

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 Reproductive Health Program Manager.

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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 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.

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 Version

French Version

Facilitator's Guide

Knowledge Assessment (Pre & Post Tests)

Direct Patient Care

Forensic Evidence Collection

Pictograms & Forms

Additional 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)

WHO/ILO PEP Guidelines (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 detailed descriptions of the exercises, presentation materials and equipment, logistical needs, 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 presents tools for assessing the participants' learning and their experience of the training. The pre/post test and training evaluation are included here. Handouts and 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.

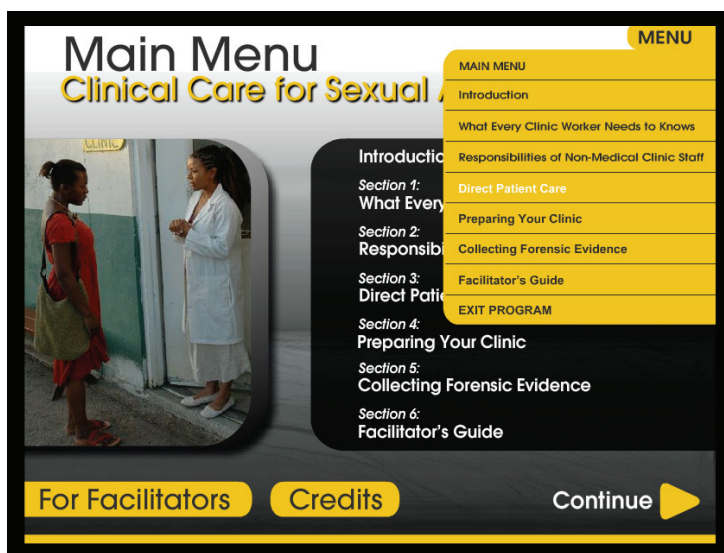
The maximum size of a training group should be 15 persons. It is recommended that 2 facilitators present the training module, particularly for groups larger than 8 - 10 persons. Ideally, one person from the health program and one person from a counseling or gender based violence prevention and response 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: reproductivehealth@theirrc.org

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.

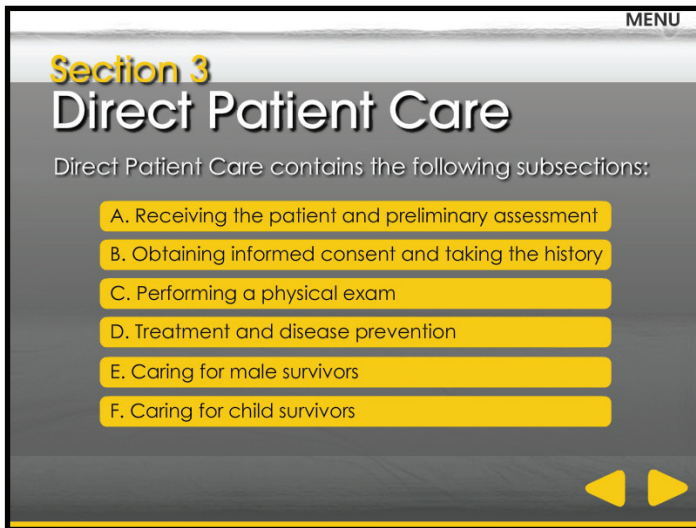
We do not recommend skipping sections or changing the order of the presentation, with the following exception: *Section 5: Collecting Forensic Evidence* should be presented prior to *Section 4: Preparing Your Clinic*. The reasons for this, as well as various options for structuring the training, are 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.

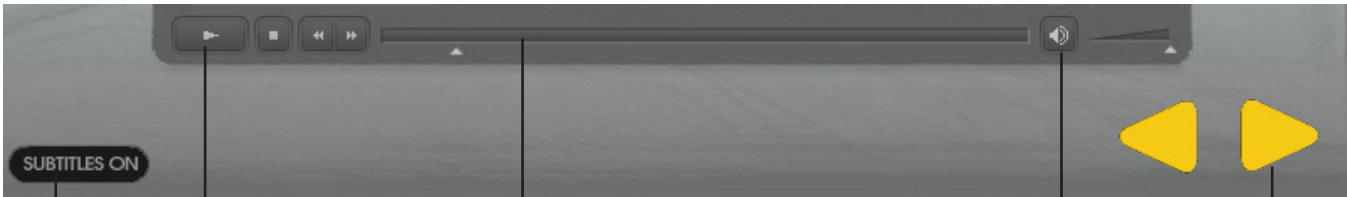
Navigate forward or backward from screen to screen by clicking on the yellow arrows at the bottom right hand corner of the screen.





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.



Subtitle Control

This is the play/pause button. When pausing click the box once and click on the box again to restart the video from the same point.

This is the progress bar for the video. It shows how far you are into the video and how much is still to come. To jump to a later point in the video you can click on a point in the bar. The length of each video segment is provided in the content notes (Chapter 3).

Volume Control

The yellow arrows allow you skip to the next slide in the DVD.
CLICKING ON THIS ARROW DURING A VIDEO WILL TAKE YOU OUT OF THE VIDEO CLIP.

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.
- 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.

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.

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 several general talking points, more talking points are suggested in the Content Notes section of this guide. The Content Notes also include the 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.

Structuring the Course

The complete training is estimated to take twelve to nineteen hours. The actual time will depend on the knowledge level of the participants, the amount of discussion, language skills, and other factors.

The training has been designed so that health workers can participate with minimal disruption to patient care. It is anticipated that trainings will be on-site and will be conducted as 1 full-day and 4 half-day sessions, which would allow regular clinical activities to take place for at least half-day throughout the week of training. Alternatively, the training can be conducted over longer or shorter periods of time, depending on the particular needs of your health staff and facility.

The five sections of the program with their intended audience and approximate duration are as follows:

Section	Audience	Estimated Time
1. What Every Clinic Worker Needs to Know	All clinic staff	3 hours 15 min
2. Responsibilities of Non Medical Clinic Staff	All clinic staff	2 hours
3. Direct Patient Care	Medical care providers	9 hours
4. Preparing Your Clinic	Medical care providers, management, an non-clinical staff who interact directly with patients	3 hours 10 min
5. Collecting Forensic Evidence	Medical care providers	1 hour

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 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 reproductivehealth@their.org of the trainings you conduct using this DVD, the names and contact information of participants and dates and location of the training.

SUGGESTED AGENDA: FIVE DAY TRAINING (HALF DAYS)

Day One

Introduction and Sections 1 & 2 for Non-Clinician Staff (5.75 hours)

DURATION	CONTENT	METHOD	RESOURCES
INTRODUCTION			
60 min	<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 (choose one from the facilitator's guide or use your own) • Discuss need for sensitivity and confidentiality. Indicate that sharing is valued but not required. • Write out code of conduct on flipchart and post in room. • Discuss issues such as lodging, per diem, meals, schedule, etc. as needed. 	<ul style="list-style-type: none"> <input type="checkbox"/> Flip chart of objectives (prepared in advance) <input type="checkbox"/> Handout: Detailed Objectives for Sections 1 and 2 <input type="checkbox"/> Flip chart, markers <input type="checkbox"/> Name tags
SECTION ONE: What Every Clinic Worker Needs to Know			
40 min	<ul style="list-style-type: none"> • Introduction • The global burden of sexual assault 	<ul style="list-style-type: none"> • DVD and group discussion 	<ul style="list-style-type: none"> <input type="checkbox"/> Computer, projector, white screen, speakers <input type="checkbox"/> Paper for "parking lot"
BREAK (15 min)			
95 min	<ul style="list-style-type: none"> • How cultural beliefs affect survivors • Survivors' universal rights • Caring for yourself and your staff 	<ul style="list-style-type: none"> • DVD and group discussion • True-False exercise on DVD 	<ul style="list-style-type: none"> <input type="checkbox"/> As above
BREAK (15 min)			
SECTION TWO: Responsibilities of Non-Medical Clinic Staff			
65 min	<ul style="list-style-type: none"> • The harmful effects of sexual assault 	<ul style="list-style-type: none"> • DVD and group discussion • Case studies on DVD 	<ul style="list-style-type: none"> <input type="checkbox"/> Computer, projector, white screen, speakers
40 min	<ul style="list-style-type: none"> • What you can do: compassion, competence and confidentiality 	<ul style="list-style-type: none"> • Exercise 1: Compassion, Competence and Confidentiality Role Play 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Compassion Competence and Confidentiality Role Play <input type="checkbox"/> Camera/video to record role plays
15 min	WRAP UP DAY ONE	<ul style="list-style-type: none"> • Discuss role plays, summarize key points • Thank participants who will be leaving and explain how the rest of the training will proceed 	

Day Two
Section 3 Direct Patient Care (3.25 hours)

