are presented as a series of animated images with voice-over describing a particular scenario trainees may face. At the end of the animated series of images, a question is posed to the group. These questions are in multiple-choice format. The answer is provided on the slide following the question. The questions are another opportunity for group discussion.

Text Cards

A great deal of information is presented in the form of simple text. In general these text cards repeat or reinforce messages also found elsewhere. These cards should be read out loud by either a facilitator or one of the participants.

Image Viewers

At certain points during the clinical section of the training images of body parts, some with injuries are used as examples. If these images don't show up well in your training room, set aside time for participants to look at the relevant images directly on a computer. Don't spend time presenting images that participants can't see well.

⚠ A note on graphic images: Digital animation is used to demonstrate techniques for examining the genitalia and obtaining forensic samples. These are not images of actual people. Additionally, in several instances, photographs of injuries are provided to give trainees a visual reference for the types of injuries they might expect. These are from anonymous patients who agreed to have their photographs used for educational purposes.

Structuring the Course

The complete training, with time for breaks and logistics, is estimated to take twenty to twenty four hours. The actual time will depend on the knowledge level of the participants, the amount of discussion, language skills, and other factors. In contexts where the concept of sexual violence is less well understood or more difficult to discuss, it might be necessary to add more training days to provide a deeper introduction to the concept. Additional tools can be found in the IRC CCSAS Psycho-social module and added as needed.

The five sections of the program with their intended audience and minimum duration are listed below. This does not include time for logistics, breaks, meals, extended discussions, etc.

1. What Every Clinic Worker Needs to Know	All clinic staff	1 hour
2. Responsibilities of Non-Medical Staff	All clinic staff	2.5 hours
3. Direct Patient Care	Medical care providers	9.5 hours
4. Preparing Your Clinic	Medical care providers, managers, and non-clinical staff who interact with patients	3 hours
5. Collecting Forensic Evidence	Medical care providers	45 min

Section 5: Collecting Forensic Evidence may seem inappropriate in many settings and can be omitted, but we recommend using it because it reinforces many of the messages in other sections. It can also help demystify what seems very technical and difficult, but is in fact a fairly simple procedure that will help to bring justice and help end impunity in cases of sexual assault.

Please note that these times are at best rough estimates, though we have tried to err on the side of over-estimating rather than under-estimating. It is also important to note that these times were developed with the assumption that the training would be done with groups of 9 to 12 participants.

If you are working with a significantly larger or smaller group your time estimates will need to be readjusted. We recognize that there are many ways to use the tool and encourage adaptation. One sample agenda is provided in this chapter.

Please inform us by emailing clinicalcare@iawg.net of the trainings you conduct using this DVD, the names and contact information of participants and dates and location of the training.

Training Agenda

The most commonly used training schedule is three full days, although it can be challenging to cover the material in that time. However, it is also possible to spread it out over a week or more so that health workers can participate with minimal disruption to patient care.

CLINICAL CARE FOR SEXUAL ASSAULT SURVIVORS - FACILITATOR'S AGENDA DAY ONE

TIME	CONTENT	METHOD	RESOURCES
8:30–9:00	INTRODUCTION <ul style="list-style-type: none"> ◆ Introduction to the training ◆ Introduce the participants ◆ Establish code of conduct ◆ Logistics (if necessary) 	<ul style="list-style-type: none"> ◆ Present overall objectives written on a flip chart ◆ Icebreaker (from the facilitator's guide or use your own) ◆ Present need for sensitivity, confidentiality; sharing valued but not required. ◆ Write out code of conduct on flip chart and post in room. ◆ Discuss lodging, per diem, meals, schedule, etc. as needed. 	<input type="checkbox"/> Flip chart of objectives (prepared in advance) <input type="checkbox"/> Flip chart, markers <input type="checkbox"/> Name tags <input type="checkbox"/> Paper for “parking lot”
9:00–9:30	PRE-TEST		<input type="checkbox"/> Pre/post test
9:30–10:30	1. WHAT EVERY CLINIC WORKER NEEDS TO KNOW <ul style="list-style-type: none"> ◆ Introduction ◆ The global burden of sexual assault ◆ How cultural beliefs affect survivors ◆ Survivors' universal rights 	<ul style="list-style-type: none"> ◆ Read objectives for section 1 from handout ◆ Read through introduction slides and review terminology ◆ DVD and group discussion ◆ True-False exercise on DVD (see alternative questions in <i>Content Notes</i>) 	<input type="checkbox"/> Handout: Learning Objectives for Sections 1 and 2 <input type="checkbox"/> Flip chart with Survivors' Rights written out <input type="checkbox"/> If using alternative questions, write out in advance on flip chart
15 minute break			
11:00–12:30	2. RESPONSIBILITIES OF NON-MEDICAL STAFF <ul style="list-style-type: none"> ◆ The harmful effects of sexual assault ◆ What you can do: compassion, competence and confidentiality 	<ul style="list-style-type: none"> ◆ Read objectives for section 2 from handout ◆ DVD and group discussion ◆ Case studies on DVD ◆ Introduce Exercise 1 and assign groups before lunch 	<input type="checkbox"/> Handout: Exercise 1
Lunch			
1:30–2:30	<ul style="list-style-type: none"> ◆ Compassion, competence and confidentiality (cont) ◆ Wrap up sections 1 and 2 	<ul style="list-style-type: none"> ◆ Exercise 1: Compassion, Competence and Confidentiality Role Play (40 min) ◆ Discuss role plays, summarize key points 	
2:30–4:15	3: DIRECT PATIENT CARE <ul style="list-style-type: none"> ◆ Introduction ◆ Receiving a survivor ◆ Preliminary assessment and referral ◆ Informed consent ◆ Taking the history 	<ul style="list-style-type: none"> ◆ Introduce clinical section, read objectives ◆ Case studies on DVD ◆ Exercise 2: Informed Consent (10 min) ◆ Exercise 3: Active Listening (30 min) 	<input type="checkbox"/> Handout: Learning Objectives for Sections 3 and 5 <input type="checkbox"/> Clinical Pathway Wall Diagram <input type="checkbox"/> Handout: Clinical Pathway <input type="checkbox"/> Handout: Informed Consent <input type="checkbox"/> Handout: Exercise 3
4:15–4:30	Wrap up, daily evaluation		<input type="checkbox"/> Daily evaluation forms

CLINICAL CARE FOR SEXUAL ASSAULT SURVIVORS - FACILITATOR'S AGENDA DAY TWO

TIME	CONTENT	METHOD	RESOURCES
8:30 – 9:30	3: DIRECT PATIENT CARE (cont.) <ul style="list-style-type: none"> ◆ Performing a survivor led physical exam ◆ Common injuries and possible complications (including fistula) 		<input type="checkbox"/> Supplies to continue Clinical Pathway Wall Diagram <input type="checkbox"/> Handout: Female Anatomy <input type="checkbox"/> Handout Female Genital Cutting <input type="checkbox"/> Handout Vaginal Wet Prep
9:30 – 10:15	<ul style="list-style-type: none"> ◆ Documenting the history and physical examination 	<ul style="list-style-type: none"> ◆ Exercise 4: Documentation (30 min) 	<input type="checkbox"/> Handout: Medical History and Examination Form <input type="checkbox"/> Handout: Documentation Guidelines
15 minute break			
10:30 –12:30	<ul style="list-style-type: none"> ◆ Treatment and disease prevention: preventing pregnancy, STIs, HIV and other infections 	<ul style="list-style-type: none"> ◆ DVD and group discussion ◆ Case studies on DVD 	<input type="checkbox"/> Resources: Local treatment guidelines or WHO guidelines <input type="checkbox"/> “Rape treatment kit” for display <input type="checkbox"/> Handouts: HIV PEP and ECP and STI treatment information
Lunch			
1:30 – 2:30	<ul style="list-style-type: none"> ◆ Delayed treatment principles ◆ Mental health issues ◆ Patient discharge and follow up care 	<ul style="list-style-type: none"> ◆ Exercise 5: Talking to Suicidal Patients (5 min) (optional) 	
2:30 – 3:10	<ul style="list-style-type: none"> ◆ Caring for male survivors 		<input type="checkbox"/> Handout: Male Anatomy
15 minute break			
3:30 – 4:15	<ul style="list-style-type: none"> ◆ Responding to common emotional reactions 	<ul style="list-style-type: none"> ◆ Exercise 6: Responding to Common Emotional Reactions (45 min) 	<input type="checkbox"/> Slips of paper with emotions – see description of Exercise 6
4:15 – 4:30	Wrap up, daily evaluation		<input type="checkbox"/> Daily evaluation forms

CLINICAL CARE FOR SEXUAL ASSAULT SURVIVORS - FACILITATOR'S AGENDA DAY THREE

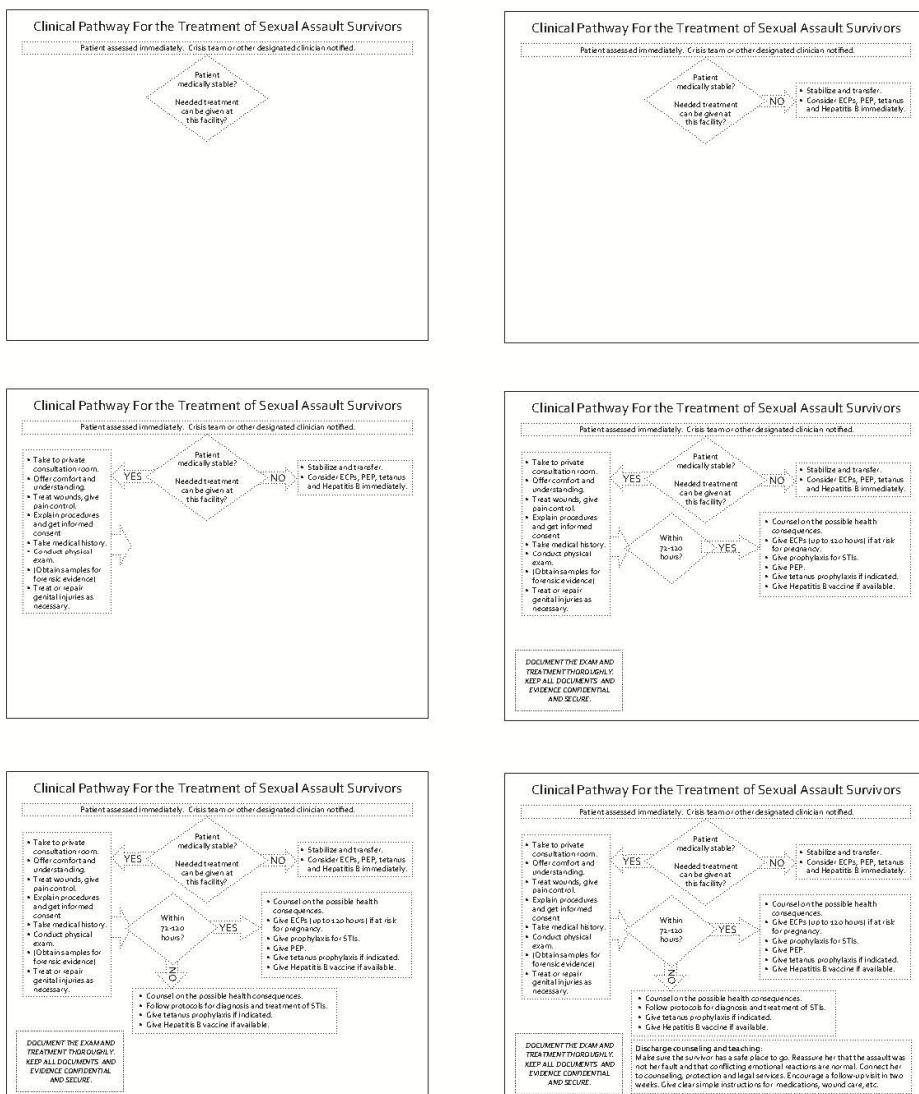
TIME	CONTENT	METHOD	RESOURCES
8:30 – 9:45	3: DIRECT PATIENT CARE (cont.) ◆ Caring for young survivors	◆ DVD and group discussion ◆ Case studies on DVD	
9:45 – 10:15	◆ Treatment options	◆ Exercise 7: Prescribing Treatment (30 min)	<input type="checkbox"/> Handouts: Exercise 7: Case Studies & Timing and Treatment
15 minute break			
10:30 – 11:15	5: FORENSIC EVIDENCE ◆ Collecting forensic evidence	◆ DVD and group discussion (shortened version)	<input type="checkbox"/> Evidence collection kit for display (if appropriate)
11:15 – 12:30	4: PREPARING YOUR CLINIC ◆ Assessing your clinic's resources ◆ Tracing a survivor's route	◆ DVD and group discussion ◆ Exercise 8: Tracing a Survivor's Route (45 min)	<input type="checkbox"/> Handout: Checklist for Clinical Care <input type="checkbox"/> Flip chart paper, pens, glue, tape, etc.
Lunch			
1:30 – 2:00	◆ Building a referral network	◆ DVD and group discussion	<input type="checkbox"/> Handout: Help-Seeking Referral Pathway
2:00 – 3:00	◆ Developing an action plan to improve clinical care for sexual assault survivors	◆ DVD and group discussion ◆ Exercise 9: Developing an Action Plan (60 min)	<input type="checkbox"/> Handout: Exercise 9: Action Plan
3:00 – 3:30	◆ Return to the topic raised earlier: Caring for yourself and your staff	◆ Short exercise: Discuss self-care with a partner (5 min)	<input type="checkbox"/> Review materials in the CCSAS Psychosocial Toolkit
15 minute break			
3:45 – 4:15	POST TEST		<input type="checkbox"/> Pre/post test
4:15 – 4:30	Wrap up, Final evaluation		<input type="checkbox"/> Final evaluation forms

Clinical Pathway Diagram

The Clinical Pathway for the Treatment of Survivors of Sexual Assault is a graphic representation of the treatment paths available to survivors who present with different symptoms at various times following the assault. This pathway shows the steps that all providers should follow in the management of sexual assault survivors.

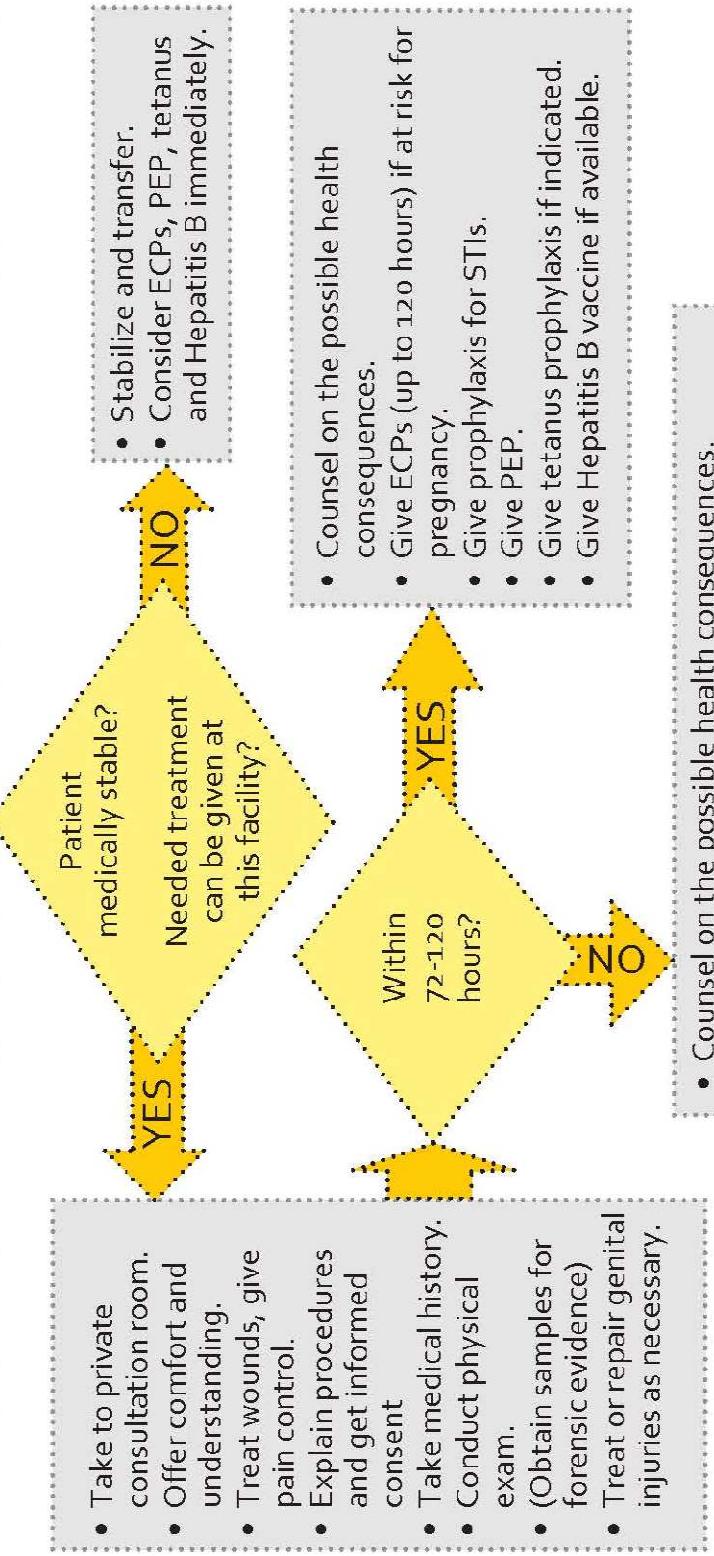
It will be helpful to review the clinical pathway with participants throughout the training to orient them to the decision making process and the steps involved with caring for survivors and to reinforce the primary messages of the training. Before the training, facilitators should prepare the pieces of the diagram using colored paper cut-outs large enough to be seen from across the room. Assemble the pathway on the wall of the training space, adding pieces as the DVD describes each step in the process. (A representation of this can be found below. The complete pathway is on the next page.)

Facilitators should guide participants through this process where indicated in the manual by the Clinical Pathway icon, adding a piece of the pathway to the wall at each of these points, as shown below.



Pathway For the Treatment of Sexual Assault Survivors

Patient assessed immediately. Crisis team or other designated clinician notified.



DOCUMENT THE EXAM AND TREATMENT THOROUGHLY.
KEEP ALL DOCUMENTS AND EVIDENCE CONFIDENTIAL AND SECURE.

Discharge counseling and teaching:

Make sure the survivor has a safe place to go. Reassure her that the assault was not her fault and that conflicting emotional reactions are normal. Connect her to counseling, protection and legal services. Encourage a follow-up visit in two weeks. Give clear simple instructions for medications, wound care, etc.

Training of Trainers (TOT)

After the initial training, you may want to add on an extra day to train participants to share the training with others.

Training of Trainer Objectives:

Participants will be able to:

- explain the importance of providing compassionate, competent, confidential care
- demonstrate understanding of the elements of direct patient care for sexual assault survivors
- describe when forensic evidence collection is appropriate and how it should be done
- analyze their programs to identify gaps and improve services
- understand how to use the DVD and facilitator's guide to present the training
- lead discussions on issues that arise during the training
- work with staff trainees to develop an action plan for improving clinical care at their facilities

Note: Participants who have not fully mastered the material presented or who have any reservations or difficulties with the principles expressed should not be trained as trainers.

The bulk of the training time should be dedicated to hands on activities using the DVD. The participants need first to become familiar with how to navigate it the DVD. Then they need to practice presenting, leading a discussion, and dealing with sensitive issues while avoiding being led off topic. It is challenging to accomplish this all in one day, especially after completing the 3 days training which can be rather intense. On the following page there is a suggested agenda for a one-day add-on TOT.

For the participant practice sessions, assign the participants to teams of 2 and give each team a section of the training to prepare, among the following: Informed Consent, PEP for HIV, Emergency Contraception, Child Survivors and Male Survivors. (Don't allow two groups to present the exact same material, but if necessary chose different parts of the assigned sections.) They should present for 10-15 minutes, using the video, leading discussion and answering questions. Do not intervene during the presentation unless there is some important fact requiring correction. Allow the "audience" to provide feedback and then offer your own comments.

TIME	CONTENT	METHOD	RESOURCES
9:00	Introductions, agenda for the day Debrief from training Review post test	Discussion, revisit “parking lot” and other issues that arose, daily and final evaluations	<input type="checkbox"/> Flip chart, pens <input type="checkbox"/> Participants’ of post-tests and answers
10:30	BREAK		
10:45	Review the Facilitator’s Guide <ul style="list-style-type: none">♦ Structure and timing♦ Audience♦ Preparing♦ Equipment♦ Exercises	Go through sections of the Facilitator’s Guide	<input type="checkbox"/> Copies of the Facilitator’s Guide for each participant
12:30	LUNCH		
1:30	How to use the DVD	Have participants work in small groups to practice starting the DVD, moving through it, using the menus, skipping or going back, finding the resource materials.	<input type="checkbox"/> Computers for each group
2:15	Participant practice sessions: <ul style="list-style-type: none">♦ Consent♦ PEP♦ EC♦ Children♦ Men	Assign participant pairs to a section of the training and have them present for 10-15 minutes, followed by feedback.	<input type="checkbox"/> Computer, projector, speakers <input type="checkbox"/> Flip chart, pens to take notes on feedback
3:00	BREAK		
3:15	Participant practice sessions continued, feedback on presentations	As above	<input type="checkbox"/> Computer, projector, speakers
4:30	WRAP UP		

Preparing and Presenting

CHAPTER 2

This chapter is divided into the following sections:

Preparing for the Training

- Participant Selection and Logistics
- Equipment and Supplies
- Information and Resources

Presenting the Training

- Training Tips
- Dos and Don'ts of Training
- Introductions and Ice Breakers
- Energizers
- Other Facilitation Methods

Preparing for the Training

Remember that thorough preparation is essential to the success of any training. Facilitators should remember that each group of participants has different needs, strengths, and weaknesses and that the training will be a different experience each time it is conducted. Each training should be adapted to the needs and circumstances of the individual site. Participants will learn best in a positive environment where their needs are met, and the facilitator is responsible for creating that environment. Whenever possible, the facilitator should involve site managers in planning and preparing for the training, to ensure that it meets the particular needs of the site and the participants. A checklist is provided at the end of this section to guide you and the site managers as you prepare.

Participant Selection and Logistics

Begin by identifying key staff or facilities where training is needed. Approach these staff and their supervisors to determine the best times and location for training. Ideally, the location would be a conference room on (or near) the health facility grounds, so that it is convenient for the participants. If the training is held at a remote site, then transportation should be provided. The room should be comfortable and have electricity to run the computer and projector. You will need a white screen, a sheet, or a white wall; and you will need to be able to darken the room, so that the video can be easily seen. Refreshments and meals should be easily accessible or provided on site.

Once you have identified the participants, you should determine the roles that they play in the facility and use that information to determine their learning needs. For example, if members of this group will be taking on new responsibilities after the training, make sure that is understood and planned for in advance of the training. While individual responsibilities might evolve as a result of the training and the team building process, the need for resources and change in organizational culture should be addressed in advance. Training staff without providing them an opportunity to use the information and skills they have obtained is frustrating and counterproductive.

The first part of the training (Sections 1 and 2 - 3.7 hours) should involve staff from all cadres. This may mean that you will need to look for a larger space to conduct the first day of activities. This session may need to be held at a different location. If the group is too large to meet in a single session, priority should be given to those staff with the most patient interaction, with the goal that all staff be trained by the end of one year with periodic trainings for new staff. It may require special effort to get management to agree to have all staff participate in the training, but it is essential to making services more accessible and acceptable to survivors.

If you need to make changes to the suggested schedule, be sure that you allow sufficient time for discussions, exercises, breaks and meals. If travel to an external training site is required, then this will also need to be figured into the training schedule. It is important to have a break at least every 2 hours because sessions longer than 2 hours are difficult for participants to sit through. Breaks should be scheduled to fall at natural breaking points in a training. If at other times the energy of the group is lagging use an energizer to revive participants. Facilitators should avoid breaks in the middle of a topic. Rather, schedule breaks between different topics or sections.

Equipment and Supplies

Equipment

- Computer, projector, white screen, speakers
- Camera/video (optional)

Supplies

- Flip chart paper
- Construction/colored paper
- Scissors
- Markers
- Tape
- Glue
- Name tags
- Certificates of completion for participants (see page 143)
- Watch or clock

Medical Supplies

Rape treatment supplies for demonstration (see IASC RH Kits, Kit 3: Post-Rape).

Forensic Evidence Collection Kit, including the following:

- sterile swabs (10) and a rack for drying them (can be a paper cup)
- clean white paper, paper bags, envelopes, labels and a box
- comb
- wooden stick (e.g., toothpick) for fingernail scrapings
- sterile saline, sterile water, glass slides
- clean gloves
- ruler, magnifying glass

CONTENTS OF IASC RH KIT 3: POST-RAPE

(DRUGS ONLY - for a population of 10,000 for 3 months <http://www.iawg.net/resources/rhkits.html>)

Levonorgestrel 1.5 mg, (treatment: single dose)	55 packs
Azithromycin, 250 mg tablet	220
Azithromycin 200 mg suspension, 200mg/5ml)	5
Cefixime, 200 mg tablet (2x 200 mg single dose for adults > 45 kg)	110
Cefixime, 100mg (suspension, 100mg /5 ml) (See treatment protocol for children)	10
Zidovudine, 300 mg / Lamivudine, 150 mg tablet combined, (2 x 1/ day x 28 days)	1800
Zidovudine, 100 mg tablet (See treatment protocol for children)	840
Lamivudine, 150 mg tablet, (See treatment protocol for children)	360
Pregnancy test, temperature stable	25

Gathering Information and Resources

Reading through this facilitator's guide will provide most of the information you need to present the training, but there are some supplementary materials you should gather and review beforehand, including local medical protocols and legal guidelines. These are listed below.

National, local and agency protocols for Clinical Care for Sexual Assault Survivors:

- HIV post exposure prophylaxis
- STI prophylaxis and treatment
- Emergency contraception
- Hepatitis B

Local legal guidelines regarding:

- Status of minors (age of majority, age of consent and laws regarding consent for medical treatment of minors)
- Definitions of sexual crimes
- Mandatory reporting of sexual assault/abuse
- Standards for medical documentation and testimony
- Pregnancy termination
- Adoption

Sample forms and pictograms can be found by clicking on the link in the facilitator's guide section at the end of the DVD.

In addition you will want to review the IRC Psycho-Social Module developed to provide more detailed information for medical professionals working with survivors.

Facilitator Checklist

✓	KEY PREPARATION STEPS	NOTES
Participant Selection and Logistics		
	Identify facilities and staff in need of training	
	Identify appropriate training site	
	Adapt schedule in consultation with participants and supervisors, share with all involved	
	Arrange participant transportation to and from the training site (if applicable)	
	Clarify housing arrangements and per diem (if applicable)	
	Arrange for breaks and meals (if applicable)	
	Arrange to set up the room the day before the course begins and check equipment	
Equipment and Supplies		
	Computer, projector, external speakers*, power source, screen	
	Flip chart stand, paper, markers and other classroom supplies	
	Medical supplies for demonstration	
Information and Resources		
	Local medical protocols	
	Local legal guidelines	
	IRC CCSAS Protocol or other up to date protocol	
	IRC CCSAS Psychosocial Module, IASC GBV guidelines, other counseling materials	
Content and Exercises		
	Review the content of the DVD	
	Coordinate with co-facilitator	
	Review and prepare the exercises	
	Prepare the handouts, clinical pathway and wall-charts	
	Make photocopies of materials for each participant <ul style="list-style-type: none"> • Protocol • Handouts • Evaluations (daily and final) • Pre-test & Post-test • Certificates (for those who 	

*The built in speakers on a computer are not loud enough for the training.

Presenting the Training

Introducing the Training

All participants should be made to feel welcome. Some participants may be sexual assault survivors themselves or know someone who is. Sexual assault can be an emotional issue for everyone. It is essential to recognize this at the beginning and to ensure that participants know that they are free to share their experiences or not, that their opinions and feelings are appreciated and that everything said during the course of the training will be kept confidential. Explain that because the course will involve emotional topics, it is vital that participants take care of themselves and each other. This can be accomplished in a range of ways, but everyone should feel free to ask for what they need as the training progresses. Facilitators should take time out to respond to emotions if needed.

Training Tips

(adapted from COPE® Handbook: A Process for Improving Quality in Health Services © 2003 EngenderHealth)

Establish a Respectful Tone Right from the Beginning

It is extremely important to set the right tone from the very beginning of the training. Below are some tips to establish an atmosphere of openness, respect, and comfort. This sends a message that the facilitators will be attentive and responsive to the needs of participants.

To set the right tone for the meeting:

- Start the training on time.
- Establish a connection with the group: by communicating the message to participants, either verbally or non-verbally, that you empathize with them.
- Demonstrate respect and sensitivity to the participants. Encourage a quiet person's opinions, for example, but do not push someone to talk if they seem truly uncomfortable.
- Demonstrate active listening skills: by allowing people to speak without interrupting them and by showing that you are concentrating on what the participant is saying. In this way you both model good group skills and establish credibility with the group.
- Relax and be natural. If you are comfortable, the participants will feel at ease.
- Walk around the room when appropriate; avoid staying at the front during the entire training.
- Check to make sure that the participants can see and hear the presentation.
- If you do not know the answer to a question, do not be afraid to say so. But tell the questioner that you will try to find the answer and will get back to him or her—and then do so. (This sends two messages—that you are open with the group, and that you will follow through on promises. Both messages build trust.)

Encourage Participation

An essential part of the training is participation. The facilitator's role is to start things off, but the more that staff participate, the better. Staff are more likely to accept suggestions and to feel ownership and responsibility for making improvements when the suggestions come from themselves rather than from the facilitators.

Facilitators need to create a comfortable atmosphere and encourage questions and lively discussion, while preventing hostility and managing conflict. One key role of the facilitators is to be particularly sensitive to gender, cultural, and socioeconomic differences between participants and to encourage all participants to share equally in the discussions.

Establish a Code of Conduct

During the first session it is important to establish ground rules or norms. Prepare a flipchart in advance with a few that you consider to be the most important group norms. Keep it covered while you ask participants to suggest norms for the group. Once the most critical issues have been mentioned, uncover your list. Add any others based on the discussion. Make sure that all participants agree in the beginning of the course to abide by the norms they set. Ask participants to monitor themselves and the group and commit to raising concerns if they believe that not everyone is abiding by the norms. Group norms help everyone learn effectively. The following are some suggested ground rules that could be useful during the training sessions:

- Speak one at a time; allow each person time to talk.
- Confidentiality (what is said in this room stays in this room).
- Agree to disagree, but do so respectfully. Value each person's unique opinions and perspectives.
- Start and end on time; come back from breaks promptly.
- Turn off cell phones and beepers.
- Honor everyone's input (regardless of educational degrees, professional or community status, or personal experiences with the topic).
- When you have questions, ask them.
- Speak for yourself, not other people (begin statements with "I" rather than "everybody" or "you").
- Support those who may have anxiety talking about emotionally difficult topics.
- Take charge of your own learning (ask for a break or an energizer if your energy is low, ask for clarification, give input to trainers if something about the course is not working for you).
- Feel free to "pass" if a certain topic or activity is uncomfortable for you.

Show Empathy

A good facilitator shows participants that he or she understands how they feel about a situation. This helps participants feel as if the facilitator is part of the group and encourages them to share their feelings and ideas. Empathetic statements can start with "I can understand that it must be difficult to..." or "I understand this is a problem for you...."

It is also important to help participants acknowledge feelings and move on to find positive steps and actions to address these feelings. This is particularly true when the feelings relate to how they deliver services. An example might be: "I can understand why it would be very difficult for you to provide services to survivors when you don't have a private place to talk to them. And I understand that this upsets you, but what can you do address this obstacle?"

Talk about Strengths as Well as about Problems

Facilitators should remind the participants that improving service quality means not just identifying problems and potential solutions, but it also involves identifying and reinforcing positive aspects of service provision. A facilitator could say: "This is very good, how can we apply it to other things we do?" or "Is there a way that could we make it even better?" Be sure to end the session on a positive note.

Working with Difficult Group Members

When groups of people come together, different personalities emerge. Personality differences can have a negative impact on the group if they are not managed well. It is important for the facilitators to recognize personality differences and take them into account so the group can operate at its most productive level. It is important to recognize that even if a member of the group is difficult, he or she may have important observations or inputs to make that would benefit the entire group. It is important for facilitators to try to turn negative comments into positive inputs. It is also important, however, for facilitators to maintain control of the training session. If a particular participant becomes disruptive or tries to dominate the session, facilitators should find a way to speak with him or her about it privately (possibly during a break). If the individual continues to disrupt the training, then the facilitator should discretely ask him or her to leave and possibly join another training at a later time.

Dos and Don'ts of Training

The following “dos and don’ts” should ALWAYS be kept in mind by facilitators during any learning session.

Dos	Don'ts
<ul style="list-style-type: none">• Do maintain good eye contact.• Do prepare in advance.• Do speak clearly.• Do speak loud enough.• Do encourage questions.• Do recap at the end of each session.• Do bridge one topic to the next.• Do write clearly and boldly.• Do use good time management.• Do give feedback.• Do position visuals so everyone can see them.• Do avoid distracting mannerisms and distractions in the room.• Do be aware of the participants' body language.• Do keep the group focused on the task.• Do provide clear instructions.• Do check to see if your instructions are understood.• Do be patient.	<ul style="list-style-type: none">• Don't talk to the flip chart.• Don't block the visual aids.• Don't stand in one spot—move around the room.• Don't ignore the participants' comments and feedback (verbal and non-verbal).• Don't read from the curriculum.• Don't shout at the participants.

(adapted from Pathfinder International)

Introductions and Icebreakers

The activities used at the beginning of a training to help the participants get to know each other are known as icebreakers or introductions. Here are a number of icebreakers and introductions you can use.

Unique Characteristics

Even if the participants already know each other, the facilitators must get to know them. Instead of asking participants to say their names, facilitators can divide the group into pairs and give participants a few minutes to interview each other. Then, each participant should introduce their partner by name and share at least two unique characteristics about them.

One variation on this activity is to divide participants into pairs by giving each half of a picture, postcard, or a piece or a compound work (ICE-CREAM, FLAG-POLE, SURF-BOARD) and have them find their matching partner.

