STRENGTHENING COMMUNITY-BASED CARE
2024 REVISION

CAPACITY BUILDING

TRAINING SESSIONS AND MATERIALS

COMMUNITY HEALTH WORKERS TRAINING

FACILITATORS MANUAL

Pilot training tool

“all survivors need good quality care and support to help them heal and recover”

STRENGTHENING COMMUNITY-BASED CARE

CAPACITY BUILDING

10 DAYS • 8 MODULES

Facilitators Manual

Community-based management of survivors of sexual violence

Preface

Gender-based violence (GBV), including sexual violence (SV) and intimate partner violence (IPV) is pervasive in humanitarian emergencies, with risk factors and prevalence increasing across affected populations due to the impacts of conflict, epidemics and pandemics, disasters, and displacement on families, communities, institutions, and economies.[1] Risks and incidence of SV increase for all community members: women and girls, men and boys, people with disabilities, older persons, and people with diverse sexual orientations, gender identities and expressions, and sex characteristics (SOGIESC). However, care for SV survivors is frequently limited in humanitarian settings. Facilities may have been destroyed or may not have supplies and trained providers at the height of insecurity. Distance to health facilities and stigma can prevent survivors from seeking care. Survivors may also experience additional barriers, including cost of services, language, fear of deportation, or lack of documentation. GBV has only intensified amidst the global COVID-19 pandemic, and survivors face heightened barriers to lifesaving care due to lockdowns and overburdened health systems.[2]

In settings where facility-based care may be unavailable or inaccessible, a community-based approach to providing medical care to SV survivors may increase access to and uptake of essential, time sensitive medicines and health services.[3] These services are lifesaving: access to emergency contraception (EC), antibiotics, and antiretrovirals can prevent further devastating consequences for SV survivors, including HIV and other sexually transmitted infections (STIs), unwanted pregnancies and subsequent unsafe abortions, and thus higher rates of morbidity and mortality. Thus, community-based care for survivors of SV can contribute to global commitments to providing medical and psychosocial support to survivors in crisis-affected settings, the urgency of which has been recognized in UN Security Council Resolutions 1325, 1820, 1888, 1889 and 1960 on Women, Peace and Security.

Essential services that CHWs will be trained to provide as part of a pilot project are:

- Health education on the benefits of seeking care after experiencing SV;
- Presumptive treatment for sexually transmitted infections (STIs);
- Provision of emergency contraception to prevent unwanted pregnancy;
- Provision of post-exposure prophylaxis to prevent HIV;
- Provision of basic wound care to treat minor injuries;
- Provision of basic psychosocial counseling;
- Referrals for tetanus and Hepatitis B vaccines and other essential services, including safe abortion care; and
- Follow-up care.

This training package is based on current WHO guidance and recommendations, including the 2020 *Clinical management of rape and intimate partner violence survivors* guidelines, and current evidence and guidance for community-based health service delivery and SRH and protection programming in humanitarian settings, including community sensitization approaches.

1 Vu A, Adam A, Wirtz A, Pham K, Rubenstein L, et al., *The Prevalence of Sexual Violence among Female Refugees in Complex Humanitarian Emergencies: a Systematic Review and Meta-analysis* 2014; Stark L and Alastair A, *A systematic review of prevalence studies of gender-based violence in complex emergencies,* Trauma Violence Abuse 2011, 12:3, 127-134; Marsh M, Purdin S, and Navani S, *Addressing sexual violence in humanitarian emergencies,* Global Public Health 2006, 1:2, 133-146.

2 UN Women, *COVID-19 and Ending Violence Against Women and Girls*, 2020.

3 Murphy M and Bourassa A, *Gap Analysis of Gender-Based Violence in Humanitarian Settings: a Global Consultation*, 2021.

Acknowledgements

The 2014 training tool was developed for implementation by UNICEF with partners in Somalia and South Sudan. The original tool was based on learning from the Women's Refugee Commission, Global Health Access Program (GHAP), Burma Medical Association (BMA) and Karen Department of Health and Welfare's (KDHW) pilot project on community-based care for survivors of sexual assault that was implemented in Karen State, eastern Myanmar. The WRC would like to thank the invaluable hard work of GHAP, BMA, KDHW, UNICEF, and the community health workers, who have been on the frontlines to ensure health care is available to women and girls that have experienced sexual violence in their communities.

This update to the training tool has been made possible with aid from the Government of the United Kingdom, as part of the ACCESS Consortium led by the International Planned Parenthood Federation (IPPF). This update was also funded in part by a grant from the United States Department of State. The views expressed do not necessarily reflect those of the United States Department of State.

Women's Refugee Commission mission statement

The Women's Refugee Commission is a United States-based research and advocacy organization. It improves the lives and protects the rights of women, children, youth, and other marginalized groups displaced by conflict and crisis. The WRC researches their needs, identifies solutions, and advocates for programs and policies to strengthen their resilience and drive change in humanitarian practice.

About the ACCESS Consortium

The Approaches in Complex and Challenging Environments for Sustainable Sexual and Reproductive Health Rights (ACCESS) Consortium aimed to increase access to comprehensive sexual and reproductive health for hard-to-reach population, and ensure progress towards universal SRH and rights. The Consortium examined scalable, evidence-based approaches to mobilize marginalized and under-served populations across the humanitarian-development contexts of Lebanon, Mozambique, Nepal, and Uganda.

Authors of the curriculum

This curriculum was developed by the Women's Refugee Commission. The views expressed do not necessarily reflect the UK or US governments' official policies, UNICEF, or those of all Consortium partners.

Contents

Acronyms

ART	Anti-retroviral therapy
ARV	Anti-retroviral
BMA	Burma Medical Association
CHW	Community health worker
CEFM	Child, early, and forced marriage
FGC/M	Female genital cutting/mutilation
DV	Domestic violence
EC	Emergency contraception
GBV	Gender-based violence
GHAP	Global Health Access Program
HIV/AIDS	Human immunodeficiency virus/ acquired immunodeficiency syndrome
HSV2	Herpes simplex virus
HO	Handout
IASC	Inter-Agency Standing Committee
IAWG on RH in Crises	Inter-agency Working Group on Reproductive Health in Crises
IEC	Information, education, and communication
IFRC	International Federation of the Red Cross/Red Crescent Societies
IPV	Intimate partner violence
IRC	International Rescue Committee
IUD	Intrauterine device
KDHW	Karen Department of Health and Welfare
LGBTQIA+	Lesbian, Gay, Bisexual, Transgender, Queer or Questioning, Intersex or Asexual
LNG	Levonorgestrel
MSF	Médecins Sans Frontières
NGO	Non-governmental organization
NSAIDs	Non-steroidal anti-inflammatory drugs
PEP	Post-exposure prophylaxis
PID	Pelvic inflammatory disease
PTSD	Post-traumatic stress disorder
RHRC	Reproductive Health Response in Crises Consortium
SEA	Sexual exploitation and abuse
SOGIESC	Sexual Orientation, Gender Identity and Expression, Sex Characteristics
STI	Sexually transmitted infection
SV	Sexual violence
TBA	Traditional birth attendant
UNFPA	United Nations Population Fund
VCAT	Values clarification and attitude transformation
VCT	Voluntary Counseling and Testing for HIV
WHO	World Health Organization
WRC	Women's Refugee Commission

Overview of the training tool

The objectives of the training tool are to enable CHWs to:

- Understand SV and IPV and their consequences in the context of crisis settings;
- Provide key messages to community members about the importance and benefits of seeking timely care after incidents of SV as part of routine activities to facilitate health-seeking behavior;
- Use a survivor-centered approach when caring for survivors of SV and IPV;
- Refer survivors to health care and other multi-sectoral services, respecting their safety, confidentiality, and dignity; and
- Directly provide clinical care and psychosocial support in circumstances where facility-based care is not available and/or accessible.

Scope of GBV and care for survivors of sexual violence and sexual forms of IPV

The focus of the training tool is on the clinical management of SV. SV includes any act of forced or nonconsensual sex or sexual contact, or attempted sex or sexual contact, perpetrated by a stranger, partner, family member, or someone known to the survivor, in or outside of a marriage or partner relationship, among any age group or sex, regardless of whether the act constitutes "rape" or other forms of sexual assault as defined in the particular legal, institutional, or cultural context. Sexual forms of IPV are thus included within this scope. For the purposes of this tool, the term used to denote any act of forced sex, as defined by the person that experienced it, is "sexual violence." The term "sexual assault" may also be used synonymously with SV in this curriculum.

For the purposes of this training tool, a "survivor" as defined in this tool is a person who has experienced sexual violence. Because the majority of survivors are women and girls, the tool focuses specifically on this group. It is important to recognize, however, that boys, men, and transgender and gender non-conforming persons also experience SV, and require clinical care and psychosocial support. This tool includes content to prepare CHWs to understand and address the unique needs of male survivors. Special consideration is additionally given to child and adolescent survivors, People with disabilities, survivors with diverse SOGIESCs, including lesbian, gay, bisexual, transgender, queer, intersex (LGBTQIA+) and gender non-conforming persons, and older persons (Older people).[4]

- **Children and adolescents:** Adolescent girls may be at particular risk of SV because they are restricted to their homes or unable to go to school due to age and gender. This can further prevent them from accessing services. Child, early, and forced marriage (CEFM) also increases in humanitarian settings. Social or cultural norms related to honor and virginity may also hinder their access to services.
- **Men and boys:** Men and boys are less likely to report an incident of SV because of shame, criminalization, or stigmatization of same sex relations, and negative or dismissive attitudes and/or a lack of recognition regarding the extent of the problem by service providers. Service providers may not have been trained to care for men and boys who have experienced SV.

[4] Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. IAWG; 2018.

- **People with disabilities:** People with disabilities are at a higher risk of SV and often face extreme discrimination by service providers.
- **People with diverse SOGIESC:** Each population has separate needs and face different risks. Transwomen face extremely high rates of SV, but very often face discrimination by health providers that prevent them from seeking SRH services, including clinical care for SV.
- **People selling sex:** This population often face stigmatization and discrimination by health providers, who may be less likely to treat SV against this population as a serious concern. Survivors who engage in sex work are very often less likely to seek services due to stigmatization and criminalization of sex work.

The tool does not include specific steps on how to establish a GBV program, as such guidelines already exist. Instead, the tool focuses on preparing the facilitator to train CHWs on the essential competencies required to play a role within a larger program or system that responds to the needs of survivors of SV.

For more information on how to design, implement and evaluate programs for survivors of sexual violence, including those that address primary prevention, see:

- Inter-agency Standing Committee (IASC). *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015.
- International Rescue Committee (IRC) and UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, 2012.
- WHO, *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines*, 2017.

Key Concepts and Definitions

The following key concepts are the foundation for this training. Trainers would benefit from familiarity with the following concepts and their application.