DURATION	CONTENT	METHOD	RESOURCES
INTRODUCTION			
45 min	<ul style="list-style-type: none"> Introduce objectives for Section 3 Redefine group now that non-clinician staff have left Reiterate code of conduct Logistics as needed 	<ul style="list-style-type: none"> Present general objectives written on flip chart, review detailed objectives at the beginning of each section. Have group share their experiences working with survivors, what they hope to learn and how they will use the skills they gain. Have participants write out three things they want to learn on large slips of paper and post them. Discuss how each will be addressed and what will not be addressed. Review previously written code of conduct 	<ul style="list-style-type: none"> <input type="checkbox"/> Computer, projector, white screen, speakers <input type="checkbox"/> Handout: Detailed Objectives for Sections 3 and 5 <input type="checkbox"/> Resource: IRC CCSAS protocol <input type="checkbox"/> Flip chart with code of conduct <input type="checkbox"/> Large note cards or half pieces of paper and markers
30 min	<ul style="list-style-type: none"> PRE-TEST 		<ul style="list-style-type: none"> <input type="checkbox"/> Copies of pre-tests
BREAK (15 min)			
Section 3: Direct Patient Care			
75 min	<ul style="list-style-type: none"> Receiving a survivor Preliminary assessment When to refer Informed consent Taking the history Active listening 	<ul style="list-style-type: none"> DVD and group discussion Case study on DVD Exercise 2: Informed Consent (15 min) 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Consent Form <input type="checkbox"/> Paper cut outs, pens, glue or tape for large sized <u>Clinical Pathway Diagram</u>
30 min	<ul style="list-style-type: none"> Active listening (continued) 	<ul style="list-style-type: none"> Exercise 3: Active Listening 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Active Listening
10 min	WRAP UP DAY TWO		

Day Three
Section 3 Direct Patient Care Continued (4 hours)

DURATION	CONTENT	METHOD	RESOURCES
Section 3: Direct Patient Care - continued			
70 min	<ul style="list-style-type: none"> Performing a survivor led physical exam Common injuries and possible complications (including fistula) 	<ul style="list-style-type: none"> DVD and group discussion 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Female Anatomy <input type="checkbox"/> Supplies to continue <u>Clinical Pathway Diagram</u>
30 min	<ul style="list-style-type: none"> Documenting the history and physical examination 	<ul style="list-style-type: none"> Exercise 4: Documentation 	<ul style="list-style-type: none"> <input type="checkbox"/> Computer, projector, white screen, speakers <input type="checkbox"/> Handout: Medical Examination Form
BREAK (15 min) - DISPLAY RAPE KIT			
65 min	<ul style="list-style-type: none"> Treatment and disease prevention: preventing pregnancy, STIs, HIV and other infections Delayed treatment principles Mental health issues Patient discharge and follow up care 	<ul style="list-style-type: none"> DVD and group discussion Case studies on DVD Exercise 5: Talking with Suicidal Patients (OPTIONAL) 	<ul style="list-style-type: none"> <input type="checkbox"/> Resources: Local treatment guidelines or IRC CCSAS protocol <input type="checkbox"/> "Rape treatment kit" for demonstration
40 min	<ul style="list-style-type: none"> Caring for male survivors 	<ul style="list-style-type: none"> DVD and group discussion Case studies on DVD 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Male Anatomy
10 min	WRAP UP DAY THREE		

Day Four

Section 3 continued & Section 5 Forensic Evidence Collection (4 hours)

DURATION	CONTENT	METHOD	RESOURCES
Section 3: Direct Patient Care - continued			
90 min	<ul style="list-style-type: none"> Caring for young survivors 	<ul style="list-style-type: none"> DVD and group discussion Case studies on DVD 	
BREAK (15 min)			
30 min	<ul style="list-style-type: none"> Summarizing the clinical pathway 	<ul style="list-style-type: none"> Exercise 6: Timing and Treatment 	<ul style="list-style-type: none"> <input type="checkbox"/> Supplies to finish <u>Clinical Pathway Diagram</u> <input type="checkbox"/> Handout: Timing and Treatment
30 min	<ul style="list-style-type: none"> Responding to common emotional reactions 	<ul style="list-style-type: none"> Exercise 7: Responding to Common Emotional Reactions 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Responding to Common Emotional Reactions
Section 5: Forensic Evidence Collection			
60 min	<ul style="list-style-type: none"> Collecting forensic evidence 	<ul style="list-style-type: none"> DVD and group discussion 	<ul style="list-style-type: none"> <input type="checkbox"/> Computer, projector, white screen, speakers <input type="checkbox"/> Evidence Collection Kit for display (if appropriate)
10 min	WRAP UP DAY FOUR		

Day Five

Section 4: Preparing Your Clinic (4 hours)

DURATION	CONTENT	METHOD	RESOURCES
30 min	<ul style="list-style-type: none"> POST TEST FOR CLINICAL STAFF 		<ul style="list-style-type: none"> <input type="checkbox"/> Copies of the Post Test
BREAK (15 min)			
Section 4: Preparing Your Clinic			
90 min	<ul style="list-style-type: none"> Assessing your clinic's resources Tracing a survivor's route 	<ul style="list-style-type: none"> DVD and group discussion Exercise 8: Tracing a Survivor's Route 	<ul style="list-style-type: none"> <input type="checkbox"/> Resources: Local treatment guidelines and IRC CCSAS protocol <input type="checkbox"/> Flip chart paper, pens, glue, tape, etc. <input type="checkbox"/> Camera to document exercise
BREAK (15 min)			
75 min	<ul style="list-style-type: none"> Building a referral network Developing an action plan 	<ul style="list-style-type: none"> DVD and group discussion Exercise 9: Developing an Action Plan 	<ul style="list-style-type: none"> <input type="checkbox"/> Handout: Action Plan
20 min	WRAP UP TRAINING		

This chapter is divided into the following sections:

Preparing for the Training

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

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 day of training (5.7 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

Supplies

- Flip chart paper
- Construction/colored paper
- Scissors
- Markers
- Tape
- Glue
- Name tags
- Certificates of completion for participants (see page 103)
- Watch or clock

Medical Supplies

- Rape treatment supplies for demonstration (see IASC RH Kit, Sub-kit 2: Rape treatment). The Sub-kit includes medications to provide CCSAS services for a for a population of 10,000 for 3 months. The table below shows the drugs included in this Sub-kit.

CONTENTS OF IASC RH KIT - SUB-KIT 2: RAPE TREATMENT (DRUGS ONLY - for a population of 10,000 for 3 months)	
Part A: Basic treatment after a rape, including treatment for children	
Levonorgestrel 0.75 mg, packet of 2 pills/ per woman	55 pck
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
Pregnancy test, temperature stable	25
Part B: Post Exposure Prophylaxis for HIV, including treatment for children <i>Assuming that 30 adults and 8 children (4 children weighing 10 - 19 kg and 4 children weighing 20 – 39 kg) present within 72 hours of the assault.</i>	
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

- 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

Equipment

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

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.

Exercises

Handouts for the exercises are in the "Participant Handouts" section of this guide, starting on page 111.

I. Compassion, Competence and Confidentiality Role Play (40 min) **(Page 43)**

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 116. 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 that:
 - survivors are never to blame for the assault; they have done nothing wrong and deserve the best possible care.
 - 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 47)

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 also involves helping the survivor understand what to expect during the clinic visit and to answer any questions that she might have. This is an important and difficult skill to master and requires practice.

For this exercise 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 50)

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 . . ."
- Do not ask "why" questions. They are often judgmental.
- 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 exchanging their impressions of the interview.

4. Documentation (30 min) **(Page 55)**

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 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 the information that participants were able to collect, using the completed forms included here. Be sure that the terminology participants used was appropriate and accurate. Also ask participants to identify elements missing from Dr. Ngozi's interview.

5. Talking with Suicidal Patients (10 min) - Optional **(Page 70)**

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. Timing and Treatment (30 min) **(Page 79)**

This exercise summarizes and reinforces the primary elements of treatment for survivors of sexual assault. Draw a blank version of the chart below (with category headings only, leaving the boxes under the timeframes blank) on a flipchart. Work through it as a group. Encourage discussion and provide clarification as needed. Emphasize that HIV testing within 2 weeks of the assault will tell us whether the survivor was infected prior to the assault, not whether the assault resulted in infection. Similarly pregnancy testing will reveal the existence of a prior pregnancy. Women who are pregnant should still receive prophylaxis for STIs and HIV. The medications for STI prophylaxis will need to be adjusted (refer to local protocols for the correct dosages). 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.**

TREATMENT FOLLOWING SEXUAL ASSAULT		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

7. Responding to Common Emotional Reactions (60 min) (Page 82)

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. 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 (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.

8. Tracing the Survivor's Route (75 minutes) **(Page 83)**

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. Managers and other staff involved in receiving the survivor and providing services (laboratory staff for example) should join the discussion, if possible. Have participants who work at the same facility or area sit together. 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. Make sure the toilets and bathing facilities are included, as well as laboratory and pharmacy services. How many people does the survivor need to talk to? How many times does she or he need to move? Are her rights to privacy and confidentiality protected? Also include how information about the survivor travels through the clinic. Who needs to know? When is the case identified and a code number assigned? Where are the completed documents kept?