Fact or Fiction

Each person writes down four statements about themselves, one of which is not true. Each person takes turns reading their list aloud and the rest of the group writes down the one they think is not true. When all are done reading the lists aloud, the first person reads their list again and identifies the statement which is not true. The group compares their guesses with the correct answers.

Marooned

Divide the participants into teams. Ask the participants to pretend they are marooned on an island. Have the teams choose five (facilitators can use a different number, such as seven, depending upon the size of each team) items they would have brought with them if they knew there was a chance that they might be stranded. Note that they are only allowed five items per team, not per person. Ask each team to write their items on a flipchart and discuss and defend their choices with the whole group. This activity helps them to learn about others' values and problem solving styles and promotes teamwork.

Finish the Sentence

Ask each person to complete one of these sentences (or something similar):

- The best job I ever had was...
- The riskiest thing I ever did was...
- Today on my way to training I was thinking about ...

When starting a training and you want everyone to introduce themselves, you can have them complete "I am in this training because..."

Ball of Yarn

For this exercise facilitators will need a ball of yarn. A facilitator should say her/his name and an interesting fact about her/himself. Then, holding the end of the yarn, toss the ball to a participant. The participant will say his/her name and an interesting fact, then, holding on to part of the yarn, toss the ball to another participant. By the time everyone has spoken, there will be a large web of yarn. This activity can also be used as a review tool - each participant says something about the topic, then tosses the yarn. The job of untangling can also be a good team building and warm-up exercise.

Energizers

Energizers are used to reinvigorate participants after a long session or following meals. Energizers should be fun and engaging activities that get people up out of their chairs and moving around. Energizers should be used as needed to help people remain attentive. Participants often have their own ideas for energizers such as songs or games. Asking for contributions can be a good way to get people involved. The following are examples of energizers that facilitators can use:

C-O-C-O-N-U-T

Have participants stand and use their whole body to spell the word COCONUT.

Life Boats

Have everyone stand up. You will then call out a number and people must quickly move to form groups of that number, linking arms to symbolize the formation of a full life boat. People not in a 'boat' are out. Repeat the process with different numbers until there is no one left who is not a member of a group and declare that 'boat' the winning team.

Spider Web

Have all participants stand in a circle (with large groups divide into smaller groups of 6-8 people). All participants should put their right hand in and clasp hands with another person. Then they all put their left hands in and clasp hands with someone. Then they should untangle themselves so they are again standing in a circle. (This activity may be inappropriate with mixed groups in cultures where men and women do not touch.)

Other Facilitation Methods

Parking Lot

A 'parking lot' is a commonly used mechanism in trainings. It is a useful way to acknowledge a topic of importance to participants, while allowing the training to move forward and stay on track. The parking lot is generally represented by a large piece of paper with "Parking Lot" written across the top where participants or the facilitator can write topics/questions that come up but cannot be addressed immediately because of time constraints or because it will be distracting. So in the same way that you park a car in a lot you are parking the idea in the lot to be addressed later. (Variations: Use the concept of a cattle corral instead of a parking lot if that is more meaningful to the participants in the local context.) Facilitators should review the issues listed at the end of the training and tick-off the topics already covered and then open up discussion of the topics in the 'parking lot' that were not addressed.

Content Notes

CHAPTER 3

How to use the content notes:

The left column contains the program script. It is given almost in its entirety, with the exception of some sections of dialogue and voice-over that repeat information given in the text slides. We recommend that a facilitator or participant read the text slides as they are presented and then provide clarification if needed. However, it is important to limit or postpone lengthy discussion until all of the relevant information on the topic has been presented. Suitable points for extended discussion and suggested questions are in the right column. The right column also includes issues to explain, emphasize, or correct and key points to summarize. It is not necessary to read these verbatim, just make sure that all of the points are covered.

Symbols are used to guide the facilitator through the training as follows:

Suggested timing.....		Stop or Break.....	
Discuss.....		Restart.....	
Correction.....		Handout.....	
Exercise.....		Refer to other resources.....	
Clinical Pathway Diagram.....		Sensitive Content.....	

Program Script

INTRODUCTION

While anyone can be sexually assaulted, most people who are sexually assaulted are women and girls. In this presentation, we will use the pronouns, “she” and “her” when referring to sexual assault survivors.

We use the term “survivor” instead of “victim” throughout the presentation to highlight the strength and resilience of those who overcome the experience of sexual assault.

TEXT CARD: Portrayal of Sexual Assault Survivors

Individuals shown in the case studies and recreations on this DVD are actors or friends of the IRC playing the roles of sexual assault survivors or clinicians. Actual sexual assault survivors appear in some of the documentary style video footage by consent.

Notes to the Facilitator

DO NOT SKIP THE INTRODUCTION. THERE IS IMPORTANT INFORMATION ON TERMINOLOGY.

EMPHASIZE:

Many participants may be surprised by or unfamiliar with this use of the word “survivor”. It is important that participants understand the power of language and why it can help someone to be defined as a “survivor” instead of a “victim”. You may also want to revisit this issue at the end of *Section 2: What Every Clinic Worker Needs to Know*.

EXPLAIN: In keeping with the basic principle of confidentiality, we have not used any images of survivors without their permission. We have used actors in most of the videos and case studies and images are recreations.

SECTION I: **WHAT EVERY CLINIC** **WORKER NEEDS TO KNOW**

In this section, you will learn about the following topics:

- The worldwide problem of sexual assault
- How cultural beliefs affect sexual assault survivors
- Survivors' universal rights

VIDEO: The Global Burden of Sexual Assault (03:52)

[NARRATOR] Sexual assault is a horror that occurs everywhere in the world. It affects the physical and mental health of individuals, and can also impact entire communities, leaving them devastated by violence, disease, broken families, and unwanted children. Sexual assault is often particularly rampant during times of war, when it is used as a weapon to cause terror and harm innocent people.

Tragically, many cases are not reported. Often, women are too scared or embarrassed to report episodes of sexual assault due to concern about stigma or fear of repercussions within their communities.

[KATY MITCHELL] "Sexual assault is, is a huge problem. It's not only not only a violation of human rights, a violation to a woman's right to health, a right to security. It's also a huge public health problem, because it leads to issues such as sexually transmitted disease, unwanted pregnancies which can be problem not only for the woman but also for the unborn child. It leads to HIV. It leads to stigma of the woman who has been raped."

[YAYA SIDI SACKOR] "I see like a big relationship between like, abuse of --sexual abuse or sexual assault and human rights violation."

[WILMA DOEDENS] "Being raped is such a violation of your own integrity and your own belief in yourself that many people do not seek help, and in traditional societies, where we work, this is even a bigger problem."

[JONATHAN NDZI] "It's a public health issue, but of unknown dimension because of the under-reporting. And the under-reporting is associated with confidentiality, privacy, and stigmatization."

[SUSAN PURDIN] "Sexual assault happens in all communities, in all settings, in peace and in conflict. But what we've seen in the conflict setting is an increased incidence of sexual assault. It happens more frequently. It's different from what communities experience in peacetime. It's often seen as, it often is a strategy of war. It's done to punish the whole community. It's not simply an assault on an individual but an assault on a population. Sexual assault

LEARNING OBJECTIVES

Participants will be able to:

- Explain why sexual assault is underreported.
- Name the universal human rights which are particularly important for sexual assault survivors.
- Give an example of how these rights can be realized in their work.
- Define the terms "sexual assault" and "rape" and explain why the term sexual assault is used in this training.

HANDOUT: Learning Objectives for Sections 1 and 2 (p. 99)

happens in all communities, in peace and in conflict, but what we've seen in the conflict situation is that it happens more often done to punish the whole community."

[NARRATOR] Sexual assault is defined as any type of unwanted physical violence or contact that is of a sexual nature. Sexual assault also includes rape, which is the penetration of the vagina or anus with the penis, another body part, or a foreign object, without consent. Rape includes forced oral sex. As a clinic worker, you are not responsible for determining whether sexual assault or rape has occurred. The legal definition of rape is different in different countries. That is the job of legal officials.

[SUSAN PURDIN] "It's not your responsibility to identify whether a rape has occurred, but rather to give care to anybody who comes with a concern about sexual assault. So our role as clinicians is to provide care to people that's competent so we know what we're doing. That's compassionate because the person has been injured and it's our job to help them heal. And confidential because it's not public information, it's private information that stays with the provider and the client. So our job as clinic workers is to receive patients who have-- whatever their complaint is--and to give the appropriate care and to help them start to heal. That's the key element that we can provide."

 **STOP AND DISCUSS**
 **20 MINUTES**

 **BREAK**

VIDEO: How Cultural Beliefs Affect Survivors of Sexual Assault (01:37)

[NARRATOR] Community attitudes about sexual assault often affect whether the survivor will report the incident or seek medical care. Sexual assault survivors are sometimes rejected by their families and communities and even blamed for being assaulted. Sometimes there are strongly held beliefs within communities that men cannot control their urges and that women are to blame for men's behavior. People will say things like "she was dressed the wrong way." People may decide that a woman who has been assaulted is unmarriageable and forever a burden. These attitudes make the effects of sexual assault even worse.

DISCUSS:

- What is the local definition of rape?
- What is the local age of consent?
- At what age can girls and boys marry?

EMPHASIZE:

The legal definition of rape in the country you are working in may be different than the definition provided here. Rape is a legal term, not a medical diagnosis. Clinic workers and medical providers should not try to determine whether rape has occurred. Nor should these definitions change the quality of care given to the survivor.

DISCUSS:

- What terms are commonly used where you work?
- What do the following terms mean to you: gender based violence, sexual assault, sexual violence, sexual abuse, defilement?
- Why are we talking about sexual assault rather than sexual violence or GBV?

EXPLAIN:

GBV is the general term for all forms of violence directed at women because they are weak or to prove the superior power of the attacker. GBV includes domestic violence, forced prostitution or marriage, as well as sexual assault. This training focuses on sexual assault because of its health consequences and the role of health care workers in caring for survivors.

 **REFER to CCSAS Psychosocial Toolkit, Topic 1: Introduction to Gender-based Violence for more information.**

► RESTART:

Before starting the next video, introduce the following section by explaining that it describes the cultural beliefs that make sexual violence doubly harmful to the survivor.

[LYDIA MUGALU] "In Nigeria women don't report about rape cases because of the stigma attached to it. In Nigeria we believe you get married to a virgin, and because of that, nobody will want anybody to know that they are no longer virgins."

[KATY MITCHELL] "We also see that young girls who have been raped are afraid to report that they've been raped. And that's because of the shame that they experience, but also because of the fear that they experience, that they will be rejected from their families--by their parents. And also the fear that they won't be eligible to get married. In many societies, if you're not a virgin, you can't get married. So if anyone knows that a girl has been raped, that ruins her prospects for a future."

☒ STOP THE VIDEO AT THIS POINT

[NGUYEN-TOAN TRAN] "Malaysia, truly Asia, the country of Muslim majority, 60%, and Hindu and also Buddhist. Malaysia, in some part of these multi-ethnic cultures, has been dealing with this secret and silent tsunami, I would say, tsunami of sexual violence."

TRUE/FALSE EXERCISE:

Beliefs about Sexual Assault

"A survivor of sexual assault may have deserved the attack because of the way she or he dressed or acted."

FALSE. Nobody deserves to be sexually assaulted no matter how she or he dresses or acts. The way someone dresses or behaves is never justification for sexual assault.

"A survivor of sexual assault may have no visible injuries."

TRUE. Not all survivors of sexual assault have visible injuries.

"If a woman's husband or boyfriend forces her to have sex, it does not count as sexual assault."

FALSE. Many sexual assaults are committed by someone a woman knows. Anytime someone is forced to have sex against her will, it is a sexual assault whether the act was committed by someone known, such as a husband, boyfriend, teacher, or by a stranger.

"Sexual assault is a crime of uncontrollable passion or lust."

FALSE. Sexual assault is a crime of violence. People commit sexual assault because they seek to dominate, humiliate and punish others. There is never any justification for sexual assault.

"If a woman is sexually assaulted, she will carry a disease for life."

FALSE. Even though sexual assault can cause physical and mental harm, the consequences of these conditions can be eliminated or greatly reduced with timely care.

NOTE: The next speaker is speaking of the situation in his country in a way that is not appropriate for this training.

ALTERNATE TRUE/FALSE QUESTIONS

"Domestic violence primarily affects poor, rural, uneducated women."

FALSE: Domestic violence occurs in families from all social, economic, racial, ethnic, educational and religious backgrounds. It has been found that poorer women are at higher risk for domestic violence; however, violence occurs among wealthy women and middle-class women as well.

"Only women and homosexual men are targets of sexual violence."

FALSE: Most male rape victims, as well as their rapists, identify themselves as hetero-sexual. Rapists are motivated by the desire to have power and control over another person, not by sexual attraction. Many male victims do not report the assault because of shame or embarrassment, and because they fear further humiliation from a society that expects men to always be strong, in control and able to protect themselves.

"Alcohol and drug abuse cause a man to be violent."

FALSE: Alcohol and drug abuse do not cause violence, though it may be more severe when alcohol or drugs are involved. Alcohol and drugs may also intensify existing violent behavior. Many batterers do not abuse alcohol or drugs, and many alcohol or drug abusers do not batter - the two problems need to be dealt with separately.

DISCUSSION CARD: Beliefs about Sexual Assault

- Please take this time to discuss beliefs and common attitudes about sexual assault in your own community.
- What have you heard people in your community say about sexual assault?
- Do you think sexual assault happens in all communities?
- Does a lack of injuries mean that a woman consented?
- Does a married woman have a right to say no to her husband?


STOP AND DISCUSS
 **30 MINUTES****VIDEO: Respecting a Survivor's Universal Rights**

(01:07)

[NARRATOR] Universal rights apply to everyone who seeks care at your clinic, including sexual assault survivors. At all times, a person seeking care should be treated with dignity and non-discrimination and provided with the best health care possible. As a clinic worker, respecting these universal rights is not only essential to a survivor's healing, it is your responsibility.

[CAROL MWANGI] "Sometimes in our culture the way we've been brought up, you know, women are supposed to be complacent, you know, they're supposed to be submissive. So actually when these things do happen to them, some of them think it's the norm. Okay, so, they need to be told it's not the norm, that it's something that's violating their rights--their right to dignity, their right to self-determination. So they should, they should report as soon as possible. And that way we can be able to help them. And that way we will be able to decrease the number of *culprits* who actually perpetrated such crimes."

TEXT CARD: Right to Health Care

Every survivor has a right to health care. Survivors of sexual assault have a right to high quality health care to help them heal physically and psychologically regardless of their ability to pay.

TEXT CARD: Right to Non-Discrimination

Every survivor has a right to non-discrimination. All survivors of sexual assault have the right to receive respectful and competent health care regardless of their race, sex, age, national or social origin, marital status, tribal identification, religion or socioeconomic status.

DISCUSS

- Do you think sexual assault happens in all communities? (religious, rich, traditional, modern)
- Does consenting to having sex once mean you don't have the right to say "no" the next time?

EXPLAIN:

Sexual assault happens in every community, though it is often hidden and denial is strong. Survivors may have no injuries because they were threatened into submission. International human rights law protects every individual's right to make decisions about their bodies and sexual and reproductive behavior.

EMPHASIZE:

Since beliefs will be hard to change, the main message facilitators should convey is: "Your belief should not affect the survivor's right to compassionate health care."

► RESTART:

Before starting the next video explain that the next section reviews the basic universal human rights that apply to everyone, but are particularly important for sexual assault survivors.

EMPHASIZE: Have a list of the key rights discussed written out in advance and follow along with the list to make sure they are well understood. It will be useful to return to this list throughout the training as issues come up around balancing different priorities : remind participants that human rights should always take precedence.

TEXT CARD: Right to Information

Every survivor has a right to information in a language she understands.

She has a right to know about:

- her right to privacy, confidentiality, and self-determination
- the details of the examination
- treatment options available to her
- the effects and side effects of prescribed medications
- available referral services

TEXT CARD: Right to Privacy

Every survivor has a right to privacy.

- A survivor's privacy should be maintained by caring for her in a separate room where she cannot be overheard by those not involved in her care.
- She should not be required to move from room to room in the clinic.
- She should not have to interact with people other than those trained staff who are caring for her directly.

TEXT CARD: Right to Confidentiality

- Every survivor has a right to confidentiality.
- All medical and health information related to the survivor should be kept confidential, even from family members
(unless the survivor is a child).
- Clinic workers may give information about the survivor only to those directly involved in her care. Any other release of information requires the survivor's permission.
- Clinic records of sexual assault survivors should be kept in a locked cabinet.

TEXT CARD: Right to Self-Determination

Every survivor has a right to self-determination.

- A survivor has the right to choose what kind of care she wants.
- A survivor may stop telling her story or stop the examination at any time.
- Clinic workers should not pressure a survivor to do anything she does not wish to do.


STOP AND DISCUSS
 **20 MINUTES**

DISCUSS

- What does the concept of human rights mean to you?
- Do you think human rights apply to everyone?
- Sometimes people think of human rights as a "western imposition." It is important to note that many of these principles and values such as equality, have roots in the world's religions and local cultures. There are also local groups in many countries who advocate for rights.

EXPLAIN This training does not provide detailed information on the history or meaning of human rights. Refer participants who want more information to other sources such as international human rights treaties.

VIDEO: Caring for Yourself and Your Staff (00:54)

[NARRATOR] Working with survivors of sexual assault can be emotionally difficult for clinic staff. You yourself may be a survivor of sexual assault. Feelings of distress, anxiety, guilt, frustration, concern, confusion and exhaustion are real and important. If you are feeling this way, do not try to ignore these emotions or work through them alone; instead, discuss them with your supervisor or someone you trust. You too can use the counseling services available to patients. And if you are a supervisor, be sensitive to the needs of your staff.

[DAN KOROS] “Every clinician or person who is involved in management or treatment of survivors of rape must be trained. They should not rely on the medical school training or that kind of experience. They need to be given specific training on how to manage survivors of sexual violence.”

NOTE: More time will be given to this topic later in the training. It is also covered in more detail in the **CCSAS Psychosocial Toolkit**, Topic 7: Self- Care for Providers.



SECTION 2: RESPONSIBILITIES OF NON-MEDICAL CLINIC STAFF

This section will cover the following topics:

- The consequences of sexual assault
- How you can help a survivor start to heal

VIDEO: Harmful Effects of Sexual Assault (01:21)

[NARRATOR] As a non-medical staff member, you may be the first person a sexual assault survivor sees. In order to understand your important role, it is helpful to understand what she may be experiencing. When a survivor enters your clinic, she may be feeling depressed, ashamed, or powerless. She may have considered suicide. Some survivors are abused or abandoned by their families rejected by their spouses or shunned by their communities. Girls may not be allowed to return to school and may find that they are no longer considered suitable for marriage. A survivor may be afraid that clinic staff will tell others about her assault. She may feel she is taking a great risk by entering a clinic fearing the consequences if anyone finds out what happened to her.

[KATY MITCHELL] “Rumors can start in the clinic, and we have to be very sure that we’re maintaining confidentiality at all times so every person from the gardener to the cleaner to the security guard to the nurses and doctor that are taking care of the rape survivor need to know that anything that happens in the clinic is confidential and cannot be discussed outside, not even with your closest friends and family.”

TEXT CARD: Public Health Consequences

Sexual assault can lead to pregnancy.

- The birth of a child outside of marriage is considered a crime in some communities
- Unwanted children may be abused or neglected.
- Unwanted pregnancies often lead to unsafe abortions.

Sexual assault can lead to sexually transmitted infections.

- These infections include chlamydia, gonorrhea, human immunodeficiency virus (HIV) and syphilis
- If untreated, these STIs may cause chronic illness or infertility. In addition, the survivor may unknowingly spread the infection to her husband or children.

 **STOP AND SUMMARIZE**

LEARNING OBJECTIVES

- Name the public health consequences of sexual assault.
- Describe how compassion, competence and confidentiality can help the survivor begin to heal.
- Demonstrate appropriate ways to protect survivors' human rights.

SUMMARIZE:

The public health consequences include pregnancy, infection, injury and infertility. These are in addition to the social and personal consequences of sexual assault. The sooner after the assault survivors come in for care the more chance we have of preventing these problems.

VIDEO: What You Can Do (02:50)

[NARRATOR] You are part of a team of people with the important role of providing compassionate, competent, and confidential care to sexual assault survivors.

COMPASSION: Treating sexual assault survivors with compassion means creating a safe and supportive environment. You may not know which patients are sexual assault survivors, so it is important to treat everyone with kindness and respect.

COMPETENCE: Competence means having the required skills and qualifications to do your job well. No matter what your job is, doing it in a competent and professional manner will help sexual assault survivors feel better about seeking care. For example, you can make sure that sexual assault survivors do not have to wait a long time to see a doctor. Avoid having survivors re-tell the incident many times to different people, as this stalls treatment and may force survivors to relive the trauma of the experience.

CONFIDENTIALITY: Whatever happens in the clinic must never be discussed outside the clinic. You may overhear conversations about a patient or recognize a survivor seeking care. By discussing this outside the clinic you are betraying the patient's trust and may be putting her in danger.

[SUSAN PURDIN] "As a clinic worker our job is to provide care for people who come to us for assistance, and our job is to provide that care in a safe environment, providing compassion, concern for people as people for whatever they have experienced. Competent care, so that we know what we're doing and we do it appropriately and carefully for people. And confidential care for sexual assault, because it's a private matter and the responsibility is with the clinician to care for the client. Not to share that information."

[LILIAN KIAPA-IWA] "Confidentiality is a big issue, because most clinics are crowded. The staff that work in those clinics know the community, maybe they are even from the same community. And a lot of the staff who work at the lower level cadres, who really don't have like a medical ethics perspective of things, and so sometimes we may not be really certain that this person may not divulge what they saw in the clinic when they go back home in the community, because the temptation is really big, and they don't have a lot of training."

[NARRATOR] All clinic workers can improve patient care by showing compassion, demonstrating competence, and ensuring confidentiality. By doing this, you, the clinic worker play an important role in reducing the harmful effects of sexual assault.



STOP AND SUMMARIZE

SUMMARIZE:

Make sure everyone understands the meaning of compassion, competence and confidentiality and how by adhering to these principles they can help survivors recover.

EXPLAIN:

"Confidentiality" does not mean keeping secrets. Secrets may imply something bad about the client. Rather, the idea is: "I could harm you instead of helping you by revealing your information." Bring back to "trust" and the principle of "giving help not doing harm."

EMPHASIZE:

Anyone's health care is confidential (not just GBV survivors')

SURVIVORS WHO ARE SEEN WITHIN 72 HOURS OF THE ASSAULT CAN RECEIVE THE MOST COMPLETE CARE

CASE STUDY: Receiving the Patient

A young woman walks to the reception area. The staff member impatiently asks, “What do you want?” The young woman leaves. What could the staff member have done differently?

- A. Prepared to refer the patient to higher-level care.
- B. Asked, “Good morning, how can we help you?”
- C. Said, “Wait in line,” since the patient appeared to be fine.

Answer: B. A better response would have been “Good morning, how can we help you?”

All staff members must do their part to make the clinic a compassionate environment for patients. This begins the first moment a patient enters the clinic. In the description, there is not enough information to suggest that the patient should be referred for a higher level of care. While most patients may need to wait in a queue, you must first take the opportunity to be kind and considerate. Treat everyone who walks into the clinic with respect and compassion.

CASE STUDY: Confidentiality

A cleaner overhears a health care worker talking to a survivor about her sexual assault. The cleaner recognizes her... and decides he had better tell a few people from their neighborhood so that the community can offer her support. Is the cleaner making a good decision?

- A. No, because it is the cleaner’s responsibility to keep all clinic information confidential.
- B. Yes, because the survivor has suffered and may not know how to ask for support.
- C. Yes, because the community must learn how to treat survivors with compassion.

Answer: A. Like every other clinic worker, a cleaner must respect a patient’s right to privacy and confidentiality. The cleaner may have good intentions, but his primary responsibility is to keep all information about a survivor completely confidential. He may wish to support the patient and decrease the stigma of sexual assault, but he should do this without breaking confidentiality.

CASE STUDY: Privacy

A young girl and her mother walk into the clinic. A security guard recognizes them and addresses them kindly, asking: “How are you? What happened? Is everything okay?”

What could the security guard have done differently?

- A. He did nothing wrong because he was kind and compassionate.
- B. He should not have addressed them at all C. He should have said “Hello, please go right in.”

Answer: C.

► RESTART

Introduce this as the first case study. Read the options out loud to the group and have them select an answer. Then show the correct answer and the rationale (subsequent case studies can be read by a participant).

IMPORTANT NOTE ON CONFIDENTIALITY:

There are limits to confidentiality: To protect the survivor’s life and health you will communicate with other providers involved in her care or public officials if necessary.

There are limits to confidentiality: To protect the survivor’s life and health you will communicate with other providers involved in her care or public officials if necessary.

All IRC staff should be aware of IRC’s Mandatory Reporting Policy for the prevention of and response to sexual and gender-based violence, including sexual abuse and exploitation. IRC staff have the responsibility to report any known, reported or suspected cases of sexual exploitation and abuse by IRC staff, any other humanitarian or development workers, representatives of local or national government, police, military personnel, outside contractors who are associated with the IRC and/or all third parties doing business with the IRC. IRC staff must report any case immediately to their supervisor, another senior manager or the Country Director. It is not the responsibility of the reporting member of staff to find out whether or not the complaint is true. It is his/her responsibility to report any concern in good faith.

The security guard was kind and compassionate, but by asking, “What happened?” he was asking them to tell him confidential information. You may address people you know, using common greetings, but do not ask why they have come to the clinic. Non-medical clinic workers should not make conversation with patients or delay them from seeing the health worker.

TEXT CARD: Be Part of the Healing Process

Sexual assault survivors suffer physical, emotional, and mental pain. Sexual violence is a crime against both individuals and communities. You are part of a team of people with the important role of treating sexual assault survivors, and all patients visiting your clinic, with compassion, competence, and confidentiality. By doing your job well, you will help survivors heal.

This is in addition to any legal requirements to report sexual abuse and exploitation of children or other categories of people mandated by the countries in which we work.

The best interest of your client always comes first.

 **REFER to CCSAS Psychosocial Toolkit, Topic 2: Understanding the consequences of GBV for more information.**


**'STOP AND GO TO EXERCISE I
40 MINUTES**

THIS IS THE END OF THE TRAINING FOR MOST NON-CLINICAL STAFF.


BREAK

EXERCISE 1: COMPASSION, CONFIDENTIALITY AND COMPETENCE

Role-play activity—have groups act out situations using what they have learned. (See page 83 for complete directions)

 **HANDOUT: Exercise 1 (p. 100)**

SUMMARIZE:

- Survivors deserve respect and compassion. They are never to blame for their attack. They often hide their experience out of fear and shame.
- Survivors have a right to health care, privacy, confidentiality, self-determination, and information.
- Compassion, competence and confidentiality can help a survivor feel safe and are part of your job.
- Sexual assault can lead to unwanted pregnancy and sexually transmitted infection. The risk all of these can be reduced if a survivor seeks care within 3 days.

NOTE: Acknowledge any participants who will be leaving, thank them for their contributions, explain that the sections that follow are medical and discuss who will rejoin for the final section (*Preparing Your Clinic*).

SECTION 3: DIRECT PATIENT CARE

⚠ Contains graphic images and sensitive material. Genital examination slides are digitally animated.

Direct patient care contains the following subsections:

- A. Receiving the patient and preliminary assessment
- B. Obtaining informed consent and taking the history
- C. Performing a physical exam
- D. Treatment and disease prevention
- E. Caring for male survivors
- F. Caring for child survivors

SECTION 3A: Receiving the patient and preliminary assessment

In this section you will learn how to:

- Receive a sexual assault survivor
- Conduct a preliminary assessment
- Refer for higher level care if necessary

VIDEO: Preparing Your Clinic to Receive a Sexual Assault Survivor (00:49)

[DAN KOROS] “There are lot things that goes in the mind of the victim. That for a person to come forward and report, there is a lot of infighting in her or his mind before making that decision. And this person really, in my experience, has contemplated many times not to say. And, by the time they come, they really need a lot of support.”

TEXT CARD: Know Your Capabilities

- All clinics are different. It is important to know what you can and cannot do for a survivor of sexual assault.
- Even if your clinic does not meet the standards described in this presentation, provide survivors with the best care you can.

VIDEO: Receiving a Sexual Assault Survivor (01:27)
[JUDITH BARASA RAMOYA] “First and foremost is to show empathy to the survivor and to create privacy for the survivor of rape. And, make follow up visits. They should also get the medical treatment which we are giving at the moment, but first and foremost is privacy and confidentiality. And not...I should say the ethics, the medical ethics, have to be adhered to, so that you, I mean you don’t tell people so-and-so was raped because she came to your clinic.”

NOTE: At the beginning of this section the number and character of the participants will change. Spend some time redefining the group. If appropriate, review individual clinical roles of participants. Do they do genital exams on a regular basis? Are they comfortable doing speculum exams? Who has and who has not worked with sexual assault survivors in the past?

LEARNING OBJECTIVES

Participants will be able to:

- Describe the purpose of the preliminary assessment.
- Describe what treatment you would offer to a patient who is being referred to a higher level facility before she leaves your care
- Follow the clinical pathway to ensure that the key elements of care are provided.

HANDOUT Clinical Pathway (p. 103)

EXPLAIN:

The scenario played out in this training raises questions: Why did the doctor go out to get her? Should the doctor have used her name? How did she already know that she had been sexually assaulted? What is shown may not be what happens in your clinic. You and your team will have to work together to determine the best way to receive SAS in your context. (The discussion should be brief since it is the substance of the last day of training.)

EMPHASIZE:

Health care workers are not expected to provide services for survivors beyond their skill set. They should focus on providing the best that they can and following the basic principles of compassion, confidentiality and competence.

If a health professional has any personal, cultural, or religious barriers to providing complete services to survivors he or she should allow another provider, at the same facility, to care for the survivor.

TEXT CARD: Tips for Receiving a Sexual Assault Survivor

- Allow a trusted companion to remain with her throughout the examination if she wishes
- Determine the best way to communicate. A survivor may need a translator, but the translator should also be someone she is comfortable with and who understands how to maintain confidentiality
- Only clinic staff necessary for the survivor's care should ask questions of her, and everyone should treat her with respect

VIDEO: Preliminary Assessment (1:27)

TEXT CARD: Preliminary Assessment

- Note the patient's general appearance and mental state
- Document vital signs and assess for shock (low blood pressure and weak pulse)
- Immediately refer patients if higher level care is needed

TEXT CARD: Referring the Patient

While awaiting referral:

- Provide life-saving interventions, stabilization and pain control as necessary
- Ask if there is anything you can do to make them more comfortable or to help them make arrangements for the transfer
- Counsel and provide preventive treatment for STIs and pregnancy before patient leaves your care. Post exposure prophylaxis for HIV should be started as soon as possible.
- Provide referrals to mental health, legal assistance and social support services, encourage her to return to the clinic for follow up

CASE STUDY: Receiving the survivor

A 25-year-old female comes to the clinic several hours after a sexual assault. She is crying and supporting her right wrist, which is deformed and appears broken. The patient's vital signs are normal and she is awake and speaking normally. What should the physician do?

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

Answer: D. The patient is awake, alert, and her vital signs are normal. After determining the patient has no immediate life-threatening conditions, care providers should treat the patient's pain.

Clinical Pathway Diagram

The preliminary assessment is the first decision point in the clinical pathway. Put up the corresponding diamond on the wall. (see page 12 for complete instructions)

Clinical Pathway Diagram

Referring the patient is the next decision point in the clinical pathway. Put up the corresponding "no" arrow and box for referrals.

Quick pain control and supportive care, such as wrist splinting, creates trust and shows compassion. Leaving the patient in pain or instructing her to calm down is neither compassionate nor helpful. Delaying treating this patient's pain to perform a complete physical exam is not necessary given the patient's otherwise normal general appearance and stable vital signs.

SECTION 3B: Obtaining informed consent and taking the history

In this section, you will learn how to:

- Obtain informed consent
- Create a safe and respectful environment for the survivor of sexual assault
- Obtain the medical and historical information needed to provide appropriate medical care
- Empower the survivor, allowing her to control the course of the evaluation

VIDEO: Obtaining Informed Consent (02:19)

DISCUSSION CARD: Informed Consent

- Discuss the importance of informed consent.
- How does informed consent help protect a survivor's rights?
- What might informed consent mean to your patients?
- How might they react to the form?
- What is the best way to make sure survivors are fully informed and give consent where you work?

LEARNING OBJECTIVES

Participants will be able to:

- Describe the purpose of obtaining informed consent.
- Demonstrate how to properly obtain informed consent and fill out the form.
- Explain what to do if a survivor refuses to give consent.
- List the elements of the health history. Demonstrate active listening skills.

Clinical Pathway Diagram

Once a survivor is medically stable and it has been determined that she can be treated effectively at your facility, begin the process of obtaining consent. Put up the corresponding "yes" arrow and left hand box listing steps in providing care.

STOP AND DISCUSS **10 MINUTES**

CASE STUDY: Informed Consent

A patient consents to a physical examination. The health care worker then explains the pelvic examination. The patient appears uncomfortable and becomes increasingly quiet and withdrawn. The health care worker asks if she would like more explanation. The patient nods "yes." The health care worker provides more information and then asks the patient if she consents to the examination. The patient shakes her head "no." How should the health care worker respond?

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

EMPHASIZE:

Consent forms may not be in use in every clinic, but it is important that the patient receives an explanation of everything and is able to make an informed decision about whether or not she wants to be examined and treated.

The principle of informed consent applies to all, not just survivors of sexual assault.

A signed release is required before any details about the case can be given to anyone outside the facility.

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



'STOP AND GO TO EXERCISE 2 10 MINUTES

VIDEO: Taking the Patient's History (05:05)
[MAQSOODA KASI] "I think that listening—the listening skill is so important for the health care provider to listen to woman. Only I think it's the one ability which will make the woman talk to you. I think it's when she comes initially—here introduction, introduction of me as a health care provider, to make her calm relaxed. I think that these are very important. They might look very minor, but what we experienced is that they are very important for the woman to come... Before taking the history, before you have a pen and pencil and write something, I think it's important to talk to the woman."

[NGUYEN-TOAN TRAN] "When the client gives you a history that is not very coherent, you really have to listen under, under the words."