Community health workers (CHWs): The term CHW is broad, and CHWs can be defined as health workers who have been trained to some extent but do not possess a formal professional certificate, many live and work in the community. It encompasses a wide range of health workers, paid and unpaid, professional and lay, experienced and inexperienced, including traditional birth attendants, village health workers, peer supporters, community volunteers, and health extension workers. (WHO)

Frontline health workers: Frontline health workers are comprised of all types of health workers—including nurses, midwives, community health workers, doctors, pharmacists, and more—who provide care directly to their communities. Frontline health workers provide services directly to communities, especially in remote and rural areas. They are the first, and often only link to essential health services. (Frontline Health Workers Coalition)

Gender: The socially constructed roles, behaviors, activities, and attributes that a given society considers appropriate for men and women. (WHO)

Gender-based violence (GBV): An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females. The term "gender-based violence" is often used interchangeably with the term "violence against women." The nature and extent of specific types of GBV vary across cultures, countries and regions. GBV includes:

- Sexual violence, including sexual exploitation/abuse and forced prostitution
- Domestic violence/intimate partner violence
- Trafficking
- Child, early and forced marriage
- Harmful traditional practices such as female genital mutilation, honor killings, widow inheritance and others.

(IASC *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*)

Gender mainstreaming: Gender Mainstreaming is a globally accepted strategy for promoting gender equality. Mainstreaming involves ensuring that gender perspectives and attention to the goal of gender equality are central to all activities, including policy development, research, advocacy/ dialogue, legislation, resource allocation, and planning, implementation and monitoring of programs and projects. (UN Women)

Inter-agency Reproductive Health Kits: A set of 13 kits containing medicines and other commodities aimed at facilitating the implementation of priority SRH services of the MISP for SRH. The RH Kits complement the Inter-Agency Emergency Health Kit (IEHK), which is a standardized emergency health kit that also contains essential drugs, supplies, and equipment for the provision of primary health care. (*Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

Inter-agency Working Group (IAWG) on Reproductive Health in Crises: A broad-based, highly collaborative coalition that works to expand and strengthen access to quality SRH services for persons affected by conflict and natural disaster. (IAWG on RH in Crises, 2018)

Lesbian, gay, bisexual, transgender, queer, intersex and asexual (LGBTQIA+) people:

- **Lesbian:** A woman who is emotionally, romantically, or sexually attracted to other women.
- **Gay:** A person who is emotionally, romantically, or sexually attracted to members of the same gender.
- **Bisexual:** A person who is emotionally, romantically, or sexually attracted to more than one sex, gender, or gender identity, though not necessarily simultaneously, in the same way, or to the same degree.
- **Transgender:** An umbrella term for people whose gender identity and/or expression is different from cultural expectations based on the sex they were assigned at birth. Being transgender does not imply any specific sexual orientation. Therefore, transgender people may identify as straight, gay, lesbian, bisexual, etc.
- **Queer:** A term often used to express fluid identities and orientations.

- **Intersex:** An umbrella term often used to describe a wide range of natural bodily variations. In some cases, these traits are visible at birth, and in others they are not apparent until puberty. Some chromosomal variations of this type may not be physically apparent at all.
- **Asexual:** A person who has a complete or partial lack of sexual attraction or lack of interest in sexual activity with others. Asexuality exists on a spectrum, and asexual people may experience no, little or conditional sexual attraction.

(Human Rights Campaign, cited in 2019 MISP Module)

Minimum Initial Service Package (MISP) for SRH: A coordinated set of priority life-saving activities to be implemented at the onset of every crisis event. First developed in 1997 by UN agencies, governments and non-governmental organizations (NGOs), the standard is an essential element in an emergency response and its components are recognized in the Sphere Standards. The objectives of the MISP for SRH are:

- Ensure the health sector/cluster identifies an organization to lead implementation of the MISP.
- Prevent sexual violence and respond to the needs of survivors.
- Prevent the transmission of and reduce morbidity and mortality due to HIV and other STIs.
- Prevent excess maternal and newborn morbidity and mortality.
- Prevent unintended pregnancies.
- Plan for comprehensive SRH services, integrated into primary health care, as soon as possible.

The standard also recognizes that it is a priority to ensure safe abortion care to the full extent of the law, in health centers and hospital facilities. (*Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

Persons with disabilities: The Convention on the Rights of Persons with Disabilities defines "persons with disabilities" as those with "long-term physical, mental, intellectual or sensory impairments which, in interaction with various barriers, may hinder their full and effective participation in society on an equal basis with others." Persons with disabilities can include those in the community who have trouble: seeing, even if wearing glasses; hearing, even if using a hearing aid; walking or climbing steps; remembering or concentrating; caring for her or himself, such as washing all over or dressing; or understanding or being understood in their usual language. (Adapted from the *Washington Group on Disability's classification, 2009)*

Post-abortion care: Treatment of hemorrhage or septic shock (immediate uterine evacuation via vacuum aspiration or misoprostol, sepsis treatment, referral for higher level care). (*Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

Preparedness: The knowledge and capacities developed by governments, response and recovery organizations, communities and individuals to effectively anticipate, respond to, and recover from the impacts of likely, imminent or current disasters. Preparedness is based on a sound analysis of disaster risks and good linkages with early warning systems, and includes such activities as **contingency planning, the stockpiling of equipment and supplies, the development of arrangements for coordination, evacuation and public information, and associated training and field exercises**. These must be supported by formal institutional, legal, and budgetary capacities. (UNDRR terminology, updated February, 2017)

Safe abortion care to the full extent of the law: Provision of accurate information; explanation of legal requirements, and where and how to obtain safe, legal abortion and their cost; provision of medication abortion (mifepristone/misoprostol or misoprostol alone), vacuum aspiration, dilatation and evacuation, or induction procedures as recommended by WHO; provision of post-abortion contraception; and provision of presumptive treatment for gonorrhea and chlamydia. (*Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018)

Sexual and reproductive health: A state of physical, emotional, mental, and social wellbeing in relation to all aspects of sexuality and reproduction, not merely the absence of disease, dysfunction, or infirmity. A positive approach to sexuality and reproduction should recognize the part played by pleasurable sexual relationships, trust, and communication in the promotion of self-esteem and overall wellbeing. All individuals have a right to make decisions governing their bodies and to access services that support that right. (Guttmacher–Lancet Commission, June 2018)

Svex: Sex refers to the biological characteristics that define humans as female or male. While these sets of biological characteristics are not mutually exclusive, as there are individuals who possess both, they tend to differentiate humans as males and females. (WHO)

Sexual Health: "…a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled." (WHO)

Sexual orientation, gender identity and gender expression, and sex characteristics (SOGIESC): Sexual orientation refers to a person's physical, romantic and/or emotional attraction towards other people. Gender identity reflects a deeply felt and experienced sense of one's own gender. Gender expression is the way in which we express our gender through actions and appearance. Gender expression can be any combination of masculine, feminine, and androgynous. A person's gender expression is not always linked to the person's biological sex, gender identity or sexual orientation. Sex characteristics are physical or biological characteristics, such as sexual anatomy, reproductive organs, and hormonal patterns and/or chromosomal patterns. These characteristics may be apparent at birth or emerge later in life, often at puberty. (UN Office of the High Commissioner for Human Rights)

Sexuality: "…a central aspect of being human throughout life encompasses sex, gender identities and roles, sexual orientation, eroticism, pleasure, intimacy, and reproduction. Sexuality is experienced and expressed in thoughts, fantasies, desires, beliefs, attitudes, values, behaviors, practices, roles, and relationships. While sexuality can include all of these dimensions, not all of them are always experienced or expressed. Sexuality is influenced by the interaction of biological, psychological, social, economic, political, cultural, legal, historical, religious, and spiritual factors." (WHO)

Sexually Transmitted Infections (STIs): Infections that are spread primarily through person-to-person sexual contact. There are more than 30 different sexually transmissible bacteria, viruses, and parasites. The most common conditions they cause are gonorrhea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV) infection, and hepatitis B infection. Several STIs, in particular HIV and syphilis, can also be transmitted from mother to child during pregnancy and childbirth, and through blood products. (WHO)

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

Sexual violence takes many forms, including rape, sexual slavery and/or trafficking, forced pregnancy, sexual harassment, sexual exploitation and/or abuse, and forced abortion. (*IASC Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*)

Voluntary Contraception: Contraception prevents pregnancy by interfering with ovulation, fertilization, and/or implantation. Family planning refers to the comprehensive range of practices that allow individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. The use of contraception should be on a strictly voluntary basis. (WHO)

Understanding the training tool package

This Facilitator's Manual is one component for the Community Health Workers Training tool package.

The training tool package also includes:

- Community Health Workers Training - Getting Started Guide: Key considerations for program staff in piloting community-based care for survivors of sexual violence, including intimate partner violence
- Community Health Workers Training – Participant Packet

The purpose of the Getting Started Guide is to support program staff to plan the pilot of community-based care for survivors of sexual violence (SV), including IPV in their community programming. **Implementing organizations should refer to and complete the preparations detailed in the Getting Started Guide before organizing the CHW training.**

This Facilitator's Manual has eight modules that will guide the facilitator in training CHWs to manage and care for SV survivors in their community. Each module has an overview with: an introduction to the topic, list of sessions, their expected length, any required preparation, corresponding handouts and training aids, and methods to evaluate performance.

Modules 1-4 are relevant for CHWs that are only involved in health education about SV and referring survivors to higher level health care providers and facilities. Modules 1-8 are applicable to CHWs that may be directly treating survivors.

Each module is comprised of sessions, which contain mini lectures, exercises and activities that will guide the facilitator in training the participants.

Throughout the training package:

Time: Indicates the recommended and estimated amount of time required for each session, including summarizing and receiving participant feedback.

Objectives: States what participants are expected to know or be able to apply by the end of each session.

Methods: Indicates the type of method(s) the facilitator will use for the session, such as mini-lectures, discussion groups, scenarios, role play, model demonstrations, games and so on.

Preparation: Contains any tasks that the facilitator needs to complete to prepare before each session.

Training aids, materials and handouts: Provides important information, tools and materials for the trainer to conduct the session.

Evaluation and assessment: Notes activities to assess and evaluate participants' learning and skills.

Additional resources: Lists additional resources for the facilitator to learn more, if additional information about the session topic will be helpful.

Steps: Provides detailed, step-by-step instructions for the facilitator to conduct the session. Facilitators may adapt the steps according to the preferences and needs of the participants.

Special considerations

Highlights specific processes, treatment options or considerations for specific populations with unique needs, including but not limited to children, adolescents, persons with disabilities, and people with diverse sexual orientations, gender identities and expressions, and sex characteristics.

Facilitator's notes

Provides additional information needed to carry out the steps, possible responses to questions asked during the sessions and any key points to emphasize.

Participants/Trainees

The training curriculum has been designed for CHWs with varying levels of training and experience. "Category 1" CHWs can be non-literate with very little experience serving as CHWs, and can include health promotion volunteers and staff. "Category 2" CHWs should have basic numeracy and literacy and experience serving as CHWs within their community. "Category 3" CHWs require advance training and experience in related sexual and reproductive health interventions. CHWs should be working in the same communities in which they live.

Typically, Category 2 and 3 CHWs will be women, given the nature of the issue addressed; however, men and boy survivors may request to receive care from a man. To create an enabling environment for all survivors to feel comfortable seeking care, it will be important for the pilot to recruit and train a diverse cohort of CHWs, including those with disabilities, identify as having diverse SOGIESCs, or represent other marginalized or minority communities.