After about 25 minutes, have the group go through the checklist of needs for clinical care of sexual assault survivors (page 7 of the IRC protocol) to mark where each item is located on their map. Note which items are missing or need to be moved or changed in order to streamline services, or any other improvements that should be made.

After another 30 minutes, ask the participants to begin finalizing their presentations. If the participants are all from one facility then 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.)

If a presentation to stakeholders cannot be organized at the time of the training it should be done at another time. During the training participants can then divide into groups by facility or if there is a big group all working in the same facility they can be divided up so that there are no more than six people per group. They can then have 10 minutes to present to one another and suggestions can be shared to develop a collective presentation and action plan (see exercise 9).

9. Developing an Action Plan (75 minutes) **(Page 85)**

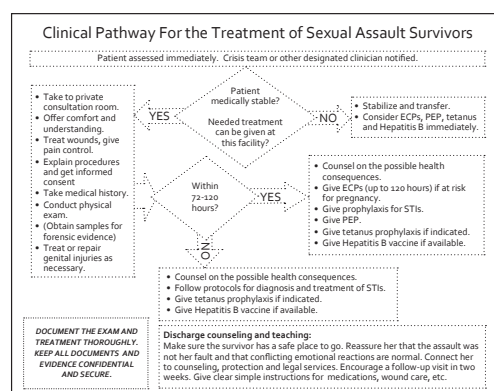
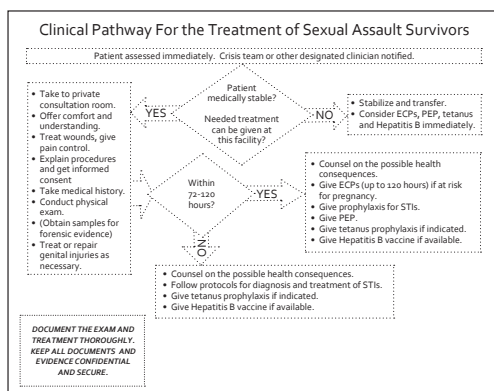
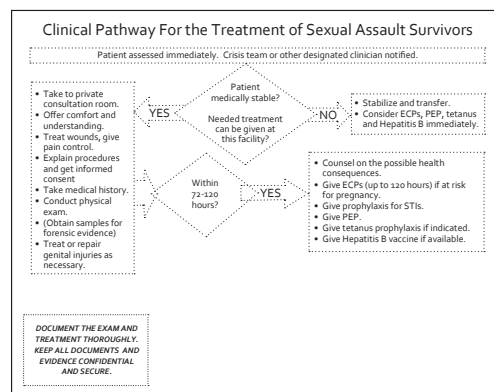
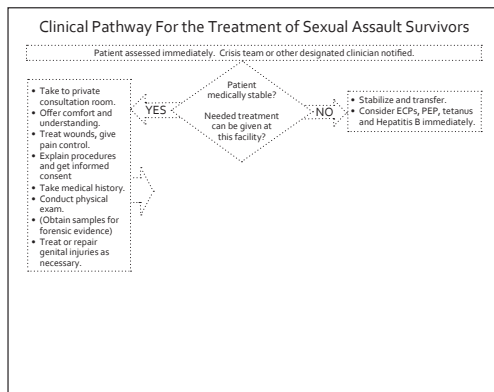
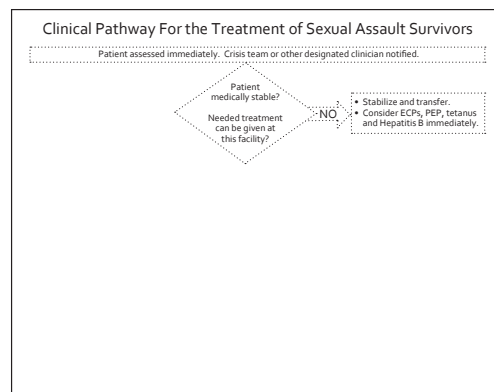
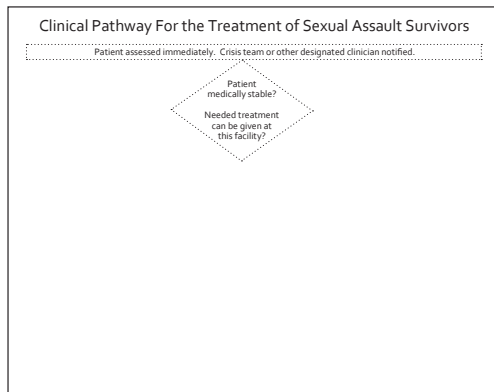
Based on the issues identified, suggestions offered, and feedback from stakeholders (if possible) have the groups develop an action plan for improving clinical care for sexual assault survivors in their program or site. Use the suggested template (see "Participant Handouts: Action Plan" on page 128) or have them develop their own. Be sure all major decision-makers are present or at least aware of the process. If key stakeholders are absent, the action plan can be presented along with the situation analysis developed in exercise 8 and revised afterwards.

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.)

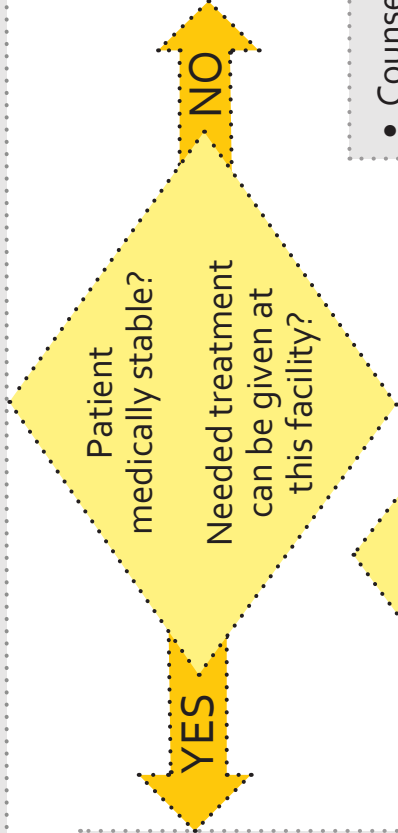
Facilitators should guide participants through this process where indicated in the manual by the Clinical Pathway icon, adding a piece of the pathway to the wall at each of these points, as shown below.



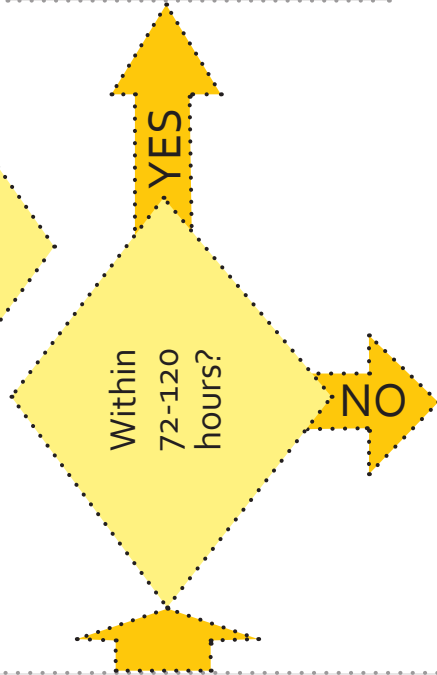
Clinical Pathway For the Treatment of Sexual Assault Survivors

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

- Take to private consultation room.
- Offer comfort and understanding.
- Treat wounds, give pain control.
- Explain procedures and get informed consent
- Take medical history.
- Conduct physical exam.
- (Obtain samples for forensic evidence)
- Treat or repair genital injuries as necessary.



- Stabilize and transfer.
- Consider ECPs, PEP, tetanus and Hepatitis B immediately.



- Counsel on the possible health consequences.
- Give ECPs (up to 120 hours) if at risk for pregnancy.
- Give prophylaxis for STIs.
- Give PEP.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

- Counsel on the possible health consequences.
- Follow protocols for diagnosis and treatment of STIs.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

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.

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 (if applicable)	
	Clarify per diem rates (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, masking tape and other classroom supplies	
	Medical supplies for demonstration	
Information and Resources		
	Local medical protocols	
	Local legal guidelines	
	IRC Protocol	
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 needed materials for each participant <ul style="list-style-type: none"> • Protocol • Handouts • Evaluations (daily and final) • Pre-test • Post-test • Certificates 	

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

Presenting the Training

Introducing the Training

All participants must be made to feel welcome. Some participants may be sexual assault survivors themselves or know someone who is. This can also be an emotional issue for people who have not directly experienced assault. 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 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.
- Take risks; step outside your comfort zone.
- 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 (for example, 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 (for example, 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

(adapted from Pathfinder International)

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 encourage participation.• 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.

Introductions and Ice Breakers

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 of a compound work (ICE - CREAM, FLAG - POLE, SURF-BOARD) and have them find their matching partner.

Fact or Fiction

Each person writes down four facts 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 fact, which is not true. The group should compare their written responses 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 more appropriate to 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.