TEXT CARD: Health history

Obtain and document the following medical information:

- past medical history
- last menstrual period
- current contraceptive methods
- medications (including traditional or folk remedies)
- allergies to medications
- family and social history to identify sources of support

VIDEO: Gathering Information about the Assault (04:13)

TEXT CARD: Information about the assault

Obtain the following information:

- When did the assault take place?
- Was there penetration (oral, vaginal or anal)?
- Did the assailant use physical force?
- Did the assailant use a foreign object?
- How many assailants were there?
- Was it a single assault or was it repeated over hours or days?

EXERCISE 2: INFORMED CONSENT

Have the group divide into pairs to practice obtaining consent using the consent forms. Participants should think about how to explain the examination in a way that a survivor in their country will understand. For example, what words would they use to explain "pelvic exam" and "speculum exam" to someone who has never heard of these things? (See page 84 for complete directions)

HANDBOUT: Consent Form (p. 104)

REFER to CCSAS Psychosocial Toolkit, Topic 3: Basic Communication Skills for more information on confidentiality and informed consent.

Clinical Pathway Diagram

Indicate where you are in the clinical pathway.

EXPLAIN:

The way the video is edited makes it a bit unclear, but Dr. Ngozi says: "Anything you tell me will remain confidential. I'm not going to share it with anyone unless I have your permission. However, if something poses a threat to your life, I am obligated to let the authorities know so that no more harm is done to you."

- Did the patient lose consciousness?
- Was the assailant a stranger or an acquaintance?

CASE STUDY: Gaining Information

A 22-year-old woman was sexually assaulted by soldiers and arrives at the clinic for care. During the patient history she states, “one of the soldiers raped me,” and then pauses. What is the most appropriate next question?

- Did you fight back or scream?
- Can you help me understand what you mean by rape?
- Did he have any identifiable birthmarks or scars?

Answer: B. The interviewer should ask open-ended questions in a compassionate way. Asking the patient to help the interviewer understand what she means by rape allows the patient to describe what happened to her physically.

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

CASE STUDY: Active Listening

A health care worker asks the patient where and when the assault occurred. The patient replies, “It happened next to my grandmother’s house.” The patient has tears in her eyes and she is quiet. The health care worker doesn’t acknowledge the patient’s answer, and quickly moves onto the next question. The patient declares she doesn’t want to talk anymore. What could the interviewer have done better?

- Reassure the patient by saying, “I know this is hard, please continue when you are ready.”
- Ask the patient if she needs to take a break.
- Both answers A and B.

Answer: C.

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

CASE STUDY: Eliminating Survivor Blame

The health care worker says, “I want to be sure that you’ve had a chance to tell me anything you want me to know. Is there anything else you would like to talk about?”

EXPLAIN:

You are collecting this information for medical purposes only – to guide the examination and treatment. Do not ask her unnecessary questions or pressure her to talk about things she is not comfortable with. You are not trying to determine whether rape occurred, but to assess her medical condition so that you can provide appropriate care.

The patient appears frightened, and says “I’m very scared that my husband will find out.” What is the best way to respond?

- A. I will keep everything you tell me completely confidential.
- B. You are not to blame. This is not your fault.
- C. You did all the right things, you survived, and you are safe here.
- D. All of the above.

Answer: D. It is very important to keep all information confidential for the patient’s security. Explain to her what confidentiality means, how you will keep the information secure and any limits to confidentiality in her case. You should also remind the patient that the assault was not her fault and that she did the right thing by seeking care. These supportive words should be repeated throughout the examination and treatment.

STOP AND GO TO EXERCISE 3

30 MINUTES



BREAK

SECTION 3C: Performing a Physical Exam

In this section you will learn how to:

- Perform a proper physical examination
- Allow the patient to be in control of the physical examination
- Recognize common injuries related to sexual assault
- Appropriately refer a patient to a higher level of care

VIDEO: Performing a Physical Examination (01:48)

[LINDAH MUTUA] “They have the right to know what is being done to them. They might wonder, are you just coming and examining me, and this is me. Yeah, and then of course they are traumatized, they have been assaulted, and then next you want to go and examine them? That adds more injury to the trauma.”

[LAUREN BIENKOWSKI] “Ask only those questions that are relevant, going at the survivor’s pace. If she needs to stop, you need to be respectful of that, keeping in mind the survivor’s dignity throughout this process. That she needs to feel that she’s in control of what is happening throughout the healing process.”

TEXT CARD: Giving the Patient Control of the Exam

Here are some things you can do to help the patient feel that she has control of what will happen during the examination:

- Explain every step of the examination and your findings as you go along using terms that she can understand

EXERCISE 3: ACTIVE LISTENING

Have participants practice active listening skills.

(See page 84 for complete directions)

HANDOUT: Active Listening (p. 105)

REFER to CCSAS Psychosocial Toolkit, Topic 3: Basic Communication Skills for more information on active listening and other principles of communication with survivors.

LEARNING OBJECTIVES:

Participants will be able to:

- Describe how to give the survivor control over the examination.
- Describe how to use information from the history to guide the exam.
- Determine when a speculum exam is needed.
- Describe the cause and the signs and symptoms of fistula.
- Explain the importance of correct documentation.
- Demonstrate how to correctly fill out the medical exam form.

- Encourage her to ask questions and express her feelings and fears.
- Tell her that you will stop any time she says so.
- Ask for permission before touching her.
- Allow the patient to have a companion during the exam if she wishes.

TEXT CARD: Clinical Care within 72 Hours

Within 72 hours of an assault, you should provide:

- a complete physical examination
- immediate care for injuries
- treatment to prevent
- unwanted pregnancy
- sexually transmitted infections (STIs) including HIV
- long term complications that might result from injuries or infections
- hepatitis B and tetanus
- information and referrals for legal, mental health and social support services

VIDEO: General Exam (04:29)

TEXT CARD: Suspected Intra-abdominal Injuries

- Abdominal pain and tenderness may indicate internal injuries, such as rupture of an organ or significant internal bleeding.
- Examine the patient carefully if she reports being punched in the abdomen or being penetrated by a foreign object during the assault.
- If you suspect an internal abdominal injury, transfer the patient to a facility that can provide surgical care immediately.

VIDEO: General Exam Continued (00:53)

 **To avoid sensitive images cover the projector before advancing.**

 **STILL PHOTO VIEWER: Common Injuries**

VIDEO: Oral Examination (01:09)

STILL PHOTO VIEWER: Oral Exam

TEXT CARD: Pelvic Exam

The pelvic exam consists of two parts:

- External Genital Exam
- Vaginal Speculum Exam

 This section of the training includes sensitive images such as breasts and genitalia in order to show how to correctly perform an examination and to document common injuries. The videos use computer animation, not real people. While all images are meant for educational purposes, some individuals or groups may find them inappropriate.

The warning symbol is used to guide the facilitator wishing to avoid showing these images to participants. Use cardboard to cover the projector when noted. Use anatomic drawings as necessary to explain typical injuries and how to document them.

 In this video Dr. Ngozi examines Alisha's abdomen through the sheet. That is not the correct way to do an abdominal exam. Proper draping is very important but you need to see the part of the body you're examining.

 **To avoid sensitive images do not show the photo viewer.**

Note on the photo viewer: If images do not show up well in your training room, set aside time for participants to look at relevant images directly on the computer. Don't spend time discussing images participants can't see well.

TEXT CARD: Genital Exam

- The purpose of the external genital exam is to evaluate the area for injury.
- The exam is recommended even if the patient does not have bleeding or pain.
- The exam is often helpful in providing reassurance to the survivor that her genitals are uninjured or will heal if injured.

⚠ VIDEO: External Genital Exam (04:55)**TEXT CARD: Considerations for Circumcised Women**

- If a previously circumcised (infibulated) patient has vaginal tears, it is better not to re-stitch the vaginal opening.
- Immediate repair following trauma carries a higher risk of infection. Suturing a dirty wound increases the risk of an infection.
- Female genital cutting or circumcision carries long-term risks and is never medically indicated.
- IRC personnel should never be involved in female genital cutting
- Repairs should always leave genitalia in as natural a state as possible.


STOP AND DISCUSS **15 MINUTES****⚠ To avoid sensitive images cover the projector before advancing.****⚠ STILL PHOTO VIEWER:
Genital Exam / Common Injuries****TEXT CARD: Vaginal Speculum Examination: Indications**

Perform a vaginal speculum exam only for the following indications:

- heavy or uncontrolled vaginal bleeding
- foul smelling vaginal discharge when a foreign object is suspected (otherwise treat symptomatically)
- forensic evidence collection

TEXT CARD: Vaginal Speculum Examination: Contraindications

A speculum exam should not be performed on:

- a prepubescent child
- any patient who declines the exam
- A speculum exam on a woman in the second half of pregnancy with vaginal bleeding can cause increased bleeding and should be done only by a health care worker trained in the management of pregnancy complications.

⚠ HANDBOUT: Female Anatomy (p. 106)

In order to document their findings, providers need to be familiar with the anatomical terms. If needed, review these using the handout.

⚠ To avoid sensitive images cover the projector at 03:50 when the doctor says, "Please let me know if it is too uncomfortable, ok?" Uncover again at 04:40 when the narrator finishes saying, "The patient's genital exam may be completely normal."**⚠ HANDBOUT: Female Genital Cutting (p. 107)****DISCUSS:**

If female circumcision is practiced in your area, stop and discuss how it affects women who have been sexually assaulted. Have you ever been asked to repair an infibulation? How would you handle the situation?

⚠ To avoid sensitive images do not show the photo viewer.**EMPHASIZE:**

IRC personnel should never be involved in female genital cutting or re-sewing. There is no medical reason to re-sew (reinfibulate) a woman.

EMPHASIZE:

You cannot do an exam at the family's request. Only the survivor can request or consent to an exam.

► RESTART:

A speculum exam was not needed for Alicia, so here we see a different case illustrating how to do a speculum exam.

⚠ VIDEO: Vaginal Speculum Examination (1:28)

TEXT CARD: Speculum Examination

Excessive force or the use of a foreign object during an assault may result in deep tears of the vaginal wall or cervix. Such injuries are rare, but can lead to severe complications, such as fistula, and require surgical repair.

If there are signs of bleeding, evaluate its source:

- Bleeding originating from inside the cervical os is usually due to normal menstruation and not related to injury, but may also signal miscarriage of a pre-existing pregnancy.
- Bleeding originating from the vaginal wall or the outside of the cervix is usually due to injury.

TEXT CARD: Retained Foreign Matter

Foul smelling discharge from the vagina or cervix may indicate the presence of foreign matter.

- If you suspect retained foreign matter, gently try to retrieve it and carefully inspect the vaginal walls for injuries.
- Do not remove a foreign object if it appears deeply embedded in tissue. Refer such patients to a higher level of care.

⚠ VIDEO: Anal Examination (1:03)

Anoscopy may be needed if there is bleeding from the rectum that is heavy or does not stop after a few hours. In these cases the patient may need to be referred to another facility.

TEXT CARD: Rectal Injury

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

VIDEO: Physical Examination more than 72 Hours after the assault (3:27)

[WESTON KHISA] "Survivors of sexual violence present normally late, after 72 hours, and the main reason is because they don't want to tell anybody what happened to them. Or they want to hide what has happened to them."

[KATY MITCHELL] "Women do come in late—yeah, and again, it's because you know, you kind of have to think about it—you have to make sure that you feel secure and safe before coming in to report it. And then also, if there's

⚠ To avoid sensitive images cover the projector at 00:49 when the doctor says, "Now I am touching your labia."

☒ CORRECTION:

The way the speculum is inserted in the animation is not correct. Discuss proper procedure (rotating the speculum slightly at beginning, then turning it back to the level position once it is in the vagina).

SUMMARIZE:

Review the indications and contraindications for performing a speculum exam.

📄 HANDBOUT: Vaginal Wet Prep

(p. 110)

⚠ To avoid sensitive images cover the projector at 00:47 when the narrator says, "gentle separation technique will allow you to better visualize the anus when checking for injuries."

EXPLAIN:

An anoscope is an instrument that allows the interior of the rectum to be seen. We do not expect most clinics to have them. If there is severe or prolonged bleeding, the patient should be referred to higher level care.

EXPLAIN:

This section shows another scenario in which a survivor presents several days after an assault. The consent process is not repeated here but we should assume the patient has consented to the examination and has already been offered pain medication.

a complication -- if someone is bleeding or someone has an infection, she may come in and maybe is not saying that this is really what has happened to her."

[MELISSA ALVARADO] "One of the biggest challenges to providing good quality health care for sexual assault survivors for us in the Thailand refugee camp, would be one, that they often arrive very late after the sexual assault. They usually are so ashamed that they don't tell anyone for a long time, and we very rarely see anybody within three to five days, you know to provide those essential sort of emergency response treatments. So women lose out on the opportunities for emergency contraception, HIV prophylaxis, and things like that. That is one of our important challenges that we're trying to respond to and let women know about the services that are available to them."

⚠ VIDEO: Assessing For Fistula (1:17)

⚠ VIDEO: Delayed Complications from Severe Genital or Anal Injuries (3:26)

[WESTON KHISA] "The life after they develop fistulas for example is very bad—is devastating—the life is such a way that they want to run away from the general public. And that they don't want to sit with people for long. ... And because of also the smell, they are not free even to cook for people or seek employment. So that keeps them withdrawn socially. And some even think they have been bewitched, because they wonder what happened to them. So you find that these are very depressed people, socially withdrawn, and can contemplate even suicide."

[BIRUK TAFESSE AMARE] "I think one of the serious complications is the development of traumatic fistula. So I would say if I see somebody with a sexual assault, then I'm dealing with the most complicated type of sexual assault. I usually operate on obstetric fistula patients, but often times also see patients with traumatic fistula. We call them traumatic fistula. Of course obstetric fistula is in a wider sense a kind of trauma, but this is a direct trauma, a sharp injury to the genital tract."

TEXT CARD: Severe Genital or Anorectal Injuries

- A variety of injuries are possible depending on the type of assault.
- These may include anal sphincter tears, fistulas, or other genital mutilation.
- These injuries can usually be repaired by a surgeon.
- Any survivor who complains of involuntary leaking of feces or urine should be referred to a surgeon.
- These injuries can have long-term consequences for the patient's health and psychological well-being.

DO NOT show the whole video. Use ONLY the first section, stopping after Melissa Alvarado says, "... and let women know about the services that area available to them." We skip the reenactment because the case presented is not accurate.

Skip the video

The video begins with medical diagrams describing different kinds of fistula. To avoid these images cover the projector for the first 40 seconds.



STOP AND DISCUSS

5 MINUTES

TEXT CARD: Documentation

It is not your job to prove or disprove that a rape occurred. Rape is a legal designation to be proven in court. Your responsibility is to document your medical findings and observations in a thorough and objective way.

- Documentation guides further medical care and ensures quality and consistency of care.
- Documentation can contribute to legal justice.

The clinic record is sometimes the only documentation of the assault. It may be subpoenaed by the court. It can give information on the approximate timing of the assault. For this reason it should include descriptions of any pre-existing injuries.

VIDEO: Documentation Guidelines (01:16)

STOP, PUSH PAUSE AND GO TO EXERCISE 4
 30 MINUTES

VIDEO: Documentation Exercise (17:00)

To avoid sensitive images cover the projector at 15:00 when the doctor says, “Please let me know if it is too uncomfortable, ok?” Uncover at 15:20 when the doctor asks, “Are you ok?” Cover again at 15:52 when the doctor says, “It will only take a moment.”



BREAK

DISCUSS:

At the end of this section, take some time to ask the group if they have any questions.

- Have they ever seen a fistula?
- Is there a place where women can be referred for repairs?

EXPLAIN:

The most common cause of fistula is obstructed labor, but traumatic fistula is often seen in conflict zones where assaults tend to be more violent.



Clinical Pathway Diagram

Proper documentation is the next point of interest to note on the clinical pathway. Put up the corresponding box.

HANDBOUT: Documenting the Examination (p. 112)

To avoid sensitive images cover projector at 00:25 when the narrator says, “without guessing at the cause or stating any personal conclusions.” Uncover at 00:50 When the narrator says, “Remember to protect the patient’s safety and her right to confidentiality.”

EXERCISE 4: DOCUMENTATION

Play the next video which repeats most of Alisha’s history and physical exam. Have participants fill out the form. Review correct documentation.

(See page 85 for complete directions and a sample completed form.)

HANDBOUT: Medical History and Examination Form (p. 113)

Section 3D: **Treatment and Disease Prevention**

In this section you will learn how to:

- Provide appropriate preventive treatment
- Educate patients about their medical care

VIDEO: Treatment Principles (1:12)

[THERESE MCGINN] "They must be offered post exposure prophylaxis for HIV and emergency contraception, treatment for potential sexually transmitted infections has to be offered. And all of this has to be done in a way that absolutely assures her dignity and her humanity. You know she's just been through a terrible experience, and we have to....it's not enough to just give the clinical care, it has to be done in a way that actually begins the emotional and human treatment as well, and that has to be done."

TEXT CARD: Treatment Principles

The sooner a survivor of sexual assault seeks medical care, the more you can provide in the way of treatment and preventive care. Your care of the patient will be different depending on how much time has passed since the assault.

In addition to providing treatment for any physical injuries, medical care can prevent:

- unwanted pregnancy
- sexually transmitted infections, including HIV, chlamydia, and gonorrhea infections
- hepatitis B and tetanus infection

VIDEO: Treatment Options (1:24)

[DAN KOROS] "The survivor for example, many times has very limited information regarding the risk of getting HIV, the complications of rape, the availability of treatment, and availability of services and many things, which will many times rely on the doctor or the physician to give explanations and it's a very important point for all clinicians who manage survivors that they must give all the information."

TEXT CARD: Treatment of Non-Emergent Injuries

Basic Wound Care

- Clean the wound
- Dress the wound
- Update tetanus vaccinations
- Provide comfort measures (e.g., sprint fractures, pain control)

VIDEO: Preventing Pregnancy (2:16)

[NARRATOR] Pregnancy is one of the most serious complications of rape. It occurs in approximately five percent of rapes and may have devastating consequences.

LEARNING OBJECTIVES:

Participants will be able to:

- List the elements of treatment for survivors.
- Describe the use of emergency contraception.
- Describe which patients should be offered PEP and list the patient teaching messages.
- Describe how you would approach a survivor who came to you 6 months after a sexual assault.
- Describe common reactions to sexual assault and demonstrate the ability to express compassion for what the survivor is feeling.
- Describe when the survivor should come back for follow up and what should be addressed at each follow up visit.



Clinical Pathway Diagram

Medications and other treatments for survivors seen within 72 (120) hours is the next point of interest on the clinical pathway. Put up the corresponding diamond, the "yes" arrow and the box listing treatment for those seen within 72 (120) hours.

[JONATHAN NDZI] "In that environment, when a woman is raped, she is abandoned by her family she is ostracized, rejected. The pregnancy--because she is pregnant out of rape and without a husband--nobody in that community will ever marry her. And besides that, babies issued out of rape do not have the rights to nationality, because they have no identified parents, and babies--children out of rape have no, also no right, they don't have a right to free marriage. They wouldn't be able to marry anybody in that environment because they are children who are born out of rape."

[WILMA DOEDENS] "There is a fairly high risk that someone who is raped gets pregnant, and in situations like in Darfur, where we think many many women are raped, they'll be people, and there's no access to safe abortion, many women will attempt an unsafe procedure to abort themselves, to terminate their pregnancy, which can lead to a lot of health problems and hospitals being quite full with cases of incomplete abortion or women who have serious complications after the procedure. Prevention of pregnancy you can do within five days and there is an emergency contraceptive method which is a hormonal method which is very efficient if taken up until five days. So we do recommend that all women who present within five days get that contraceptive method."

TEXT CARD: Emergency Contraception

Emergency Contraceptive Pills (ECP) can prevent pregnancy if given within five days after intercourse.

- Offer ECP to all female patients of reproductive age if there has been vaginal intercourse.
- Administer ECP as soon as possible, up to 120 hours after the assault
- ECP reduce risk of pregnancy by 80 to 90%.
- There are no absolute contraindications to providing ECP.

TEXT CARD: Emergency Contraceptive Pills (ECP)

- Oral levonorgestrel (dedicated products called Postinor or Optinor)
 - is the most effective form of ECP
 - has the fewest side-effects
 - is given in a single dose
- Side effects:
 - usually minor, better if taken with food
 - include mild breast pain, nausea, vomiting, and irregular vaginal bleeding
- If patient vomits within one hour, repeat dose.

 The speaker is expressing some strong personal opinions that may not be correct in all settings. The challenges that illegitimate children face are the result of social policy and can be changed.

EMPHASIZE:

1. The 120 hour (5 day) window replaces the old 3 day recommendation.
2. The single dose regimen for levonorgestrol has also replaced the 2 dose regimen. If you are using combined OCs then you still need to use the 2 dose regimen.

 **Handout: Emergency Contraception**
(p. 118)

TEXT CARD: ECP Protocol

- Review local protocol for treatment regimen.
- If no dedicated product is available, several standard oral contraceptive pills can be used for the same effect.

DISCUSSION CARD: ECP in Your Setting

- Discuss your experiences with ECP
- Are ECP available?
- What is the approved product or regimen?
- Are there barriers to providing ECP?
- Are some people uncomfortable giving ECP?


STOP AND DISCUSS **20 MINUTES****TEXT CARD: Pregnancy Testing**

A pregnancy test is not required before giving a patient ECP. If your clinic routinely tests for pregnancy, remember the following:

- A positive test result within a week of rape indicates a pre-existing pregnancy.
- If a pregnant woman takes ECP, it will neither end the pregnancy nor harm the fetus.
- A positive pregnancy test may change the choice of antibiotics or other medications used to treat sexual assault survivors.

TEXT CARD: Patient Teaching Messages

- ECP may cause mild nausea, vomiting, breast pain, or slight vaginal bleeding.
- ECP are not always effective in preventing pregnancy.
- ECP can make her period come later or earlier than expected.
- If she does not get her menstrual period within a week after it is expected, the patient should return to the clinic for a pregnancy test.
- ECP will not protect against pregnancy from future sexual intercourse.

TEXT CARD: Intrauterine Device (IUD)

A copper IUD, sometimes called an intrauterine contraceptive device (IUCD), can also be used as a method of emergency contraception.

TEXT CARD: Intrauterine Device (IUD)

- An IUD is effective only if inserted within seven days of intercourse.
- It should be inserted by a trained health worker.
- A negative pregnancy test is required before insertion.
- The IUD can be removed at the next menstrual period or left in place for future contraception.

 Refer to the RHRC distance learning module “Emergency Contraception for Conflict-Affected Settings” included in the resources at the end of the DVD.

EMPHASIZE:

- ECP is on WHO’s Model List for Essential Medicines.
- ECP is recognized as a safe and effective method of contraceptive.
- It does not cause abortion; rather, it prevents pregnancy and it does not affect a pre-existing pregnancy.

EXPLAIN:

A pregnancy test can provide very important information, but ECP should not be delayed or denied if a test is not available or if the survivor does not want one.

DISCUSS:

If IUDs are commonly used in your setting, what are the implications of inserting one into a woman who has just been sexually assaulted? It is a very effective way to prevent pregnancy, but it may increase her risk of infection and will need to be removed if she does not want long-term contraception.

CASE STUDY: Preventing Pregnancy

A 35-year-old woman comes to the clinic four days after vaginal rape. The patient reports that at first she had some general vaginal soreness, but now feels no pain. Her physical exam is normal.

Question #1: Teaching messages for this patient should include which of the following:

- A. Information about the risk of pregnancy and STIs (including HIV) as a result of the sexual assault and what can be done to decrease the risk.

- B. Reassurance that she is completely healthy.

Answer: A. You do not know if she is completely healthy.

Pregnancy or infection resulting from the assault would not yet show any symptoms. She needs information about these risks and how they can be reduced. Reassure her that you can provide medicine that will reduce the risk and that you will do everything you can, but do not offer false promises.

Question #2: In terms of preventing pregnancy, which is correct?

- A. ECP are no longer indicated for this patient.

- B. ECP should be offered immediately.

- C. A negative pregnancy test is necessary before giving ECP.

- D. She is not a candidate for an IUD

Answer: B. The patient's risk of pregnancy depends on the time of the assault in relation to her menstrual cycle.

Emergency contraception should be offered immediately to this patient. She is a candidate for either ECP which can be effective up to five days (120 hours) after the sexual assault or an IUD which can be inserted up to seven days after.

⚠ VIDEO: Preventing Common Sexually Transmitted Infections (STIs) (1:30)

[NARRATOR] Sexually transmitted infections, also known as STIs, pose a significant health risk for survivors of sexual assault. These infections can cause vaginal or anal discharge and pain and can lead to chronic pain, pregnancy complications, and sterility. Often there are no symptoms. In addition to medical consequences, STIs may have social consequences as well, especially if left untreated. A survivor who contracts an STI may face domestic violence, divorce, and abandonment. Infertility caused by STIs can result in social stigma. If treated quickly and confidentially, these social consequences can be lessened. Common STIs include gonorrhea, chlamydia and syphilis infections. However, other infections may also be common in different regions of the world.

TEXT CARD: Guidelines for Preventing STIs

- Appropriate antibiotics can prevent sexually transmitted infections, if given soon after the assault.

⚠ To avoid sensitive images cover projector at 00:48 when the narrator says, "If treated quickly and confidentially, these social consequences can be lessened." The projector can be uncovered again at 01:09 when the doctor says, "These antibiotics are effective in preventing gonorrhea and chlamydia."

- Offer preventative medication to all survivors who have experienced vaginal or anal penetration.
- Administer as soon as possible (preferably within 72 hours of assault).
- Some antibiotics may be effective for up to two weeks after an assault.
- Know which sexually transmitted infections are common in your area.

TEXT CARD: Antibiotic Regimens for Preventing STIs

- Regimen commonly includes antibiotics against both:
 - gonorrhea infection (e.g., ceftriaxone)
 - chlamydia infection (e.g., azithromycin or doxy)
- Follow your local guidelines for specific regimens.
- Some antibiotics are not safe in pregnancy. If a woman is pregnant she should be treated according to appropriate guidelines.

TEXT CARD: Patient Teaching Messages

- Antibiotics may not be effective in preventing all types of STIs.
- Antibiotics do not protect against infection from future sexual acts.
- STI symptoms may include anal or vaginal discharge or pain.
- If the patient develops such symptoms, she should return to the clinic immediately.

VIDEO: Preventing HIV Infection (1:36)

[NARRATOR] More than 37 million adults and two million children worldwide are infected with the human immunodeficiency virus, also known as HIV. Almost three million deaths per year result from HIV infection. Rape survivors who have tissue injuries due to the violent nature of the act have an increased risk of HIV infection.

[WILMA DOEDENS] “Every woman who comes in after a rape, within 72 hours, must be prescribed post exposure prophylaxis. It is important that you tell all women how to take it, and also to explain the side effects, because women will understand and will continue taking the medication if they understand the importance why they are taking the medicine, and how they can deal with the side effects.”

TEXT CARD: HIV Post-Exposure Prophylaxis (PEP)

HIV PEP is medication that can prevent HIV infection if given within 72 hours of exposure.

- Offer HIV PEP to patients who come to the clinic within 72 hours of:
 - sexual assault with vaginal or anal penetration
 - having their eyes, nose, mouth, or open wounds exposed to an assailant's blood or semen

Administer HIV PEP as soon as possible - to avoid delay
PEP can be started before the complete history and physical

HANDOUT: WHO Recommended STI Treatment (p. 121)

 **REFER** to local treatment guidelines. If there is no established treatment guideline then refer to the WHO STI Guidelines at the end of the DVD.

TEXT CARD: HIV Post-Exposure Prophylaxis (PEP)

- Side-effects of PEP include mild to moderate nausea, fatigue, weakness, headache, or inability to sleep.
- It is essential that the survivor take the PEP medication for the complete period of the prescription (28 days).
- HIV PEP is safe for pregnant women and for children with dosage adjustment.
- The two drug regimen (ZDV-3TC) is well-tolerated and appropriate in most countries where treatment rates are low.

TEXT CARD: HIV Testing

HIV testing should be offered to all sexual assault survivors.

HIV testing is not necessary before administering PEP. Do not withhold PEP from a survivor because she has not been tested.

TEXT CARD: Positive HIV Test

- A positive HIV test within a few weeks of sexual assault means the patient had a pre-existing HIV infection.
- A patient who tests positive for HIV should not be given PEP. It will not help someone who already has HIV.
- An HIV positive patient should be referred to appropriate medical care and counseling services.

TEXT CARD: Patient Teaching

Messages

- Discuss potential benefits of HIV PEP and management of side-effects.
- Stress the importance of taking the medication for the full period.
- If the patient experiences intolerable symptoms or side-effects she should return to the clinic before stopping the medications.
- Recommend follow-up in two weeks to see how she is tolerating the medication.
- Counsel her on the need for follow up testing.

STOP AND DISCUSS

 **5 MINUTES**

HANDBOUT: HIV Post-Exposure Prophylaxis (p. 119)

DISCUSS:

- Is HIV testing available in your facility?
- What are local guidelines regarding PEP?
- Are pediatric doses available?
- What would you do if someone did not want to be tested?
- Where would you refer someone who tested positive?

EMPHASIZE:

PEP is a short course of antivirals and though it can cause side effects it is very safe and should be available to anyone who has experienced sexual assault. The two drug regimen is well-tolerated. In countries with high levels of resistance a three drug regimen (AZT+3TC Combivir + a protease inhibitor such as indinavir) is often recommended but patients find it much harder to take and it is more likely to cause significant side effects.

EXPLAIN:

PEP is also available at all field offices for all IRC staff who have experienced a possible exposure, whether in their work or due to sexual assault. The protocol for occupational exposure (needle stick, for example) is slightly different than that for sexual assault since testing of the source is usually possible.

CASE STUDY: Post-Exposure Prophylaxis

A 41-year-old survivor arrives at the clinic two days after the assault accompanied by her son who translates for her. She was attacked by multiple assailants who raped her vaginally and anally. She presents with moderate vaginal bruises and anal abrasions.

Question #1: Should post-exposure prophylaxis (PEP) against HIV be offered to the patient?

- A. No, because the risk of HIV transmission in this case is low.
- B. No, because the effectiveness of PEP is unknown.
- C. Yes, PEP against HIV should be offered as soon as possible.
- D. Postpone the decision until the patient's HIV status can be confirmed.

Answer: C. Due to the nature of the assault (multiple assailants, broken skin, and vaginal and anal penetration) the patient is at higher risk for HIV infection. PEP against HIV infection needs to be given as soon as possible. HIV testing is not required before offering PEP. Even though a positive HIV test would eliminate the need for PEP, delaying the administration of the medication would greatly diminish its potential benefit. PEP against HIV is not indicated if more than 72 hours have passed since the assault.

Question #2: The patient returns to the clinic several days later. She complains of nausea and vomiting and is worried that she is seriously ill as a result of the sexual assault. She reports that she has been taking all her medications without fail. What is the appropriate response?

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

Answer: D. Nausea and vomiting are well-recognized side effects of the medications used for HIV PEP. Patients should be encouraged to complete the regimen. Care-providers can provide anti-nausea (anti-emetic) medication to make the PEP medications more tolerable.

VIDEO: Preventing Hepatitis B Infection (1:16)

[NARRATOR] Four hundred million people are chronic carriers of the hepatitis B virus. Hepatitis B causes liver failure, cirrhosis, and liver cancer in 15 to 40% of cases and leads to more than one million deaths per year. The virus may be transmitted via contact with an infected individual's blood or secretions. Rape survivors have a significant risk of infection due to tissue injury that results from the violent nature of the act.

EXPLAIN:

Having her son translate for her is not ideal, but may be a very real situation. If a participant raises the issue here, acknowledge this and tell the group that it will be discussed later. (Parking Lot)

TEXT CARD: Hepatitis B Vaccination Guidelines

- All unvaccinated or inadequately vaccinated survivors of penile vaginal or anal penetration should be offered hepatitis B vaccine.
- To prevent infection the vaccine must be given within 14 days of exposure.
- The vaccine is safe and effective in pregnant women and children.
- The only known contraindication is a serious allergic reaction to a prior dose of hepatitis B vaccine or a vaccine component.

EMPHASIZE:

Many people are unfamiliar with Hepatitis B, but it is a very serious and common infection. It causes chronic problems and often goes undiagnosed.

TEXT CARD: Patient Education and Follow-Up Plan

- The patient may experience redness and tenderness at the vaccination site.
- Severe allergic reactions are very rare.
- Encourage the patient to complete the vaccination series with repeat doses at one and six months.

TEXT CARD: Preventing Tetanus Infection

- Tetanus is a serious disease caused by bacterial infection entering a wound.
- Tetanus infections result in death in 20% of cases.
- The disease is preventable through immunization.

TEXT CARD: Preventing Tetanus Infection

- Adequate lifetime immunization involves five doses: three doses in infancy and two in childhood
- Two doses are recommended in pregnancy.
- Review your local treatment protocol for specific regimen.

NOTE:

Most women who have been through antenatal and delivery care have been vaccinated. They do not need to be vaccinated again, but there is no danger if they are vaccinated unnecessarily.

TEXT CARD: Tetanus Vaccination Guidelines

- Provide tetanus toxoid booster vaccination if the patient has not had five lifetime doses or if her status is uncertain.
- If the patient has not completed a primary immunization series against tetanus infection give her a dose immediately and a follow-up dose in four weeks.

CASE STUDY: Treating a Pregnant Survivor

A 20-year-old female presents two days after being raped vaginally and anally. The patient has had painful bowel movements mixed with blood. She has no unusual vaginal discharge. An exam reveals multiple cuts around her anus. Her pregnancy test is positive.

Question #1: When considering medications to prevent STIs in this patient, including HIV and hepatitis B, and tetanus, which statement is correct?

- A. There are no safe preventative medications for the above-listed diseases in pregnancy.
- B. In pregnancy, carefully selected medications can be given to prevent the above-listed infections.
- C. Tetanus vaccine is the only preventative medication that is safe in pregnancy.

- D. Pregnancy does not affect the selection of preventative medications.

Answer: B.

The patient can be offered medications that are safe in pregnancy to prevent STIs including HIV, tetanus, and hepatitis B. Antibiotic regimens for STI prevention will need to be modified to ensure they are compatible with pregnancy. Clinic staff must be familiar with local treatment protocols. Both hepatitis B vaccine and Combivir®, the most common form of PEP, are safe in pregnancy.