The role of the CHW may differ in the pilot sites, depending on national policies, local health infrastructure, and existing skill sets of CHWs. In circumstances where higher level health care providers—such as nurses, midwives, and doctors—are available, CHWs may only be involved in referring survivors of SV and IPV for appropriate services. However, in settings where higher level providers are lacking, health facilities are inaccessible, or survivors face barriers to accessing facility-based care, CHWs may play a larger role in managing survivors of SV within the overall health system.

CHW Category 1: CHWs only conduct health education as part of daily activities and refer survivors (Modules 2-4). **Non-literate CHWs will fall into this category.** Eligibility criteria are:

- No literacy or numeracy required.
- Limited experience serving as a CHW; could be volunteers or health promotion staff.
- Compassion/empathy and willingness to care for survivors.
- Understands the importance and can maintain confidentiality of survivors.

CHW Category 2: CHWs involved in the provision of basic treatment and follow-up care to survivors (Modules 2-6). **Many CHWs will fall into this category**, whose eligibility criteria are:

- Some level of reading and written literacy (not non-literate) to read instructions and complete client records/forms.
- Basic numeracy to count days and hours, and measure dosages.
- Basic training in primary health care based on national policies.
- Understands the importance and can maintain confidentiality of survivors and any data collected.
- Demonstrates compassion/empathy and willingness to care for survivors.
- Capacity to provide minimal documentation if the survivor would like a record for themself.

CHW Category 3: CHWs involved in higher-level care (Module 2 and Advance Module 8). This category is applicable only in settings where CHWs have advanced roles[5] with clinical experience and skills, as well as capacities in the site for robust monitoring and supervision. Eligibility criteria include:

- Basic literacy and numeracy.
- Advanced training and experience providing clinical SRH care based on national or international policies.
- Understands the importance and can maintain confidentiality of survivors and any data collected (through previous experience with HIV testing, for example).
- Demonstrates compassion/empathy and willingness to care for survivors.
- Capacity to provide minimal documentation upon request.

[5] Such as, "maternal health workers" in Mullany LC, Lee CI, Paw P, Shwe Oo EK, Maung C, et al. The MOM project: delivering maternal health services among internally displaced populations in eastern Burma. Reprod Health Matters 2008, 16:44-56.

If CHWs lack specific skills pertaining to primary health care, such as basic hygiene, nutrition, immunizations, treatment of common illnesses or basic first aid, the facilitator may wish to consult existing CHW training curricula on such topics. Some examples include:

- WHO/UNICEF, *Integrated management of childhood illness: caring for newborns and children in the community*, 2011.
- WHO, *Community case management during an influenza outbreak: A training package for community health workers*, 2011.
- WHO/UNICEF, *Caring for the newborn at home*, 2012.
- IFRC, *International first aid and resuscitation guidelines*, 2020.

Determining the role of the CHW

The role of the CHW may differ in the program, depending on national policies and the setting. These policies will determine which clinical services can be provided by CHWs, and/or outside of a health facility setting. In circumstances where higher level health care providers—such as nurses, midwives, and doctors—are available, and/or where there are restrictions on CHWs providing clinical services, CHWs may only be involved in health education about SV and referring survivors to appropriate services. However, in settings where higher level providers are lacking or health facilities inaccessible, the program may consider tasking CHWs with a larger role in managing survivors of SV in their community in the context of a well monitored pilot project.

Modules 2-4 are applicable for settings where CHWs play a role in health education and referral of survivors; Modules 5-6 for situations where CHWs may themselves treat survivors of sexual violence. In some instances, CHWs may be tasked with certain activities listed in Module 5—such as, provision of emergency contraception (EC) to prevent pregnancy, or antibiotics to prevent sexually transmitted infections (STIs)—but not all components of the package of care. Advance Module 8 is only applicable in settings where CHWs are the providers of last resort and they have the experience, skills, and capacity to provide this level of care.

When planning the training, facilitators should be mindful of what the CHWs are being asked to do with their existing experience and skills within national and local policies. The tool has been designed with the possibility of a phased introduction of activities, such that the earlier modules do not require clinical skills, prescribing medication or experience, while the delivery of Module 5 as a package of health care assumes prior training and experience.

Facilitators

The ideal facilitator is a provider with clinical training and experience in managing survivors of SV, and has experience working with CHWs. It is preferable for the facilitator to have prior experience in delivering trainings. However, as the modules include step-by-step guidance on how to train participants in each topical area, no additional coursework is required to prepare facilitators to deliver the training. The facilitation team will ideally be comprised of 1-3 facilitators, and the implementing organization and/or partner organizations' staff can be included in the facilitation team, given their expert knowledge of the local context, available referrals, and coordination of care for survivors.

Methodology

The sessions combine mini lectures, discussions, scenarios, role plays, demonstrations, games, and practice to enable participants to gain knowledge and skills, clarify concerns and apply newly learned concepts and skills. Facilitators should repeat and emphasize key messages during the training. Additionally, during scenarios and role plays, they should give participants equal opportunities to play the role of the CHW, so that everyone has a chance to practice. Trainings should have no more than 20 people; fewer numbers are encouraged to ensure adequate participation.

Language, interpretation, and translation

It is important to consider the language and dialect in which the training should be delivered, based on the needs of the community being served and participating CHWs. An interpreter can be used if needed. The choice of language is critical in maintaining cultural competency and sensitivity to the local context. Also consider sign interpretation for participants that use sign language. It is essential to plan for sufficient time and funding for translations of all materials, including the Participant Packet and Participant Handouts, so that participants can fully engage.

Schedule

The training is designed for roughly eight days with breaks during the day (total coursework hours is roughly 40 hours including optional activities; almost 46 hours including Advanced Module 8). It can be shorter or longer if select modules or sessions will be taught, depending on the role the CHWs will play in the particular context and their previous level of training.

MODULE 1 INTRODUCTION

SESSION 1.1: Administration

1 hour 30 minutes

SESSION 1.2: Training overview

30 minutes

SESSION 1.3: Pre-test

30 minutes (CHW 1), 1 hour (CHW 2), 1 hour 15 minutes (CHW 3)

MODULE 2 WHAT IS SEXUAL VIOLENCE AND WHAT ARE ITS CONSEQUENCES?

SESSION 2.1: Unpacking gender, sexual violence, and social norms

3 hours

1. **Understanding gender**
   - 1.1 What is gender?
2. **Understanding gender-based violence**
   - 2.1 What is gender-based violence?
   - 2.2 What are examples of gender-based violence?
   - 2.3 What is intimate partner violence?
3. **Social norms and sexual violence, including intimate partner violence**
   - 3.1 What are social norms and how do they relate to gender and sexual violence?
   - 3.2 How are social norms linked to sexual violence?
   - 3.3 Why does sexual violence happen, and what are some risks/contributing factors?
   - 3.4 What are some norms and attitudes that may be helpful for survivors of sexual violence?
4. **Understanding sexual violence in the framework of human rights**
   - 4.1 What are human rights?

SESSION 2.2: Addressing sexual violence in crisis settings

4 hours

1. **Risks and vulnerabilities to sexual violence in crisis settings**
   - 1.1 What happens during a conflict, natural disaster, epidemic/pandemic, or displacement?
   - 1.2 Why does sexual violence happen in crisis settings, and what are some additional risks/ contributing factors?
   - 1.3 Who is most at risk of sexual violence in crisis settings?
2. **Consequences of sexual violence for survivors and their community**
   - 2.1 What are the health consequences of sexual violence?
     - 2.1.1 Acute physical injuries
     - 2.1.2 Unintended pregnancy and unsafe abortion
     - 2.1.3 What are sexually transmitted infections?
     - 2.1.4 What are HIV and AIDS?
     - 2.1.5 Who is at risk for HIV and AIDS?
       - 2.1.5.1 How do we know if someone has HIV?
       - 2.1.5.2 How can HIV be prevented?
       - 2.1.5.3 What are treatment options for persons living with HIV and AIDS?
       - 2.1.5.4 What are some of the consequences of HIV and AIDS for the individual and the family?
       - 2.1.5.5 Why are people living with HIV/AIDS vulnerable in crisis settings? (additional risk factors)
       - 2.1.5.6 What are some ways to reduce stigma against people living with HIV/AIDS in the community, and how can CHWs be agents of change?
   - 2.2 What are the emotional, psychological, and social consequences of sexual violence?
3. **Health and other benefits for seeking timely care**
   - 3.1 What are the health benefits of seeking care?
   - 3.2 What is timely care?
   - 3.3 What other services can survivors access if they would like?
   - 3.4 What are some barriers that survivors face to receive care?

SESSION 2.3: Health education to facilitate health-seeking behavior

1 hour 15 minutes

1. **Key messages around sexual violence**
   - 1.1 What are the key messages that the community should know about sexual violence and the importance of seeking care?

MODULE 3 PRINCIPLES OF WORKING WITH SURVIVORS OF SEXUAL VIOLENCE

SESSION 3.1: Principles of working with survivors of sexual violence

2 hours

1. **Key principles of working with survivors of sexual violence**
   - 1.1 What are the key principles to working with survivors of sexual violence?
2. **Interacting with survivors**
   - 2.1 How should survivors be treated?
   - 2.2 How should CHWs communicate with a survivor?
   - 2.3 What to avoid when communicating with a survivor
   - 2.4 What are some tips of working with survivors of diverse backgrounds, including persons with disabilities, LGBTQIA+ persons, children, men and boys, and people selling sex?
   - 2.5 How can interpreters be engaged if necessary?
3. **Understanding informed consent**
   - 3.1 What is informed consent?
   - 3.2 What is informed assent?
   - 3.3 What is the difference between informing and advising?

SESSION 3.2: Addressing policy and societal barriers to providing and accessing care (CHWs 2 and 3 only)

1 hour 30 minutes (1 hour without optional activities)

1. **Understanding mandatory reporting requirements (optional: CHWs 2 and 3 only)**
   - 1.1 What is mandatory reporting and when does it apply?
   - 1.2 What does it mean to act in the best interests of the child?
2. **Barriers hindering access to care**
   - 2.1 What are the legal or policy barriers that may hinder survivors' access to services? (optional)
   - 2.2 How can we address social and cultural barriers for survivors when delivering services?
   - 2.3 How can we address barriers for persons with disabilities when delivering services?

MODULE 4 RECOGNIZING SURVIVORS AND FACILITATING REFERRALS FOR SEXUAL VIOLENCE

SESSION 4.1: Recognizing survivors of sexual violence

25 minutes

1. **Recognizing survivors of sexual violence**
   - 1.1 What are some signs that a person is in distress?
   - 1.2 How can CHWs create an enabling environment for someone who may have experienced sexual violence?

SESSION 4.2: Referring survivors for health care and other services

2 hours 40 minutes (2 hours 30 minutes without optional activity)

1. **Referring survivors for care**
   - 1.1 What is the role of the CHW in making referrals?
   - 1.2 What are the services to which CHWs will be referring survivors?
   - 1.3 How should CHWs refer survivors of sexual violence?
   - 1.4 What can be shared with survivors to refer them for health services?
   - 1.5 What should be shared with survivors to refer them to other support services?
   - 1.6 What if no referral services are available? (optional)
2. **Putting this all together**
   - 2.1 How can critical skills be demonstrated?