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		Handout	
Correction		Refer to other resources	
Exercise		Restart DVD	
Clinical Pathway Diagram			

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 re-creations 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 when working with survivors, 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

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.

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 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



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.



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.

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.

[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."

[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.

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



DISCUSS:

- Do you think sexual assault happens in communities?
(our, 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.

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.

TEXT CARD: Right to Information

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

She has a right to know about:

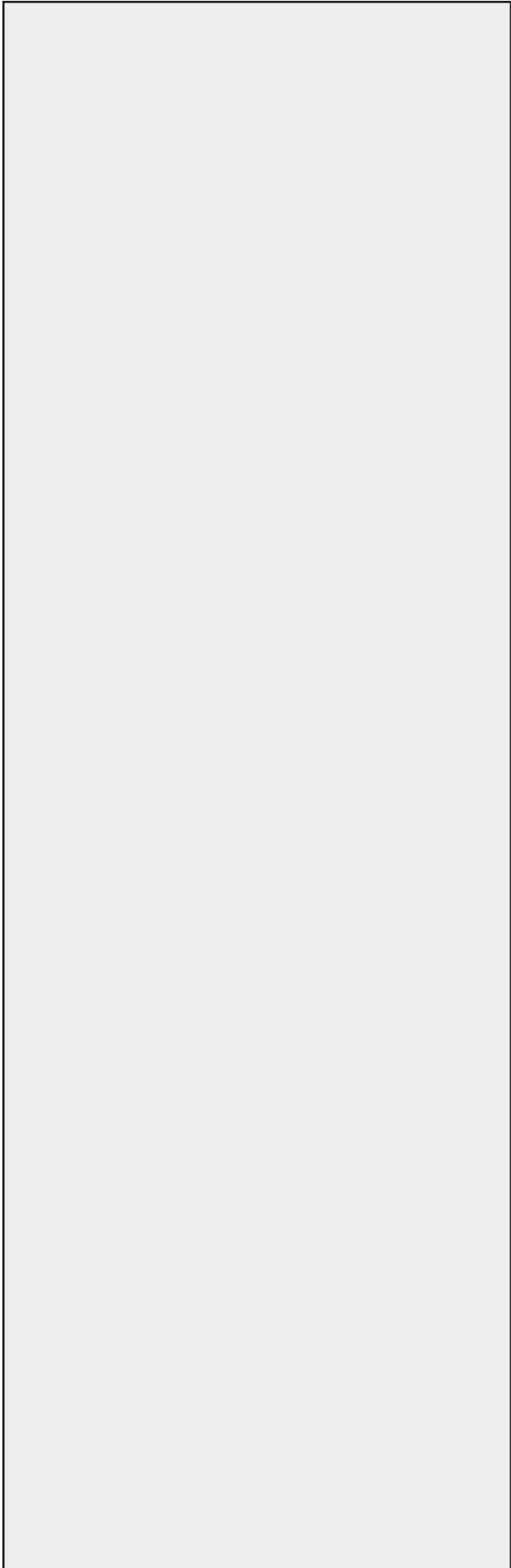
- her right to privacy, confidentiality, and self-determination
- the details of the examination
- treatment options available to her
- the effects and side effects of prescribed medications
- available referral services

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

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.”



STOP AND DISCUSS



10 MINUTES



BREAK

DISCUSS:

- Have a list of rights on a flip chart to summarize. Check for understanding of complex terms.
- 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 including The Convention on the Rights of the Child, International Covenant on Economic Social and Cultural Rights, Convention on the Elimination of All Forms of Discrimination Against Women, and Protocol to the African Charter on Human And Peoples’ Rights on the Rights of Women in Africa.

DISCUSS:

- How would you like to be supported?
- Does your HR department have a system for support?
- What can you do to support each other?

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.

LEARNING OBJECTIVES

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.



STOP AND SUMMARIZE

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 any of 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

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.

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

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

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

▶ RESTART

Introduce this as the first case study. Read the options aloud 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).

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.

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.



STOP AND GO TO EXERCISE I



40 MINUTES

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



BREAK

EXERCISE I: COMPASSION, CONFIDENTIALITY AND COMPETENCE

Role-play activity—have groups act out situations using what they have learned. (See page 19 for complete directions)

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.

Acknowledge the staff 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.

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 you have any personal, cultural, or religious barriers to providing complete services to survivors you 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.

Clinical Pathway Diagram

The preliminary assessment is the first decision point in the clinical pathway. Put up the corresponding diamond on the wall.

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.

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. 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?



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

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

For patients who can be managed at the facility the consent process is the next point of interest on the clinical pathway. Add the yes arrow and the corresponding box and note where Alicia and Dr. Ngozi are in the pathway.



DISCUSS: Informed Consent

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.

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.

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



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 20 for complete directions)



HANDOUT: Consent Form



Clinical Pathway Diagram

Taking the survivor’s history is the next point of interest to note on 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.”

- 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?
- 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

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.

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.

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.

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?

- A. Reassure the patient by saying, "I know this is hard, please continue when you are ready."
- B. Ask the patient if she needs to take a break.
- C. 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?" 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
- 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.

 **EXERCISE 3: ACTIVE LISTENING**

Have participants practice active listening skills.

(See page 20 for complete directions)

 **HANDOUT: Active Listening**

 **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.

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 (00:53)

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

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.

CORRECTION:

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.

HANDOUT: Female Anatomy

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

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

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 - Contradictions

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.

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,



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?

EMPHASIZE:

IRC personnel should never be involved in female genital cutting or resewing. 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.



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 contradictions for doing a speculum exam.

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

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.

to make sure that you feel secure and safe before coming in to report it. And then also, if there's 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. Even if they have to go to church. Either they are going to out of church often to keep changing their nappies, or pads if they can afford them, or that they don't go there at all. 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. So traumatic fistula in general is the worst form of sexual violence."

▶ RESTART:

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.

✕ CORRECTION:

Although the patient in this video is in pain and diagnosed with fistula, pain is not usually a symptom of fistula. Her symptoms look more like pelvic inflammatory disease (PID). Her bleeding after one week is not explained by the diagnosis of fistula either.

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.



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 on any pre-existing injuries

VIDEO: Documentation Guidelines



STOP, PUSH PAUSE AND GO TO EXERCISE 4



30 MINUTES



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.



EXERCISE 4: DOCUMENTATION

Play the video of Alisha's history and physical exam. Have participants fill out the form. Review correct documentation. (See page 21 for complete directions)



HANDOUT: Medical History and Examination Form



Clinical Pathway Diagram

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

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 ST--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..the care is--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., sprain fractures, pain control)

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

Treatment 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.

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.

[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

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.

- 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.

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. (Refer to RHRC distance learning module “Emergency Contraception for Conflict-Affected Settings”)

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.

This module is included in the resources at the end of the DVD.



DISCUSS: ECPs

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 survivors does not want one.

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.

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

 **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.

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.
- 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 doxycycline)
- 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



REFER to local treatment guidelines. If there is no established treatment guideline then review the IRC protocol. For more detail refer to the WHO STI Guidelines at the end of the DVD.

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

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

EXPLAIN:

Not all survivors need PEP. If there is neither penile penetration nor ejaculation PEP is not indicated. If there have been serial attacks over weeks or months it may not be appropriate.



REFER to the local protocol. If there is no local protocol, refer to IRC protocol.

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

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?

- No, because the risk of HIV transmission in this case is low.
- No, because the effectiveness of PEP is unknown.
- Yes, PEP against HIV should be offered as soon as possible.
- 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



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.

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 it and tell the group that it will be discussed later. (Parking Lot)

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.

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.

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.

NOTE:

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

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?

- A. Advise the patient to keep the genital area clean and take a stool softener to promote healing of her injuries.
- B. The patient is pregnant as a result of the assault and needs to let her husband know about it
- C. 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

TEXT CARD: Delayed Care Seeking

Some survivors seek care weeks or months after an assault. You may learn

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.

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.

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: Injuries

Provide care based on signs and symptoms:

- Treat any unhealed or infected wounds.
- Evaluate whether vaccinations are indicated.
- Incontinence of urine or stool may indicate severe complications resulting from injury, such as fistula or rectal sphincter damage. Such patients should be referred for further evaluation and care.

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 testing for HIV.
- HIV testing can be done as early as six weeks after an assault but should then be repeated at three to six months.

 **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.

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

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.

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

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.

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.