Question #2: Which of the following set of discharge instructions is most appropriate?

- Advise the patient to keep the genital area clean and take a stool softener to promote healing of her injuries.
- The patient is pregnant as a result of the assault and needs to let her husband know about it
- The patient should consider taking ECP to prevent this pregnancy from progressing.

Answer: A.

If the injured genital area is not kept clean the patient might develop an infection. A pregnancy test would not be positive until at least seven days after intercourse and likely even longer. Reassure her that the positive pregnancy test cannot be the result of the assault and represents a prior pregnancy. ECP are not effective against an already established pregnancy but would not harm an existing pregnancy if they were given without knowing.



STOP AND SUMMARIZE

TEXT CARD: Delayed Treatment Principles

When a survivor comes to the clinic more than 72 hours after the assault the examination and treatment will depend on her condition and history. Consider the following issues:

- treatment of injuries
- pregnancy prevention
- symptomatic treatment of STIs
- HIV counseling and testing
- vaccination against hepatitis B and tetanus
- information and referrals for legal, mental health and social support services

SUMMARIZE:

When survivors seek care within 72 hours they can receive the most complete care. After 72 hours it is too late to begin preventative treatment for HIV. Emergency contraceptive pills can still be given up to 120 hours after the assault (IUDs up to 7 days). Prophylaxis for STIs is most effective if given within 72 hours but can be given up to 2 weeks after the assault.

► EXPLAIN: In the following section we are talking about survivors who present after 72 - 120 hours.



Clinical Pathway Diagram

Care of survivors presenting more than 72 (120) hours is the next point of interest to note on the clinical pathway. Put up the "no" arrow and the corresponding box.

TEXT CARD: Delayed Care Seeking

Some survivors seek care weeks or months after an assault. You may learn about an assault during a visit for another problem. Although the physical wounds may have healed, the survivor still deserves compassionate, competent, and confidential care. Information, referrals, and emotional support can help the survivor heal and are important no matter how long it has been since the assault.

TEXT CARD: Delayed Treatment Principles:

Unwanted Pregnancy

- All patients should be assessed for pregnancy status.
- Be familiar with any available adoption services in your area as well as local laws regarding termination of pregnancy resulting from sexual assault.
- If a woman is pregnant as a result of sexual assault, provide clear information about local pregnancy management options, give her emotional support and refer her to the appropriate clinical and counseling services.

STOP AND DISCUSS

 **10 MINUTES**

TEXT CARD: Delayed Treatment: STIs

- If a patient presents with symptoms of a sexually transmitted infection, such as vaginal discharge, follow your local treatment protocol.
- All patients should be counseled and offered HIV testing.
- HIV testing can be done as early as six weeks after an assault but should then be repeated at three to six months.

Case Study: Treatment Options (I)

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

Question #1: This patient should be given preventative care against all of the following except:

- A. Gonorrhea and chlamydia infections
- B. HIV
- C. Pregnancy
- D. Hepatitis B
- E. Tetanus vaccine

Answer: **B.** PEP against HIV infection needs to be started within 72 hours (three days) after the rape. Although more effective if given earlier, ECP are still quite effective up to 120 hours (five days) after intercourse. Hepatitis B, gonorrhea, and chlamydia medications can also be provided within this time frame. Ideally, a tetanus vaccine

DISCUSS:

What might happen to a woman who has a child as a result of rape? What are the options (if any) available to women in your setting who become pregnant as a result of rape? (for example, adoption, legal abortion, keeping the baby)

 **REFER** to the local syndromic management protocol for STIs.

booster is administered within 72 hours of a break in the skin, but it can also be given later.

Case Study: Treatment Options (2)

Question #2: The patient returns for a follow-up visit six weeks after the assault. She has not had a period since the event, and her pregnancy test from today is positive. When you inform the patient about the positive pregnancy test, she begins to cry and states that she does not want to have the baby.

The most appropriate intervention would be:

- A. Provide ECP immediately to this patient.
- B. Give her information about all options that are available to her, including adoption and abortion services if legal.
- C. Perform a pelvic examination to document uterine size and the stage of the pregnancy.

Answer: B. Health care providers should be familiar with local counseling services, available adoption alternatives and local law regarding termination of pregnancy as a result of rape. The survivor should be given information about all options available to her so that she can make her own informed choices. While ECP are 80% to 90% effective in preventing pregnancy from occurring, they have no effect once a woman has become pregnant. A pelvic exam would not change management and might add to the patient's distress. If she decides to keep the pregnancy, encourage her to seek prenatal care as early as possible.

She will also benefit from counseling and emotional support.

VIDEO: Mental Health Counseling (01:53)

[NGUYEN-TOAN TRAN] "I would deal with the client in a very compassionate, caring, nonjudgmental, and non-guilt giving way."

[BIRUK TAFESSE AMARE] "Providing the compassionate care is very important, because they are very much in turmoil, these women are in turmoil. So we have to give our hearts, not just our technical skills."

TEXT CARD: Key Messages for the Survivor

While being cared for in your clinic, the survivor will need to hear some important messages:

- She is not to blame for the assault.
- She may experience a series of confusing emotions that may take a while to go away.
- Her response is normal and understandable given what happened to her.
- Early medical care will help prevent serious physical problems.
- She is not alone. Talking about the experience often helps people.
- Let her know what sources of support are available to her.

EXPLAIN:

In this scene the doctor and Alisha hug. This may not be appropriate in some cultures. There are many ways to express concern and support.



Clinical Pathway Diagram

The discharge counseling process is the next point of interest to note on the clinical pathway. Put up the corresponding box.

TEXT CARD: Mental Health Counseling

- Survivors of sexual assault may suffer severe emotional trauma. There is no single right way to cope with this trauma. Each survivor reacts differently.
- If possible, all survivors should be referred to trained counselors who can provide professional psychological evaluation and care.

TEXT CARD: Common Reactions to Sexual Assault

Common reactions to sexual assault include:

- anger
- severe anxiety and fear
- flashbacks and nightmares
- embarrassment and shame
- feelings of guilt or self-blame
- powerlessness
- depression
- social fears and isolation

These are all normal reactions to a terrifying, violent experience. They may last for years, causing prolonged suffering, and may sometimes lead to self-harm or even attempted suicide. Ongoing professional mental care can be crucial for a survivor.

TEXT CARD: Suicide and Sexual Assault Survivors

A sexual assault survivor may consider suicide. Asking a survivor if she is suicidal can be difficult; however, asking the question gives her an opportunity to talk about how she is feeling and can help her to deal with those feelings.

Listen carefully to her response. An initial response of “I don’t know” or “no” may really mean yes. Usually if a survivor says no and means it, she will then talk about something specific that she is living for.

TEXT CARD: Suggestions for Asking About Suicide

- Are you feeling so bad that you’re considering suicide?
- That sounds like a lot for one person to take; has it made you think about killing yourself to escape?
- Has all that pain you’re going through made you think about hurting yourself?
- Do you sometimes wish you could go to sleep and not wake up?

TEXT CARD: Interacting with Suicidal Patients

When someone tells you they are having suicidal thoughts and feelings it is essential that you take the time to listen.

- Encourage her to talk about her feelings.
- Take her seriously.
- Try to extract a promise from the patient that if she thinks she’s going to harm herself she will contact you, or someone else who can help, such as a counselor or doctor.

NOTE: You may want to return to this text card during the discussion about talking to a survivor who is thinking about suicide.

TEXT CARD: Referral for Suicidal Patients

Talking may not seem very effective, but it can be a powerful means of decreasing a survivor's sense of isolation and distress, and consequently help to reduce her immediate risk of attempting suicide.

Getting the survivor to talk is a short term strategy. It is important to refer them to someone who is equipped to offer them the help they need, while you continue to offer support as well.

DISCUSSION CARD: Discuss Severe Emotional Reactions

- What are common attitudes towards suicide in your community?
- What makes it difficult to talk about suicide?
- How should suicidal patients be handled at your clinic?
- Discuss your experiences working with emotionally unstable or suicidal patients.



STOP AND DISCUSS

5 MINUTES

OPTIONAL EXERCISE 5

TEXT CARD: Delayed Treatment: Referrals for Mental Health Care

No matter when a survivor of sexual assault arrives at the clinic, they've experienced a severe emotional trauma.

- If possible, all patients should be referred to mental health care services for psychological counseling and care.
- As a health care worker you are not expected to provide mental health counseling, but you do need to understand the survivor's needs and do your best to make appropriate referrals.

CASE STUDY: Psychological Support and Referral

A 15-year-old female presents three weeks after being vaginally raped by her uncle who lives with her family. The patient has only confided in her mother, who told her to be brave and not mention the assault to anyone. She reports no vaginal discharge or bleeding. Her physical examination is normal.

Question #1: What is the next course of action?

- A. Perform a pelvic examination.
- B. Give her preventative antibiotics against STIs, including HIV infection.
- C. Provide a referral for psychological counseling and support and ensure that the patient has a safe place to go.

DISCUSS:

- What are common attitudes towards suicide?
- What makes it difficult to talk about suicide?

'Y' EXERCISE 5 (OPTIONAL):

TALKING TO SUICIDAL PATIENTS

If the group feels that this issue comes up often, allow time for them to practice by role playing using the suggested statements or others that the group formulates. See earlier text card, "Suicide and Sexual Assault Survivors" for suggestions when asking about suicide. (See page 91 for complete directions)



REFER to CCSAS Psychosocial Toolkit, Topic 3: Basic Communication Skills for more information on how to listen to and counsel survivors.

Answer: C. Referring the patient to psychological counseling and social support services is an important part of caring for the survivor of sexual assault. Since she is not getting support at home, this patient would greatly benefit from referral to a local community center that can offer her confidential emotional support.

The patient's situation at home indicates she may still be in danger. It is your responsibility to find out if she has a safe place to go. If she does not, help her find one. A pelvic exam is not indicated as the patient has no vaginal bleeding, pain, or discharge. Medications against STIs, including HIV infection, are not indicated this long after the assault.

TEXT CARD: Patient Discharge

At the end of the patient's visit, make sure she has a safe place to go and reinforce the following:

- how to care for her injuries
- how to take medications
- how to access referral services
- when to return for follow-up
- she can return anytime if she has problems, questions or just wants someone to talk to

TEXT CARD: Legal Issues: Medical Certificate

- In most countries, the care provider is required to prepare a medical certificate.
- The medical certificate is a legal document that serves as an element of proof.
- It may be the only evidence available in a court of law.
- The patient has the sole right to make all decisions regarding its use.
- You must know your local laws and protocol.



STOP AND DISCUSS

5 MINUTES

TEXT CARD: Follow-Up Care

- All patients who have survived sexual assault will benefit from follow-up medical and psychological care
- Patients should be encouraged to return to the clinic at two, six, and 12 weeks after the assault.

TEXT CARD: At the Follow-Up Visit:

- Assess the patient's pregnancy status.
- If the patient has symptoms of a sexually transmitted infection, provide appropriate testing and treatment.
- Counsel on HIV and offer testing or refer.
- At each visit, assess the patient's emotional state and ensure she has appropriate psychosocial support.
- Refer the patient to additional services as needed.

EMPHASIZE:

Many survivors will not come back for follow up care. This makes it especially important to provide as comprehensive care as possible when she is at your clinic. The best way to encourage survivors to return is to provide support and understanding and to respect their privacy. Explain what services you will provide when they return for follow up but do not withhold medication to force them to return.

DISCUSS:

- What is the medical certificate used locally? Who can fill it out?
- Review the form with the group. (A sample medical certificate is included with the forms and pictograms in the resources for facilitator's at the end of the DVD.)

EMPHASIZE:

You are only documenting what you find, not confirming or denying a rape. For example your findings may include, "bruising consistent with recent assault."

SECTION 3E: Caring for Male Survivors

In this section, you will learn how to:

- Offer compassionate and confidential support to a male sexual assault survivor
- Modify a physical examination for a male survivor

VIDEO: Caring for Male Survivors (02:14)

[CARMEN LOWRY] “Men experience sexual violence. They experience sexual assaults. We know that boys experience sexual assault. Sexual assaults often time occur to people when they have reduced when they have increased vulnerabilities. So boys are particularly at risk. And one of the issues is that if boys or men are sexually violated—if you’ve got a really strong norm that says this is what it is to be a male and this is what it is to be female, lots of times men or boys are less likely to come forward and say, “I have been sexually assaulted.” Because what that means is it starts cutting away at what it means to be a man.”

STOP AND DISCUSS

 **15 MINUTES**

TEXT CARD: How to Support a Male Survivor

- Reassure him that all his information will be kept completely confidential.
- Remind him that the assault was not his fault.
- Men who have reached puberty may feel shame if they experience an erection or orgasm during the assault.
- Reassure these patients that erection and orgasm are normal reflexes they could not control.

VIDEO: Physical Examination for Male Survivors (00:56)

LEARNING OBJECTIVES:

Participants will be able to:

- Describe how male survivors may react to a sexual assault.
- Describe how to communicate with a male survivor.
- Explain what physical response men can experience during an assault and how this may make them feel.
- Describe signs to look for during the male genital exam.

DISCUSS:

It is very important to recognize that men and boys do experience sexual assault. Play the first video and then start a discussion about attitudes towards male survivors of sexual assault. Does the group believe the man in the video could be a survivor? Why or why not? Is male sexual assault recognized in the community? Encourage the group to share experiences working with male survivors.



STOP AND DISCUSS



5 MINUTES

⚠ To avoid sensitive images cover the projector before going to the next card.

⚠ TEXT CARD: Modifying the Physical Exam for Males

- Perform a careful examination of the penis and scrotum.
- TEXT CARD: Modifying the Physical Exam for Males**
In addition to the guidelines outlined in the adult female assault section, it is also important to note the following:
- Pain and swelling of the testicles may represent serious conditions.
 - Patients with these symptoms should be referred for higher levels of care.
 - Be aware that prostate infections caused by anal penetration can be difficult to treat and require antibiotics for an extended period of time.

VIDEO: Treatment and Follow-Up Care (01:40)

[WILMA DOEDENS] “There are some beliefs that if a man is raped, that he is really a homosexual, and in many countries homosexuality is very stigmatized. So we do see that providers have a lot of difficulty dealing with that. The treatment options, the treatment issues for a man are very much the same as for a woman, apart, obviously from the emergency contraception.”

“Also it’s important for medical care providers to understand that they work with the community, and inform (them) that men and boys also get raped, and should come forward to the treatment centers for the same treatment. That it’s not a stigma, that it’s not a shame, but that they do need help and support.”

CASE STUDY: Caring for Male Survivors

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

Question #1: What is the best response to the patient's question regarding his risk of becoming infected with HIV as the result of the assault?

- A. Reassure him saying, “Don’t worry. You will be fine.”
- B. Inform him he is at potential risk for HIV given the nature of the assault.
- C. Explain to him that his risk of infection may be lowered with PEP.
- D. Both B and C.

DISCUSS:

Does this scene seem uncomfortable? How do you think the doctor could make the patient feel more comfortable? What should happen if the man refuses the genital examination?

⚠ To avoid sensitive images skip this card.

EXPLAIN:

In many cases it may be possible to prescribe medication after a thorough history even if you do not do an exam.

📄 HANDBOUT: Male Anatomy (p. 123)

In order to document their findings providers need to be familiar with the anatomical terms. If needed, review these using the handout.

☒ CORRECTION:

Follow-up should be at two weeks, not three weeks.

Answer: D. The patient has suffered a potentially significant exposure to HIV. You do not know his exact risk of getting HIV but he has a right to be informed. Never give false reassurances. While some patients who take HIV PEP develop side effects like nausea, headaches, and vomiting, it will not be effective if it is not taken for the full 28 days.

Question #2: The patient appears increasingly anxious during the course of his examination. He reluctantly tells you that he thinks he experienced an erection during the assault. He expresses shame and feelings of disgust with himself. Besides referring the patient for psychological counseling, what are the appropriate messages that you should convey to him?

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

Answer: D. Both answers A and B reflect the importance of providing basic, healing support to this patient. Keeping sexual assault a secret can intensify feelings of embarrassment and shame. Reassure the patient, encourage him to seek emotional support from people he trusts, and refer him to counseling services.

Question #3: The patient returns to the clinic two weeks later for a follow-up examination. He complains of fecal incontinence. You perform a digital rectal exam and discover the rectal sphincter muscle is torn. What is the appropriate course of action?

- A. Explain that the rectal sphincter injury will heal on its own.
- B. Refer the patient for surgical consultation.
- C. Put the patient on oral antibiotics.
- D. Schedule a repeat visit in three days for a recheck.

Answer: B. A significant rectal sphincter tear will not heal on its own. All rectal sphincter muscle injuries that cause fecal incontinence should be evaluated by a surgeon. These injuries require surgical repair. Having the patient return in three days for a repeat evaluation or providing antibiotics will not improve this patient's clinical course.



STOP AND SUMMARIZE BREAK

EXERCISE 6: Y COMMON EMOTIONAL REACTIONS ⌚ 45 MINUTES

SUMMARIZE:

The needs of male survivors are essentially the same of those of females, but oftentimes the subject is even more sensitive and many providers are uncomfortable. The key to providing good care to male survivors is to be comfortable and professional yourself and to convey to the survivor your respect and compassion.

REFER to CCSAS Psychosocial Toolkit, Topic 6: Special considerations for working with Male Survivors for more information.

Y EXERCISE 6: COMMON EMOTIONAL REACTIONS

In this exercise, the participants will explore the complex emotional responses that a sexual assault survivor may experience and practice communication techniques. Participants will play the role of a sexual assault survivor or of a person who is trying to support the survivor. (See page 91 for complete directions.)

SECTION 3F: **Caring for Young Survivors**

In this section you will learn how to:

- Provide a safe and caring environment for young survivors of sexual assault
- Gather important medical information from children
- Modify the medical examination for child survivors
- Modify treatment options for child survivors

TEXT CARD: Know your Clinic's Resources

To the greatest extent possible, ensure that your clinic has the following:

- care providers familiar with child development and anatomy and comfortable talking with children
- understanding of national child abuse laws as well as local police and court procedures
- procedures for communicating with child support agencies and other social services

TEXT CARD: Receiving a Young Survivor

- Begin by building trust and creating a safe environment.
- Make the young person feel at ease by allowing a trusted adult to accompany her.
- Talk to the young person respectfully. Use language she understands.
- Explain what you're doing and ask questions about normal topics, like school and friends, while doing the preliminary assessment.

VIDEO: Receiving a Young Survivor (02:53)

[SIDIKI KANNEH] “In the first place children are very...it’s very difficult for them to grow confidence in someone that they do not know. So the first is that you make them feel at ease. Talk to them in a child friendly manner so they try to open up, bit by bit, and they expose their problems.”

[LILIAN KIAPA-IWA] “Child survivors are always a tricky thing because there are ethical issues involved. We have like the really young children who get assaulted or raped. Most victims of rape get brought in by a parent. We don’t--clinicians don’t usually have the skills to counsel children or get information from young children, and this is not part of the training normally. So it becomes very difficult to really know like how can you help this child when you’re not sure what really happened.”

[WILMA DOEDENS] “You need to give the child some time to get used to you and make sure that it feels comfortable before you start the interview. Children, you will usually ask for supporting person to come with the child, which can be the parent or a legal guardian. However you have to be careful that that person that comes with the child is not actually the abuser. And you’re better off asking the child who it wants with him or her in the room as a support person.”

LEARNING OBJECTIVES:

Participants will be able to:

- Describe the issues to getting consent for the examination of a child.
- List the information you need to gather from a child survivor.
- Discuss what it means to always put the best interest of the child first.
- Describe under what conditions it would be inappropriate to perform a genital exam on a child.
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP if vaginal penetration has occurred.
- Describe what treatment you would offer for a child survivor.
- Demonstrate how to advise parents on a child’s possible reactions to sexual assault.

EXPLAIN:

The actress in the video is 15 years old, playing a 13 year old. Because of the sensitivity of the content we could not film a younger child. Even very young children experience sexual assault and need to be cared for in ways suitable to their age.

TEXT CARD: Informed Consent for a Young Survivor

- Provide the guardian and child with information about the examination you are about to perform.
- Obtain consent for each element of the history and physical exam, while reminding the child and guardian that even if consent is given, they can refuse to continue at any point.
- The parent or legal guardian should sign the consent form unless he or she is a possible abuser.
- If necessary, the form may be signed by a representative from the police, child welfare agency, community support service, or a court-appointedee.

VIDEO: Taking a Young Survivor's History (05:44)
[LAUREN BIENKOWSKI] "For children it is very difficult to sit with someone and talk, so play therapy techniques are important so that they're doing something with their hands. They can either act out with dolls what happened, or you know, being able to do something tactile with their hands while they are expressing or telling the story."

TEXT CARD: Speaking with Young Survivors Privately

There may be issues that a young survivor does not want to discuss in front of her parent or guardian. Take a few minutes privately to explore these issues.

Suggested questions include:

- Has this (sexual assault or abuse) happened before?
- Is the person who did this someone you know? Do you know where he is?
- Did he say something bad would happen if you told anyone?
- Is there anything else you'd like to talk about?

TEXT CARD: Child Abuse

- Many young sexual assault survivors are subject to ongoing abuse.
- An examination may not reveal signs of injury because sexual assault of young people does not always involve physical force as much as coercion and manipulation.

TEXT CARD: Child Abuse

- Children are often abused by family members or neighbors.
- Most information suggesting child abuse is gathered while taking the history.
- A suspected parent should not remain with the child.
- Clinic staff should work with social services to be sure the child has a safe place to go to (not home with a suspected abuser).

EXPLAIN:

Internationally a child is defined by the Convention on the Rights of the Child as someone under 18 years old, but national laws may be different. The universal human rights we reviewed in the beginning all apply to children, even if there are limits to their right to self-determination and confidentiality. Explain to the child what information you will keep confidential and what information you will share with others.

Children are unable to give legal consent to services, but they should not be compelled to undergo an examination or treatment. Include children in the decision making as much as possible.

✗CORRECTION:

In the video the time the doctor spends alone with Lawan is very short. In reality the interview can take quite a long time. It would be appropriate to repeat all the questions again with the child alone to get more information and the child's perspective and to check for inconsistencies.

EXPLAIN:

Parents may be uncomfortable leaving the child alone with the provider. You cannot force this, but only make sure that parents understand the process. If a parent will not leave the child alone with the provider it may be because the parent is the abuser or is covering for the abuser. If you believe the child is in danger notify your supervisor and seek assistance from a local NGO, government agency, or law enforcement.

TEXT CARD: Assessing Child Abuse

If you suspect a case of chronic child abuse try to determine:

- whether the child has a safe place to stay
- how the sexual assault was discovered
- who did it, and whether he or she is still a threat
- when the abuse began and the date of the last incident
- if any siblings are at risk
- additional information suggesting a pattern of abuse

TEXT CARD: Reporting Child Abuse

- Refer to local child protection programs, gender-based violence programs, or other non-governmental agencies in your community.
- Reporting events can be harmful if a child cannot be kept safe.
- Be familiar with who can serve as an expert witness in cases of child abuse.



VIDEO: Physical Examination Guidelines (01:23)

TEXT CARD: When a Child is Distressed

Following are recommended measures if a child is highly distressed:

- Delay or omit the examination entirely unless there is pressing medical need (acute injury, infection or bleeding).
- Do not restrain or physically force a child to be examined.

TEXT CARD: Distressed Child in an Emergency

- If a highly distressed child requires a physical examination because of an emergency situation, consider sedating the child.
- An example would be when there is vaginal bleeding heavy enough to be life threatening.
- In general, sedation is not recommended and should be used very carefully.

TEXT CARD: When to Perform a Genital Exam on a Child

DO conduct an external genital exam on a child under the following conditions:

- The attack was recent enough (within five to seven days) that injuries might still be evident.
- The child is calm and agrees.
- The parent/guardian provides consent.
- If the parents are seeking a medical certificate or other documentation.
- The history suggests the possibility of genital injury.

EXPLAIN:

When we talk about child abuse we are focusing on abuse within the family. Incest and other forms of child sexual abuse put the child at higher risk for repeated assault and are often kept secret. It can be very difficult to determine whether a family member is the abuser. The child may not tell you and it can be difficult to interpret the child's behavior

DISCUSS:

- What resources are available locally?
- Who can children be referred to in cases of abuse?
- What happens in your community when an event is reported?
- Are there negative consequences to reporting events?
- What are the laws in your country regarding mandatory reporting?

EMPHASIZE:

Evaluate each case individually, always considering the best interest of the child. Lots of things come into play in determining the best interests of the child; there is no one factor used to determine the child's best interests. Health workers must consider the child's views/wishes, the views/ wishes of family/caregiver, potential and identified risks for future harm, and the family/caregiver environment. If protection cannot be assured, it may be harmful to report.

TEXT CARD: When NOT to Perform a Genital Exam on a Child

Do NOT conduct an external genital exam on a child if:

- The child does not wish it and there is no compelling medical reason.
- You cannot obtain consent from the parent/guardian.
- The history does not suggest possible genital injury.

NOTE: Do NOT conduct a genital exam to determine virginity. This is not an appropriate action for a health worker.

STOP AND DISCUSS **5 MINUTES**

VIDEO: Pelvic Examination (02:18)

IMAGE VIEWER: Common Injuries in Young Survivors

TEXT CARD: Vaginal Speculum Examination in Children

In most cases, a speculum exam is NOT indicated. It is ONLY indicated when the child may have internal bleeding from a penetrating vaginal injury.

- In this case, a speculum examination is usually done under general anesthesia.
- The child may need to be referred to a higher level health facility for this procedure.
- For small girls, a nasal speculum may be more appropriate than a vaginal speculum.

NOTE: Whenever possible, do NOT do a speculum exam on girls who have not reached puberty. It is extremely painful and may cause injury and further trauma.

To avoid sensitive images, cover the projector before advancing.

TEXT CARD: Examining a Male Child

- Check for injuries to the skin that connects the foreskin to the penis.
- Check for discharge at the urethral meatus (tip of penis).
- In an older child the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child.

TEXT CARD: Performing an Ano-rectal Examination on a Child

- Examine the anus in all children (boys and girls). Look for bruises, tears, or discharge.
- Help the child to lie on her back or on her side. Avoid the knee-chest position, as assailants often use it.
- Do not perform a digital examination unless an internal rectal injury is suspected.

DISCUSS:

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

EMPHASIZE:

There is no medical test for virginity. Every hymen looks different.

 **To avoid sensitive images stop at 00:40 sec. when the narrator says "Cover instruments you will not use." Restart at 01:42. when the doctor asks, "How are you, Lawan?"**

 **To avoid sensitive images cover projector before hitting next and skip image viewer.**

EXPLAIN:

In the last of these images there is no way to tell whether the ragged hymen is due to sexual penetration or is a normal variant.

 **To avoid sensitive images cover the project and read this text card.**

TEXT CARD: Treatment, Prevention, and Follow-Up

- Although children require dosage adjustments based on their size, they have the same prevention, treatment, and follow-up needs as adults.
- Reassure young survivors, reminding them and their parents or guardians that wounds heal quickly.

TEXT CARD: Ongoing Infections or Discharge

During follow-up visits, if a vaginal or anal infection or discharge still exists after treatment, consider the following possibilities:

- A foreign body may still be inside.
- Sexual abuse may be continuing.

VIDEO: Pregnancy Prevention for Young Survivors (00:55)**CASE STUDY: Caring for a Young Survivor**

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

Question #1: What is the appropriate message to convey to the patient in terms of her injuries?

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

Answer: E. Explain to the patient that the assault caused a small tear in the vaginal opening. This wound is similar to a cut on the inside of the mouth that she might have experienced after biting her own cheek while chewing, and it will heal with similar speed. No one will be able to tell from looking at her genitals that she was penetrated. A speculum exam is not indicated because she is not actively bleeding and the source of the prior bleeding was found.

Question #2: The patient has not yet begun menstruation. Should you offer EC to this patient?

- A. Yes
- B. No

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

EMPHASIZE:

As soon as a girl develops breast buds or other secondary sexual characteristics, she is a candidate for ECP.

VIDEO: Mental Health and Treatment Referrals (02:59)

[LAUREN BIENKOWSKI] “The social worker can also act as advocate, in providing emotional or psychological education as well as support. So I think that that's extremely important. I think as girls--women--who go back home, sometimes the effects, the emotional effects, of rape can take place months down the road. Because initially they're coping they are surviving—some of those coping mechanisms come right into play, but then, as time goes on, the community, the family, has moved on, but that individual--it's harder for them to move on.”

[SUSAN PURDIN] “The solution or the healing of a sexual assault isn't just what happens in the clinic. It takes a psychological opportunity--or an opportunity for psychological healing, and that may mean a referral to counseling services or social services. It takes an opportunity for justice, and that may require a referral to a legal system; to a police force or to a court system. So that sexual assault isn't an isolated illness. It's a community illness that requires a network of support for healing.”

TEXT CARD: Common Behavioral Reactions

Explain to parents or guardians that young survivors may exhibit the following reactions:

- clinging to caregivers
- nightmares, trouble sleeping, or fear of the dark
- hyperactivity or inactivity
- stop growing (stunting)
- aggressive or sexualized play
- bedwetting
- refusal to talk or to eat
- complain of headaches or stomach aches
- depression and withdrawal
- plans for revenge

TEXT CARD: Tips for Parents of Child Survivors of Sexual Assault

- Children do not lie about being sexually assaulted.
- The child is not responsible for the assault and should not be blamed.
- It will take the child some time to recover from this difficult experience.
- Hug, hold and comfort the child frequently.

TEXT CARD: Tips for Parents of Child Survivors

- Encourage the child to draw pictures or to express herself through play.
- Explain to parents that reactions like bedwetting are likely to stop as the child begins to feel safe, and that punishment for such behavior is not helpful.
- Encourage parents to listen to their children and help them talk about their feelings, nightmares, and flashbacks.

EMPHASIZE:

Reactions depend on age as well as what happened and the context of the situation. In general younger children may take a backward step in development.

 **REFER to CCSAS Psychosocial Toolkit, Topic 5: Survivor-centered Communication with Children for more information.**



STOP AND DISCUSS

 5 MINUTES**TEXT CARD: Applying Your Training**

Remember sexual assault can happen to anyone and it is different for each person. It is an intensely personal and traumatic experience. Your job is to listen without being judgmental and to provide the highest quality health care you can while being sensitive to the needs of each individual.

VIDEO: Applying Your Training (00:37)

[SUSAN PURDIN] ‘This training is designed to help us as service providers to develop the skills to provide good care to people who have survived sexual assault. And, it doesn’t end with this experience—this training opportunity. That we’ve learned some skills. We need to apply those skills, and we need to retrain ourselves to maintain those skills so that we’re giving the kind of care that people deserve. Again, the compassionate, competent, confidential care for any survivor of sexual assault.’

 GO TO EXERCISE 7
 30 MINUTES

END OF SECTION
PROCEED TO SECTION 5
(Optional Forensic Evidence Collection)

DISCUSS:

What are ways parents use to comfort their children in your community?

EMPHASIZE:

Caring for a child is very sensitive and difficult. Do not hesitate to seek assistance. By adhering to the same principles as you do with adults while adapting your approach to the child’s level of development, you can make a real difference for the child and family.

EXERCISE 7: PRESCRIBING TREATMENT

This exercise summarizes and reinforces the primary elements of treatment. Participants work in groups to review case studies and determine correct treatment. Each group should then present their case and the appropriate treatment. Allow time for discussion and clarification. (See page 92 for complete directions and answers.)

 **HANDOUT: Case Studies (p. 125)** **HANDOUT: Timing and Treatment (p. 129)**

Section 5: Collecting Forensic Evidence may seem inappropriate in many settings and can be omitted, but we recommend using it because it reinforces many of the messages in previous sections. It can also help demystify what seems very technical and difficult, but is in fact a fairly simple procedure that will help to bring justice and help end impunity in cases of sexual assault.

If you are using section 5, skip ahead to it now and then return to **Section 4: Preparing Your Clinic**.

SECTION 4: PREPARING YOUR CLINIC

In this section, you will learn how to:

- Assess your clinic's resources
- Organize the staff and materials needed to care for survivors
- Map out your referral network

VIDEO: Coordinating Care through a Referral Network (01:35)

[ANTONIUS L. LANSANA] “We have some referral systems in place and these are very important in the work we do. In the first place you know we, we work with other partners because rape and all other of sexual assault are community issues that need the input of other actors.”

[NARRATOR] When your clinic cannot provide everything a survivor needs, use your clinic's referral network. Make sure your clinic can refer patients to the following:

- A women's center where sexual assault survivors can safely stay for longer periods of time.
- Higher-level medical care.
- A counseling center.

Good communication with referral facilities is important, so that you can contact them and prepare them to care for the patient, and get feedback on how best to prepare survivors for the referral. Transportation to take a survivor to another facility should be readily available. If your clinic does not have a car and driver, you can negotiate with a local car-for-hire to be prepared to assist your clients.

[WILMA DOEDENS] “The clinical management has to go hand in hand obviously with counseling and proper examination and further crisis intervention referral.”

[NARRATOR] Every clinic is different. Some will have many resources, most will have very few. As a clinic worker, it is important that you are proactive. Do the best with what you have to make sure a survivor receives the best possible care in your clinic.

NOTE: Managers and key non-clinical staff rejoin the training at this point.

LEARNING OBJECTIVES:

Participants will be able to:

- Map out current patient flow and response to sexual assault survivors and identify areas for improvement.
- Use the checklist to develop a draft work plan improving facility practices to meet standards for CCSAS and the adaptation and implementation of the CCSAS protocol.
- Describe the information needed to adapt the protocol to your local setting.
- Describe what referral resources are needed for sexual assault survivors.
- Determine what resources are currently missing in your referral network and develop a plan for filling gaps and improving communication between the various organizations.
- Describe the resources available to inform your work with sexual assault survivors.
- Describe what resources are available at the country and TU level to support CCSAS.

EMPHASIZE:

Referral forms should never include details of the assault or identifying information.

TEXT CARD: Establishing a Response to Sexual Assault Survivors

Steps in establishing a response to sexual assault survivors:

- train ALL staff on the basic principles of responding to sexual assault
- adapt protocol to local context and laws
- identify medical staff who will care for survivors and train them
- identify location for confidential examinations and stock it with needed materials
- identify and train translators and any partner organizations supporting survivors
- establish a referral network for social support services

TEXT CARD: Assess Your Clinic's Resources

- It is essential that your clinic is well organized and stocked with supplies to care for sexual assault survivors.
- Private examination areas are particularly important for maintaining confidentiality and helping the patient feel as comfortable as possible.