MODULE 5 PROVIDING COMMUNITY-BASED CARE FOR SURVIVORS OF SEXUAL VIOLENCE

SESSION 5.1: Refreshing key skills

2 hours 35 minutes

1. **Reviewing treatment options for survivors of sexual violence**
   - 1.1 What should happen when survivors of sexual violence talk about sexual violence to a community health worker?
2. **Reviewing key skills to providing health care to survivors**
   - 2.1 How can medicines be given accurately?
   - 2.2 How can medicines be given safely?
   - 2.3 How should medicines be stored?
   - 2.4 How can infections be prevented when caring for survivors?
3. **Completing the intake form**
   - 3.1 What is an intake form?
   - 3.2 How are the intake forms and monitoring forms completed?
   - 3.3 How should the intake forms and monitoring forms be stored?

SESSION 5.2: Providing basic community-based health care to survivors of sexual violence in settings with minimal resources

9 hours 30 minutes (9 hours 5 minutes without optional activities)

1. **Preparing the survivor**
   - 1.1 How should the survivor be prepared to receive treatment?
2. **Taking the survivor's history**
   - 2.1 How should the survivor's history be taken?
   - 2.2 What questions should be asked to a survivor when taking a health history?
3. **Providing presumptive treatment for sexually transmitted infections**
   - 3.1 What are sexually transmitted infections?
   - 3.2 How can sexually transmitted infections be prevented and what are the medicines to provide to survivors?
4. **Obtaining a pregnancy test and providing options counseling**
   - 4.1 To whom should a pregnancy test be offered?
   - 4.2 What if a survivor tests positive?
   - 4.3 What if a survivor's preference for the pregnancy does not align with a CHW's faith or beliefs?
   - 4.4 What is options counseling?
   - 4.5 How can referrals be made for safe abortion care to the full extent of the law?
5. **Providing emergency contraception to reduce the risk of pregnancy**
   - 5.1 Who is at risk for pregnancy after sexual violence and what are the consequences of pregnancy?
   - 5.2 What is emergency contraception and how is it provided to female and transgender male sexual violence survivors?

SESSION 5.3: Providing follow-up care to survivors of sexual violence

3 hours (2 hours 50 minutes without optional activity)

1. **Providing follow-up care**
   - 1.1 What is follow-up care?
   - 1.2 How should CHWs follow up with survivors on their treatment?
     - 1.2.1 How can partners be encouraged to get treated/tested for STIs and HIV?
     - 1.2.2 What are the benefits of couples HIV testing and counseling over individual testing?
   - 1.3 What should CHWs do if a survivor learns they are pregnant? (optional)
   - 1.4 What if a survivor has attempted to terminate a pregnancy?
   - 1.5 What are other ways CHWs can support the survivor during follow-up care?
   - 1.6 How can CHWs address survivors' emotional needs?
   - 1.7 How should CHWs end the follow-up visit?
2. **Following up at one month**
   - 2.1 What should be addressed at the one-month follow-up visit?
3. **Following-up at three months**
   - 3.1 What should be addressed at the three-month follow-up visit?
4. **Following-up at six months**
   - 4.1 What should be addressed at the six-month follow-up visit?

MODULE 6 SELF-CARE FOR COMMUNITY HEALTH WORKERS

SESSION 6.1: Self-care for community health workers

2 hours 20 minutes

1. **Stress related to working with survivors of sexual violence**
   - 1.1 What causes stress?
   - 1.2 What are different forms of stress?
2. **Coping with stress**
   - 2.1 How can I manage and recover from stress?
3. **Planning for self-care**
   - 3.1 How is a self-care plan developed?

MODULE 7 SUMMARY, NEXT STEPS AND CLOSING

SESSION 7.1: Next steps

30 minutes

SESSION 7.2: Post-test and clinical assessment

30 minutes (CHW 1),

1 hour (CHW 2),

1 hour 15 minutes (CHW 3)

45–60 minutes for clinical assessment

SESSION 7.3: Closing and workshop evaluation

1 hour

ADVANCED MODULE 8 PROVIDING ADVANCED COMMUNITY-BASED CARE TO SURVIVORS OF SEXUAL VIOLENCE (CHWS 3 ONLY)

ADVANCED SESSION 1: Providing advanced care to survivors of sexual violence

6 hours 15 minutes

1. **Providing tetanus toxoid/immunoglobin to prevent tetanus**
   - 1.1 What is tetanus and who is at risk for tetanus infection?
   - 1.2 What is the tetanus vaccination and how does it work?
2. **Providing vaccines to prevent hepatitis B**
   - 2.1 What is hepatitis B and who is at risk?
   - 2.2 What is the hepatitis B vaccination and how does it work?
3. **Managing sexually transmitted infections (syndromic management)**
   - 3.1 How can STIs be managed and how is treatment provided?
   - 3.2 How should sexual partners be managed for STI treatment referral?
4. **Preparing to treat allergic reactions and allergic shock**
   - 4.1 What are signs of allergic reactions and allergic shock?
   - 4.2 How should allergic reactions and allergic shock be treated?

Venue

When selecting the training venue, a number of factors should be considered:

- The venue should be in a safe and neutral location for a diverse range of participants. Avoid hosting the training at a location (organization, government office, etc.) where there may be tension or discomfort between any participant and the staff of the training venue.
- The venue should be located as close to the community as possible, and there must be safe and accessible transportation available for participating CHWs, including CHWs with disabilities.
- The training should be held in a comfortable venue that can accommodate the number of participants and facilitators.
- The room and site should be well lit and well ventilated, with comfortable tables and chairs for all participants.
- The venue should be private, where CHWs cannot be overheard during the training.
- Electricity is not required.
- It is important to select an accessible venue for participants with diverse disabilities. This includes ensuring that both the room where the training will be held, as well as toilet, kitchen, and other facilities, are safe and accessible for people who use wheelchairs or other mobility aids, have mobility impairments, or have visual impairments.
- It is important to have a good understanding of the needs and accommodations of participating CHWs before selecting the training venue, and when planning the training. Common requests may be transport to/from the training venue, sign interpretation, electronic resources, accessible restrooms, or personal assistants. Ask if there are particular adaptations that have worked for participants in the past. Participants can be encouraged to bring their own devices or work with persons who are familiar with their needs. The training can better address inclusion if a budget is available for accessibility and accommodations.

Training evaluation

CHW assessments are conducted using pre- and post-test questionnaires and mock situations. CHWs 2 and 3 will also undergo a clinical assessment at the end of the training. Questions are based on the session objectives. Comparing test results will provide the facilitator with general information about the knowledge gained by participants.

Passing scores for post-tests are as follows:

- CHW 1: At least 70 per cent on the Module 2–4 post-test
- CHW 2:
  - At least 70 per cent on the Module 2–4 post-test
  - At least 80 per cent on the Module 2–6 post-test
- CHW 3:
  - At least 70 per cent on the Module 2–4 post-test
  - Average of 80 per cent on the Module 2–6 and Advanced Module 8 post-tests

Passing scores for the clinical assessment to be administered at the end of the training are as follows:

- CHW 2: 80 percent
- CHW 3: 80 percent

If a participant does not score appropriately, they must undergo additional training before retaking the tests.

Ongoing CHW supervision and evaluation

Ongoing supportive supervision during the project is critical to ensuring good performance of CHWs and that they can correctly apply the skills learned during the training. Program staff and supervisors can assess CHW performance by conducting 1:1 supervision visits and monthly meetings with the CHWs to demonstrate and refresh skills. This can be done through simulations of scenarios, and one-on-one supervision meetings. Topics that need more attention should be addressed through on-the-job and refresher trainings.

After the first three months of service delivery, implementing organizations should conduct follow up evaluations with CHWs using the evaluation tool consisting of qualitative questions, a quantitative questionnaire, and, for CHWs 2 and 3, a clinical assessment (similar to the assessment administered at the end of the training). The same tools can be used at different intervals throughout implementation to make sure CHWs are retaining critical skills.

Follow-up throughout implementation

- Ensure mentoring, supervision, and follow-up with CHWs.
- Convene CHWs to meet routinely to debrief and discuss challenges and emerging issues.
- Follow-up with survivors as necessary.
- Collect and report information per M&E plans and conduct data analysis.

Preparing for the training

Careful planning is important and should start several weeks before the training.

Initial planning

- Solidify objectives for the training.
- Obtain necessary permissions from local authorities and the community. This may be through meetings with community leaders and/or local government representatives to explain the purpose of the project and secure any required approvals, including documentation if required.
- Complete all preparatory activities as detailed above, including:
  - Identifying the legal, policy, and social barriers for survivors to access health care, especially any real or perceived need for mandatory reporting, a marriage certificate, husband's permission, a police report, etc.
  - Reviewing or establishing the program's care for survivors' protocols to address or overcome the barriers/challenges, as suggested above.
- Determine the cost per participant with regard to food, lodging, transportation, and materials.

Trainers and support staff needed

- Identify 1-3 facilitators who have experience providing clinical trainings to CHWs.
- Consider including the implementing organization and/or partner organizations' staff as part of the facilitation team to reflect their expert knowledge of the local context, especially in terms of available referrals and coordination of care for survivors.

Identification of participants

- Identify potential participants/trainees and establish criteria for their participation.
- Make a concerted effort to reach out to persons who identify with specific at-risk groups (People with disabilities, persons with diverse SOGIEs, persons engaged in sex work, etc.), to build their capacity as CHWs and facilitate their role in provision of care.
- Know the training needs of the participants, especially their literacy levels and accommodations needs, and have a clear understanding of their expected roles in managing survivors of SV in the community.
- Ensure attendance of participants by contacting them directly or through letters of invitation.
- Follow-up with participants to confirm their attendance.

Language, interpretation, and translation

- Consider the language and dialect in which the training should be delivered. An interpreter can be used if needed. The choice of language is critical in maintaining cultural competency and sensitivity to the local context. Also consider sign interpretation for participants that use sign language.
- Ensure all materials are appropriately translated so that participants can fully engage. It is essential to plan for sufficient time and funding for translations and review of translations.

Accessibility and accommodations

- When identifying and engaging participants, ask participants to share their specific needs for accommodations, and how to best facilitate their active participation. Common requests may be transport to/from the training venue, sign interpretation, electronic resources, accessible restrooms, or personal assistants. Ask if there are particular adaptations that have worked for participants in the past. Participants can be encouraged to bring their own devices or work with persons who are familiar with their needs. The training can better address inclusion if a budget is available for accessibility and accommodations.

Determining the training venue

- Decide the training date and venue that will work for participants, facilitators, and other stakeholders.
- Reserve the training venue and make it as conducive to learning (i.e., well-lit, good ventilation, limited external noise) as possible.