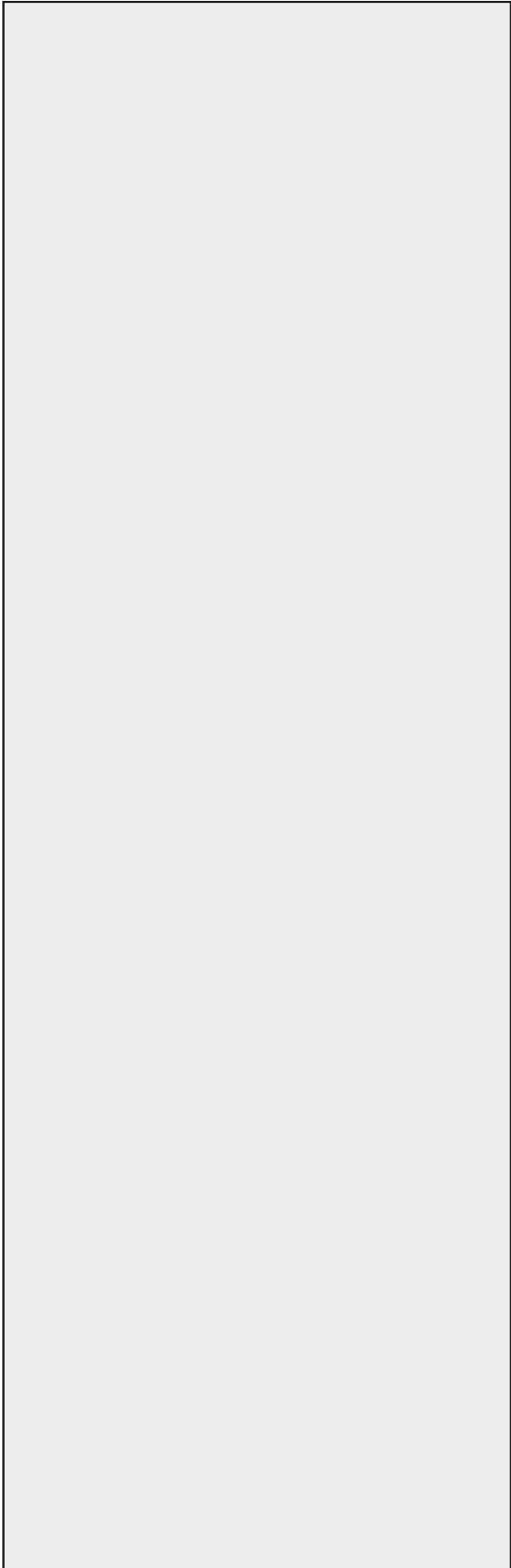
TEXT CARD: Referral for Suicidal Patients

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?

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

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

DISCUSS:

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

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 text card, "**Suicide and Sexual Assault Survivors**" for suggestions when asking about suicide.

(See page 21 for complete directions)

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.



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."

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.

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)



STOP AND DISCUSS



5 MINUTES



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.



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?

EXPLAIN:

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



HANDOUT: Male Anatomy

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

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.”

[WILMA DOEDENS] “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.

✘ 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 course (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

EXPLAIN:

The male survivor needs to hear that his reactions were normal. Tell him “This was a terrible thing that happened to you. The body reacts in ways we cannot control during such an attack, including getting an erection and even ejaculating. It does not mean that you liked it.”

return in three days for a repeat evaluation or providing antibiotics will not improve this patient's clinical course.



STOP AND SUMMARIZE



BREAK

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 and-- that they do not know. So the first is that you make them feel at ease. Talk to them just like in a child friendly manner so they try to open up, bit by bit, and they expose their problems."

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.



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.

[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.”

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-appointed.

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.

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.

X 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 the a 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.

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).

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.



STOP AND DISCUSS



20 MINUTES

EXPLAIN:

When we talk about child abuse we are focussing 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?

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.

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

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.



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 and most do not block the vaginal opening completely.

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.

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 Anorectal 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.

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.

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.

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.

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

EMPHASIZE:

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

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.



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.’



BREAK



STOP AND GO TO EXERCISE 6



30 MINUTES

GO TO EXERCISE 7



30 MINUTES



BREAK



**STOP - END OF SECTION
PROCEED TO SECTION 5**



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 6: TIMING AND TREATMENT

Use flip chart paper to fill in the chart on timing and treatment.
(See page 21 for complete directions.)



HANDOUT: Timing and Treatment



EXERCISE 7: 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 22 for complete directions.)

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.



STOP AND GO TO EXERCISE 8 TRACING A SURVIOR'S ROUTE



25 MINUTES

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.



EXERCISE 8: TRACING A SURVIOR'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 23 for complete directions.)

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)

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

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.

- 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)



STOP AND CONTINUE 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



STOP AND GO TO FINAL EXERCISE



60 MINUTES

END OF TRAINING



EXERCISE 8 CONTINUED: TRACING A SURVIVORS ROUTE

- Use the checklist and what you have learned to identify gaps in your response to sexual assault survivors. Document these on the map of your facility.
- Begin thinking about ways to improve the Clinical Care of Sexual Assault Survivors.



REFER to Checklist (IRC Protocol page 7)



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.



EXERCISE 9: ACTION PLAN

Develop an action plan with time line, assigned responsibilities and follow-up plan. (See page 23 for complete directions)



HANDOUT: Action Plan

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 this clinical care, 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

TO THE FACILITATOR:

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.

- 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
- 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:

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.

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
- 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 Examination

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,

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.

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.

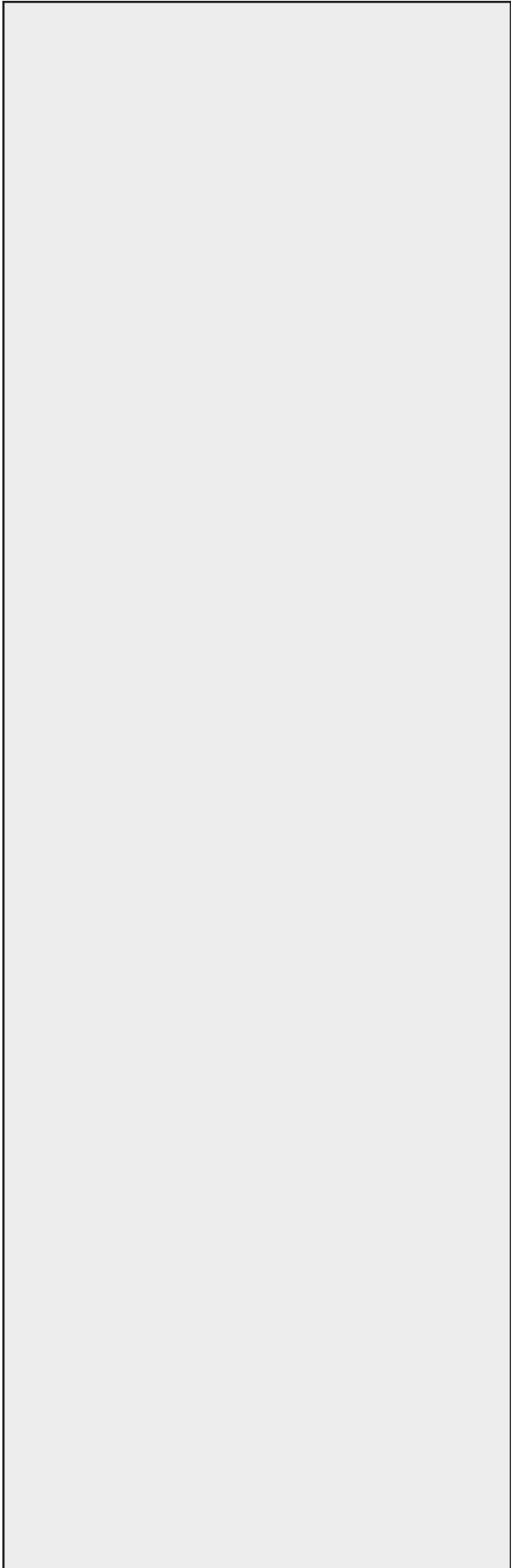
Air dry the swab at room temperature, label it, and send it to the lab for DNA analysis.

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 mucous 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.

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.

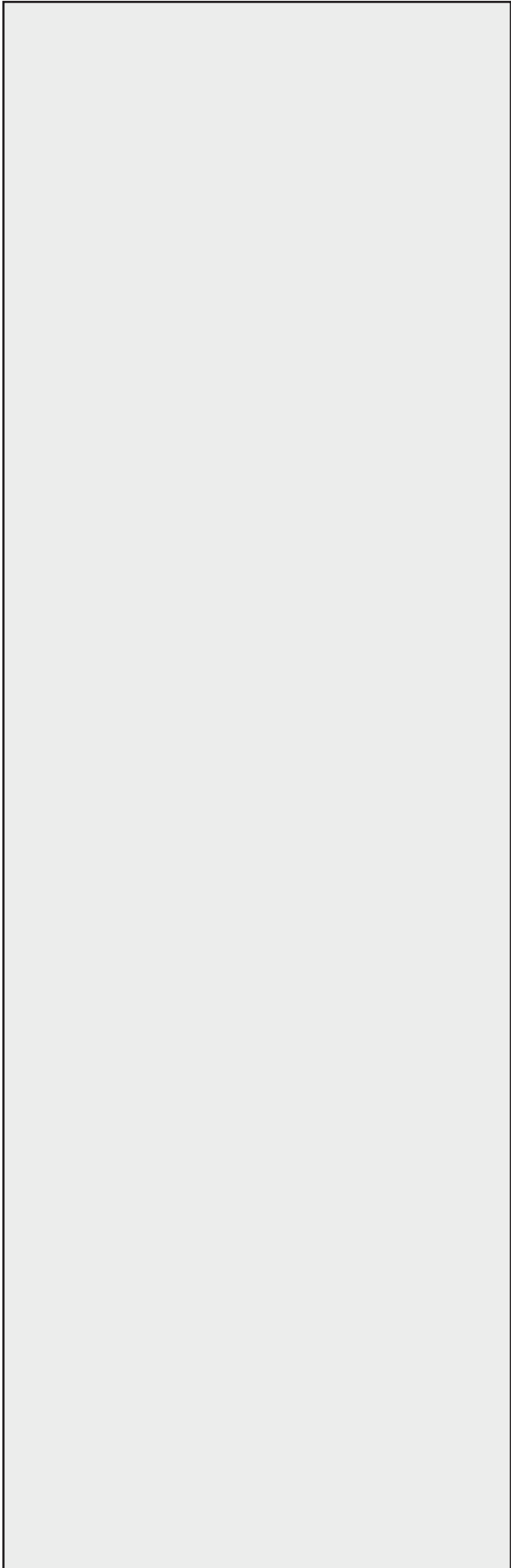
TEXT CARD: Special Considerations Regarding Children

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 Regarding 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

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.