TEXT CARD: Essential Clinic Resources

- a private room for examining the survivor with both sound and visual privacy
- good lighting
- access to a latrine
- stocked supply of appropriate drugs
- stocked supply of administrative materials
- forensic evidence supplies (if applicable)

NOTE: Sample forms can be found by clicking on the Pictograms and Forms link in the Facilitator's Guide section at the end of the DVD.

TEXT CARD: Organize staff and materials

All clinics are different, and it is important to know how yours operates and what you can do for a survivor of sexual assault. It is also important to know what your clinic is not able to do.

Even if your clinic does not meet the standards described in this presentation, provide survivors with the best care you can.

TEXT CARD: Organize staff and materials

All clinics should have:

- a health care provider specifically trained to care for sexual assault survivors on-duty or on-call at all times
- a protocol adapted to the local context and laws related to sexual assault
- a plan for referring the survivor for mental health, legal and other support services

DISCUSSION CARD: How your clinic receives sexual assault survivors

- When a survivor of sexual assault arrives at your clinic, what happens?
- Do you have a collection of drugs, supplies and equipment ready?
- What services does your clinic currently provide?
- What more could you do to improve current practices?
- Review the checklist (in Facilitator's guide)

'Y' EXERCISE 8

 **45 MINUTES**


BREAK

DISCUSSION CARD: Referral Network

- When patients need higher level medical care than you can provide, where do you refer them?
- What are the procedures for referring patients to outside care?
- What referral counseling services are available in your community to survivors of sexual assault?

Map out your referral network. It should include :

- a higher-level care facility with surgical capacity
- a psychological counseling center
- a women's center
- legal support
- agencies, clinics, or groups specific to your community

EXERCISE 8: TRACING A SURVIVOR'S ROUTE

Have participants draw out a map of their clinic and show how the survivor would move through from entry to discharge. (See page 97 for complete directions.)

 **HANDOUT: Checklist for Clinical Care** (p. 132)

 **HANDOUT: Using Translators** (p. 133)

DISCUSS:

What are the gaps in your referral network? Are there organizations or groups you should connect with? Think about social organizations, church organizations, etc., that may be able to help in the absence of professional social workers. List some possible resources on flip chart.

 **HANDOUT: Help-seeking Referral Pathway** (p. 131)

 **REFER to CCSAS Psychosocial Toolkit, Topic 4: Different Roles, Different Goals**, helping survivors access services for more information the multi-sectoral response to sexual violence.

EXERCISE 9: ACTION PLAN

Develop an action plan with time line, assigned responsibilities and follow-up plan. (See page 97 for complete directions)

 **HANDOUT: Action Plan** (p. 134)

 **REFER to CCSAS Psychosocial Toolkit, Topic 7: Self-care for providers.**

**Return to topic of self-care for providers
(introduced in section 2).
Discuss stress and self-care.**

END OF TRAINING

SECTION 5: **FORENSIC EVIDENCE COLLECTION**

In this section you will learn how to:

- Conduct a compassionate, competent, and confidential forensic examination
- Obtain forensic specimens that can be used as evidence
- Properly document and store collected evidence to ensure permissibility in court

TEXT CARD: National Legal Guidelines

This presentation provides general guidance on standard practice. Be sure to follow appropriate national legal guidelines. Evidence collected or stored incorrectly may be inadmissible in court jeopardizing the survivor's ability to obtain legal justice.

VIDEO: Introduction to Forensic Evidence Collection (01:19)
[CARMEN LOWRY] "The forensic evidence that comes into, has to do with the fact that her body has become the scene of a crime. And so there are certain types of evidence that can be gathered that later can be used for prosecution if she decides to prosecute. It really, in my mind, it allows for health care workers to become part of-a larger part of-a solution. They are providing this care, that they are clearly trained and very capable of providing, but then they also become part of a larger group of people who are working to end and to respond this violation of a person's human rights by collecting evidence."

TEXT CARD: Forensic Evidence

Forensic specimens collected may be used as evidence to:

- support the survivor's story
- confirm recent sexual contact
- prove that physical force was used
- identify the assailant

TEXT CARD: Time Sensitive Evidence

Samples should be collected as soon as possible. More than 72 hours after the incident, the amount of evidence that can be collected is greatly diminished

VIDEO: Collecting Forensic Evidence (01:25)

TEXT CARD: Preparing for the Forensic Examination

Before collecting forensic evidence, know the local laws and your clinic's protocol, including:

- which medical practitioners can collect admissible evidence and testify in court (e.g., nurses or doctors)
- types of evidence permissible in court
- forensic evidence tests that are possible in your healthcare system
- local guidelines on evidence collection, storage, and dissemination

TEXT CARD: Supplies

The supplies you will need for a forensic examination include:

- sterile swabs and a rack for drying them
- urine and blood sample containers
- clean white paper, paper bags, envelopes and a box

NOTE: This section relies heavily on video and uses few text cards. The narrator's script from the video is included for your reference.

LEARNING OBJECTIVES:

Participants will be able to:

- Describe the reasons for collecting forensic evidence.
- Describe the types of forensic evidence that can be collected.
- Describe proper packaging of samples.
- Explain why evidence collection should be done as soon as possible after the assault and what activities in particular reduce the quality of the evidence.
- Describe the process of consent for a survivor wishing to have evidence collected.

 **REFER** to local guidelines on collecting and storing forensic evidence.

NOTE: Sample forms can be found by clicking on the Pictograms and Forms link in the Facilitator's Guide section at the end of the DVD.

- unused comb
- wooden stick (e.g., toothpick) for fingernail scrapings
- sterile saline, sterile water, glass slides
- gown or alternative covering for patient
- spare clothes to replace those taken as evidence
- legal forms and pictograms

TEXT CARD: Informed Consent

You must get informed consent before collecting any evidence.

- Explain every step of the process.
- Discuss how evidence will be used, stored, and shared.
- Reinforce that evidence can only be collected during the first exam but she can later choose whether to use it or destroy it.
- The patient may choose not to have any evidence collected. Respect her choice.

TEXT CARD: Forensic Evidence and Criminal Prosecution

Even though a survivor initially may be unsure about reporting to the police or prosecuting, she may later decide she wants to prosecute her assailant. In fact, seeing justice done can be helpful to her psychological recovery, although the legal process can also be very long and difficult.

Collecting forensic evidence makes it much easier to pursue a prosecution later. After the samples are collected, the evidence collection kit should be kept in a secure place. After a set amount of time it should be destroyed if it has not been used. It is turned over to the police only when a survivor signs the release of information.

TEXT CARD: Patient Education

Important points to discuss with the patient before collecting forensic evidence:

Benefits

- Evidence collected may help her seek legal action.
- Evidence can only be collected during the first exam.
- The collection process is fairly simple and takes place during the exam.
- Collected evidence does not have to be used.

Disadvantages

- Collecting evidence may prolong the physical exam.
- There is no guarantee that the patient will be able to take her case to a court of law.
- If she does take her case to court, there is no guarantee her assailant will be convicted.

VIDEO: Documenting the Survivor's History (03:51)

TEXT CARD: Documenting the Survivor's History

Documentation should include a detailed description of:

Elements of force used

- type of violence used, including weapons
- threats of violence made by the assailant
- use of restraints
- number of assailants

Description of sexual acts

- kissing, biting, or licking
- type of penetration

EMPHASIZE:

She does not need to make a decision about whether or not to press charges against the assailant right now. By collecting evidence during the first exam she is keeping her options open. The evidence can be destroyed later if she wishes.

EXPLAIN:

In this video, we assume that she has already been informed of the process and her options and has given consent even though we do not see the doctor going through the process.

EXPLAIN:

It is not enough to ask if she wants to prosecute. She needs to understand what exactly her options are and what the forensic exam involves (see patient education text card below). Once she fully understands she can decide whether to sign the consent form.

- ejaculation in or on the body
 - use of a condom during the assault
- Post-assault activities by the survivor (bathing, urinating, etc.)
History of physical trauma not related to the episode.

TEXT CARD: Collecting Specimens before the Physical Exam

A survivor's clothing may contain evidence such as seminal fluid, soil, grass or leaves.

VIDEO: Collecting Evidence Before the Physical Exam (01:21)

VIDEO: Collecting Evidence During the Physical Exam (02:58)

[NARRATOR] While conducting the physical examination, look for any foreign materials that may be found on the patient's skin or hair, such as grass or leaves. Collect these materials as evidence.

If the patient has not bathed after the assault, saliva (where the assailant licked, kissed or bit her) or semen stains may be found on her hair or skin. Use moistened swabs to collect any potential dried secretions; then air-dry them thoroughly to preserve them as evidence.

If the assailant ejaculated into the patient's mouth, and the patient arrives at your clinic within 12 hours of the assault, collect samples from the mouth. Use a swab to rub the gums opposite the upper and lower teeth on both sides of the mouth. These samples may be examined for presence of sperm.

The underside of fingernails may contain evidence, such as fragments of the assailant's skin, blood, facial hair, or other foreign material from the assault site. Obtain specimens from the fingernails by scraping under them with a toothpick or small swab or by cutting the nails closely over a clean sheet of paper. Fold the toothpick, and debris into the paper, place it in an envelope, and package it with the other specimens.

Collect forensic specimens such as saliva or trace material prior to washing patient wounds. Document any injury findings on the examination form and on body diagrams in a clear and detailed way.

Before conducting the pelvic examination, place a clean sheet of paper below the patient's buttocks. Explain to the patient why you are performing this task and allow her to assist you if she feels more comfortable doing so. With the patient's knees bent and legs relaxed to the sides, comb the patient's pubic hair onto the paper for foreign material, particularly pubic hair belonging to the assailant. Fold the comb and pubic hairs collected into the paper and place them directly into a large paper envelope. Label the envelope.

TEXT CARD: Documenting Injuries

Describe all injuries clearly and in detail. Record the following characteristics in words and on the pictogram:

- type of injury, position, size, depth
- description of the wound's edges and surrounding tissue
- any evidence of the age of the injury, such as scar tissue, color of bruises
- make sure to document any older injuries or scars that could not be a result of the assault

EMPHASIZE:
New combs should be used each time to avoid any possibility of contamination of the evidence.

⚠ VIDEO: Collecting Evidence from the External Genitalia and Anus (00:30)

[NARRATOR] While examining the external genitalia, use separate cotton-tipped swabs moistened with sterile water to collect samples from the skin around the anus, perineum and vulva. Take swabs from around the anus and perineum before the vulva, in order to avoid spillage of vaginal contents into anal areas and confusing the source of forensic evidence.

⚠ VIDEO: Collecting Evidence from the Vagina and Rectum (02:15)

[NARRATOR] When forensic evidence is being collected from adult women, a speculum exam is indicated to obtain a vaginal sample. Remember that all patients have the right to refuse this portion of the exam.

Lubricate the speculum with warm water. Avoid using a commercial lubricant since some products have ingredients that damage evidence.

Using a cotton-tipped swab, collect fluid from the area below the cervix (or posterior fornix). Put a drop of the fluid collected on a slide, adding a drop of normal saline, if necessary.

Air dry the swab at room temperature, label it, and send it to the lab for DNA analysis.

Examine the slide under a microscope. Note the mobility of any sperm. Keep in mind that the chance of finding sperm that are still alive and moving from a vaginal wet mount more than eight hours after intercourse is very small, because sperm die quickly.

If the patient has presented after 48 hours, getting a cervical mucus sample maybe helpful. Using a separate cotton-tipped swab collect specimens from the cervical os. Air dry the swab at room temperature and send it to a lab for DNA analysis.

Samples examined by the crime lab may show sperm from the posterior fornix for up to approximately five days and from the cervical os for up to approximately 12 days after sexual assault.

If the patient refuses a speculum exam, you may, with her permission, obtain a vaginal sample by inserting a swab three to four centimeters into the vagina and aiming posteriorly (towards the patient's back).

If indicated from the patient's history, collect samples from the patient's rectum for examination for sperm and DNA analysis.

Air dry the vaginal and rectal swabs at room temperature, label them, and send them to the lab for DNA analysis.

After you have completed the examination, document all evidence collected on the patient's medical examination form.

⚠ To avoid sensitive images cover the projector at 00:15 when the narrator says, "Use separate cotton tipped swabs moistened with sterile water." Uncover again at 00:25 when the narrator says, "Take swab from around the anus and perineum before the vulva."

⚠ To avoid sensitive images cover the projector at 00:25 when the narrator says, "Avoid using a commercial lubricant since some products have ingredients that damage evidence." Uncover again after 10 seconds. Cover again at 01:00 when the narrator says, "...from a vaginal wet mount more than eight hours after intercourse is very small, because sperm die quickly." Uncover at 02:00 when the narrator says, "Air dry the vaginal and rectal swabs at room temperature, label them, and send them to the lab for DNA analysis."

📄 HANDBOUT: Vaginal Wet Prep (p. 110)

TEXT CARD: Vaginal and Cervical Samples

A vaginal swab may be all that is needed and can be done without a speculum by gently inserting the swab into the vagina.

Perform a vaginal speculum examination to collect a cervical sample if:

- The patient reports penile-vaginal penetration.
- The patient consents to the speculum exam.
- Time between assault and examination is more than 48 hours.
- Keep the vaginal and cervical samples in separate envelopes.

TEXT CARD: Control Sample DNA

A control sample of the survivor's DNA is needed to compare to the evidence collected.

This can be from either a buccal swab (the inside of the cheek) or a blood sample. The buccal swab is preferred unless there is another reason to take a blood sample.

Always follow the guidelines where you work.

TEXT CARD: Special Considerations Regarding Children

External anal and vulvar swabs:

- Usually collected without difficulty on a child of any age

Vaginal specimens:

- Do not use a speculum on any prepubescent child.
- Use a dry sterile cotton swab to collect vaginal specimens.
- Vaginal specimens may be difficult to obtain from very young children and should be the last specimen collected.

Review your local policies regarding forensic specimen collection in children.

TEXT CARD: Special Considerations for Men

- Swab the outer surface of the patient's penis with a moist swab.
- Collect anal specimens in the same way as you would from a female patient.

VIDEO: Preparation, Storage, and Dissemination of Evidence (01:32)

[NARRATOR] To ensure that evidence will be admissible in court, the chain of evidence must be maintained at all times. This means that evidence must be collected, labeled, stored, and transported properly.

All objects sent to the lab for analysis, such as clothing, cloths, swabs, or sanitary pads, need to be well dried at room temperature and packed in paper bags or envelopes.

Do not use plastic bags as they do not allow for proper drying and could lead to bacterial or fungal growth that can destroy the evidence.

Samples, such as swabs or clothing can be tested for DNA many years after the assault, provided the material was well dried. Blood and urine samples can be stored in the refrigerator for up to five days. To keep the samples longer they need to be stored in a freezer.

Clearly label all samples collected. Labeling should never include the patient's name or initials. Instead, write the patient's confidential identifying code and note the date, time, type of sample and where it was taken from, and the collector's name.

Put the samples in a container. Seal the bag or container with paper tape across the closure. Write the patient's identifying code and the date and sign your name across the tape.

TEXT CARD: Chain of Evidence

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

VIDEO: Release of Evidence (00:34)

VIDEO: The Importance of Forensic Evidence (02:05)

[LILIAN KIAPA-IWA] "Forensic evidence is very important. Especially if the survivor wants to seek the legal path. And in our setting, I would like it to be done on a routine basis."

[SUSAN PURDIN] "Some of the care that we give is basic care to heal injuries and psychological injuries. But also we have the opportunity as clinicians to collect forensic

evidence. So that perpetrators can be taken to court and prosecuted. So that those criminals who have committed these acts are treated as the criminals that they are. And society no longer treats the victim as the bad person, and allows the perpetrator to go free. And as clinicians, we have the responsibility to collect evidence that can be used to further the justice that needs to happen in these settings. Many of the situations where we work, it's very difficult. The legal system doesn't work very well, justice is hard to come by, the community's reluctant to deal with it. Women are reluctant to take cases to court because it exposes them as well. But if we're able to collect evidence and help move the system so that that justice can be provided, we can help change the world. We can help reduce the incidence of sexual assault. The more people are held to account, the more people are prosecuted, the more justice that is available in the communities where we work, the less this assault will occur, the fewer women who will suffer, and the healthier our communities will be. So even though it's difficult to collect forensic evidence, or even though you may not be able to take a case to court right now, maybe next month, maybe next year, maybe in the future, there will be fewer incidents and more prosecutions. And, the community will be healthier."

NOTE: A sample release of information form is included in the pictograms and forms link in the facilitator's guide section at the end of the DVD.

DISCUSS:

- Do you think forensic evidence could be safely collected and stored in this facility?
- Would it help survivors to have physical evidence of their assault?
- Have you ever heard of a case going to court? What happened?



STOP AND DISCUSS



10 MINUTES



BREAK

**END OF CLINICAL SECTION
MANAGERIAL STAFF SHOULD RETURN FOR
SECTION 4: PREPARING YOUR CLINIC**

Exercises and Handouts

CHAPTER 4

Exercises

(Handouts for the exercises are in the “Participant Handouts” section, starting on page 98.)

1. Compassion, Competence and Confidentiality Role Play
2. Informed Consent
3. Active Listening
4. Documenting the Examination
5. Talking with Suicidal Patients
6. Responding to Common Emotional Reactions
7. Prescribing Treatment
8. Tracing a Survivor’s Route
9. Developing an Action Plan

I. Compassion, Competence and Confidentiality Role Play (40min) (Page 37)

This exercise serves as a summation of day one of the training. It will both confirm and reinforce participants’ understanding of the concepts. Have participants act out at least 2 of the scenarios listed on the handout on page 100. They will need to spend some time discussing the situations and developing a more detailed “story”. If it is a small group, then each member of the group can be assigned one role and a single play with a series of scenes can be developed. Larger groups can be divided and each small group assigned a scenario to enact. Give each group 15 minutes to develop the scenario and 3 minutes to act it out for the larger group. Allow 5 minutes for the larger group to provide feedback after each role play.

The role plays should emphasize that all clinic workers should:

- encourage survivors to seek care as soon as possible and within 72 hours.
- help survivors get care as soon as possible.
- protect the confidentiality of survivors (and all patients).
- avoid asking questions beyond the minimum necessary to do their job and get the survivor the care she needs.

Remember:

- survivors are never to blame for the assault; they deserve the best possible care without any judgment.
- many health consequences of sexual assault can be prevented if a survivor gets care as soon as possible, ideally within 72 hours.

2. Informed Consent (15 min) (Page 41)

This exercise is an opportunity for participants to practice obtaining informed consent. Obtaining informed consent is more than just reading a list to a survivor. It involves helping the survivor understand what to expect during the clinic visit and answering any questions that she might have. This is an important and difficult skill to master and requires practice.

Instructions:

Divide participants into groups of two. One participant will act as a care provider and the other will play the role of a patient. The participants will role-play the consent process. The ‘provider’ will go through the entire consent form and explain the form to the ‘patient.’ Where appropriate the person portraying the patient should ask for more explanation.

Move between groups throughout the room and offer suggestions or constructive comments as the process is ongoing (Be selective! You can’t stop a group every time. Only stop them for serious problems!). You should also make note of problems that many groups are having and the areas in which they do well.

If time permits, allow the participants to change roles, so that each person has the opportunity to play the role of patient and care provider.

After finishing the role play, ask the participants to share how they felt as they played the role of care provider and obtained informed consent. Was it difficult to explain? Do they have any questions? How did the patients feel?

End the exercise by pointing out some of the positive points that you noticed during the role play exercise, as well as some of the problems that you observed. Make your comments general and do not identify specific groups or individuals as you share your observations. It is important to point out both the positive and the negative things that you observed, in order to keep the participants motivated. Give general advice. For example if you noticed that in several groups the ‘care provider’ was going very fast and did not stop to ask the patient if she had questions you might say, “Remember how important it is during this process to engage the patient. Some patients will be too scared to ask questions. You should go slowly and ask them several times throughout the consent process if they have any questions. This will help them feel more open about sharing their concerns and questions.”

3. Active Listening (30 min) (Page 43)

As the care provider interviews the survivor, it is important to gather appropriate information, so that her story can be documented accurately. This information will also guide the process of examination and treatment. It is very important to do this without re-traumatizing her and in a way that validates her experience and helps begin the healing process. The purpose of this exercise is to give participants a chance to practice their active listening skills. Active listening means being focused on the person speaking in order to fully understand what he or she is saying in a non-judgmental way.

Active listening techniques:

- Express your interest and concern with your body as well as your words.
- Begin with open ended questions like “Tell me about what happened. . .” Get more specific as necessary only after she has finished relating the story.
- Do not interrupt or rush her. Respect silence by waiting attentively or use supportive statements like, “I know this is difficult for you” or “I am here to listen.”
- Acknowledge her emotion with statements like, “I can see you are feeling. . .” Never discount the survivor’s feelings by using phrases like “It is not that bad.” or “Do not let it bother you.”
- Validate her feelings with statements like “It is normal to feel . . .” or “People who experience sexual assault often feel . . .”

- Avoid “why” questions. They often make the responder feel judged.
- Check that you understand correctly by repeating back to the survivor what she has said (summarize).
- Do not offer opinions or advice. Give the survivor the information she needs to make her own decision.

Instructions:

The group should be divided into sub-groups of three, with a speaker, a listener, and an observer.

To the speaker: You should talk about something that is a real concern to you. You do not need to share anything that is very private or embarrassing. Sharing a real part of your life, however, will make this exercise both more interesting and more useful. Be sure to pause often to encourage the listener to respond, even though this may seem a bit unnatural.

To the listener: Practice active listening techniques. Acknowledge and validate what the speaker says. Summarize to see if you understand correctly. Try to ask open-ended, non-judgmental questions to get more information.

To the observer: Concentrate on the person in the listener role, looking for as many active listening skills as possible. Give feedback at the end of the interview. Help the listener learn by pointing out areas needing improvement.

Each interview should last about 5 minutes. At the end the speaker should describe his or her experience (Did she feel listened to?) and the observer should comment on what she saw. If time permits the exercise can be repeated twice, after changing roles. The exercise can also be done without the observer, with only the speaker and listener.

These instructions are also included as a handout on page 105.

4. Documenting the Examination (30 min) (Page48)

The objective of this exercise is to give participants an opportunity to practice translating a survivor’s words into medically accurate terminology to complete the medical history and exam form. At the end of the section on the medical exam (Section 3c), there is a 17 minute video showing the entire history and examination done by Dr. Ngozi. Each participant should get a blank copy of the sample history and exam form (page 113) to fill out while watching the video. Briefly review the different sections of the form then instruct them to listen and watch carefully to see how much information they can gather. Afterwards, review as a group the information that participants were able to collect.

Elements that should be included are:

- The story in the survivor’s own words
- The survivor’s emotional state, general condition and appearance, including the condition of her clothing
- Vital signs
- A clear description of injuries in medical terminology, using pictograms
- Medical history and details that will direct treatment, such as last menstrual period, use of medications, pregnancy status, history of HIV testing, allergies

Be sure that the terminology participants used was appropriate and accurate. Also ask participants to identify any elements missing from Dr. Ngozi’s interview.

Documentation Exercise Answers

Medical History and Examination Form

1. General Information

Sex Female	Age 20
Date/time of examination: 25/01/08 (dd/mm/yy)	Interviewed in the presence of: <input checked="" type="checkbox"/> (note presence of translator, parent, other)

2. The Incident

Date of incident: 23/01/08 (dd/mm/yy)	Time of Incident: evening (00:00 hrs)
Description of incident (survivor's description) Two men "grabbed me" "dragged me to a field" "one of them bit my breast and then raped me" the other one forced his "penis into my mouth"	

Physical Violence		Yes	No	Type and location on body
Type (beating, biting, pulling hair, etc.)		<input checked="" type="checkbox"/>		
Use of restraints		<input checked="" type="checkbox"/>		
Use of weapon(s)		<input checked="" type="checkbox"/>		
Drugs/alcohol included		<input type="checkbox"/>	<input type="checkbox"/>	not by patient
Penetration		Yes	No	Not Sure
Penis		<input checked="" type="checkbox"/>		
Finger		<input checked="" type="checkbox"/>		
Other (describe object)		<input checked="" type="checkbox"/>		
		Yes	No	Not Sure
Ejaculation		<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Condom Used		<input checked="" type="checkbox"/>		
Location: oral, vaginal, anal, other				

3. Current Signs and Symptoms

Note pain, bleeding, discharge from vagina or rectum, any other signs or symptoms

blood in underwear (small amount)

4. Medical History

Menstrual/obstetric history		After the incident, did the survivor (circle all that apply)		
Current contraceptive use? Yes No	Method	Vomit? Rinse mouth? Urinate? Change clothes? Defecate? Wash or bath? Brush teeth? Use tampon or pad?		
Last menstrual period (dd/mm/yy) 11/01/08	Menstruation at time of event Yes No			
Evidence of pregnancy Yes No	Number of weeks pregnant Q weeks			
End of last pregnancy (delivery, stillbirth, pregnancy loss)	Q (dd/mm/yy)			
Existing health Problems (Include history of female genital mutilation, type)				
Q				
Allergies: Q				
Current medication: Q				
Vaccination Status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus	X			
Hepatitis B		X		
HIV/AIDS status	Unknown	Known	Last tested	Comments
	X			

5. Medical Examination

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

healthy, well dressed, well appearing

Mental State (calm, crying, anxious, cooperative, depressed, other)

anxious but calm and cooperative

Weight:	Height:	Pubertal stage:	mature
Pulse Rate: 75	Blood Pressure:	Respiratory Rate:	Temperature:

Physical Findings: Describe systematically and draw on the attached body pictograms the exact location of all wounds, bruises, petechiae, marks, etc. Document type, size, color, form and other particulars. Do not interpret the findings. Note old bruises, scars or other signs of injury.		
Head and face abrasions on L forehead, 2x2cm	Mouth and Nose small, 1x1cm, laceration on lower lip mucosal surface	
Eyes and Ears normal	Neck purple hand shaped bruise on L of neck, tender	
Chest 5x3cm bite mark with bruising on L breast, scant bleeding	Back normal	
Abdomen Q tenderness Q bleeding	Buttocks normal	
Arms and hands normal	Legs and feet lateral L leg abrasions with superficial bleeding, 12x12cm	
Genital Exam		
Vulva/scrotum normal	Introitus and hymen small tear at 7 o'clock with redness	Anus normal
Vagina/Penis No speculum Exam DONE	Cervix	Bimanual/ rectovaginal examination
<i>Position of patient (supine, prone, knee-chest, lateral, if child - in adult's lap)</i>		
For genital examination: Supine	For anal examination: Supine	

7. Investigations Done

Type and location	Examined/sent to laboratory	Result
NONE		

8. Evidence Taken

Type and location	Examined/sent to laboratory/stored	Result
NONE		
History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date:	(dd/mm/yy)

8. Treatments Prescribed

Treatment	Yes	No	Type and Comments
STI prevention/treatment	X		arithromycin 1g + lefixime 400mg STAT
Emergency contraception	X		postinor, 2 tabs STAT
Wound treatment	X		Cleaned + dressed
Tetanus prophylaxis	X		(L) bicep
Hepatitis B vaccination	X		(R) bicep
Post-exposure prophylaxis for HIV	X		Combivir, Q12 hrs x 28 days = 56 given
Other			

9. Counseling, Referrals, Follow-up

General Psychological status Stable; not a danger to self		
Survivor plans to report to police OR has already made report Yes No Explain: X		
Survivor has a safe place to go: Yes No Has someone to accompany her/him: Yes No		
Counseling provided: health effects reviewed, how to take medication, when to return		
Referrals: UHURU women's Centre		
Follow up required: 2 week follow up; HIV test at 3-6 months		
Date of next visit (dd/mm/yy):		

Name of health worker conducting examination/interview: Dr. Ngozi

Title: MD

Signature: Dr. Ngozi

Date: 25/01/08

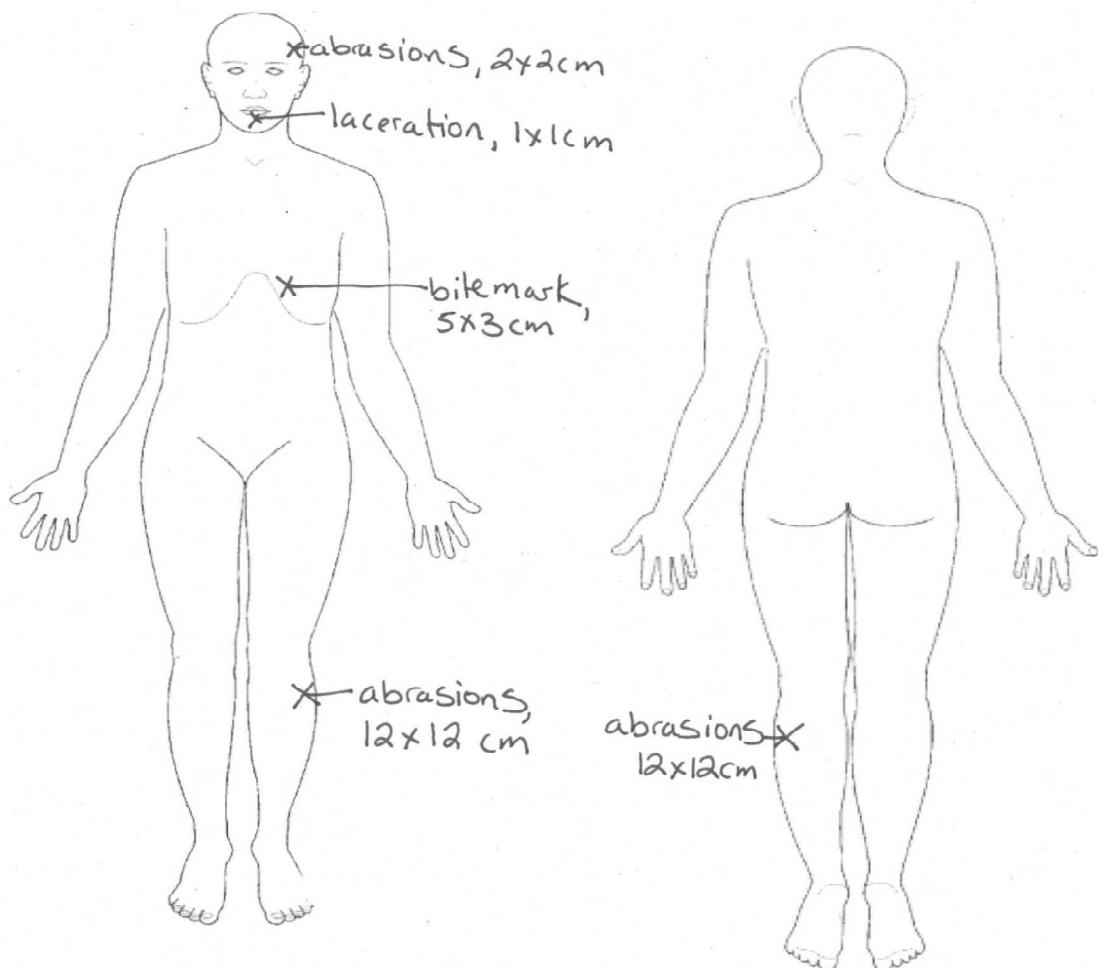
Follow up notes:

Date of follow up visit (dd/mm/yy):

Name/Title: _____

Signature: _____

Date: _____



5. Talking with Suicidal Patients (10 min) - Optional (Page 61)

The objective of this exercise is to practice talking with survivors who are under extreme emotional stress. Sexual assault survivors often contemplate suicide, but this is a subject that most health care providers feel uncomfortable discussing. The risk of a survivor committing suicide after making a suicidal statement varies among cultures, but a suicidal statement should always be taken seriously by the care provider. Explore the issue with your group and if the group feels that this issue comes up often allow time for them to practice by role playing with a partner using the suggested statements on the text card titled: "Suggestions for Asking about Suicide." If the suggested statements do not seem appropriate or adequate, have the group work together to formulate appropriate ways to ask about suicidal thoughts, assess risk and offer comfort and support.

6. Responding to Common Emotional Reactions (45 min) (Page 65)

In this exercise, the participants will explore the complex emotional responses that a sexual assault survivor may experience and practice communication techniques. Participants will play the role of a sexual assault survivor or of a person who is trying to support the survivor (a friend, family member, or care provider). Divide the participants into groups of two or three (depending on the size of the group) and give each group a slip of paper with one of the following emotions written on it:

- Withdrawn, silent
- Angry
- Sad, crying
- Fearful, anxious
- Nervous, embarrassed

Explain that survivors can experience any of these emotions, or all of them at different times. Give the groups 15 minutes to prepare a brief (5 minute) scenario illustrating how a survivor may exhibit this emotional reaction and how the provider could respond. The third member of the group can be either another staff person at the facility (a nurse, registrar, or assistant) or a friend or family member of the survivor. Optional: Ask at least one group to create a scenario in which a friend or family member is a negative influence needing to be controlled.

Written instructions are also included in the handout on page 124. The scenario should represent the first few minutes of the provider-patient interaction where the provider needs to gain the trust of the survivor, get a basic idea of what happened, and explain what services he or she can provide (the provider should not enact the physical examination in the scenario). Circulate around the room and observe each group as they develop their scenarios. Be sure that they are adhering to the good practices that they have learned thus far during the training (listening actively, validating the survivor's experience, not arguing or offering advice, etc.) and offer constructive suggestions.

Carefully time the presentations so that each group takes no more than 5 minutes. Sometimes less time may be needed to get the point across. Ensure that participants speak loudly enough for everyone to hear even if this seems a bit unnatural. Do not interrupt the presentation unless there is something inappropriate going on.

At the end of each presentation have viewers offer their observations and ask the presenters to comment on how it felt to act out the scenario. Reinforce good practices and briefly mention problems not already identified by other participants.

7. Prescribing Treatment (45 min) (Page 72)

This exercise summarizes and reinforces the primary elements of treatment for survivors of sexual assault. Participants work in groups to review the case studies (pages 125-128) and determine correct treatment. Each group should then present their case and the appropriate treatment. Allow time for discussion and clarification. Also use the second handout (Timing and Treatment, page 129) to summarize treatment by age and sex depending on how long after the assault the survivor is seen.