Other items to consider when identifying a training space include:

- Convenient location to public transportation or other modes of accessible transportation if participants will be commuting to the site daily.
- Neutral location for a diverse range of participants. Avoid hosting the training at a location (organization, government office, etc.) where there may be tension or discomfort between any participant and the staff of the training venue.
- Location with amenities or possibility to make accommodations, such as accessibility for People with disabilities, appropriate restrooms, and space for prayer as needed.
- Location with privacy for participants to be able to share their thoughts and engage in group activities without fear of being overheard.

COVID-19 safety protocols

The training must be organized in accordance with local and national COVID-19 restrictions, and in accordance with the most up to date recommendations from global and national public health authorities. This may include:

- Requiring vaccination and testing of participating CHWs and facilitators wherever feasible.
- Reducing the number of participants in training sessions.
- Holding trainings outside or in spaces with proper ventilation.
- Organizing and adapting activities to maintain six feet of distance between participants.
- Requiring participants and facilitators to be masked at all times.

Review of the training tool

Determine the relevant modules and sessions to use in the training, based on:

- How much basic first aid participants have learned to stabilize persons in life-threatening conditions for referrals and determine the handouts to be used.
- Participants' experiences giving medicines accurately and safely.
- Standard precaution/infection prevention measures used in the project.
- Information storage and handling procedures, including where forms will be stored, who has access, and how information can be sent safely and confidentially to any centralized locations as appropriate.
- Treatment protocols for STI prevention, EC, and PEP.
- If/where intrauterine devices are available for pregnancy prevention.
- If/where referrals are available for tetanus and Hepatitis B vaccines if they are not provided by the CHWs.
- If pregnancy tests are available and how soon they can detect pregnancies.
- Legal indications for safe abortion care.
- Whether a cold chain, tetanus, Hepatitis B, and HPV injections are available, and whether CHWs can administer injections.

Collect information on:

- Any harmful traditional practices that take place in the community, and their prevalence if known.
- Relevant laws regarding SV, including age of consent, laws governing the age at which people can marry, and whether or not marital rape is recognized under the law.
- Common STIs in the community, and STI prevalence data.
- HIV prevalence, and primary routes of HIV transmission in the community if known.

Adapt as necessary, photocopy, and otherwise obtain any handouts, notebooks, demonstration models, or other reference materials for training use and distribution, including:

- Intake, health history, and monitoring forms based on services that will be offered.
- Handouts for medications, based on the local context.
- Infection prevention according to the project's protocol.
- Review and adapt the methodologies and activities of the sessions as necessary, taking into consideration literacy levels, prior experience, and capacities of participating CHWs.
- Prepare flipchart, markers, pencils, and pens. Prepare materials that are applicable and most suited to the training venue.

Sensitivity and flexibility in a crisis setting[6]

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

- Be sensitive to long hours and double shifts participants may be working. Remember that some participants may have long travel times or have competing priorities at home. It is important to be patient and supportive.
- Be prepared for participants with a range of abilities and experiences—some participants may be very new to the setting.
- Be sensitive to participants' emotional and mental health and wellbeing—many participants will have experienced the impact of crises and displacement.
- Be aware that CHW themselves may be survivors and ensure you have resources available to support any participants who may be at risk of distress or in need of services themselves.

Establishing support systems for participants during the training

Participating in trainings about SV can be distressing, and CHWs themselves may be survivors of SV. It is essential to be prepared to support participants who experience distress during the workshop and/or need referrals to psychosocial support and mental health services.

- Prior to the training, you should identify organizations in the community that can provide psychosocial support for CHWs.
- Be prepared to refer any participants who need or would like to access these services.
- Share information about services and referrals with participants at the beginning of the training.
- Facilitators should establish a working agreement between all participants that their discussions will be kept confidential, and that participants will not tell anyone outside the training any details about what specific individuals have said within the training.

[6] Adapted from Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, *Clinical Management of Sexual Violence Survivors in Crisis Settings*, 2021.

Scope of services to be provided by CHWs

As CHWs will only be offering certain elements of health care for survivors of SV, limitations will exist to the care provided. A decision-making tool on the care and tasks CHWs can be expected to implement in the setting is provided in Annex I of the Getting Started Guide. In summary, the scope of work as determined by capacity (NOT by setting specific factors) is as follows:

✓ = Yes

[Blank] = No

★ = Only if capacity exists and the intervention is warranted

Intervention	CHW 1	CHW 2	CHW 3
Conduct health education around SV, including sexual forms of IPV, and the benefits of seeking care	✓	✓	✓
Recognize survivors of SV when they come forward (passive identification)	✓	✓	✓
Actively screen for survivors of SV or sexual forms of IPV *WHO does not recommend active screening for sexual violence.*			
Provide some basic first aid to stabilize survivors for referral	✓	✓	✓
Refer survivors to higher level health staff or the health facility for health care	✓	✓	✓
Obtain informed consent and prepare the survivor		✓	✓
Take a health history		✓	✓
Collect forensic evidence *CHWs will not be trained on forensic evidence collection.*			
Conduct a minimum medical exam (physical)			★
Conduct a minimum medical exam (pelvic)			★
Complete a simplified intake form		✓	✓
Generate a medical certificate (duplicate intake form)		✓	✓
Treat minor injuries		✓	✓
Provide other wound care as feasible			★
Obtain a pregnancy test		✓	✓
Provide pregnancy options information and safe abortion care referral	✓	✓	✓

Intervention	CHW 1	CHW 2	CHW 3
Provide presumptive treatment for STIs, EC for pregnancy prevention, and supportive counseling (including psychological first aid and basic emotional support)		✓	✓
Conduct HIV counseling and testing		✓	✓
Initiate PEP*			★
Provide PEP once initiated		✓	✓
Provide tetanus toxoid vaccine		★	✓
Provide Hepatitis B vaccine		★	✓
Provide HPV vaccine if available**		★	★
Assess for safety, and refer for additional support	✓	✓	✓
Provide follow-up care to survivors		✓	✓
Provide safe abortion care (medication) for pregnancies up to 12 weeks, to the full extent of the law***			★
Manage STIs (syndromic management)			★

* As current guidelines only permit nurses and above to initiate PEP for HIV, if CHWs will engage in this activity, they will need to be supported by a robust monitoring and supervision system.

** This intervention is included in the IAFM, but not in the WHO's 2019 *Clinical Management of Rape and IPV Survivors* guidelines. Hence, this is not a priority intervention at this time.

*** Per 2015 WHO guidelines on Health worker roles in providing safe abortion care and post-abortion contraception, lay health worker "Assessing eligibility for medical abortion," "Administering the medications and managing the process and common side-effects independently," and "Assessing completion of the procedure and the need for further clinic-based follow-up" are listed under the context of "Recommended in the context of rigorous research."

While guidelines on post-rape care for clinical providers include a physical and genital exam, CHWs will NOT be trained in performing physical or genital exams as part of their intake or follow-up, as they will be referring survivors for higher level care if they present with concerning symptoms, and they are also not responsible for collecting forensic evidence. Often, findings can be subtle, and it will be difficult for the CHW to determine what to do with the information, which may cause unnecessary referrals that survivors may not desire, or place CHWs in a difficult position of figuring out if a finding is normal or abnormal. They can still provide first line care to survivors of SV and IPV where access to facility-based care may be challenging.

The exception for genital exams is CHW3, if they are the provider of last resort, they have prior training in pregnancy-related care, and they need to suture wounds or provide other emergency care. Genital exams in adults or children are not covered in this training.

General pointers for facilitators[7]

Before the training

- Read all sections of the training tool before beginning.
- Ensure that the training is contextualized for your setting, and be prepared with information about relevant terminology laws, policies, data, medication protocols, etc. prior to the training. Adapt exercises and handouts to be reflective of the community (e.g., names and ethnicities, types of crises, etc.).
- Ensure you are familiar with the referral pathways, community awareness raising activities, and procedures that CHWs will be expected to follow during the program.
- Check that all materials needed for each module, and to complete all exercises, are ready prior to each day and/or session of the training.
- Ensure that you are aware of the needs of participants, and any accommodations that will be provided. If you will be working with interpreters, including sign interpreters, you should meet with them before the training to establish expectations and agree upon how you will work together.

During the training

- Be sure to speak slowly and clearly. If you are working with an interpreter, pause frequently to allow time for interpretation.
- Pay attention to participants' energy. Be sure to provide frequent opportunities for participants to eat, drink, and use the restroom. Examples of energizers are listed below. Depending on the context and participants' needs, you may need to arrange time and space for participants to pray.
- Use the practical exercises contained in this tool. These exercises, discussions, and examples reinforce learning for participants. Give participants plenty of hands-on experience, especially demonstrations.
- Explain the purpose of each exercise included in each session. Give clear instructions, including how much time participants have to complete each activity. Follow or adapt the "steps" described for each exercise as necessary.
- Encourage active participation among all participants. Participants should raise their hand to speak during discussions. You can always call on participants who are more quiet (although you should not pressure someone to talk who seems uncomfortable). Be mindful of any participants who tend to dominate discussion or speak over others.
- It is important to be mindful of power dynamics in the room. This can include: between men and women, older people and younger people, people of different races or ethnicities, supervisors and employees, etc. You can address power imbalances by being careful about how small groups are organized, and calling on participants equally. You should also reinforce for all participants that everyone is equal in the training, and that everyone has important contributions to make.

[7] Adapted from International Rescue Committee, *Community Case Management for Malaria, Diarrhea and Pneumonia: A Training Curriculum for Community Based-Distributors Sierra Leone*, 2012.

- Asking questions can help you to assess participants' understanding.
- Provide praise and constructive criticism. Positive reinforcement increases learning.
- Remember to close each session with a recap of key points.
- The more often information is repeated, the more likely it will be remembered, especially when it is repeated in a number of ways.

Using inclusive language[8]

As a facilitator, it is important to model inclusive, respectful language when speaking about diverse people, including People with disabilities, people with diverse SOGIESCs, people living with HIV/AIDS, and people selling sex. You should never use slurs or derogatory words to describe people. It is important to use person first language (for example, "person with a disability" instead of "disabled person"). As part of preparing for the training and to implement the program, implementing organizations can work with community-based organizations serving diverse populations to ensure the program is inclusive and accessible, and these organizations can also provide guidance on respectful, appropriate language in your context.

As a facilitator, you should also be prepared to stop and respectfully address any instances in which a participant uses harmful, discriminatory, or derogatory language. CHWs should learn and use respectful, inclusive language to ensure they treat all survivors equally.

When speaking about or working with People with disabilities:

Avoid…	**Consider using…**
Emphasizing a person's impairment or condition *For example:* Disabled person	Focus on the person first, not their disability *For example:* Person with a disability
Negative language about disability *For example:* "suffers" from polio "in danger of" becoming blind "confined to" a wheelchair "crippled"	Instead use neutral language *For example:* "has polio" "may become blind" "uses a wheelchair" "has a disability"
Referring to persons without disabilities as "normal" or "healthy"	Try using "persons without disabilities"

[8] Women's Refugee Commission, Disability Inclusion in Gender-based Violence (GBV) Programming, 2015.

Participants may come from different countries or ethnic groups. It is important to foster a respectful environment for CHWs to work together. Discussing the different cultural beliefs surrounding survivors of sexual violence may help participants understand that provider attitudes can be helpful or a hindrance in a survivor's ability to seek care.