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.”



STOP AND DISCUSS



10 MINUTES



BREAK

**END OF CLINICAL SECTION
MANAGERIAL STAFF SHOULD
RETURN FOR THE NEXT SECTION**



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?

Evaluating Training Participants

Either prior to 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. The grading rubric is found in the answer key. 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
- E. All of the above

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 should 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.

Direct Patient Care

1. We don't 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. A and B
 - E. none of the above

2. Match the universal rights with the following things a clinic worker should do. More than one action may fit a single right, but choose only one letter for each of the numbered rights.
 1. Right to health care
 2. Right to non-discrimination
 3. Right to information
 4. Right to privacy
 5. Right to confidentiality
 6. Right to self-determination
 - a) Have the lab technician go to the survivor rather than making him or her go into the lab if any testing is needed.
 - b) Give an unarmed male survivor treatment even though he is a member of the military group which previously attacked your village.
 - c) Respect a survivor's decision to refuse an HIV test before starting PEP.
 - d) Give a survivor the care she needs even if she cannot pay.
 - e) Make sure a survivor understands her treatment choices.
 - f) Don't tell anyone that someone came to the clinic for an HIV test.

3. The term rape. . .
 - A. is the same as sexual assault.
 - B. includes forced oral sex.
 - C. is a medical diagnosis.
 - D. B and C
 - E. all of the above

4. 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. provide documentation of any injuries.
 - D. B and C
 - E. all of the above

5. When counseling the survivor...
 - A. listen closely to her concerns.
 - B. offer concrete advice.
 - C. ask direct yes or no questions.
 - D. do not talk about HIV infection risk unless you can offer treatment.
 - E. all of the above

6. All of the following must be true if you are going to do a speculum exam, EXCEPT
 - A. the survivor has been fully informed and given her consent.
 - B. the survivor is past puberty.
 - C. you have received necessary clinical training.
 - D. the family has agreed to the examination.
 - E. all of the above must be true.

7. What is an appropriate thing to say to a survivor who refuses a genital examination?
- I will not be able to give you any medicine.
 - How can I tell whether your story is true?
 - I am still glad you came. Let's talk about your health concerns.
 - A and C
 - all of the above
8. When you are taking the survivor's history of the assault...
- always ask what he or she was wearing
 - begin with very specific questions
 - make sure there is a third person in the room to take notes
 - let him or her tell the story in his or her own words
 - all of the above
9. List four possible health effects of sexual assault
- _____
- _____
- _____
- _____
10. All of the following are true about informed consent EXCEPT
- Information needs to be given in a language the survivor understands well.
 - The survivor can consent to some elements of the examination and refuse others.
 - The survivor needs to be able to read the form to give consent.
 - Even after she has given consent the survivor can change her mind.
 - a child cannot legally give consent
11. After a sexual assault...
- there are always visible injuries.
 - injuries to the mucous membranes usually heal quickly.
 - survivors can receive the most complete treatment if they come in within 5 days (120 hours).
 - A and C
 - all of the above
12. During the preliminary assessment you should...
- assess for shock.
 - consider whether the survivor needs to be referred.
 - take time to explain to the survivor what you are doing.
 - A and B
 - all of the above
13. If a conscious survivor needs to be referred to higher level care you should . . .
- provide her with a written referral explaining that she was assaulted.
 - provide her with ECP and HIV PEP if she is at risk and has no contraindications, even if you have not completely examined her.
 - have her send for family to bring money so that she can pay for public transportation.
 - A and B
 - none of the above
14. If a survivor comes after 72 hours she will not . . .
- be able to start post-exposure prophylaxis for HIV.
 - be able to use emergency contraception.
 - need a physical exam.
 - be eligible for vaccinations against Hepatitis B or tetanus.
 - A and C

15. Options for emergency contraception within 120 hours (5 days) include:
- A. progestin only single dose regimen
 - B. combined oral contraceptives in a 2-dose regimen
 - C. insertion of a copper IUD
 - D. A and B
 - E. all of the above
16. Sexual assault...
- A. should always be reported to the police or other authorities.
 - B. is a crime of passion.
 - C. can happen to anyone.
 - D. B and C
 - E. all of the above
17. People who experience sexual assault...
- A. usually made a mistake that put them at risk
 - B. find it difficult to tell their stories
 - C. may experience both anger and guilt
 - D. B and C
 - E. all of the above
18. When taking the survivor's medical history ask about all of the following, EXCEPT
- A. any significant medical conditions
 - B. age of first intercourse
 - C. current use of contraceptives
 - D. last menstrual period
 - E. allergies
19. 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. A and B
 - E. all of the above
20. In order to provide quality clinical care to sexual assault survivors you need to...
- A. avoid asking embarrassing questions.
 - B. memorize the dosages of medications to prevent sexually transmitted infections.
 - C. be prepared to receive a survivor at any time.
 - D. all of the above
 - E. none of the above
21. During the examination...
- A. keep the survivor covered as much as you can.
 - B. do not talk to the survivor since it may embarrass her.
 - C. only look at the areas where she reported injuries.
 - D. do not do an anal exam unless she reports anal penetration.
 - E. all of the above
22. When teaching a survivor about HIV post exposure prophylaxis tell her...
- A. she must be tested for HIV before starting the medication.
 - B. she should stop the medication immediately if she has any side effects.
 - C. it is always effective.
 - D. if she is already positive it will not fight the infection.
 - E. A and D

23. Compared to women, men who have been sexually assaulted...
- A. are less likely to contract HIV.
 - B. are less likely to report the incident.
 - C. are less likely to need mental health counseling.
 - D. A and B
 - E. all of the above
24. When it is time for a survivor to leave the clinic, be sure to reinforce that...
- A. she is not to blame for the assault
 - B. she should come back for follow up in 2 weeks or sooner if she develops any new symptoms
 - C. she should not tell anyone what happened to avoid being stigmatized
 - D. A and B
 - E. all of the above
25. Which of the following female survivors should be offered emergency contraception?
- A. A 12 year old who has not yet begun menstruating.
 - B. A 32 year old who gave birth 5 weeks ago and has been breastfeeding her baby.
 - C. A 40 year old who reports forced anal sex 2 days ago.
 - D. A 23 year old who reports repeated assaults with vaginal penetration until she escaped 8 days ago.
 - E. none of the above
26. When interviewing a child...
- A. always keep a parent or relative with the child.
 - B. remember that children are not reliable sources of information.
 - C. use language the child can understand.
 - D. A and C
 - E. all of the above
27. When a child comes in for care after a sexual assault...
- A. seek consent from a responsible adult guardian.
 - B. include the child in the decision-making process.
 - C. provide prophylaxis for HIV and STIs regardless their age.
 - D. A and B
 - E. all of the above
28. An 8 year old child is brought to you by an older friend. She says that she is being abused by her step-father who is a police officer and she is afraid to go home. When you tell her you will have to contact her mother, she begins to cry. She says her mother knows about it and told her not to tell. You should...
- A. send someone to the police station right away to get her step-father.
 - B. explain that her safety is your primary concern and help her identify an adult relative she can trust to tell her story to.
 - C. reassure her that you will not tell anyone about it.
 - D. all of the above
 - E. none of the above
29. During the physical examination of a female child assaulted 2 weeks before...
- A. a genital exam should be done to determine virginity.
 - B. a genital exam should be done to document injuries.
 - C. a genital exam should only be done with the child's agreement.
 - D. B and C
 - E. all of the above