Key points:

- HIV testing soon after the assault will tell us whether the survivor was infected prior to the assault, not whether the assault resulted in infection. It can take several months after infection for a test to become positive.
- Pregnancy testing will reveal the existence of a prior pregnancy. Women who are pregnant should still receive prophylaxis for STIs and HIV with some adjustments.
- HIV testing should be considered for everyone, but children who have not previously had sexual intercourse and who have no health problems do not need to be tested.
Testing is voluntary and should never be a requirement for treatment.
Likewise, delays in testing should never lead to delays in treatment.

Prescribing Treatment for Survivors of Sexual Assault - Answers

Case Study I:

An adult woman survivor comes to the clinic 36 hours after being sexually assaulted. She states she wants all available treatment. Her physical exam is completely normal. She states she has no allergies that she knows of. You have no Postinor, however, you do have a combined oral contraceptive with estrogen estrodiol 50 µg and levonorgestrel 250 µg.

The treatment offered to the woman should include:

To prevent	Give treatment (include dosage)
Pregnancy	Combined oral contraceptive, 2 pills now and 2 pills in 12 hours.
Chlamydia	Azithromycin 1g stat or doxycycline 100 mg bid x 7d
Syphilis	Nothing if given azithromycin benzathine penicillin 2.4 MIU
Gonorrhea	According to local STI protocol. Preferably stat oral dose. i.e cefixime 400 mg stat.
Trichomonas	metronidazole 2g stat (we did not discuss this in the training but depending on local prevalence and guidelines may be indicated)
Hepatitis B	Hepatitis B vaccine, 1st dose stat, #2 in 30 days, #3 in 6 months
Other STIs according to your setting	azithromycin (1g) also gives good coverage for chancroid.
HIV/AIDS	Combivir bid for 28 days
Tetanus	Tetanus vaccination if not completely immunized

What points would you include in your counseling and care plan?

- Reassure her that she was not to blame for the assault. She has done the right thing by seeking care and many of the health risks can be reduced. It is ok to feel emotional, angry, sad, confused.
- Evaluate for pregnancy risk, offer test. If already pregnant not due to assault. ECP do not cause abortion. Can cause nausea and vomiting. Return to clinic if she vomits within 2 hours after dose (consider giving extra dose so she does not have to come back. Get follow up pregnancy test if menses do not come as expected).
- Take meds with food to ease upset stomach. Take full course. Do not stop without seeking medical advice. PEP in particular can cause nausea, weakness, fatigue. These symptoms will go away at the end of the treatment.
- Offer HIV test. If not done now should be done within 2 weeks. Testing to check if she was already infected. PEP does not treat already existing infections. Need to repeat test in 3 - 6 months. Use condoms until negative test.
- If symptoms of vaginal soreness, itching, pain, painful urination develop she should seek medical care immediately (especially if you did not treat for trichomonas or any of the other STIs).
- Offer first dose of Hepatitis B vaccine and counsel on where and when to get next 2 doses.

What other services would you offer or refer her to?

- Follow up in 1 week to see how she is tolerating the medicine.
- Give referrals for HIV testing if not done today and cannot be done at this facility.
- Refer to support group/women's center/counselor and to a legal support center if available.

Case Study 2:

A 5 year old boy comes to the clinic 70 hours after being sexually assaulted. The assault included anal penetration. The boy is crying and can't sit normally. He has no other injuries. His mother states she wants all available treatment. She states he has no allergies that she knows of. He weighs 16.5 kgs.

The treatment offered to the boy should include:

To prevent	Give treatment (include dosage)
Pain	paracetamol 250 mg, stool softeners
Chlamydia	azithromycin 350 (or 500 if not available) stat or erythromycin 200 mg qid for 7 days
Syphilis	Nothing if azithromycin given or benzathine penicillin 800,000 IU stat IM or Erythromycin for 14 days (same daily dose as above)
Gonorrhea	According to local protocol (preferably stat dose orally) for example cefixime 150 mg
Trichomonas	Not indicated with anal abuse
Hepatitis B	Hepatitis B vaccine, 1st dose stat, #2 in 30 days, #3 in 6 months
Other STIs according to your setting	azithromycin also gives good coverage for chancroid.
HIV/AIDS	zidovudine 100mg capsule tid for 28 days lamivudine 75 mg (1/2 of a 150 mg tablet) bid for 28 days

What points would you include in your counseling and care plan?

- The child is not to blame for the assault. Will need extra attention, patience and affection over next weeks, months. Bedwetting, nightmares, etc., part of normal reaction. Needs to continue daily routine, school.
- Evaluate for risk of repeated abuse and work to ensure safety. Report to authorities if in child's best interest. Follow local laws.
- Give stool softeners, warm soaks to reduce anal discomfort, avoid hold stool.
- Give meds with food to ease upset stomach. Take full course. Do not stop without seeking medical advice. PEP in particular can cause nausea, weakness, fatigue. These symptoms will go away at the end of the treatment.
- Needs HIV test in 3 - 6 months. Normal precautions against infection are enough during this period. No risk of infection to other children, family members.
- Evaluate whether he is already fully immunized against tetanus and give if needed. Refer for full vaccinations if need.
- Offer first dose of Hepatitis B vaccine and counsel on where and when to get next 2 doses.

What other services would you offer or refer the child and his mother to?

- Refer to support group, other social services, authorities.
- Follow up in 1 week to see how he is tolerating the medicine.
- Give referrals for HIV testing

Case Study 3:

An 11 year old girl is brought to the clinic by her aunt who is her guardian. She reports multiple sexual assaults by a group of 5 soldiers 4 days ago. Her aunt is very concerned about HIV. Wants all possible treatment. Her weight is 35 kg. On examination you find multiple bruises on breasts, healing lacerations around introitus and anal tears. When she takes off her skirt you see that she has wet herself.

To prevent	Give treatment (include dosage)
Pregnancy	Postinor-2, 2 pills stat.
Chlamydia	azithromycin 750mg stat or erythromycin 500mg qid for 7d
Syphilis	Nothing if given azithromycin benzathine penicillin 1.8 MIU
Gonorrhea	According to local STI protocol. Preferably stat oral dose. i.e. cefixime 280 mg stat. If not available give ceftriaxone 125mg stat
Trichomonas	metronidazole 2g stat (we did not discuss this in the training but depending on local prevalence and guidelines may be indicated)
Hepatitis B	Hepatitis B vaccine, 1st dose stat, #2 in 30 days, #3 in 6 months
Other STIs according to your setting	azithromycin (Ig) also gives good coverage for chancroid.
HIV/AIDS	Not indicated because of time elapsed since assault.
Wound care if necessary	Clean and dress wounds Tetanus vaccination

What points would you include in your counseling and care plan?

- Reassure her that she was not to blame for the assault. She has done the right thing by seeking care and many of the health risks can be reduced. It is ok to feel emotional, angry, sad, confused. Explain to guardian that she will need extra attention, patience and affection over next weeks, months. Bedwetting, nightmares, etc., part of normal reaction. Needs to continue daily routine, school.
- Evaluate her safety and report to authorities if in her best interest. Follow local laws.
- Even if she has not yet started menstruating, she may be at risk for pregnancy. ECP does not cause abortion and it will not affect her ability to get pregnant in the future. It may cause some spotting.
- Take meds with food to ease upset stomach. Take full course. Do not stop without seeking medical advice.
- She is not a candidate for HIV PEP. Her risk of being infected is small but she should be tested in 3 – 6 months to check her status. Evaluate for risk of prior HIV infection and offer HIV test if appropriate. The disease is transmitted through blood or sex. Friends or family members are not at risk.
- If symptoms of vaginal soreness, itching, pain, painful urination develop she should seek medical care immediately (especially if you did not treat for trichomonas or any of the other STIs).
- Evaluate whether she is already fully immunized against tetanus and give if needed.
- Offer first dose of Hepatitis B vaccine and counsel on where and when to get next 2 doses.

What other services would you offer or refer her to?

- Follow up in 1-2 weeks.
- Give referrals for HIV testing in 3 months if it cannot be done at this facility.
- Refer to support group/women's center/counselor and to a legal support center if available.

Case Study 4:

A 51 year old women reports being severely beaten and sexually abused by a soldier 2 days ago. Perpetrator unable to achieve sufficient erection for vaginal penetration. Survivor was forced to perform oral sex on perpetrator who did not achieve erection nor ejaculate. On examination you find multiple bruises around face and legs and abdomen and lacerations on forehead and abrasions on elbows. She is very emotional and very concerned about HIV. She says she wants all possible treatment.

To prevent	Give treatment (include dosage)
Pain	paracetemol 500mg tid for 3 days
Pregnancy	Not indicated
Chlamydia	azithromycin 1 g stat or doxycycline 100 mg bid for 7 days
Syphilis	Nothing if given azithromycin benzathine penicillin 2.4 MIU
Gonorrhea	According to local STI protocol. Preferably stat oral dose. i.e. cefixime 400 mg stat. If not available give ceftriaxone 125mg stat
Trichomonas	Not indicated
Hepatitis B	Not indicated
Other STIs according to your setting	Not indicated
HIV/AIDS	Not indicated
Wound care if necessary	Clean and dress wounds Tetanus vaccination

What points would you include in your counseling and care plan?

- Reassure her that she was not to blame for the assault. She has done the right thing by seeking care. It is ok to feel emotional, angry, sad, confused.
- She may have been exposed to an STI during the oral penetration, but the drugs are very effective at preventing disease. Oral exposure has a very low risk of HIV infection.
- Evaluate whether she is already fully immunized against tetanus and give if needed.

What other services would you offer or refer her to?

- Follow up in 1-2 weeks.
- Refer to support group/women's center/counselor and to a legal support center if available.

8. Tracing a Survivor’s Route (45 minutes) (Page 74)

The objective of this exercise is for participants to examine how survivors are currently received at their facility, to identify gaps and to find ways to improve and streamline care. Form participants into groups, keeping those who work in the same facility, same region or similar contexts together so that they can explore a real situation. Managers and other staff involved in receiving the survivor and providing services (e.g. laboratory staff) can join the discussion. Give participants the Checklist for Clinical Care to help guide the process. Give them flip chart paper and markers. Ask them to draw out a map of their facility marking out all the spaces a survivor needs to pass through to get care, from the reception or waiting area all the way to discharge.

►After about 20 minutes, check in with the groups. Remind them to use the checklist and to mark where each item is located on their map. Make sure the toilets, bathing facilities, laboratory and pharmacy are all included. Prompt them with questions such as: How many people does the survivor need to talk to? How many times does she or he need to move? Are rights to privacy and confidentiality protected? Where are the completed documents kept? Remind them to note which items are missing or need to be moved or changed in order to improve services. ►After about 35 minutes let them know time is almost up and that they will have an opportunity to continue working and to put together some ideas for presentation in a following session.

9. Developing an Action Plan (60 minutes) (Page 75)

This a continuation of the group work begun in Exercise 8. Based on the issues identified, have the groups develop an action plan for improving care for sexual assault survivors in their program or site, or in the site they used as an example in exercise 8. Have them use the suggested template (see “Participant Handouts: Action Plan” on page 134) or write their plan out on flip chart paper. These should then be presented to the larger group for discussion.

Optional – Presentation to Stakeholders

If the participants are all from one facility or region, try to arrange for them to present their work and ideas for improvement to the community health committee, the MoH, upper level management, or other stakeholder group to let them know what steps are being considered and to get their feedback. (In this case more time may be needed to polish the presentation and they may want to develop a PowerPoint or some other more formal presentation.)

Handouts

(Listed in the order in which they are used during the training.)

1. Learning Objectives for Sections 1 and 2
2. Exercise 1: Compassion, Competence and Confidentiality Role Play
3. Learning Objectives for Sections 3 and 5
4. Clinical Pathway Diagram
5. Informed Consent Form (for Exercise 2: Informed Consent)
6. Exercise 3: Active Listening
7. Female Anatomy
8. Female Genital Cutting
9. Vaginal Wet Prep Instructions
10. Documenting the Examination
11. Medical History and Examination Form (for Exercise 4: Documenting the Examination)
12. Emergency Contraception
13. Post Exposure Prophylaxis (PEP) for HIV
14. WHO Recommended STI Treatment Protocols
15. Male Anatomy
16. Exercise 6: Responding to Common Emotional Reactions
17. Exercise 7: Prescribing Treatment (case studies 1-4)
18. Timing and Treatment
19. Learning Objectives for Section 4
20. Help-Seeking Referral Pathway
21. Checklist for Clinical Care (for Exercise 8: Tracing a Survivor's Route)
22. Notes on Using Translators
23. Exercise 9: Action Plan for Preparing Your Clinic

Learning Objectives: Section 1 & 2

Section 1: What Every Clinic Worker Needs to Know

Participants will be able to:

- Explain why sexual assault is under-reported.
- Name the universal rights which are particularly important for sexual assault survivors.
- Give an example of how these rights can be realized in your work.
- Define the terms “sexual assault” and “rape” and explain why the term sexual assault is used in this training.

Section 2: Responsibilities of Non-Medical Clinic Staff

Participants will be able to:

- Name the public health consequences of sexual assault.
- Describe how compassion, competence and confidentiality can help the survivor begin to heal.
- Demonstrate appropriate ways to protect survivors’ human rights.

Exercise 1: Compassion Competence and Confidentiality Role Play

You have 15 minutes to prepare one of the following scenarios. Your presentation should last no longer than 5 minutes. Spend some time discussing the scenario and developing a more detailed “story”. Each member of the group should have a role.

Scenarios:

1. One member of the group works as a guard at the clinic. The clinic is closed. “Sarah” comes to the clinic saying that someone she knows was sexually assaulted and seeking advice about what to do.

Suggestions: The group can decide if Sarah is actually the one who has been assaulted or if it really is someone she knows. Either way, you need to decide what questions the guard should ask and what information he should give. The other members of the group assume the roles of other staff members, or friends and family of Sarah. For example, one could be a friend or family member with Sarah, one could be another guard or a doctor or nurse who works at the facility.

2. One member of the group is a non-medical clinic worker who helped when “Sarah” came in for care after being sexually assaulted. A friend or relative comes to ask about what was wrong with Sarah: “Why did she come to the clinic?” What does the clinic worker say to this person?

Suggestions: The group should decide who the questioner is and how hard he or she pushes for information and how the clinic worker should answer. Other members of the group could be witnesses to the questioning and perhaps make it harder for the clinic worker by asking why he or she doesn’t just provide the information. What happens if the questioner gets angry? Another group member could be a friend or co-worker with whom the clinic worker shares his or her feelings after being asked for this information.

3. Another clinic worker overhears some acquaintances talking about “Sarah”. There is a rumor going around that she’s a “loose woman”. What should the clinic worker say?

4. “Sarah” comes back to the clinic worker complaining that he or she told what happened and now everyone knows and no one will talk to her. Everyone says she must have asked for it. What should you say to her? How can you make her feel better about her decision to come to the clinic even if it means people have guessed what happened (or someone told)? What damage does it do when other people find out? How can that damage be reduced?

Learning Objectives: Section 3 & 5

Section 3: Direct Patient Care

3a: Receiving the patient and preliminary assessment

Participants will be able to:

- Describe the purpose of the preliminary assessment.
- Describe what treatment you would offer to a patient who is being referred to a higher level facility before she leaves your care
- Follow the clinical pathway to ensure that the key elements of care are provided.

3b: Obtaining informed consent and taking the history

Participants will be able to:

- Describe the purpose of obtaining informed consent
- Demonstrate how to properly obtain informed consent and fill out the form
- Explain what to do if a survivor refuses to give consent
- List the elements of the health history.
- Demonstrate active listening skills.

3c: Performing a physical exam

Participants will be able to:

- Describe how to give the survivor control over the examination.
- Describe how to use information from the history to guide the exam.
- Determine when a speculum exam is needed for a female survivor.
- Describe the cause and the signs and symptoms of a fistula.
- Explain the importance of correct documentation.
- Demonstrate how to correctly fill out the medical exam form.

3d: Treatment and disease prevention

Participants will be able to:

- List the elements of treatment for survivors.
- Describe the use of emergency contraception.
- Describe which patients should be offered PEP and list the patient teaching messages.
- Describe how you would approach a survivor who came to you 6 months after a sexual assault.
- Describe common reactions to sexual assault and demonstrate the ability to express compassion for what the survivor is feeling.
- Describe when the survivor should come back for follow up and what should be addressed at each follow up visit.

3e: Caring for male survivors

Participants will be able to:

- Describe how male survivors may react to a sexual assault.
- Describe how to communicate with a male survivor.
- Explain what physical response men can experience during an assault and how this may make them feel.
- Describe signs to look for during the male genital exam

3f: Caring for child survivors

Participants will be able to:

- Describe the issues involved in getting consent for the examination of a child.
- Demonstrate appropriate techniques for interviewing a child.
- List the information you need to gather from a child survivor.
- Discuss what it means to always put the best interest of the child first.
- Describe under what conditions it would be inappropriate to perform a genital exam on a child.
- Explain why it is impossible to test for virginity.
- Explain at what age a girl should be offered ECP if vaginal penetration has occurred.
- Describe what treatment you would offer for a child survivor.
- Demonstrate how to advise parents on a child's possible reactions to sexual assault.

Section 5: Collecting Forensic Evidence

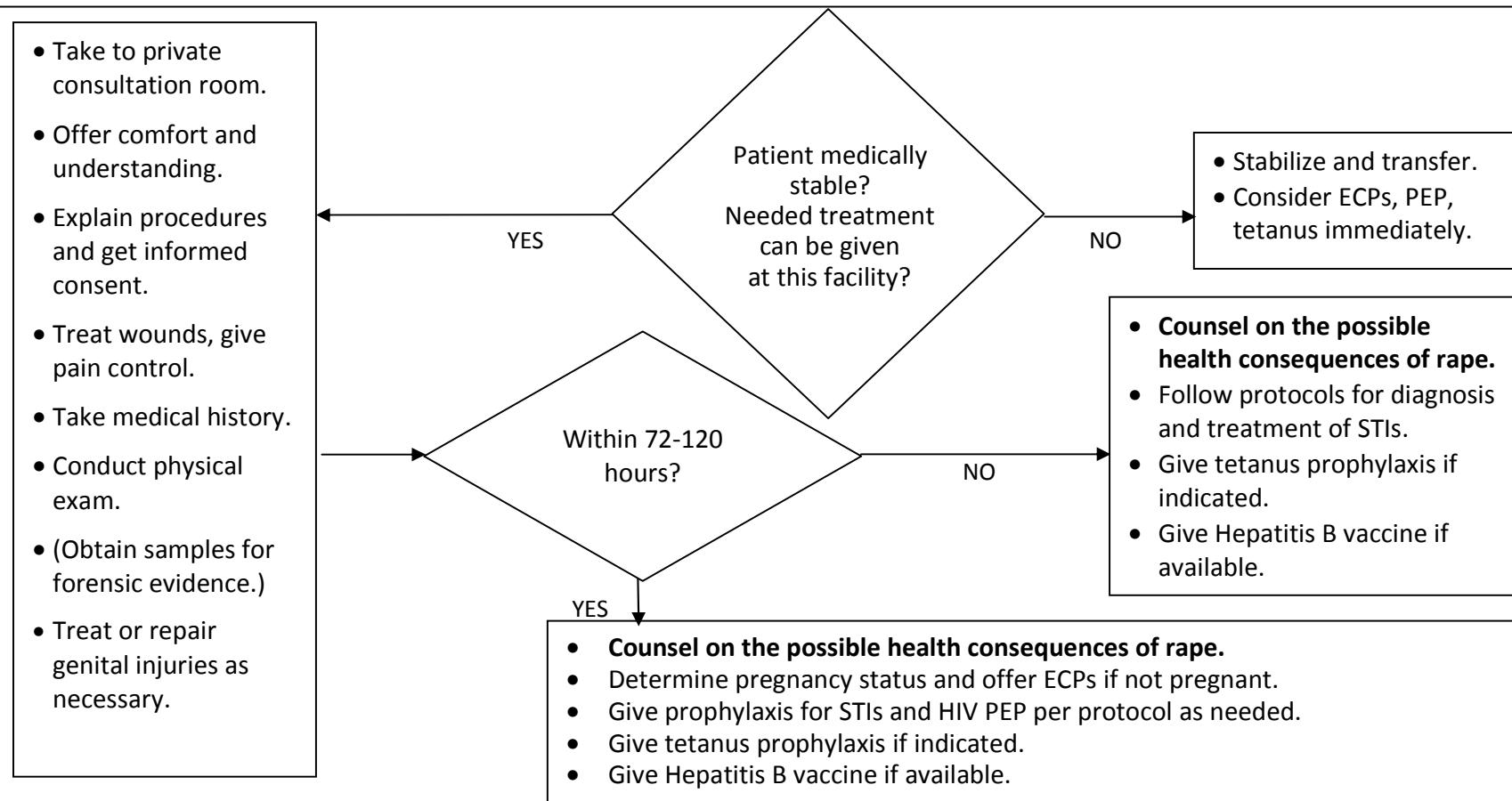
Participants will be able to:

- Describe the reasons for collecting forensic evidence.
- Describe the types of forensic evidence that can be collected.
- Describe proper packaging of samples.
- Explain why evidence collection should be done as soon as possible after the assault and what activities in particular reduce the quality of the evidence.
- Describe the process of consent for a survivor wishing to have evidence collected.

CLINICAL PATHWAY FOR TREATMENT OF SEXUAL ASSAULT SURVIVORS

Patient assessed immediately. Rape crisis team or other designated clinician notified.

It is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination.



Discharge counseling and teaching: Make sure the survivor has a safe place to go and refer as needed to Security/Protection, Legal, Psycho-social, etc. services. Encourage a follow-up visit in two weeks. Give clear simple instructions for any medications, wound care, etc.

DOCUMENT THE EXAM AND TREATMENT THOROUGHLY. KEEP ALL DOCUMENTS AND EVIDENCE CONFIDENTIAL AND SECURE.

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CONSENT FOR EXAMINATION

This form should be read to the client or guardian in her/his first language. Clearly explain to the client what the procedure for the medical examination involves and allow her/him to choose any or none of the options listed. The survivor can change his/her mind at any time and a new form can be completed.

I, _____, give my permission for _____
(medical provider's name and title)
to perform the following (select one option for each, do not leave blank):

• A medical examination	YES	NO
• A pelvic examination	YES	NO
• A speculum exam (if medically necessary)	YES	NO
• Collection of evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of fingernails.	YES	NO
• Blood draw for HIV (or specify for what purpose)	YES	NO
• Provide evidence and medical information to the police and/or courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided.	YES	NO

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

Client/ Guardian Signature: _____

Staff Signature: _____ Date: _____ (dd/mm/yy)

Exercise 3: Active Listening

During the interview with a survivor you need to gather information to accurately document her story and determine what kinds of examination and treatment is appropriate. It is very important that you do this without re-traumatizing her and in a way that validates her experience and helps begin the healing process. The purpose of this exercise is to give you a chance to practice your active listening skills. Active listening means you are focused on who you are listening to in order to fully understand what he or she is saying in a non-judgmental way.

Active listening techniques:

Express your interest and concern with your body as well as your words.

Begin with open ended questions like “Tell me about what happened. . .” Get more specific as necessary only after she has finished relating the story.

Do not interrupt or rush her. Respect silence by waiting attentively or use supportive statements like, “I know this is hard for you” or “I am here to listen”.

Acknowledge her emotion with statements like, “I can see you are feeling. . .” Never discount the survivor’s feelings by using phrases like “it is not that bad” or “don’t let it bother you”.

Validate her feelings with statements like “it is normal to feel . . .” or “people who experience sexual assault often feel . . .”

Do not ask “why” questions. They are often judgmental.

Check that you understand by repeating back to the survivor what she has said (summarizing).

Do not offer opinions or advice. Give the survivor information she needs to make her own decision.

Instructions:

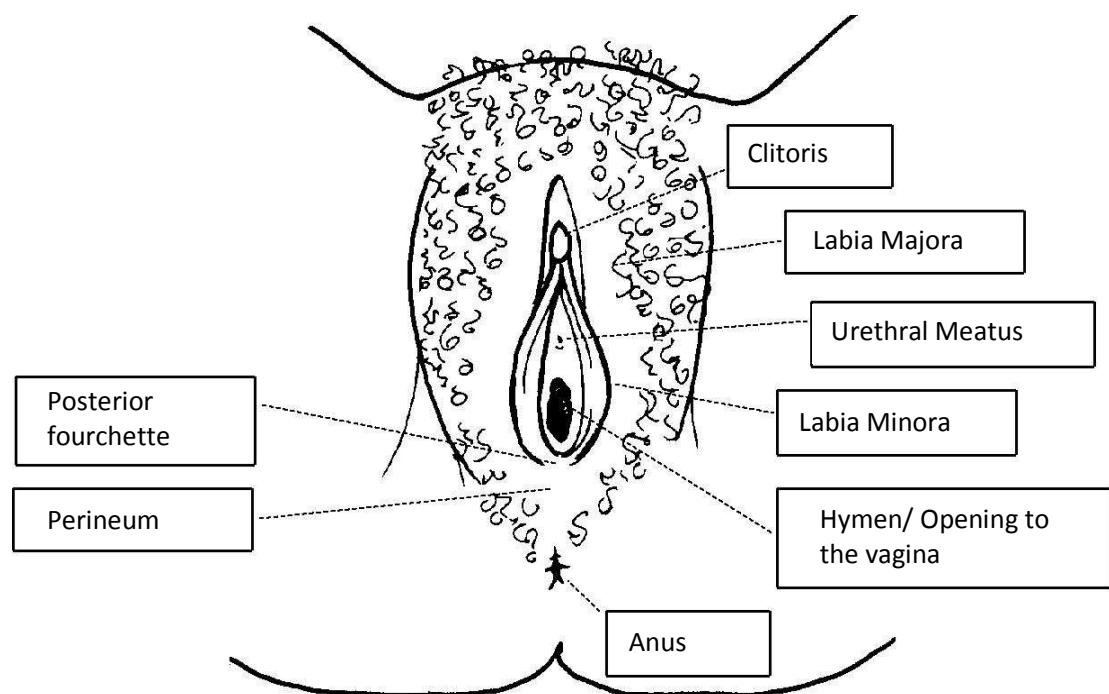
Divide into groups of three, each with a speaker, a listener, and an observer.

To the speaker: You should talk about something that is a real concern to you. You do not need to share anything that is very private or embarrassing. Sharing a real part of your life, however, will make this exercise both more interesting and more useful. Be sure to pause often to encourage the listener to respond, even though this may seem a bit unnatural.

To the listener: Practice active listening techniques. Acknowledge and validate what the speaker says. Summarize to see if you understand correctly. Try to ask open-ended, non-judgmental questions to get more information.

To the observer: Concentrate on the person in the listener role, looking for active listening techniques. Give feedback at the end of the interview. Help the listener learn by pointing out areas needing improvement.

Female Anatomy



Female Genital Cutting (FGC)

Background

Female genital cutting is recognized internationally as a violation of the human rights of girls and women. It reflects deep-rooted inequality between the sexes, and constitutes an extreme form of discrimination against women. It is nearly always carried out on minors and is a violation of the rights of children. The practice also violates a person's rights to health, security and physical integrity, the right to be free from torture and cruel, inhuman or degrading treatment, and the right to life when the procedure results in death.

What do we mean by FGC?

FGC has been defined by the World Health Organization (WHO) as "all procedures which involve partial or total removal of the external female genitalia or injury to the female genital organs whether for cultural or any other non-therapeutic reasons". It exists in a number of forms, although four main types are commonly recognized, and are classified as follows:

Type 1: The removal of the prepuce with or without excision of part or all of the clitoris.

Type 2: Clitoridectomy; also known as excision. This is the removal of the clitoris with partial or total excision of the labia minora, and constitutes about 80% of FGMs performed.

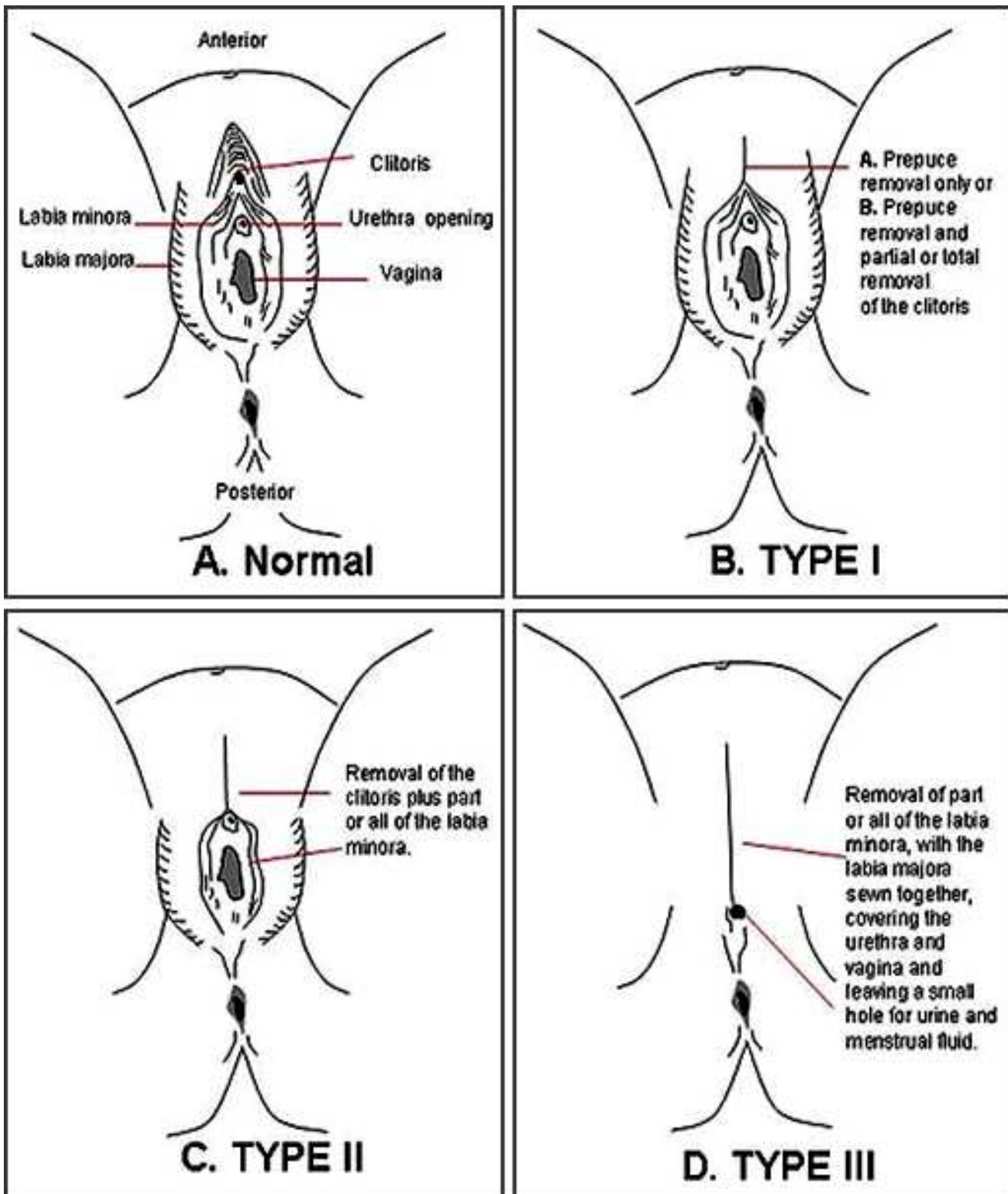
Type 3: Infibulation; also known as pharaonic circumcision. This involves the removal of the clitoris, labia minora and labia majora with narrowing of the vaginal opening by means of stitching. It is the most extreme form of FGM and involves the removal of two thirds of the female genitalia. It constitutes approximately 15% of mutilations performed.

Type 4: Unclassified: pricking/piercing/incising the clitoris and/or labia, cauterization by burning of clitoris and surrounding tissue, scraping (angurya cuts) of the vaginal orifice or cutting (gishiri cuts) of the vagina to cause bleeding.

The procedures are usually performed without anesthetic and in unhygienic conditions. The practitioner, who typically has no medical training, uses crude, non-sterile implements such as broken glass, pieces of a tin can or razors to perform the procedure. Where stitching is involved, this is often done using thorns. In Type 3 forms of FGC, the girl's legs are often bound together for up to 40 days to ensure the intended aperture. Women and girls who have undergone the Type 3 procedure may have the stitched vaginal opening either cut or torn open on their wedding night.

Additional resource:

Eliminating female genital mutilation: an interagency statement UNAIDS, UNDP, UNECA, UNESCO, UNFPA, UNHCHR, UNHCR, UNICEF, UNIFEM, WHO, 2008. http://www.who.int/reproductive-health/publications/fgm/fgm_statement_2008.pdf Available in Arabic, English, French, and Portuguese.



The health consequences of FGC

The procedure has no health benefits for girls and women. There are numerous short and long term consequences, including:

Short term consequences	Long term consequences
<ul style="list-style-type: none">• severe pain and shock• infection• urine retention• injury to adjacent tissues and organs (which can be severe, depending on the extent to which the girl or woman subject to the procedure struggles)• immediate fatal hemorrhage	<ul style="list-style-type: none">• extensive damage of the external reproductive system• uterus, vaginal and pelvic infections• cysts and neuromas• increased risk of vesico-vaginal fistula• complications in pregnancy and childbirth, including obstructed labor• psychological damage resulting from trauma• sexual dysfunction and painful sexual relations• difficulties in menstruation

Other potential problems include sterility, chronic pain and lameness. Victims of FGC, particularly where the procedure is performed on more than one girl or woman at a time, are also at a heightened risk of contracting HIV and other potentially fatal infections as a result of the use of non-sterile implements.

Reasons advanced for the performance of FGC include:

- custom and tradition
- religion (in the mistaken belief that FGC is a religious requirement)
- preservation of virginity/chastity
- social acceptance (especially for marriage)
- hygiene and cleanliness
- increasing sexual pleasure for the male
- family honor; and
- enhancing fertility.

Medicalization of FGC

Traditionally older female members of the community performed FGC, but recent trends show that, in some countries procedures are now taking place in hospitals and health clinics, performed by medical professionals who use surgical instruments and anesthetics. The ‘medicalization’ of FGC can be attributed to early advocacy efforts that placed a strong emphasis on the health consequences of the procedure, without referencing the practice in the larger context of human rights. This has led to a misconception that medicalization decreases the negative health consequences of the procedure. Even under sanitary conditions still represents willful damage of healthy body parts and organizations such as the WHO, UNICEF, and the International Council of Nurses have all declared their opposition to the trend.