Tips on working with CHWs as adult learners[9]

Adult learners have valuable experiences of everyday life and work. Any training with adults should be built upon recognition and respect for their knowledge and experience.

- Express your appreciation for participants' knowledge and experience, and emphasize the value of their contributions to the training.
    - Show respect for the experience of participants by asking them to share their ideas, opinions, and knowledge, and recognize that they may be a good resource for reaching your teaching goals.
    - Facilitate discussions and activities in such a way that participants feel safe to ask questions and are confident that their contribution will be respected.
    - As adults are decision-makers and self-directed learners, do not seek to make the participants obey you. Be the "guide on the side" rather than the "sage on the stage". Listen to what the participants want and need, be flexible in your planning, and change your approach if your agenda or methods are not working.
    - Seek feedback from participants and use this feedback to improve your training style as well as the content and flow.
    - The content must be meaningful, relevant, and worthwhile to participants. Become aware of what they want (and need) to learn, how much they already know and the priorities and life events that might affect their attention span and participation.
    - Make sure everyone is actively participating, and use examples of situations that are familiar to them.
    - Be thoughtful and kind, and respectful of participants' time.

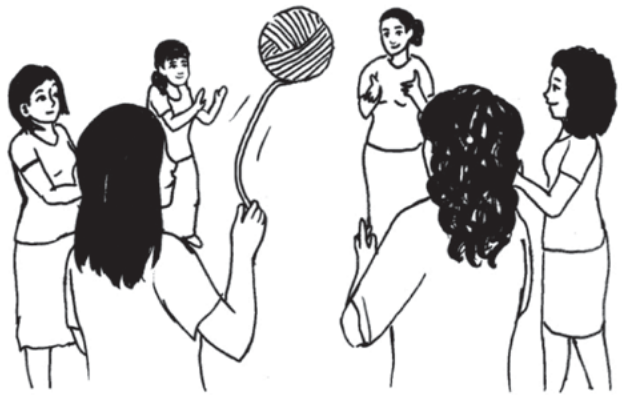
For more tips on training methods and how to prepare and conduct a training course, you can consult the first chapter of the *Facilitators' guide* for the WHO's Rapid containment of pandemic influenza training course.

[9] Adapted from World Health Organization, *Community case management during an influenza outbreak: A training package for community health workers*, 2011. Adapted from International Rescue Committee, *Community Case Management for Malaria, Diarrhea and Pneumonia: A Training Curriculum for Community Based-Distributors Sierra Leone*, 2012.

Examples of introductions and icebreakers[10]

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

- **Fact or Fiction:** Each participant thinks of four facts about themselves, one of which is not true. Each person takes turns saying her/his list, and the rest of the group guesses the one they think is not true.
- **What made you smile this morning**: Each participant thinks of what made them smile on their way to the training. This is a good way to have participants smile, especially on their first day when they may not know each other.
- **Finish the sentence**: Ask each person to complete one of these sentences:
  - 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, they can complete the sentence, "I am in this training because..."



- **Ball of Yarn**: For this exercise facilitators will need a ball of yarn. The facilitator should say their name and an interesting fact about themself. Then, holding the end of the yarn, toss the ball to a participant. The participant who receives the ball will say her/his 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 where 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.

[10] Excerpted from International Rescue Committee, Clinical Care for Sexual Assault Survivors, 2020.

Examples of energizers[11]

Energizers are used to reinvigorate participants after a long session or following meals. Energizers should be fun and engaging for participants to get out of their chairs and move. Participants often have their own ideas for energizers such as songs or games. Asking for contributions can be a good way to involve participants. The following are examples of energizers that facilitators can use:

- **C-O-C-O-N-U-T:** If participants are able to spell, have them stand and use their whole body to spell the word COCONUT. Other words that use letters that can be drawn can also be used.
- **Lifeboats**: 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 lifeboat. 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. Declare the last "boat" that can form 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. They can 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.)

- **Shake It Off:** Encourage everyone to shake out their body. Feel all the stress leaving the shoulders and back and coming out the fingertips. Pull the energy out of your arm and through your fingers. Shake your hands vigorously.

[11] Excerpted from International Rescue Committee, Clinical Care for Sexual Assault Survivors, 2020.

Tips on grouping participants

If you are grouping participants for any exercises, one way to do this is to group according to assigned numbers. The facilitator can have the participants count from one to a certain number (i.e. the desired number of groups). For example, count from one to three, if you wish to have three groups. Remind the participants to remember the number they call out. Group together all the similar numbers (i.e., group together everyone who called out one, everyone who called out two, and everyone who called out three if you wish to have three groups).

Different exercises in this training require groups to write on flipchart paper. Participants may have different literacy levels, and some participants may not be literate. Be sure that each group a participant who can scribe for the group.

Tips on using visual materials

Visual materials help participants learn and remember. These materials include sample drugs, posters, pictures, flip charts, drawings, and diagrams, such as those in this curriculum. Even simple, handmade materials are better than none at all. While no audio or motion media materials are included in the training tool, here are some tips on using materials:

- Make sure all participants can clearly see the materials.
- Explain pictures or have participants explain them and point to them as you talk.
- Look mostly at the participants, not at the flip chart or poster.
- Use samples when explaining how to use the drugs, and make sure they are not expired.
- Invite participants to touch and hold sample drugs, instruments, etc.
- If the participants are literate and safety permits, give the participants a few key instruction sheets to take home. These print materials can remind participants what to do. Be sure to go over the materials with the training participants.

MODULE 1

Introduction

SESSION 1.1 Administration

Session time	1 hour 30 min
Objectives	By the end of this session, participants will be able to: • Identify where to access administrative information. • Identify at least two ways to make the workshop run smoothly.
Methods	• Discussion • Brainstorming
Preparation	• Develop workshop timetable using the table in the training tool overview section. • If registration forms will be used, have copies ready for participants to fill in as they enter the training. • Have a sign-in sheet and pen on the table at least 30 minutes before the workshop begins. • Arrange participants' materials on the registration table so participants can easily be given one of each as they register.
Training aids, materials and handouts	• Flip chart, markers, tape; pencil sharpener. • Session objectives written on flip chart paper. • Workshop registration form if used, sign-in sheet, and pen (See annex at the end of the facilitator's guide). • For each participant: ▸ Pen, pencil, eraser, notebook, clipboard if possible • Workshop timetable
Evaluation and assessment	• None
Additional resources	• None

Steps

1. Registration, distribution of materials, and logistics (30 minutes)

1. Ensure that all participants sign their names on the sign-in sheet as they enter the training room. Assist any non-literate participants by writing their names for them. If participants are affiliated with different organizations, you should write this information down too. Give each person their packet as they sign in.
2. After all participants have arrived, review the logistics related to the training with participants, such as start and end times, how breaks and lunch will be handled, where the restrooms are, whom to ask if they have administrative questions, any funds to be provided, and so on. Ensure that any participants with disabilities or who require special accommodation have everything they need to participate in the training.
3. Briefly review the workshop timetable.

2. Introduction of participants and facilitators (30 minutes)

1. Tell participants they will now have one to two introduce themselves. In their introduction, they should say their name, where they live, one thing that is special about the village or district in which they live, and one reason they enjoy or are excited to be a CHW in their area.
2. Facilitators should start by introducing themselves, setting an example.

3. Training group norms and expectations (30 minutes)

1. Ask participants to come up with simple rules and expectations to help the training run smoothly. Call on all participants who raise their hands, and write down the rules and expectations on a sheet of flip chart paper to display throughout the training.
2. After you have called on all participants, add anything important that might be missing, like:
   - Respecting COVID-19 safety procedures
   - Turning off cell phones
   - Raising one's hand and speaking one at a time
   - Asking questions when you do not understand something
   - Using respectful, inclusive language to discuss diverse community members
   - Treating all participants equally and with respect
   - Keeping discussions during the training private and protecting one another's confidentiality

3. Ask: Now, I would like to hear your expectations for this training. What do you expect to learn? What do you expect that you will be able to contribute to this training? Call on as many participants as wish to speak.
4. As participants share their expectations, write them down on flip chart paper to refer to during the training, and at the end to see which expectations were met. If any participants' expectations are not realistic, clarify that they will not be met during this particular training.
5. Conclude asking participants how they can share in the responsibility of ensuring that norms are followed and expectations are met.

Facilitator's notes

You should also share your expectations with participants, such as:

- Participants will engage actively in the learning process, including sharing relevant knowledge and experience. Caution against mentioning names or sharing identifying information to protect survivors.
- Participants should feel free to ask questions when they do not understand or would like clarification.

SESSION 1.2 Training overview

Session time	30 minutes
Objectives	By the end of this session, participants will be able to: • State key training objectives • Understand their overall role in community-based management of survivors of sexual violence.
Methods	• Mini lecture
Preparation	• Know the exact role(s) that CHWs will play in community-based management of survivors of sexual violence. • Complete the corresponding table on CHWs' roles and scope of work. • Write training objectives on flip chart paper.
Training aids, materials and handouts	• On flip chart paper taped to wall: name of training, training objectives, and facilitator's name.
Evaluation and assessment	• None
Additional resources	• None

Steps

Training goals, objectives, timetable

MINI LECTURE (30 minutes)

Facilitator's notes

Prior to this session, you should complete the table below with the different activities that each level of CHW participating in the program will provide. You should adapt this mini lecture to reflect the levels and activities of CHWs in the pilot program. If there are multiple levels of CHWs in the pilot program, be sure that each participant understands their role, and the scope of work they will be trained to provide.

1. Explain to participants:
   - The purpose of this training is to prepare CHWs to help survivors of sexual violence.
   - At the end of this training, you will be able to:
     - Understand SV and IPV, and their consequences;
     - Educate community members about why it is important to seek care as soon as possible after SV, and how they can access services.
     - Use a survivor-centered approach when working with survivors;
     - Help survivors to access the services they need, including health services, protection services, and mental health and psychosocial support services.
     - Protect and respect survivors' safety, wellbeing, and privacy;
     - Depending on your role, provide clinical care and psychosocial support to survivors.
   - Level 1 CHWs will play an important role in leading community outreach activities, to help members of the community learn more about SV, why it is important for a survivor to seek care as soon as possible, and where people can go for services. Levels 1 CHWs will also be trained to refer survivors that come to them. "Refer" means that you will connect the survivor to the health facility, or to Level 2 or 3 CHWs, to receive care.
   - In addition to these activities carried out by Level 1 CHWs, Level 2 CHW can offer some basic, but very important, clinical services to survivors. They will also refer survivors to the health facility, or to Level 3 CHWs, for more advanced care, and for other important mental health, safety, support, and legal services.
   - In addition to these activities carried out by Level 1 and 2 CHWs, Level 3 CHWs will provide additional, more advanced health services, especially if survivors may not be able to go to a health facility, or if the health facility cannot provide the care the survivor needs.