30. 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 having a trained counselor or another trusted adult to talk to.
 - D. the child should stay at home as much as possible.
 - E. all of the above
31. All of the following are sexually transmitted infections that can often be prevented if a survivor is seen soon after the assault EXCEPT
- A. Chlamydia
 - B. Herpes
 - C. Hepatitis B
 - D. Syphilis
 - E. B and C
32. Before taking the history of a man who reports being sexually assaulted...
- A. explain the services you can provide him.
 - B. ask whether he would rather be seen by a female or a male provider.
 - C. ask him whether he has had sex with a man before.
 - D. A and B
 - E. all of the above
33. A man comes to the clinic because of generalized body aches. After some questioning he tells you "Some soldiers attacked me a few weeks ago. They did something horrible to me and I haven't felt right since. I can't control my bowels. I feel ashamed. I haven't gone back to my family." He refuses to let you examine him. 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 it is good he came to see you.
 - D. B and C
 - E. none of the above
34. When adapting the standard protocol to your local context...
- A. consider the local prevalence of sexually transmitted infections.
 - B. the country's protocol may be out of date and should be ignored.
 - C. use the universal definition of child as anyone under 18 years old.
 - D. A and B
 - E. none of the above
35. When assessing the current quality of care for sexual assault survivors...
- A. include managers and non-clinical staff in the discussion.
 - B. consider drug availability.
 - C. work with GBV prevention and response services.
 - D. B and C
 - E. all of the above
36. If your facility cannot provide adequate services for sexual assault survivors, your options include:
- A. tell survivors to find another health care facility.
 - B. don't tell anyone in the community because you don't want to discourage survivors from seeking care.
 - C. identify the gaps in care and work with your managers, coordinators and technical advisors to make improvements.
 - D. B and C

37. A survivor lives in a remote village with no formal support services. You should...
- A. encourage her to come back to see you if she wants to talk.
 - B. encourage her to seek information and possible support from members of a women's group in her area since you know they are concerned about violence against women.
 - C. have the local priest visit her since you know she regularly attends his church.
 - D. A and B
 - E. all of the above

Forensic Examination

1. Forensic specimens collected may be used as evidence to...
- A. support the survivor's story.
 - B. prove that physical force was used.
 - C. identify the assailant.
 - D. A and B
 - E. all of the above
2. A survivor asks to have forensic evidence collected 3 days after the assault. She has already taken a bath and changed her clothes. You should...
- A. reassure her that you will be able to collect high quality samples.
 - B. get her permission to do a speculum examination to collect cervical samples.
 - C. make sure the provider who examines her is able to provide evidence in court.
 - D. B and C
 - E. all of the above
3. When counseling the survivor about the possibility of collecting forensic evidence tell her...
- A. the only 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. A and C
 - E. none of the above
4. When collecting forensic evidence...
- 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. A and B
 - E. none of the above
5. All health care providers should...
- A. know where a sexual assault survivor can get quality medical care.
 - B. be able to perform a forensic examination.
 - C. be able to quickly take a sexual assault survivor's history.
 - D. A and C
 - E. all of the above

PRE-/POST-TEST ANSWER KEY

Do not give to participants until the end of training.

The Direct Patient Care portion of the Pre/Post-Test is comprised of 37 questions. Question 2 is worth 6 points, Question 9 is worth 4 points and all other questions are worth 1 point for a total of 45 points. A participant must get at least 36 points out of 45 points to attain 80% and receive a certificate. The Forensic Evidence section of the test is composed of 5 questions, each worth 1 point, a participant must get 4 points out of 5 points right to get 80% and be awarded a certificate.

Direct Patient Care

1. B
2. D
B
E
A
F
C
3. B
4. D
5. A
6. D
7. C
8. D
9. HIV, STIs, Fistula, Unwanted Pregnancy, Mental Health Problems, Sexula Dysfunction
10. C
11. C
12. E
13. B
14. A
15. E
16. C
17. D
18. B
19. E
20. C
21. A
22. D
23. B
24. D
25. A
26. C
27. E
28. B
29. C
30. C
31. B
32. D
33. C
34. A
35. E
36. C
37. D

Forensic Examination

1. E
2. D
3. A
4. E
5. A

CERTIFICATE OF PARTICIPATION

This certificate is awarded to

In recognition of completion of ____ hours of training

ON THE

THE CLINICAL CARE OF SEXUAL ASSAULT SURVIVORS

WITH THE INTERNATIONAL RESCUE COMMITTEE'S MULTI MEDIA TRAINING TOOL

Location: _____ Date: _____

Signature _____

Date _____



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.

Workshop 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).

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 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 EC 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 term used by health care providers.

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.

Participant Handouts

1. Detailed Objectives for Sections 1 and 2
2. Detailed Objectives for Sections 3 and 5
3. Detailed objectives for Section 4
4. Exercise 1: Compassion, Competence and Confidentiality Role Play
5. Informed Consent Form
6. Exercise 3: Active Listening
7. Female Anatomy
8. Medical Examination Form
9. Male Anatomy
10. Exercise 6: Timing and Treatment
11. Exercise 7: Responding to Common Emotional Reactions
12. Exercise 9: Action Plan for Preparing Your Clinic
13. Notes on Using Translators

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.

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.

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.

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?

CONFIDENTIAL
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	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:

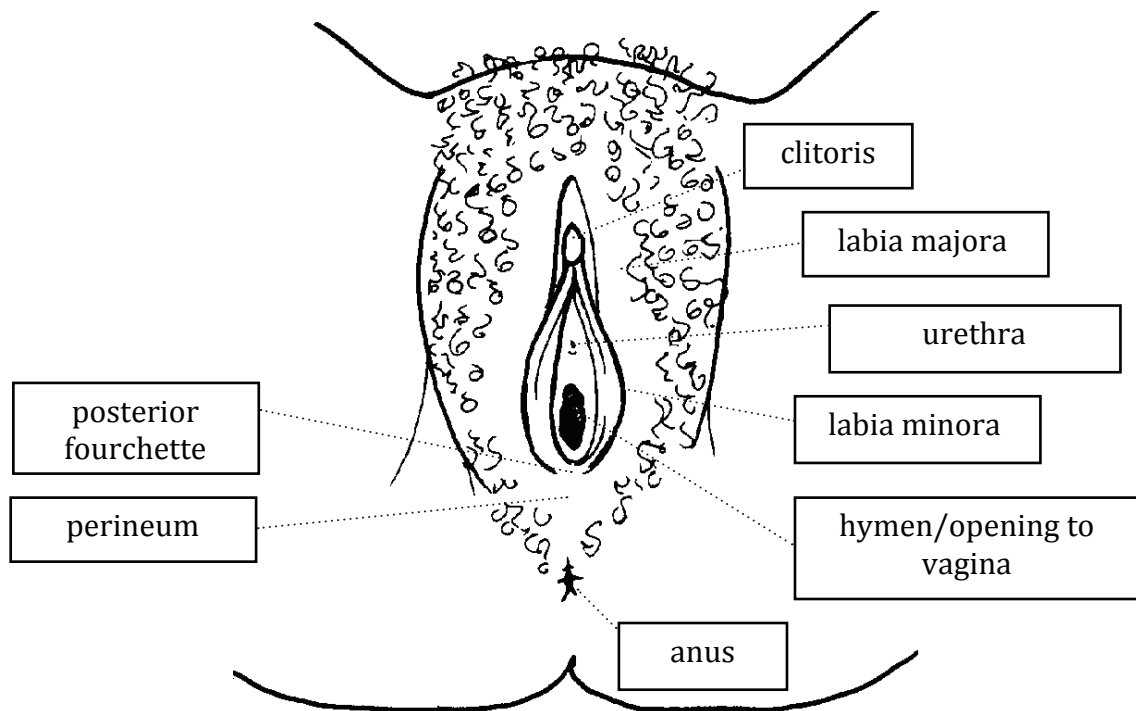
The participants should be divided into groups of three, with a speaker, a listener, and an observer.

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 active listening techniques. Give feedback at the end of the interview. Help the listener learn by pointing out areas needing improvement.