Vaginal Wet Prep (Wet Mount) Instructions

Patient Preparation

There is no patient preparation needed. Ideally the patient should have not inserted anything into her vagina since the penetration occurred.

Specimen Collection

- Universal Precautions must be followed when handling potentially infectious agents.
- Using a sterile swab, swab the vagina and cervix, and immerse the swab into the vial containing 2 mls of sterile 0.9% Sodium Chloride, NaCl, and label. The mouth or rectum can also be swabbed separately if there is a history of rectal or oral penetration.
- Do not refrigerate; examine immediately.

Equipment and Supplies

- Vials for vaginal samples - add 2 mls of 0.9% NaCl. Do not use plain water or other mixture.
- Sterile swab
- Glass microscope slides and cover slips
- Binocular microscope
- Gloves

Procedure

- Take the swab in the vial directly to the laboratory.
- Wearing clean gloves, dab the cotton swab on the surface of the slide and cover with the cover slip. Touch only the edges of both the slide and cover slip. Avoid bubbles as they can lead to confusing results.
- Place on the microscope stage, in the correct position over the opening and turn on the microscope.
- Begin with the low power lens to find material from the sample, then turn to a higher power to see more detail.
- Once you are finished, turn off microscope and dispose of slide and glass vial in sharps container and swab and gloves in contaminated waste.
- Wash hands.
- Document all findings on the patients record.

Findings

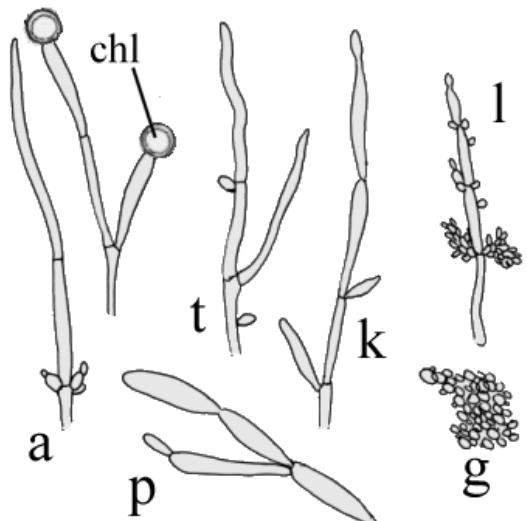
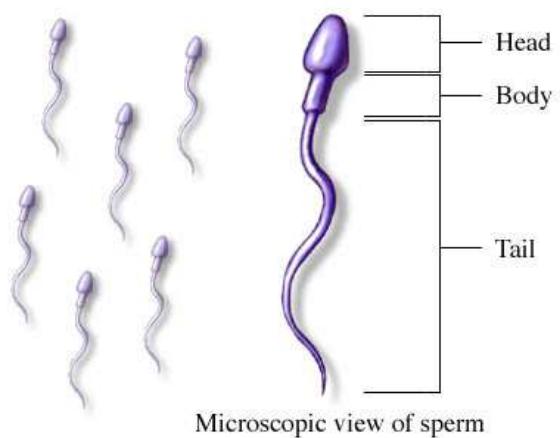
- The absence of sperm does not prove that a rape did not occur. It is not possible to give an exact time of intercourse based on the finding of motile sperm.
- Motile sperm can live in the vagina for 6-8 hours. Non-motile sperm are most likely to be found within 20 hours but can sometimes be found in the cervix for up to 72 hours. In the mouth sperm can be found for 3 – 4 hours. In the rectum sperm may be found up to 12 hours after assault.
- Motile sperm are unmistakable. The only other motile (moving) element you might see in a wet mount are trichomonas but they have very short tails and move in circles. Non-motile sperm can be harder to identify. Do not confuse them with budding yeast (candida).



Multiple sperm in wet mount, high magnification.



Above: Single branch of budding yeast.
Below: multiple stalks of candida albicans.



Candida morphology: a = albicans, t=tropicalis, k=krusei, l=lusitaniae, g=glabrata, p=parapsilosis; chl=chlamydospore (After Campbell et al.)



Trichomonas: Don't confuse this parasite with motile sperm

Documenting the Examination

The main purpose of the examination is to determine what medical care should be given. Proper documentation assures quality care and follow up. The documentation of the examination may also be the only evidence the survivor has that an assault took place.

It is not your responsibility to determine whether or not a woman has been raped. Document your findings without stating conclusions about the legal status of the case. In many cases of sexual assault the examination will be completely normal.

Record the interview and your findings in a clear, complete, objective, non-judgmental way. Record the survivor's story in her own words. Include any statements of threat made by the assailant. Use quotes to indicate the survivor's exact words. Avoid words such as "claims" or "alleges" which imply the survivor may not be telling the truth.

Note whether the patient was seen alone or with another person as translator or support person.

Complete all parts of the form including any treatment provided, vaccinations given, or samples collected.

Note the survivor's emotional state and general appearance, condition of her clothing (torn, dirty, neat, well cared for).

Document all injuries clearly and systematically using standard medical terminology. Record your findings on the medical history form and the pictograms, noting size, color, type, etc. (see below). Health workers who have not been trained in forensics or injury interpretation should not speculate about the cause of the injury.

Describing features of physical injuries:

Feature	Notes
Classification	Use accepted terminology: abrasion, contusion, laceration, incision, gun shot
Site	Record the anatomic position in words and on the pictogram
Size and depth	Measure the dimensions of the wounds
Shape	Describe whether straight, round, irregular. The edges of the wound can help identify the weapon used
Color	Particularly in reference to bruises
Contents	Note the presence of foreign material (dirt, glass)
Age	Comment on signs of healing – scabbing, granulation, scar tissue. Old injuries should also be noted.

Adapted from Clinical Management of Rape Survivors, Geneva, WHO, 2004.

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CODE: _____

Medical History and Examination Form

1. General Information

Sex	Age	
Date/time of examination:	Interviewed in the presence of:	
(dd/mm/yy)	(00:00 hrs)	(not presence of translator, parent, other)

2. The Incident

Date of Incident:	(dd/mm/yy)	Time of Incident:	(00:00 hrs)		
Description of incident (survivor's description)					
Physical Violence	Yes	No	Type and location on body		
Type (beating, biting, pulling hair, etc.)					
Use of restraints					
Use of weapon(s)					
Drugs/alcohol included					
Penetration	Yes	No	Not Sure		Describe: oral, vaginal, anal
Penis					
Finger					
Other (describe object)					
	Yes	No	Not Sure		Location: oral, vaginal, anal, other
Ejaculation					
Condom Used					

3. Current Signs and Symptoms

Note pain, bleeding, discharge from vagina or rectum, any other signs or symptoms

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4. Medical History

After the incident, did the survivor				
Yes		No		
Vomit?		Rinse mouth?		
Urinate?		Change Clothes?		
Defecate?		Wash or bathe?		
Brush teeth?		Use tampon or pad?		
Contraceptive use				
Yes	No	Method:	Notes:	
Menstrual/obstetric history				
Last menstrual period (dd/mm/yy)			Menstruation at time of event Yes No	
Evidence of pregnancy		Yes	No	Number of weeks pregnant _____ weeks
Date of last delivery:				
Existing health Problems (Including history of female genital mutilation, type)				
Allergies:				
Current medication:				
Vaccination Status	Vaccinated	Not Vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Last tested	Comments		

5. Medical Examination

General Appearance (clothing, hair, obvious physical or mental disability)			
Mental State (calm, crying, anxious, cooperative, depressed, other)			
Weight:	Height:	Pubertal stage:	
Pulse Rate	Blood Pressure	Respiratory Rate	Temperature

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CODE: _____

Physical Findings

Describe systematically, and draw on the attached body pictograms, the exact location of all wounds, bruise, petechiae, marks, etc. Document type, size, color, form and other particulars. Be descriptive, do not interpret the findings.

Head and face	Mouth and Nose
Eyes and Ears	Neck
Chest	Back
Abdomen	Buttocks
Arms and hands	Legs and feet

6. Genital Exam

Vulva/scrotum	Introitus and hymen	Anus
Vagina/Penis	Cervix	Bimanual/rectovaginal examination
<i>Position of patient (supine, prone, knee-chest, lateral, if child - in adult's lap)</i>		
For genital examination:		For anal examination:

7. Investigations Done

Type and location	Examined/sent to laboratory	Result

8. Evidence Taken

Type and location	Examined/sent to laboratory	Result
History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault Date (dd/mm/yy)		

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9. Treatments Prescribed

Treatment	Yes	No	Type and Comments
STI prevention/treatment			
Emergency contraception			
Wound treatment			
Tetanus prophylaxis			
Hepatitis B vaccination			
Post-exposure prophylaxis for HIV			
Other			

10. Counseling, Referrals, Follow-up

General Psychological status			
Survivor plans to report to police OR has already made report		YES	NO
Survivor has a safe place to go to:		YES	NO
Has someone to accompany her/him:			
Counseling provided:			
Referrals			
Follow up required			
Date of next visit			

Name of health worker conducting examination/interview:

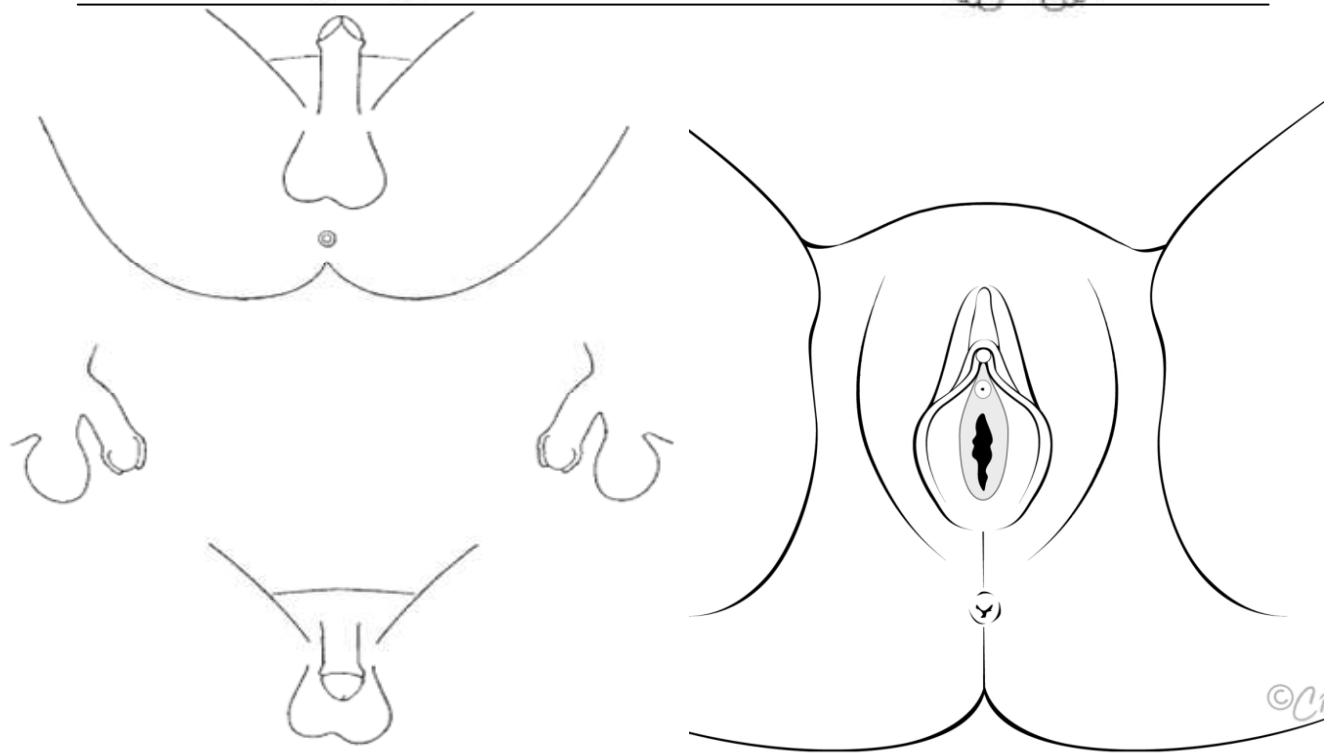
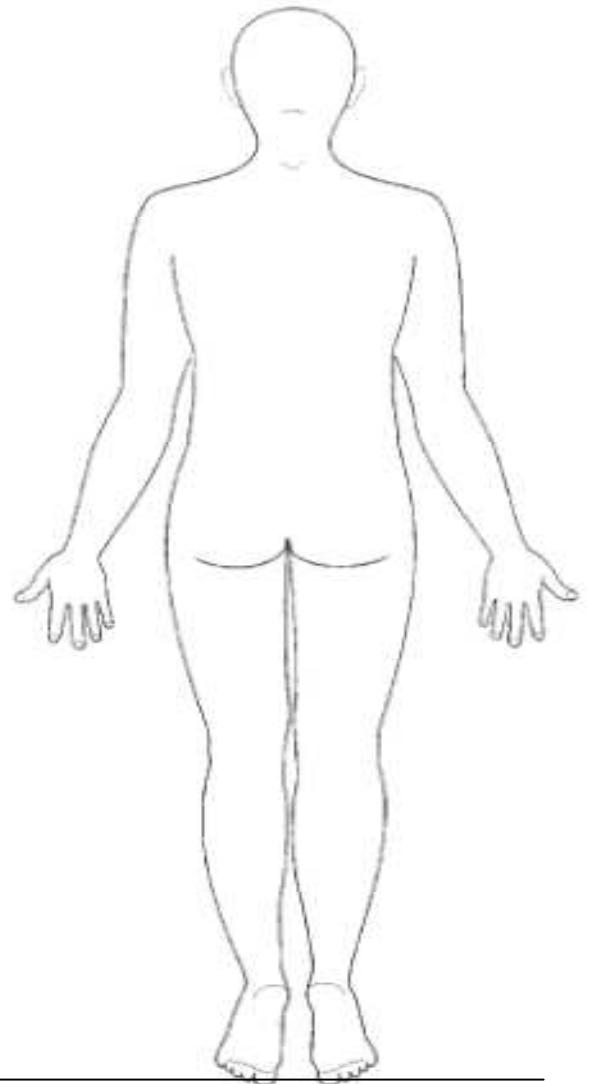
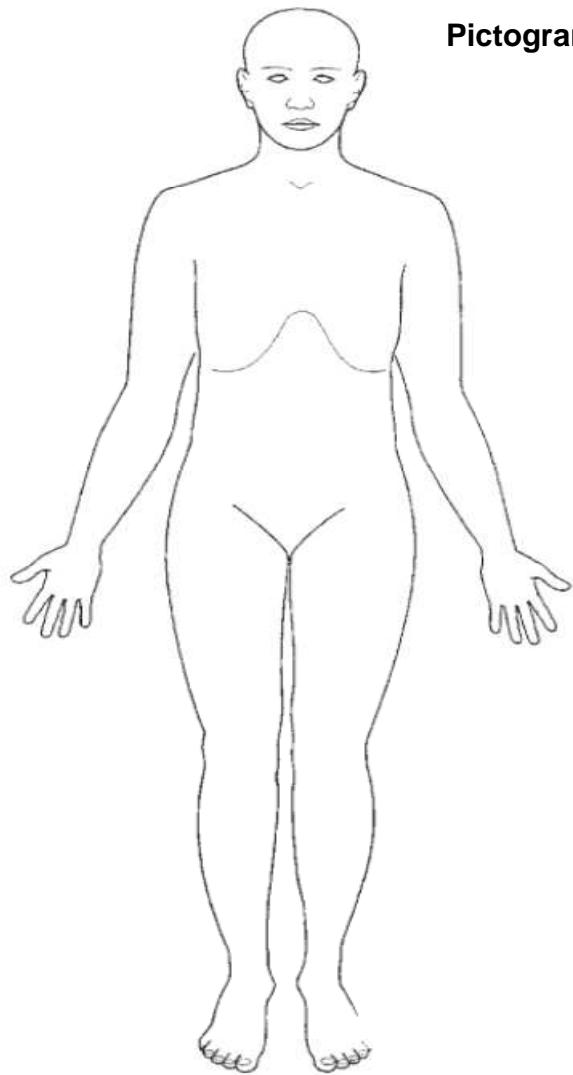
Title: _____ Signature: _____ Date: _____

Follow up Notes:

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CODE: _____

Pictograms





February 2013

Clinical Summary: Emergency contraceptive pills

Indication: Emergency Contraceptive Pills (ECPs) are indicated to prevent pregnancy after unprotected or inadequately protected sex.

ECP Regimens: Three regimens are packaged and labeled specifically for emergency contraception (EC).

- 1 tablet of levonorgestrel 1.5 mg, or 2 tablets of levonorgestrel 0.75 mg labeled to be taken twice 12 hours apart (but can safely be taken together)
- 1 tablet of ulipristal acetate 30 mg
- 1 tablet of mifepristone 10-25 mg (not widely available)

Certain types of ordinary birth control pills can also be used as EC (known as the "Yuzpe regimen"). Take the pills within 5 days after sex, as soon as possible after the sex act.

How ECPs Work: The primary mechanism is disruption of ovulation. Other mechanisms have been postulated but are not well supported by data. No evidence supports the theory that ECPs interfere with the implantation of a fertilized egg. ECPs do not cause abortion of an existing pregnancy.

ECP Efficacy: The levonorgestrel regimen reduces pregnancy risk by at least half and possibly by as much as 80-90% for one act of unprotected intercourse. The ulipristal and mifepristone regimens are more effective than the levonorgestrel regimen. Regular oral contraceptives used as EC (the "Yuzpe regimen") are less effective.

Safety: ECPs have no known medically serious complications. Side effects may include altered bleeding patterns, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. ECPs do not appear to be harmful if inadvertently taken in pregnancy.

Precautions and Contraindications: ECPs have no medical contraindications. Do not take ECPs if you are pregnant because they will not work.

Clinical Screening: You do not need any examinations or laboratory tests before taking ECPs.

Repeated ECP Use: ECPs can be used as often as needed, but do not need to be taken more than once every 24 hours if multiple acts of unprotected sex occur. Repeat use of ECPs is perfectly safe, but ECPs are not recommended as a regular, routine contraceptive method because they are not the most effective contraceptive method available.

Drug Interactions: Concurrent use of some drugs may reduce ECP efficacy. However, the ECP regimen is the same whether or not you are using these drugs.

Follow-up after ECP: No scheduled follow-up is required after ECP use. But if you have not had a menstrual period by 3 weeks after taking ECPs, consider that you may be pregnant.

Starting or Resuming Regular Contraceptives after ECP Use: ECPs are not designed to provide contraceptive protection at sex acts that occur in the future. Using a regular contraceptive after taking ECPs is CRITICAL to minimizing your pregnancy risk. Begin hormonal methods (oral contraceptives, patch, vaginal ring, injectables, implants, levonorgestrel intrauterine system) either immediately or after your next menstrual period; if you wait, use a barrier method such as condoms in the interim. Copper-bearing IUDs provide highly effective emergency contraception, so you do not need oral ECPs if you start using this type of IUD within 5 days after sex. Do not rely on fertility awareness methods until you have had at least one normal menstrual period.

Resources

- International Consortium for Emergency Contraception website: www.emergencycontraception.org
- The Emergency Contraception website, managed by Princeton University and the Association of Reproductive Health Professionals: www.not-2-late.com

HIV POST EXPOSURE PROPHYLAXIS (PEP)

PEP should be prescribed by qualified trained health care provider who are designated providers according to a pre-determined PEP protocol. It should be given as part of a comprehensive package of clinical care and referrals to mental health, legal and supportive services.

We do not know exactly how effective HIV PEP is at preventing transmission of HIV after a sexual assault. Based on experience with PEP for work related exposure and prevention of mother to child transmission, experts believe that starting PEP as soon as possible and not more than 72 hours after an assault will decrease the risk of transmission. Offer the first dose of PEP as soon as possible, ideally before proceeding through other aspects of the examination and treatment.

PEP will not treat those already infected. If possible patients should be counseled and voluntarily tested before beginning treatment, but if they refuse or testing is not available, the drugs should still be started as soon as possible and testing offered within 1 - 2 weeks. Patients should be counseled to use condoms every time they have sex until they have been tested again after three months. Test results, along with all other patient information should be kept confidential.

PEP should only be given to patients with a high risk of exposure to blood or body fluids. This includes both vaginal and anal penetration with a penis. Forced oral-penile penetration is a lower risk for infection. External cuts and scratches do not present a risk unless the assailant's blood got in the wounds. Human bites are not a risk for HIV infection, although they can cause bacterial infections.

Pregnancy is not a contraindication to PEP. Women in their first trimester should be counseled that the effects on the fetus are unknown. The risk of infection based on local prevalence, what is known about the perpetrator and type of assault or injury should be especially carefully considered in these women. In high risk situations, the risk of contracting HIV and passing it to the fetus will generally outweigh the unknown risk of the drug. Women who are breastfeeding should continue to do so.

PEP is recommended for all children potentially exposed to HIV through sexual contact. HIV testing is not necessary, but should be considered in children and adolescents who were sexually active prior to the incident or who have been abused over a long period of time or in young children with HIV positive mothers.

Side effects of the two drug regimen are generally tolerable and can include nausea, vomiting, loss of appetite, weakness and fatigue. Counsel patients to manage these side effects and not to stop the medication without seeking medical advice first.

Combination therapy with two drugs is recommended for 4 weeks (28 days). Give the patient the full 28 day course and ask her to come back in 1 week for a follow up visit. Giving her less than the full course puts her at risk for incomplete and probably ineffective treatment.

Sample 2-Drug Regimens for Post-Exposure Prophylaxis of HIV in Adults and Children

Treatment	Form	Dosage	30 day supply
Children <2 yrs old (5 – 9 kg)			
Zidovudine (AZT) and Lamivudine (3TC)	10 mg/ml 10 mg/ml	7.5 ml twice a day 2.5 ml twice a day	420 ml (i.e. five bottles of 100 ml or three bottles of 200 ml) plus 140 ml (i.e. two bottles of 100 ml or one bottle of 200 ml)
Children 10 – 19 kg			
Zidovudine (AZT) and Lamivudine (3TC)	100 mg capsule 150 mg tablet	one capsule three times a day ½ tablet twice a day	90 capsules plus 30 tablets
Children 20 – 39 kg			
Zidovudine (AZT) and Lamivudine (3TC)	100 mg capsule 150 mg tablet	two capsules twice a day one tablet twice a day	120 capsules plus 60 tablets
Adults and children 40 kg or more, including pregnant women			
Zidovudine(AZT) and Lamivudine (3TC)	300 mg tablet 150 mg tablet	1 tablet every 12 hours 1 tablet every 12 hours	60 tablets 60 tablets

A third drug may be necessary in the context of resistance. Options include Indinavir 800 mg 3 times a day or Efavirenz 600 mg once daily (not recommended for pregnant women). These drug may cause more severe adverse reactions. Patients taking one of these drugs should be evaluated within 72 hours after exposure and monitored for drug toxicity for at least 2 weeks.

Further reading: Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, 2007.

http://whqlibdoc.who.int/publications/2007/9789241596374_eng.pdf

Explain to the patient:

- The drugs may prevent HIV if started within 72 hours and taken for 28 days. We do not know exactly how effective it is at preventing infection.
- You will need to take two drugs: zidovudine and lamivudine. They are usually combined into a single pill (combivir) to make them easier to take. These are not the same drugs that are usually given to people with HIV to treat the disease. Do not borrow or share drugs with another person.
- We do not know exactly what the drug might do to an early pregnancy (less than 3 months) but it is believed to be safe. The drugs should be taken by pregnant women to prevent getting the infection and passing it on to the baby.
- It is best to know your HIV status before starting the medicine. A person who is already infected will not get any benefit from the medicine. If the test cannot be done immediately, it should be done within 2 weeks. If the test is positive within 2 weeks that means you were already infected with HIV. If that happens we will give you information on how to take care of yourself.
- The drugs can cause nausea, tiredness, weakness while you are taking them. It may help to take them with food. These symptoms will go away when you stop the medication. They are not dangerous. It is very important to stay on the medication for the full 28 days. If you aren't feeling well come back to the clinic for a follow up.
- Return to the clinic for a follow up test in 3 - 4 months. Use condoms every time you have sex until your follow up test is negative.

WHO-recommended STI treatment protocols for adults

Note: These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow **local** treatment protocols for sexually transmitted infections.

STI	Treatment	
Gonorrhoea	cefixime	400 mg orally, single dose <i>or</i>
	ceftriaxone	125 mg intramuscularly, single dose
Chlamydial infection	azithromycin	1 g orally, in a single dose (<i>Also active against incubating syphilis within 30 days of exposure</i>) <i>or</i>
	doxycycline	100 mg orally, twice daily for 7 days (<i>contraindicated in pregnancy</i>)
<i>Chlamydial infection in pregnant women</i>	azithromycin	1 g orally, in a single dose (<i>Also active against incubating syphilis within 30 days of exposure</i>) <i>or</i>
	erythromycin	500 mg orally, 4 times daily for 7 days <i>or</i>
	amoxicillin	500 mg orally, 3 times daily for 7 days
Syphilis	benzathine benzylpenicillin*	2.4 million IU, intramuscularly, once only (<i>give as two injections in separate sites.</i>) <i>or</i>
	azithromycin	2 g orally as a single dose (<i>for treatment of primary, secondary and early latent syphilis of < 2 years duration</i>).
<i>Syphilis, patient allergic to penicillin</i>	azithromycin	2 g orally as a single dose (<i>for treatment of primary, secondary and early latent syphilis of < 2 years duration</i>) <i>or</i>
	doxycycline	100 mg orally twice daily for 14 days (<i>contraindicated in pregnancy</i>) (<i>Also active against chlamydial infections</i>)
<i>Syphilis in pregnant women allergic to penicillin</i>	azithromycin	2 g orally as a single dose (<i>for treatment of primary, secondary and early latent syphilis of < 2 years duration</i>) <i>or</i>
	erythromycin	500 mg orally, 4 times daily for 14 days (<i>Both azithromycin and erythromycin are also active against chlamydial infections</i>)
	<i>Note: when a pregnant woman is treated for syphilis with azithromycin or erythromycin, the baby should be assumed to have congenital syphilis at birth and should be appropriately examined and treated.</i>	
Trichomonas	metronidazole	2 g orally as a single dose <i>or</i>
	tinidazole	2 g orally as a single dose <i>or</i>
	metronidazole	400 or 500 mg orally, 2 times daily for 7 days <i>Avoid metronidazole and tinidazole in the first trimester of pregnancy</i>

***Note** If the survivor presents within 30 days of the incident, **benzathine benzylpenicillin** can be omitted if the treatment regimen includes **azithromycin 1 g as a single dose**, which is effective against incubating syphilis as well as chlamydial infection.

If the survivor presents more than 30 days after the incident, **azithromycin 2 g as a single dose** is sufficient presumptive treatment for primary, secondary and early latent syphilis of < 2 years duration and also covers chlamydial infections.

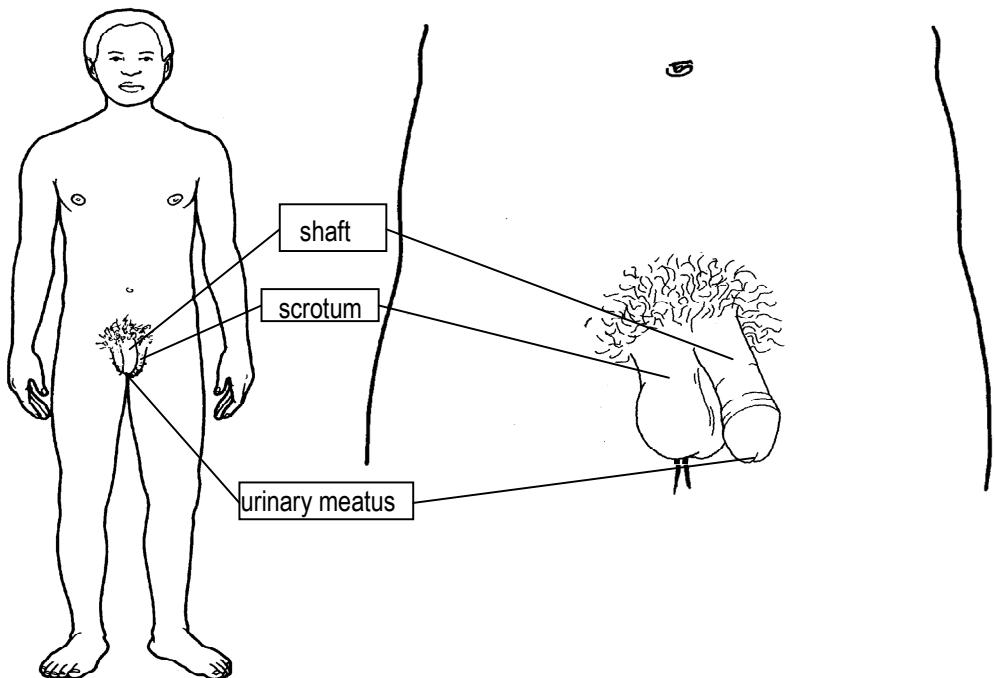
WHO-recommended STI treatment protocols for children and adolescents

Note: These are examples of treatments for sexually transmitted infections. Always follow **local treatment protocols** for sexually transmitted infections and use drugs and dosages that are appropriate for children.

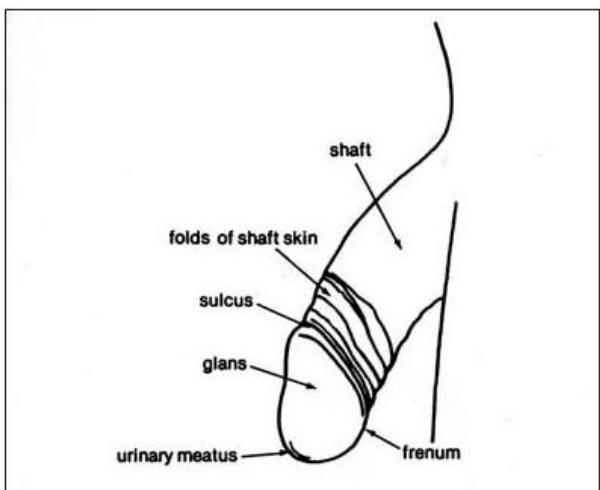
STI	Weight or age	Treatment	
Gonorrhoea			
	< 45 kg	ceftriaxone	125 mg intramuscularly, single dose or spectinomycin 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose or (if > 6 months) cefixime 8mg/kg of body weight orally, single dose
	> 45 kg	Treat according to adult protocol	
Chlamydial infection			
	< 45 kg	azithromycin	20 mg/kg orally, single dose or erythromycin 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days
	≥ 45 kg but < 12 years	erythromycin	500 mg orally, 4 times daily for 7 days or azithromycin 1 g orally, single dose
	≥ 12 years	Treat according to adult protocol	
Syphilis		*benzathine penicillin 50 000 IU/kg IM (up to a maximum of 2.4 million IU), single dose	
<i>Syphilis, patient allergic to penicillin</i>		erythromycin	50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days
Trichomonas			
	< 12 years	metronidazole	5 mg/kg of body weight orally, 3 times daily for 7 days
	≥ 12 years	Treat according to adult protocol	

***Note** If the survivor presents within 30 days of the incident, **benzathine penicillin** presumptive treatment for syphilis can be omitted if the treatment regimen includes **azithromycin**, which is effective against incubating syphilis as well as chlamydial infection.

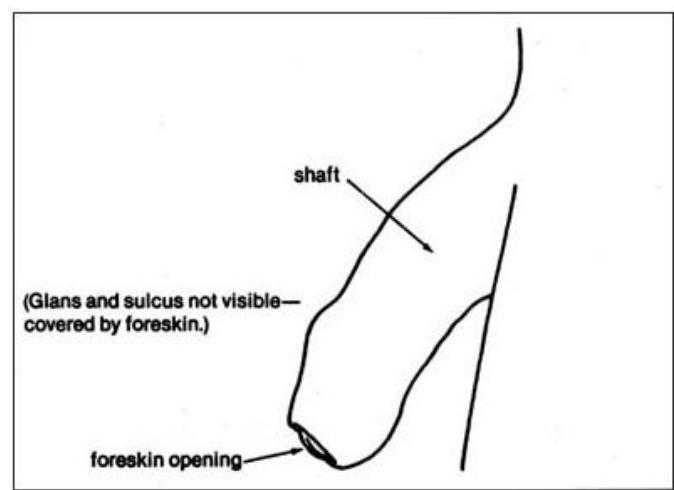
Male Anatomy



Circumcised Penis



Uncircumcised Penis



Exercise 6: Responding to Common Emotional Reactions

A provider needs to be prepared to respond calmly and non-confrontationally to whatever the survivor is feeling. The feelings of anyone accompanying the survivor, particularly parents and spouses may further complicate the picture. And our own feelings as providers can also interfere if we become frustrated and impatient, or are embarrassed or upset by what the survivor tells us. Learning to handle these situations well takes experience. This exercise will let you practice what you have learned so far.

Prepare a brief (5 minute) scenario illustrating how a survivor may exhibit this emotional reaction and how the provider could respond to provide competent, compassionate care. You will have 15 minutes. If there are three people in your group, the third member of the group can be either another staff person at the facility (a nurse, registrar, or assistant) or a friend or family member of the survivor. This person might be either supportive and helpful or a bad influence needing to be controlled. The scenario should represent the first few minutes of the provider-patient interaction where the provider needs to gain the trust of the survivor, get a basic idea of what happened and explain what services he or she can provide (not the complete exam).

Exercise 7: Prescribing Treatment for Survivors of Sexual Assault

Case Study 1

A 36 year old female survivor comes to the clinic 36 hours after being sexually assaulted. She states she wants all available treatment. She states she has no allergies that she knows of. You have no dedicated ECP (Postinor), however, you do have a combined oral contraceptive with estrogen estrodiol 50 µg and levonorgestrel 250 µg.

The treatment offered to the woman should include:

To prevent	Give treatment (include dosage)

What points would you include in your counseling and care plan?

What other services would you offer or refer her to?

Exercise 7: Prescribing Treatment for Survivors of Sexual Assault

Case Study 2

A 5 year old boy comes to the clinic 70 hours after being sexually assaulted. The assault included anal penetration. He is crying and cannot sit normally. His mother states she wants all available treatment. She states he has no allergies that she knows of. He weighs 16.5 kg.