Intervention	CHW 1	CHW 2	CHW 3
Conduct health education around sexual violence and the benefits of seeking care			
Recognize survivors of sexual violence when they come forward (passive identification)			
Actively screen for survivors of sexual violence			
Provide some basic first aid to stabilize survivors for referrals			
Refer survivors to higher-level health staff or the health facility for health care			
Take a health history			
Collect forensic evidence			
Conduct a minimum medical exam (physical)			
Conduct a minimum medical exam (pelvic)			
Complete simplified intake form			
Generate a medical certificate (duplicate intake form)			
Provide some basic first aid to treat minor injuries			
Provide other wound care as feasible			
Provide presumptive treatment for STIs, EC for pregnancy prevention and supportive counseling (including psychological first aid and basic emotional support)			
Conduct HIV counseling and testing			
Provide PEP			
Provide tetanus toxoid and/or Hepatitis B vaccine			
Provide follow-up care to survivors			
Manage STIs (syndromic management)			

2. For each level of CHW, list the components they will be providing. As you go through each level, ask participants to raise their hands to identify their level.
3. Reassure participants that even if they do not understand exactly what their work will involve now, they will have a better sense as they take part in the training.
4. Ask participants to refer to the training agenda in their participant packet. Review the training agenda with participants, highlighting the training objectives that each module will achieve, and which levels of CHW will participate in each module.
5. Break participants into pairs. Ask participants to share with their partner one to two of their personal goals or objectives for participating in the training. To conclude, ask if any participants would like to share their goal with the group. Call on 3-4 participants.

SESSION 1.3 Pre-test

Session time	30 minutes (Modules 2-4) 1 hour (Modules 2-6) 1 hour 15 minutes (Module 2-Advanced Module 8)
Objectives	By the end of this session: • Participants and facilitators will have a baseline against which to measure participants' progress.
Methods	• Individual work
Preparation	• Find out in advance which participants will need a pictorial pre-test.
Training aids, materials and handouts	• Pre-test for Literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed). • Pre-test for Non-literate CHWs (Modules 2-4) (annexed).
Evaluation and assessment	• Pre-test for Literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed). • Pre-test for Non-literate CHWs (Modules 2-4) (annexed).
Additional resources	• None

Facilitator's notes

Find out before starting the training or during the break which participants have low literacy. Be sure to give them the pictorial version of the test. When administering the pre-tests, you can take participants using the pictorial version aside in a small group, and administer the test verbally. Be sure that participants understand each question, and the answer choices. Have participants circle the appropriate picture/image as their response to the questions.

Facilitator's notes

Note that the "Pre-/post-test questionnaire for literate CHWs (Modules 2-4; 5-6; Advanced)" are divided into two sections. If participants will only cover Modules 2-4, they will only need to take the first section, through question 16. Modules 5-6 are covered in the second section; and the Advanced in the last.

Steps

1. Explain to participants:
    - To begin the training, we will take a pre-test. When we end the training, we will take a post-test. We will correct the tests together, and it will help you to see how much you have learned during the training.
    - It can also help you to see what topics you made need help with, and to keep working on.
    - The post-test is part of how we can evaluate participants to see when you are ready to begin working with survivors.
2. Tell participants:
    - You will have 30 minutes (1 hour for full test; 1 hour 15 min for Advanced test) to complete the pre-test.
    - It is important to remember that this test is asking questions about things that you haven't learned yet, and that will be covered during the training. You do not need to worry if you do not know the answers yet. This pre-test is to help us see how much we have learned.
    - You should answer as many questions as you can during the time, but do not worry if you do not finish the test.
3. Explain to participants that for some questions, they can select multiple answers. If they see a question that says "Circle all that apply," that means there may be more than one correct answer.
4. Ask participants who are using the pictorial tests to form a group. Explain to participants that the facilitators will work with them to go through each question of the test. They will be able to circle the picture or pictures for each answer.
5. Distribute the pre-tests, and make sure that participants have a pencil, so they can erase if they need to.
6. Let participants know when to start and by what time they must finish. Ask them to write their names on their pre-tests, and to bring their pre-test to you once they have finished. If participants have questions during the test, they can raise their hand.

MODULE 2

What is sexual violence and what are its consequences?

SESSION 2.1 Unpacking gender, sexual violence, and social norms

Session time	3 hours
Objectives	By the end of this session, participants will be able to: • Understand the meaning of gender, gender-based violence, sexual violence, intimate partner violence, and social norms. • Learn about the causes, contributing factors and consequences (physical, emotional, and social) of sexual violence. • Understand sexual violence in the context of human rights.
Methods	• Mini lecture • Discussion • Scenario • Game
Preparation	• Prepare lectures. • Prepare "yes," "no," and "maybe/I'm not sure" cards for all participants.
Training aids, materials, and handouts	• Flip charts, markers, and pens. • Blank sheets of paper.
Evaluation and assessment	• None
Additional resources	• IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015. • WRC, *Facilitator's Kit: Community Preparedness for Sexual and Reproductive Health and Gender*, 2021.

1. Understanding gender

1.1 What is gender?

Facilitator's notes

"Sex" is the biological differences between males and females. It does not change and remains the same across cultures and societies.

"Gender" refers to the social differences between females and males throughout the life cycle that are learned, and though deeply rooted in every culture, are changeable over time. There are wide variations of what it means to be a female or male within and between cultures. "Gender" determines the roles, responsibilities, opportunities, privileges, expectations and limitations for females and males in any culture.

Adapted from: CARE, *Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series*, 2002; IASC, Gender Handbook for Humanitarian Action, 2007; and UNFPA, Managing Gender-based Violence Programmes in Emergencies E-learning Companion Guide, 2012.

MINI LECTURE (10 minutes)

Inform participants that to provide care for survivors of sexual violence, it is important to understand the difference between sex and gender.

First, introduce the concept of **sex**. Explain:

- Sex is the biological differences between males and females.
- A person's sex is determined by their genes.
- A person is identified as female when they are born with female genitalia, a vulva.
- A person is identified as male when they are born with male genitalia, a penis and testicles.
- Other examples of male biological traits include growing facial hair, and having an Adam's apple.
- Another example of a female biological trait is the development of breasts.
- A small number of people are intersex: this means that they are born with both male and female biological traits. For some intersex people, they have genitals that look different from vulvas and penises. For other intersex people, they have a vulva or penis, but their internal organs are different. Whether or not a person is intersex is determined by their genes. Being born intersex is normal, and in most cases, it does not hurt a person's health.

Next, explain that a person's **gender is shaped by gender roles.** Explain:

- "Man" and "woman" are examples of genders.

- Gender roles are the different ways that a community defines what it is to be a woman or a man. Each community expects women and men to look, think, feel and act in certain ways, simply because of their biological sex.
- The different ways that women and men dress, cut their hair, wear makeup or wear jewelry are all examples of how people express their gender to others in their community.
- In many communities, women and men are expected to do different kinds of work.
- For example, in many communities, preparing food, gathering water and fuel, and cleaning and washing clothes are tasks that women are expected to do. In many communities, women are responsible for caring for children.
- In many communities, men are expected to be the primary earner, and work outside of the home to support their family. Gender roles are created by communities, and are shaped by laws, traditions, and religions.
- Gender roles can vary within communities based on people's level of education, wealth, social status or age.[12]
- A person's gender role can also change over time. Communities have different expectations for women and men as they age, and older women and men play different roles in their communities than younger women and men.
- People make assumptions about one another, and their skills and abilities, based on their gender. This is called gender stereotyping.

Next, explain to participants how people learn their gender roles:

- Gender roles are passed down from adults to children. From the time children are very young, parents and others treat girls and boys differently—sometimes without realizing that they do so.
- Children watch their elders closely, noticing how they behave, how they treat each other and what their roles are in the community. As children grow, they accept these roles because they want to please their parents and other respected adults, and because adults have more authority in the community. These roles also teach children what is expected of them.[13]
- **Sex and gender are not the same thing. Sex is biological. Gender is social and is defined by communities.**
- Gender is also an important part of people's identities.
- Most people who are born female identify as women. Most people who are born male identify as men. This is called being cisgender.
- However, just because someone is female does not mean that they identify as a woman, or that a male person will identify as a man. Some people are transgender. This means that a person does not identify as the gender that corresponds to their biological sex.
- Being transgender does not mean that there is something wrong with a person, or that a person is mentally ill.

12 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.
13 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- Gender is also different than sexual orientation. Sexual orientation refers to the gender of people that someone is attracted to romantically and/or sexually.
- The majority of people are heterosexual—this means that they are attracted to people of the opposite gender. This is also called being straight.
- Some people are attracted to people of the same gender. This is called being gay. In some places, gay women are also called lesbians. Some people are attracted to both men and women. This is called being bisexual. Some people identify as queer. Queer is a term that people use to describe identities other than straight and cisgender. Lesbians, gay people, bisexual people, and transgender people may all identify as queer.
- Persons who identify as queer may choose to use different pronouns rather than the traditional "she/her" for a woman, and "he/him" for a man. Some people use "they/them" pronouns to show that they identify with more than one gender category, or that they do not identify as a woman or a man.
- Many people use an acronym to refer to different groups of people with diverse sexual orientations and gender identities, including lesbians, gay people, bisexual people, transgender people, intersex people, and queer people —or LGBTQIA+.

Ask if participants have any questions before moving on to the next section.

2. Understanding gender-based violence

2.1 What is gender-based violence?

MINI LECTURE (10 minutes)

Summarizing each group's scenario, discuss when gender roles can sometimes cause harm.

Emphasize to participants:

- Gender not only shapes the way that people dress, their responsibilities, and the type of work that they do. Gender also shapes the way that that people treat one another within their communities, families, and intimate relationships.
- When a person does not behave how others expect them to based on their gender, they can experience negative consequences, and be treated badly by members of their community and family, or their partner.
- This is often the experience of transgender people, who are at high risk for violence because of their gender identity.
- In many communities, inequality between men and women is part of gender roles. Because of their gender, and gender roles in their community, women are expected to do what their husbands and partners, fathers, and other men say. Because of gender inequality, women and girls have less social, economic, and political power than men and boys.[14]

[14] Women's Refugee Commission, Supporting Survivors of Violence: The Role of Linguistic and Cultural Mediators, 2021.

- In many communities, violence is a part of men's gender role. Boys are taught to solve problems or control others using violence, and boys and girls are taught that it is acceptable or "natural" for boys and men to be violent towards others because of their sex and gender.
- "**Gender-based violence**" means violence towards a person based on their gender, and is particularly tied to women and girls' lower status in communities.
- Gender-based violence against women and girls is a very serious problem that is common in communities around the world. At least one in three women and girls—more than one billion worldwide—will experience physical and/or sexual gender-based violence at some point in their lifetime.[15]
- Transgender people are at an extremely high risk of gender-based violence. Gay people, lesbians, bisexual people, queer people, and gender non-conforming people may also be targets of violence because of their sexual orientation or gender identity or expression.[16]

Facilitator's notes

Gender-based violence (GBV) is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females. GBV can be sexual, physical, psychological/emotional and economic, and include acts—attempted or threatened—committed with force, coercion or manipulation, and without the agreement or consent of the survivor. These acts can occur in public or in private.

Adapted from: IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015.