Female Anatomy



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)	Menstruation at time of event Yes No	
Evidence of pregnancy Yes No	Number of weeks pregnant _____ weeks	
End of last pregnancy (delivery, stillbirth, pregnancy loss)	(dd/mm/yy)	

Existing health problems

(Include history of female genital mutilation, type)

Allergies:

Current medication:

Vaccination Status	Vaccinated	Not Vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Unknown	Known	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:

CONFIDENTIAL

CODE: _____

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	Mouth and Nose
Eyes and Ears	Neck
Chest	Back
Abdomen	Buttoks
Arms and hands	Legs and feet

Genital Exam

Vulva/scrotum	Introitus and hymen	Anus
Vagina/Penis	Cervix	Bimanual/rectovaginal examination

Position of patient (supine, prone, knee-chest, lateral, if child - in adult's lap)

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/stored	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)

CONFIDENTIAL

CODE: _____

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**

Explain:

Survivor has a safe place to go: **Yes** **No** Has someone to accompany her/him: **Yes** **No**

Counseling provided:

Referrals:

Follow up required:

Date of next visit (dd/mm/yy):

Name of health worker conducting examination/interview: _____

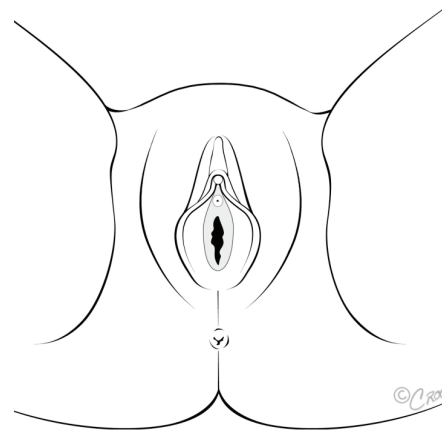
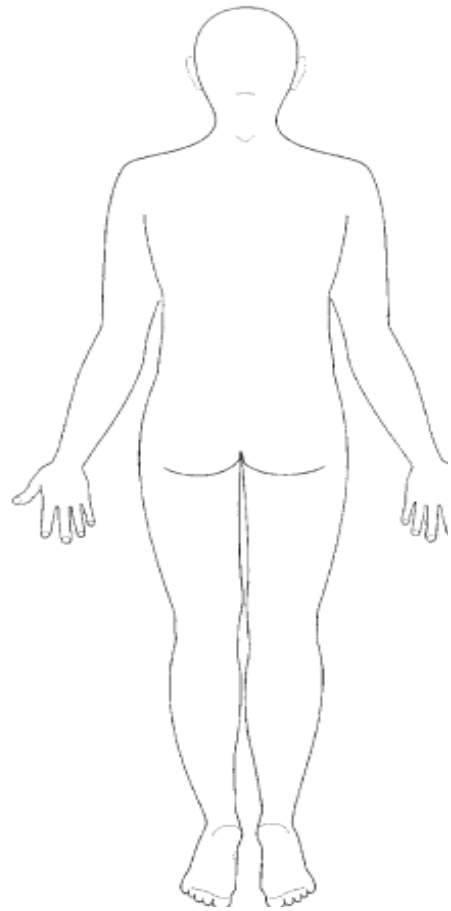
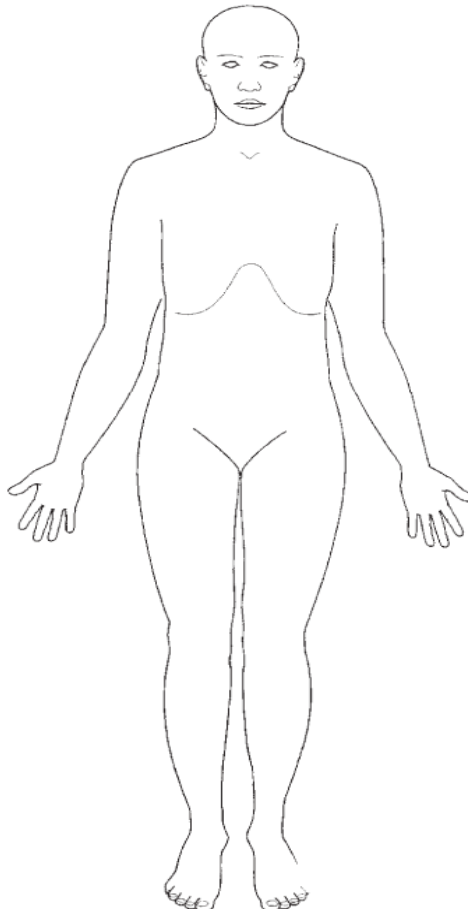
Title: _____ Signature: _____ Date: _____

Follow-Up Notes:

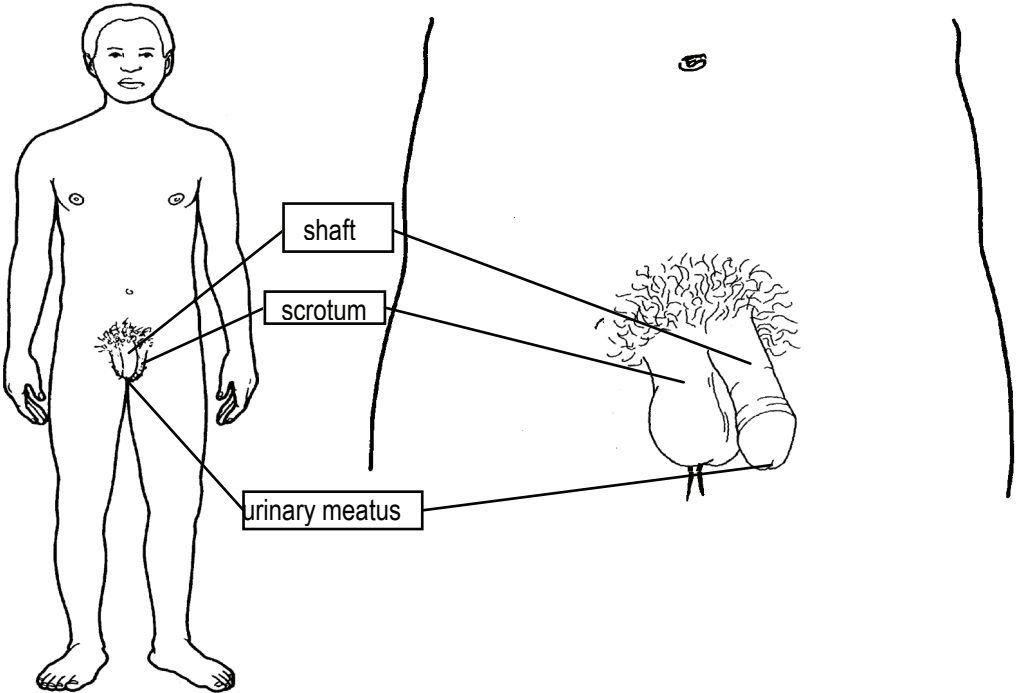
Date of follow-up visit (dd/mm/yy):

Name/Title _____ Signature: _____ Date: _____

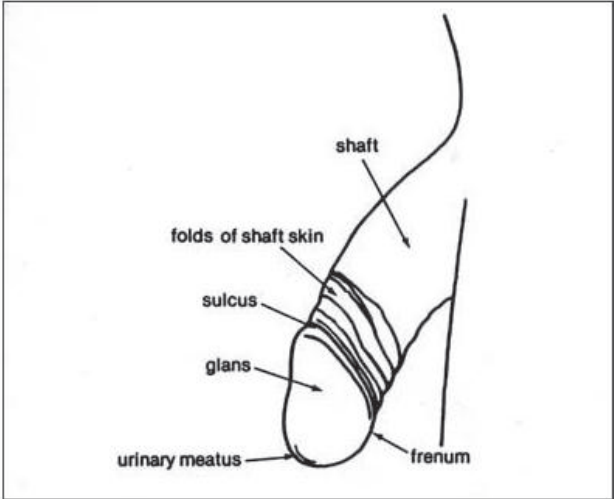
Pictograms



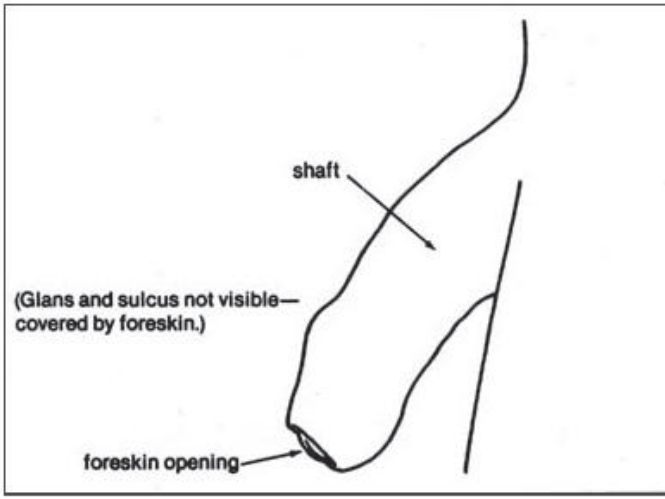
Male Anatomy



Circumcised Penis



Uncircumcised Penis



Exercise 6: Timing and Treatment

TREATMENT		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 within 2 weeks of the assault will show whether the survivor was infected prior to the assault, not whether the assault resulted in infection.
- Pregnancy testing within 2 weeks will reveal the existence of a prior pregnancy. Women who are pregnant should still receive prophylaxis for STI and HIV. The medications for STI prophylaxis will need to be adjusted (refer to local protocols for the correct dosages).
- 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.
- HIV testing is voluntary and should never be a requirement for treatment. Likewise, delays in testing should never lead to delays in treatment.

Exercise 7: 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 the emotional reaction assigned to your group 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 9: Action Plan for Preparing Your Clinic

Facility/Location:		Working Group Members:						
Date:		Priority (low, medium, high)	Immediate response	Target Date	Person(s) Responsible	Long Term Response	Target Date	Person(s) Responsible
		Resources Needed:						
		Resources Needed:						
		Resources Needed:						
		Resources Needed:						
		Resources Needed:						

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 survivor.

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 on legal documents (i.e. medical certificate).



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