The treatment offered to the boy should include:

To prevent	Give treatment (include dosage)

What points would you include in your counseling and care plan?

What other services would you offer or refer the boy to?

Exercise 7: Prescribing Treatment for Survivors of Sexual Assault

Case Study 3

An 11 year old girl is brought to the clinic by her aunt who is her guardian. She reports multiple sexual assaults by a group of 5 soldiers 4 days ago. Her aunt is very concerned about HIV. She wants all possible treatment. Her weight is 35 kg. On examination you find multiple bruises on breasts, healing lacerations around introitus and anal tears. When she takes off her skirt you see that she has wet herself.

Treatment offered to the girl should include:

To prevent	Give treatment (include dosage)

What points would you include in your counseling and care plan?

What other services would you offer or refer the girl to?

Exercise 7: Prescribing Treatment for Survivors of Sexual Assault

Case Study 4

A 51 year old women reports being severely beaten and sexually abused by a soldier 2 days ago. The perpetrator unable to achieve sufficient erection for vaginal penetration. Survivor was forced to perform oral sex on perpetrator who did not achieve erection nor ejaculate. On examination you find multiple bruises around face and legs and abdomen and lacerations on forehead and abrasions on elbows. She is very emotional and very concerned about HIV. She says she wants all possible treatment.

Treatment offered should include:

To prevent	Give treatment (include dosage)

What points would you include in your counseling?

What other services would you offer or refer her to?

Timing and Treatment

TREATMENT	Patient type	0 - 72 hours	>72 – 120 hours	> 120 hours
HIV PEP	pre-pubertal child	yes	No	no
	pubertal/adult female	yes	No	no
	pubertal/adult male	yes	No	no
EC	pre-pubertal child	no	No	no
	pubertal/adult female	yes	Yes	no (IUD)
	pubertal/adult male	no	No	no
STI prophylaxis	pre-pubertal child	yes	Yes	?
	pubertal/adult female	yes	Yes	?
	pubertal/adult male	yes	Yes	?
HIV test	pre-pubertal child	?	?	?
	pubertal/adult female	yes	Yes	yes
	pubertal/adult male	yes	Yes	yes
Pregnancy test	pre-pubertal child	no	No	no
	pubertal/adult female	yes	Yes	yes
	pubertal/adult male	no	No	no

- HIV testing soon after the assault will tell us whether the survivor was infected prior to the assault, not whether the assault resulted in infection. It can take several months after infection for a test to become positive.
- Pregnancy testing will reveal the existence of a prior pregnancy. Women who are pregnant should still receive prophylaxis for STIs and HIV with some adjustments.
- HIV testing should be considered for everyone, but children who have not previously had sexual intercourse and who have no health problems do not need to be tested. **Testing is voluntary and should never be a requirement for treatment. Likewise, delays in testing should never lead to delays in treatment.**

Learning Objectives: Section 4

Section 4: Preparing Your Clinic

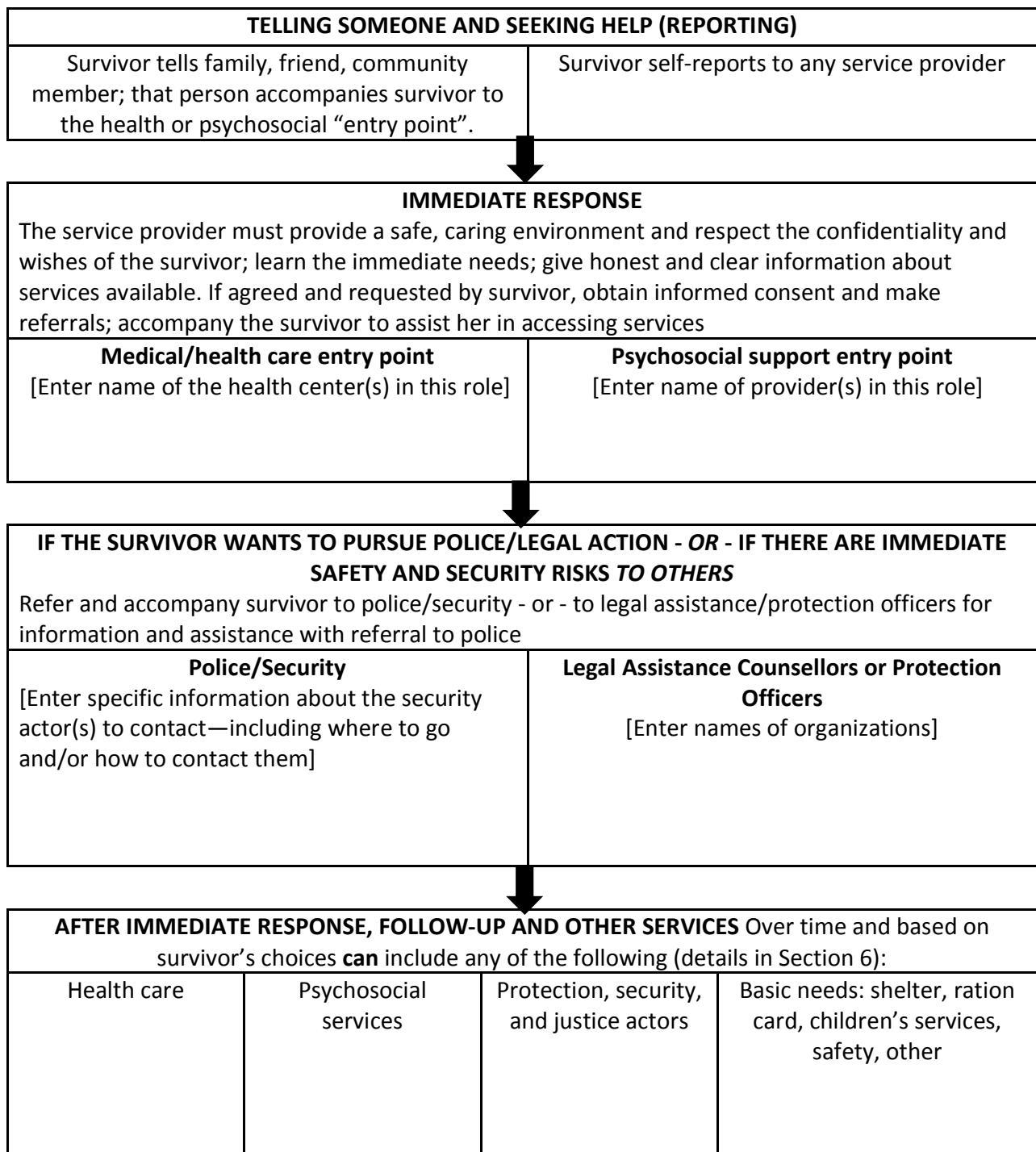
Participants will be able to:

- Map out current patient flow and response to sexual assault survivors and identify areas for improvement.
- Use the checklist to develop a draft work plan improving facility practices to meet standards for CCSAS and the adaptation and implementation of the CCSAS protocol.
- Describe the information needed to adapt the protocol to your local setting.
- Describe what referral resources are needed for sexual assault survivors.
- Determine what resources are currently missing in your referral network and develop a plan for filling gaps and improving communication between the various organizations.
- Describe the resources available to inform your work with sexual assault survivors.
- Describe what resources are available at the country and TU level to support CCSAS and what resources are needed.

HELP-SEEKING AND REFERRAL PATHWAY FOR _____

(name of site)

Use the following template to fill in details of the referral pathway for your setting. These referral pathways must be specific to one site (camp, town, or other). If the scope of these SOPS includes more than one site, there must be a separate page for each, with specific pathways for each.



From the GBV Resource Tool: Establishing GBV Standard Operating Procedures (SOP Guide), May 2008 IASC Sub-Working Group on Gender & Humanitarian Action.

CHECKLIST FOR CLINICAL CARE OF SEXUAL ASSAULT SURVIVORS

Protocol
<input type="checkbox"/> Written medical protocol in the language of the provider.
Staff
<input type="checkbox"/> Trained (local) health care professionals (on call 24 hours/day).
<input type="checkbox"/> For female survivors, a female health care provider speaking the same language or a female health worker (or companion) should be in the room during the examination.
Setting and Equipment
<input type="checkbox"/> Room (private, quiet, accessible, with access to a toilet or latrine).
<input type="checkbox"/> Examination table and light.
<input type="checkbox"/> Resuscitation equipment.
<input type="checkbox"/> Access to an autoclave to sterilize equipment.
<input type="checkbox"/> Speculum (small and medium).
<input type="checkbox"/> Sterile medical instruments (kit) for repair of tears, and suture material.
<input type="checkbox"/> Supplies for universal precautions (soap, gloves, receptacle for disposal of contaminated and sharp materials).
<input type="checkbox"/> Needles, syringes.
<input type="checkbox"/> Cloth or sheet to cover the survivor during the examination.
<input type="checkbox"/> Napkins for feminine hygiene (pads or local cloths).
<input type="checkbox"/> Pregnancy tests.
Medications
<input type="checkbox"/> For prevention or treatment of STIs per country protocol (may include Hepatitis B vaccine).
<input type="checkbox"/> For post-exposure prophylaxis of HIV (PEP) as per IRC/country protocol.
<input type="checkbox"/> For pain relief (e.g. paracetemol) and anxiety depending on local protocols.
<input type="checkbox"/> Emergency contraceptive pills or other oral contraceptive; IUCD if appropriate.
<input type="checkbox"/> Local anesthetic for suturing.
<input type="checkbox"/> Topical antiseptics for wound care.
<input type="checkbox"/> Tetanus toxoid; Tetanus immune globulin if available.
Administrative supplies
<input type="checkbox"/> Medical chart with pictograms.
<input type="checkbox"/> Consent forms.
<input type="checkbox"/> Information pamphlets and referral materials for the survivor (in the local languages).
<input type="checkbox"/> Safe, locked cabinet for keeping confidential records.
For documentation and forensic evidence collection (as appropriate)
<input type="checkbox"/> Ruler for measuring the size of bruises, lacerations, etc.
<input type="checkbox"/> Glass slides for wet and/or dry mounts (microscope and trained technician required).
<input type="checkbox"/> Cotton-tipped swabs/applicators/gauze pads for collecting samples.
<input type="checkbox"/> Laboratory containers for transporting swabs.
<input type="checkbox"/> Supplies for collecting blood samples.
<input type="checkbox"/> Comb for collecting foreign matter in pubic hair.
<input type="checkbox"/> Paper sheet for collecting debris as the survivor undresses (flip chart paper).
<input type="checkbox"/> Paper bags and tape for collecting and labeling containers/bags.

A Note on Using Translators

Assure that translators for sexual violence survivors are:

- Bound to maintain confidentiality (a signed statement)
- Speak the same language as the survivor, and are of the same ethnic background (or of an allied-ethnicity) as the survivor
- Same sex as the victim

Ask Translators to:

- Provide a literal translation as opposed to summarizing or “cleaning up” or simplifying a respondent’s answers.
- Help you to keep a dictionary of key local terms for which there might not be a translation.

When working with a translator:

- The interviewer should introduce herself and the translator to the respondent.
- The interviewer should speak directly to the respondent, not the translator.
- The interviewer should keep eye contact with the respondent, not the translator.
- The interviewer should review the translator’s notes with the translator after the interview.
- The interviewer must document a translator was used and include the person’s name.

Exercise 9: Action Plan for Preparing Your Clinic

Facility/Location:	Working Group Members:				
Date:					
Issue/Challenge Identified	Priority (low, medium, high)	Immediate response	Target Date	Person(s) Responsible	Long Term response
Resources Needed:					
Resources Needed:					
Resources Needed:					
Resources Needed:					

Evaluation Plan

CHAPTER 5

Evaluating Training Participants

Either before starting the training or at the beginning of the clinical section of the training (generally on day 2 – see suggested agenda) all of the trained health care providers should take the pre-test. It will help to identify areas of strength and areas where more attention should be paid.

The same test should be administered to the same group at the end of the training. Only those who score at least 80% will receive a certificate. A plan should be made to work with anyone who does not do well enough but who needs or wants to provide care to sexual assault survivors. Please keep pre and post-tests so that scores can be compared to evaluate the effectiveness of the course. (We would very much appreciate getting copies of the tests so that we can track the effectiveness of this training.) Provide answers to participants at the end of the training so that they can review and seek clarification if needed.

Write out the sample questions below on a flip chart and review them with the group prior to administering the test. The format may present challenges to some so give them time to ask questions.

Sample Questions

A health care provider is...

- A. A doctor
- B. A nurse
- C. A security guard
- D. A and B

The correct answer is D since both doctors and nurses are health care providers.

Childhood vaccines have been developed for all of the following EXCEPT:

- A. Tuberculosis
- B. Polio
- C. Malaria
- D. Tetanus
- E. Hepatitis B

The correct answer is C since no vaccine for malaria has been developed.

In order to learn in this training you should...

- A. Listen to what others have to say
- B. Ask questions
- C. Apply the information to your setting
- D. A and B
- E. All of the above

The correct answer is E since all of the choices will contribute to helping you learn.

Certificate

After taking and passing the post-test, with a score of at least 80%, participants can be awarded a certificate of completion for the training. There is a standard certificate at the end of this section of the manual that can be printed in color or photocopied and filled-in by hand. If you have access to facilities to make your own certificates, the language found in the standard certificate should be used. The certificate has no legal standing and does not imply any official license to practice.

Circle: pre-test / post-test

Name _____

Date _____

KNOWLEDGE ASSESSMENT FOR HEALTH CARE PROVIDERS

Please read each question carefully. Choose ONE best answer for each question.

Direct Patient Care

1. We do not know how many people experience sexual assault because . . .
 - A. many people make accusations that are untrue.
 - B. many people do not tell anyone about it.
 - C. no one is doing any research about it.
 - D. registration books are incomplete.

2. By providing clinical care for survivors in a separate room, you are respecting which of the following universal rights?
 - A. Right to non-discrimination
 - B. Right to information
 - C. Right to privacy
 - D. Right to self-determination

3. By giving treatment to all survivors presenting at the health facility, you are respecting which of the following universal rights?
 - A. Right to non-discrimination
 - B. Right to confidentiality
 - C. Right to self-determination
 - D. Right to information

4. By making sure a survivor understands her treatment choices you are respecting which of the following universal rights?
 - A. Right to health care
 - B. Right to confidentiality
 - C. Right to information
 - D. Right to non-discrimination

5. By not telling anyone that someone came to the clinic for an HIV test you are respecting which of the following universal rights?
 - A. Right to non-discrimination
 - B. Right to confidentiality
 - C. Right to self-determination
 - D. Right to information

6. The term “Sexual assault” . . .
 - A. is the same as rape.
 - B. includes forced oral sex.
 - C. refers to violence against women and girls only.

7. The purpose of the physical examination of a sexual assault survivor is to...
 - A. determine whether rape occurred.
 - B. determine what kind of treatment to offer.
 - C. collect data on prevalence of sexual violence.
 - D. prove if the survivor is still a virgin.
8. When counseling the survivor...
 - A. listen closely to her concerns.
 - B. tell her what treatment she has to take.
 - C. avoid questions that will make her/him sad.
9. Before doing a genital exam on a woman, her family/spouse need to agree.
 - A. True
 - B. False
10. What will you tell to a survivor who refuses a genital examination?
 - A. I will not be able to give you any medicine.
 - B. How can I tell whether your story is true?
 - C. I am still glad you came. Let's talk about your health concerns.
 - D. I will refer you to my supervisor for further information.
11. Any certified nurse/midwife/doctor can perform a speculum exam.
 - A. True
 - B. False
12. When you are taking the survivor's history of the assault...
 - A. always ask what he or she was wearing.
 - B. begin with very specific questions.
 - C. make sure there is a third person in the room to take notes.
 - D. let the survivor tell the story in his or her own words.
13. When giving informed consent ...
 - A. the survivor needs to understand the language being used.
 - B. the survivor cannot change her mind once she has given consent.
 - C. the survivor needs to be able to read the form to give consent.
14. After a sexual assault...
 - A. there are always visible injuries.
 - B. injuries are usually only located in the genital area.
 - C. survivors can receive the most complete care if they come in within 72 hours.
 - D. it is the health providers responsibility to give drugs only.
15. During the preliminary assessment you should...
 - A. assess for shock.
 - B. consider whether the survivor needs to be referred.
 - C. explain to the survivor what you are doing.
 - D. All of the above
16. If a survivor needs to be referred to higher level care you should . . .
 - A. tell the driver what happened to her.
 - B. provide her with ECP and HIV PEP if she is at risk and has no contraindications.
 - C. send the family to bring money so that she can pay for transportation.
 - D. make sure to file a police report after the emergency is over.

17. A survivor who comes to the clinic more than 72 hours after the assault. . .
- A. will not be able to start post-exposure prophylaxis for HIV.
 - B. will not be able to use emergency contraception.
 - C. will not need a physical exam.
 - D. will not be eligible for vaccinations against Hepatitis B or tetanus.
18. Options for emergency contraception after 120 hours (5 days) include:
- A. Emergency Contraceptive Pills.
 - B. Oral contraceptive pills in a high dose.
 - C. Insertion of a copper IUD.
 - D. No option is available after 120 hours.
19. Sexual assault...
- A. should always be reported to the police or other authorities.
 - B. is always the result of unsatisfied sexual needs.
 - C. can happen to anyone.
 - D. is impossible to prevent.
20. People who experience sexual assault...
- A. usually made a mistake that put them at risk
 - B. always want to speak to providers of their own sex
 - C. may experience both anger and guilt
 - D. usually seek help within 120 hours
21. When taking the survivor's medical history, you do NOT need to ask about:
- A. any significant medical conditions
 - B. age of first intercourse
 - C. current use of contraceptives
 - D. last menstrual period
22. When caring for a sexual assault survivor, it is important to exhibit compassion, confidentiality and competence because...
- A. it will help her feel safe again.
 - B. it will enable her to tell her story.
 - C. all patients should be treated this way.
 - D. All of the above
23. In order to provide quality clinical care to sexual assault survivors you need to...
- A. have a specialized department for survivors only.
 - B. services available 5 days every week.
 - C. Have trained staff and good referral systems in place.
24. During the physical examination...
- A. the survivor can decide to stop at any time.
 - B. do not talk to the survivor since it may embarrass her.
 - C. do not examine the anus unless she reports anal penetration.
 - D. uncover the survivor completely to get a full overview of injuries
25. When teaching a survivor about HIV post exposure prophylaxis tell her...
- A. she is required to take an HIV test before starting the medication.
 - B. she should stop the medication immediately if she has any side effects.
 - C. that the PEP drugs are always effective if taken correctly.
 - D. if she is already positive it will not fight the infection.

26. Compared to women, men who have been sexually assaulted...
- A. are less likely to contract HIV.
 - B. are less likely to feel ashamed.
 - C. are less likely to need mental health counseling.
 - D. are less likely to seek care.
27. When a survivor leaves the clinic, always reinforce that...
- A. she/he will be okay.
 - B. she/he should come back in 2 weeks or sooner if she develops any new symptoms.
 - C. She/he should not tell anyone what happened to avoid being stigmatized.
28. Which of the following female survivors should NOT be offered emergency contraception?
- A. A 12 year old who has not yet begun menstruating.
 - B. A 32 year old who gave birth 3 months ago.
 - C. A 45 year old whose last menses was 3 months ago but who tests negative for pregnancy.
 - D. A 23 year old who was forced to perform oral sex by a teacher.
29. When interviewing a child...
- A. make sure to have a witness in the room at all times.
 - B. remember that children cannot be trusted to tell the truth.
 - C. always use language the child can understand.
 - D. the caretaker is to answer all questions.
30. When a young child comes to the clinic for care after a sexual assault...
- A. seek consent from a responsible adult guardian.
 - B. include the child in the decision-making process.
 - C. assess for HIV risk and provide prophylaxis for HIV and STIs.
 - D. All of the above
31. An 8 year old child has been abused by an uncle and is brought to the clinic by an older sister. You should...
- A. send someone to the police station right away.
 - B. tell them to come back and see the social worker the next day.
 - C. help her identify an adult she can trust to tell her story to.
32. During the physical examination of a female child assaulted 2 weeks ago...
- A. a genital exam should be done to determine virginity.
 - B. a genital exam may be done to document any signs of injury.
 - C. a genital exam should be done even without the child's consent.
 - D. a genital exam should be done by a doctor only.
33. A 10 year old was assaulted by a stranger. Tell the child's parent that ...
- A. the child is too young to understand what has happened.
 - B. the child should be encouraged to forget what happened.
 - C. the child would benefit from a trained counselor or another trusted adult to talk to.
 - D. the child should stay at home as much as possible.
34. Which of the following infections cannot be prevented by a drug or a vaccine?
- A. Chlamydia
 - B. Herpes
 - C. Hepatitis B
 - D. HIV

35. Before taking the history of a man who reports being sexually assaulted...
- A. explain the services you can provide him and get consent.
 - B. ask if anybody saw him enter the clinic.
 - C. ask him whether he has had sex with a man before.
 - D. make sure that he is seen by male staff only.
36. A man survivor comes to the clinic and tells you that he cannot control his bowels. He refuses a physical exam. You should...
- A. tell him you cannot do anything without an examination.
 - B. give him a medicine for diarrhea and have him come back in 2 weeks.
 - C. tell him that he did not do anything wrong and that you will do what you can to help him.
 - D. you call your supervisor.
37. When adapting the standard protocol to your local context...
- A. use your country's guidelines on treating STIs.
 - B. if your country's protocol is out of date it can be ignored.
 - C. use the international definition of child as anyone under 18 years old.
38. If your facility cannot provide adequate services for sexual assault survivors, you should:
- A. explain to survivors what service you can provide and what services they will be able to get if they agree to be referred to a referral facility.
 - B. let the community know that you don't provide care for survivors.
 - C. accept that clinical care for survivors is not your responsibility.
 - D. try to identify traditional healers in your community who have herbal treatment.

Circle: pre-test / post-test

Name_____

Date_____

KNOWLEDGE ASSESSMENT ON FORENSIC EVIDENCE COLLECTION

Please read each question carefully. Each question has only one right answer.

1. Forensic specimens should NOT be used as evidence to...
 - A. support the survivor's story.
 - B. prove that physical force was used.
 - C. identify the assailant.
 - D. determine whether rape occurred
2. A survivor asks to have forensic evidence collected 3 days after an assault. She has already taken a bath and changed her clothes. You should...
 - A. reassure her that you will still be able to collect high quality samples.
 - B. go ahead and collect the samples without consent since she knows what she wants.
 - C. Make sure she can be examined by a health worker whose medical report will be accepted in court.
 - D. Inform her that she is too late and send her home.
3. When counseling the survivor about the possibility of collecting forensic evidence tell her...
 - A. the best time to collect evidence is during the first physical examination.
 - B. she should be sure to wash before she is examined.
 - C. once evidence is collected it cannot be destroyed.
 - D. if evidence is collected people will believe her story.
4. When collecting forensic sample from the survivors body...
 - A. put swabs immediately in an envelope.
 - B. label every sample with the survivor's name and the date of the examination.
 - C. do not talk to the survivor since it may compromise the quality of the evidence.
 - D. make sure the survivor knows why you are taking the samples.
5. All health care providers should...
 - A. inform the legal services when forensic evidence is collected.
 - B. be able to perform a forensic examination.
 - C. provide the survivor with the information she needs to decide what kind of treatment and testing she wants.
 - D. always collect forensic evidence from survivors.

Pre/Post Test Answer Key

Direct Patient Care

- 1. B
- 2. C
- 3. A
- 4. C
- 5. B
- 6. B
- 7. B
- 8. A
- 9. B
- 10. C
- 11. B
- 12. D
- 13. A
- 14. C
- 15. D
- 16. B
- 17. A
- 18. C
- 19. C
- 20. C
- 21. B
- 22. D
- 23. C
- 24. A
- 25. D
- 26. D
- 27. B
- 28. D
- 29. C
- 30. D
- 31. C
- 32. B
- 33. C
- 34. B
- 35. A
- 36. C
- 37. A
- 38. A

Scoring: To achieve a passing score on the post test, the participant must answer at least 30 of the questions correctly.

The scoring does not include the forensic section.

In contexts where official licensure exists, those requirements should always be deferred to. Passing the test and receiving a certificate does not confer any legal rights or license to practice.

Forensic Evidence Collection

- 1. D
- 2. C
- 3. A
- 4. D
- 5. C

CERTIFICATE OF PARTICIPATION

This certificate is awarded to

*in recognition of completion of
the International Rescue Committee's Multimedia Training*

on

***The Clinical Care of
Sexual Assault Survivors***



Location:

Date:

Signature:

Evaluating the Training

Part of all good training is evaluation. Evaluation is done with participants, to assess how much they have learned and what they need more work on as done with the pre-test and post-test earlier in this chapter. But the second part of evaluating a training, which is equally important, is to evaluate the way the material was presented. To do this the facilitator should use daily and final evaluations to get feedback from participants on sections of the training that they like, areas they thought could use more time and areas where the participants were struggling with the concepts.

Daily Evaluations

Attached is a daily evaluation form that should be given out at the end of each day of training. The facilitator should then review the daily evaluations each evening and make adjustments to the training schedule or approach for the following day based on the requests and recommendations of participants. It is not always possible to address all of the concerns but it is important to address the problems that have been raised and pay special attention to issues that are repeated by multiple participants

The final evaluation should be given at the end of training on the final day. This will offer a more comprehensive view of how the training as a whole unit went and will help to guide the facilitator in future trainings or in designing follow up training with the same group of participants.



INTERNATIONAL RESCUE COMMITTEE

Clinical Care for Sexual Assault Survivors
Multi Media Training

DAILY EVALUATION

Date: ____ / ____ / ____

1. List 2 things you learned today:

a. _____

b. _____

2. List 2 things you liked about today:

a. _____

b. _____

3. List 2 things you did not like about today:

a. _____

b. _____

4. Comments / suggestions:



INTERNATIONAL RESCUE COMMITTEE

Clinical Care for Sexual Assault Survivors
Multi Media Training

DAILY EVALUATION

Date: ____ / ____ / ____

1. List 2 things you learned today:

a. _____

b. _____

2. List 2 things you liked about today:

a. _____

b. _____

3. List 2 things you did not like about today:

a. _____

b. _____

4. Comments / suggestions:



Clinical Care for Sexual Assault Survivors Training FINAL EVALUATION

date: _____

location of training: _____

1. How well were you able to understand the content of the training?

very well **well** **poorly** **not at all**

2. How well did the training meet your need for technical information about providing care to sexual assault survivors?

very well **well** **poorly** **not at all**

3. How well did the training meet your need to understand how to communicate with survivors?

very well **well** **poorly** **not at all**

4. How well did the training help you overcome any concerns you had about caring for sexual assault survivors?

very well **well** **poorly** **not at all**

5. How much will the training change how you care for sexual assault survivors in the future?

very much **somewhat** **very little** **not at all**

6. Did the training change your attitude toward survivors of sexual assault?

very much **somewhat** **very little** **not at all**

7. How would you rate the video part of the training?

very good **good** **poor** **very poor**

8. How would you rate the exercises used in the training?

very good **good** **poor** **very poor**

9. How would you rate the facilitation of the training?

very good **good** **poor** **very poor**

Please use the back for any comments or suggestions. THANK YOU!

Glossary

A

Anorectal injury: Injury at the intersection of the anal canal and the rectum.

C

Cervical os: The opening of the cervix (the neck of the uterus).

Chain of evidence: Documentation and testimony that proves that the evidence has not been altered or tampered with since it was obtained.

Cirrhosis: An abnormal liver condition characterized by irreversible scarring of the liver.

Chlamydia infection: Sexually transmitted infection (STI) caused by the bacterium, Chlamydia trachomatis, which can damage a woman's reproductive organs. It is often asymptomatic in women, but can lead to scarring and infertility.

Circumcision (female): Circumcision refers to the practice of cutting parts of the external female genitalia. Infibulation is the most severe form in which the labia majora (outer lips of the vulva) are sewn together to partially seal the vagina, leaving only a small hole for the passage of urine and menstrual blood. This practice is also known as female genital mutilation (FGM) or Female Genital Cutting (FGC).

Confidentiality: The right of an individual to have personal, identifiable medical information kept private.

Contraindication: A situation which makes a particular treatment or procedure inadvisable.

D

Delayed care: In the context of the clinical care for sexual assault survivors, delayed care is care given more than 72 hours after an assault because that is the window during which the most complete preventive treatment can be given.

Documentation: Gathering and recording information in order to verify something (sexual assault).

E

Emergency Contraception (EC): The use of a drug or device to prevent pregnancy after unprotected sexual intercourse.

Emergency Contraceptive Pills (ECP): Hormonal methods (pills) of contraception that can be used to prevent pregnancy after unprotected intercourse. ECPs can be used up to 120 hours (five days) after unprotected intercourse.

Emotional trauma: Lasting mental and physical effects of an experience that is emotionally painful, distressful, or shocking.

F

Fistula: An obstetric fistula develops when blood supply to the tissues of the vagina and the bladder (and/or rectum) is cut off during prolonged obstructed labor. The tissues die and a hole forms through which urine and/or feces pass uncontrollably. A traumatic fistula is caused by sexual violence such as violent rape, mass rape, including forced insertion of objects such as gun barrels and sticks into a victim's vagina or anus.

Vesico vaginal: Between the bladder and the vagina

Recto vaginal: Between the rectum and the vagina

Forensic evidence collection: Gathering evidence in order to strengthen a case for criminal prosecution.

G

Genital cutting or mutilation (female): Procedures involving partial or total removal of the female external genitalia or other injury to the female genital organs for non-medical reasons. Genital mutilation includes female circumcision and infibulation.

Gonorrhea infection: A sexually transmitted infection (STI) which is often silent (no symptoms) in women, but can cause infertility. In men it often causes discharge.

H

Hepatitis B: A virus that infects the liver. It is spread through contact with the blood and body fluids of an infected person. Hepatitis B is nearly 100 times more infectious than HIV. Worldwide, about 1 million deaths occur each year due to chronic forms of the disease.

HIV Post-exposure prophylaxis (PEP): Use of antiretroviral drugs within 72 hours following exposure or potential exposure to prevent HIV infection.

I

Incontinence: Inability to control excretions. Urinary incontinence is inability to keep urine in the bladder. Fecal incontinence is inability to retain feces in the rectum.

Infertility: Not being able to have children.

Infibulation: see circumcision

Informed consent: An agreement to do something or to allow something to happen, made with complete knowledge of all relevant facts, such as the risks involved and any available alternatives.

Intrauterine device (IUD)/ intrauterine contraceptive device (IUCD): A device inserted into the uterus (womb) to prevent pregnancy. The IUD can be a coil, loop, triangle, or T-shape. It can be plastic or metal. The most common IUD is the Copper T, which contains copper which stops sperm from making their way up through the uterus. An IUD can also be used as a form of emergency contraception if inserted within seven days of unprotected intercourse.

M

Medical certificate: A document signed by a doctor giving a judgment on somebody's state of health.

Miscarriage: Unintended loss of a pregnancy.

P

Pelvic exam: Procedure used to assess the well-being of a female patients' lower genito-urinary tract.

External genital exam: Visual inspection and palpation of the external genitalia.

Vaginal speculum exam: An instrument called a speculum is inserted into the vagina in order for the examiner to be able to view the vaginal walls and cervix.

Posterior fornix: Recesses in the vagina behind the cervix.

Prepubescent: A child at the stage of development just before puberty. Usually, puberty starts between ages 8 and 13 in girls and ages 10 and 15 in boys. The first signs of puberty for girls are breast development, growth of hair in the pubic area and armpits, and acne. Menstruation usually happens last. For boys, puberty usually begins with the testicles and penis getting bigger, then hair grows in the pubic area and armpits. Muscles grow, the voice deepens, and acne and facial hair develop.

Preventive treatment: Medical treatment to protect against disease or infection after suspected or known exposure.

Prostate: A gland within the male reproductive system that is located just below the bladder. Prostatitis is an inflammation of the prostate. Symptoms include chills, fever, pain in the lower back and genital area, urinary frequency and urgency often at night, burning or painful urination, and body aches

R

Rape: Rape is defined as penetration of the vagina or anus with the penis, other body part or foreign object without consent. It also includes forced oral sex. It is a legal term and not a medical diagnosis.

Referral network: A group of providers who you can refer your patient to for care.

S

Self-determination: The ability or right to make your own decisions without interference from others.

Sexual assault: Any type of unwanted physical violence or contact that is of sexual nature, including rape.

Sexually transmitted infection: Disease transmitted by sexual contact.

Social support services: Psycho-social and legal services provided by viable service providers, as well as long-term peer support in communities.

Socioeconomic status: Indicator of economic and social position in society.

Sphincter: A ring-shaped muscle that relaxes or tightens to open or close a passage or opening in the body.

Specimen: A sample (such as tissue, blood, or urine) used for analysis and diagnosis.

Subpoena: A written court order requiring the attendance of the person named in the subpoena at a specified time and place for the purpose of being questioned under oath concerning a particular matter which is the subject of an investigation, proceeding, or lawsuit.

Suicide: The act of intentionally killing oneself.

Survivor blame: Blaming the survivor for an assault. It is common for victims of sexual violence to feel like the incident was somehow their fault and for communities to hold the survivor responsible or even to punish her.

Suturing: The type of binding or stitch that doctors, and especially surgeons, use to hold skin and other tissues of the human body together after they have been severed by injury or surgery.

T

Tetanus toxoid vaccination: A type of immunization that protects against tetanus. Tetanus is a bacterial disease that leads to stiffness of the jaw muscles and other muscles. Tetanus is frequently a fatal infectious disease. Tetanus enters the body through deep wounds and puncture wounds, which can be caused by nails, splinters or insect bites, or burns, any skin break, and injection-drug sites.

Time sensitive evidence: Evidence that needs to be collected within a certain timeframe. In this context it is physical evidence that will remain on the survivor's body for only a few days at most.

U

Urethral meatus: The opening to the urethra. On males this is on the tip of the penis.

V

Vaginal discharge: Vaginal discharge is a fluid produced by glands in the vaginal wall and cervix that drains from the opening of the vagina. Normal vaginal discharge is white or clear and has a slightly sour smell. Bad smelling, yellow or thick discharge may represent a vaginal or cervical infection.