2.2 What are examples of gender-based violence?

Steps

DISCUSSION[17] (35 minutes)

1. Ask participants to name some examples of GBV. Draw and/or list these on flip chart paper. Encourage participants to discuss with one another to generate ideas about diverse types of violence. Continue brainstorming until participants have filled out roughly two flip chart pages.
2. Next, introduce four general categories of gender-based violence: sexual violence, physical violence, psychological and emotional violence, and economic violence. Write each category on a new flip chart page. For each category, first ask if any participants can define the type of violence. Then, examples of each category of violence. For example, you can explain:
   - If someone forces a person to have sexual intercourse against their will, that is sexual violence. If someone kisses a woman or touches a woman's breasts without permission, that is sexual violence.

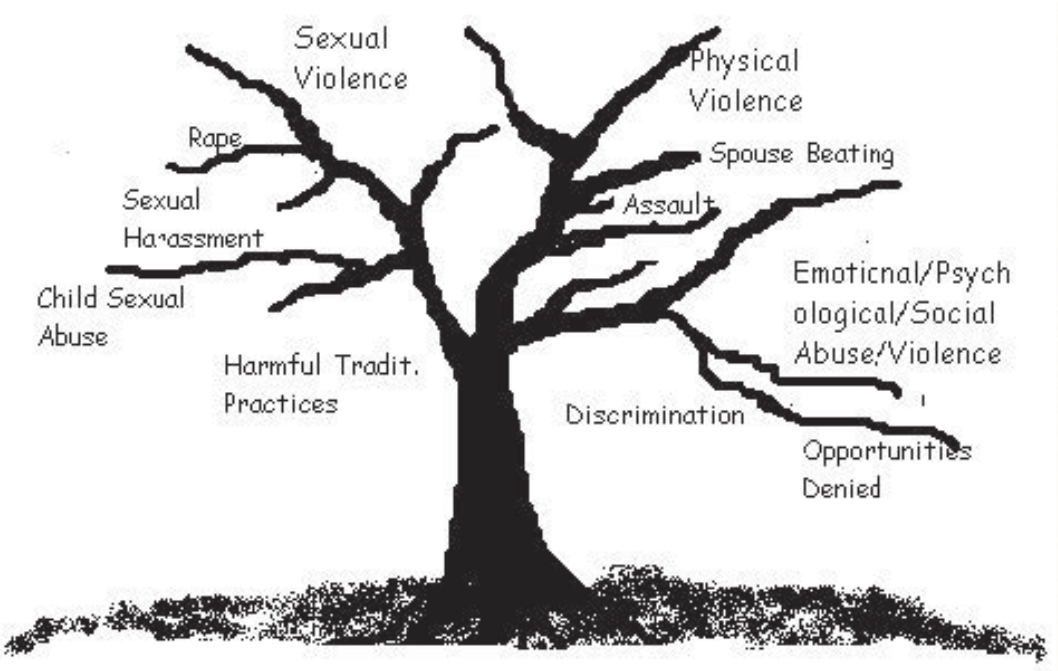
15 World Health Organization, Violence against Women, 2021.

16 United Nations, Ending Violence and Discrimination against Lesbian, Gay, Bisexual, Transgender and Intersex People, 2015.

17 Adapted from Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series, 2002; and UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012.

- If a man beats a woman when he is angry, that is **physical violence**. If a man shoves or slaps his partner, that is **physical violence**. If a transgender woman is beaten because of her gender identity, that is physical violence.
- If a husband says to his wife that she is worthless, calls his wife names, or insults his wife, that is **psychological or emotional violence**. If a husband does not allow his wife to have contact with her friends or family, that is **psychological or emotional violence**.
- If a husband takes all of his wife's earnings, that is **economic violence**. If a husband refuses to allow his wife to have any money, that is **economic violence**.

3. Divide participants into four groups and assign each group to a category. Tell participants they have 10 minutes to discuss and three minutes to present. They should select one person to speak on behalf of the group, but others can add as relevant. Ask participants to:
   - Identify which types of GBV from the flip chart fall within their assigned category, and to add any that they think are missing.
   - Discuss how the different acts of violence play out in different relationships. Relationships can be between a husband and wife, unmarried couples, a mother-in-law and a daughter-in-law, parents and children, and other people in the community.
   - Think about any potentially harmful practices that only apply to certain sex or age groups in their community. Could they be considered GBV?
4. While participants are discussing, draw a simple tree on flip chart paper. Use only the top two-thirds of the page (the bottom one-third is for contributing factors/causes). Draw four large branches and label them with the four broad categories.
5. Ask each group to present what was discussed in each group. As the presenters speak, draw smaller branches and write or draw the types of GBV they list.



From: CARE, *Moving from Emergency Response to Comprehensive Reproductive Health Programs*, 2002.

6. When all groups have finished presenting, ask if they see anything missing. You can refer to the list provided in the Facilitator's Note, below. Participants may suggest examples of violence that are not based on gender. In these cases, ask participants to reflect on why or why not this type of violence is based on gender. If it is helpful, you can refer back to the earlier definition of GBV in the Facilitator's notes. Make notes on the flip board while participants are discussing. **The process of thinking through diverse examples of GBV, and discussing examples that may not be immediately considered violence should support participants to reflect on their assumptions, opinions, biases, and cultural issues/beliefs.**
7. Be sure that participants include gender-based harmful practices that take place in their context/community, especially if these practices relate to SV, and discuss why these practices are a type of GBV.
8. End this session by emphasizing for participants that:
    - Striving towards gender equality and respect for all persons, no matter their gender, can reduce GBV.
    - Equality between women and men means that women, girls, boys, and men can equally enjoy their rights, opportunities, resources, and rewards.
    - Equality does not mean that women and men are the same, but it does not matter whether a person is born female or male to enjoy the same rights, opportunities, and life chances.[18]

Explain to participants that we will discuss more about GBV, equality, and human rights in later sections.

Ask if participants have any questions before moving on to the next section.

[18] IASC, Gender Handbook for Humanitarian Action, 2007.

Facilitator's notes

Some definitions:

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

Sexual violence includes:

- **Rape/attempted rape:** Rape is an act of non-consensual sexual penetration. This can include the penetration, even slightly, of the vagina, anus, or mouth with a penis, other body part, or object. . Rape and attempted rape involve the use of force, threat of force, coercion, or use of drugs and alcohol so a person is not able to consent to sexual activity Efforts to rape someone that do not result in penetration are considered attempted rape.
- **Sexual abuse:** Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal or coercive conditions.
- **Sexual exploitation:** any actual or attempted abuse of a position of vulnerability, differential power or trust for sexual purposes, including, but not limited to, profiting monetarily, socially or politically from the sexual exploitation of another. Some types of forced and/or coerced prostitution can fall under this category.
- **Sexual assault:** Any form of non-consensual sexual contact that does not result in or include penetration. Examples include: attempted rape, as well as unwanted kissing, fondling, or touching of genitalia, breasts, and buttocks.
- **Trafficking**: The recruitment, transportation, transferring, harboring or receipt of a person, by threat, use of force or other forms of coercion, abduction, fraud, deception, abuse of power or vulnerability, and giving or receiving of payments or benefits. This is done for the purpose of exploitation, including for prostitution or other forms of sexual exploitation, forced labor or services.
- **Sexual harassment:** Any sexual advance, request for sexual favors or other verbal or physical act that is sexual in nature and makes a person feel unsafe or uncomfortable (like sexual jokes, comments, intimidation).

As a reminder, this training tool focuses on sexual violence that includes any act of forced sex, perpetrated by a stranger or family member, in or outside of a marriage or partner relationship, among any age group or sex, regardless of whether the act constitutes "rape". Any act of forced sex as defined by the person that experienced it is "sexual violence". Where "sexual assault" is used, this is the same as "sexual violence" in this project.

Adapted from: IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015; IAWG, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012.

Facilitator's notes

The following are types of GBV. When participants present, be sure that they include those items in bold:

Sexual

Rape (including forced anal and oral penetration)
Attempted rape
Marital/partner rape (forced sex in marriage)
Abuse/exploitation
Child sexual abuse
Incest (forced or consensual sex between family members)
Molestation (inappropriate touching)
Forced prostitution
Trafficking
Sexual harassment (unwanted sexual advances or remarks)
Forced pregnancy
Forced abortion
Forced sterilization

Physical

Assault and other physical violence
Beating, hitting, slapping, punching,
Neglect (starvation, deprivation)
Murder/Femicide
Forced labor
Child labor
Abandonment/denial of housing
Cutting, shoving, burning
Shooting/use of weapon
Acid attack
Strangulation
Restricted mobility

Psychological/ Emotional

Emotional abuse, Harassment, Stalking,
Stalking/harassing online,
Blame, Humiliation,
Isolation, Threats,
Discrimination, Denial of opportunity
Spouse confinement

Economic

Controlling money
Denial of opportunity, such as employment or education
Forced labor
Denial of resources or services

***Harmful traditional practices can include sexual, physical, and psychological/emotional types of violence. Examples include:**

Female genital mutilation/cutting (partial or total removal of female genitalia)
Child marriage
Forced marriage (forcing a woman to marry against her will)
Honor killings
Widow inheritance
Punishments direct at women and girls for crimes against culture

Other examples (if relevant) are:

Sex-selective abortion/female infanticide
Son preference/daughter neglect

Adapted from CARE, Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series, 2002; Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021; UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012.

2.3 What is intimate partner violence?

MINI LECTURE (10 minutes)

Explain to participants:

- One of the most common types of GBV is intimate partner violence (IPV).
- IPV is physical, emotional or psychological, or sexual violence, or denial of opportunities, that takes place between intimate partners.
- Husbands and wives, boyfriends and girlfriends, and romantic or sexual partners are all examples of intimate partners.
- IPV can take place between partners even if they do not live together in the same home. It can also take place between adolescents and young people.
- It is important to know that IPV can take place between partners who are no longer together—ex-husbands and ex-wives, ex-boyfriends and ex-girlfriends.
- IPV also takes place in same-sex relationships, and both men and women can be violent to their partner. **However, IPV is by far most common against women by male partners, and most severe against women.[19] Nearly 1 in 3 women around the world have experienced IPV, or SV from someone who is not their partner, or both.[20]**
- IPV very often happens in a pattern, or a cycle, in a relationship. A man may be violent to his partner, and then say that he is very sorry, and treat his partner very well for a while, before he becomes violent again. IPV often gets worse and worse over time.

Emphasize: In many communities, because of gender roles and social norms, it is considered normal and acceptable for men to be violent towards their partner—to beat their wives and girlfriends if they do not obey them, or to force them to have sex when they do not want to. However, it is never, ever acceptable for a man to be violent to his partner. Remind participants that if a husband or boyfriend forces his wife or girlfriend to have sex, it is still SV—even if they are married, or in a relationship.

- Share the legal status of "spousal rape" in the setting with participants, but emphasize strongly that is SV, regardless of whether it is recognized by national law, or custom.

Facilitator's notes

As part of preparing for the workshop, you should identify laws about the legal age at which a person can be married, and whether or not spousal rape is recognized under the law.

Explain to participants:

- IPV takes place in countries and cultures all over the world.
- IPV becomes more common in conflicts, after disasters, and/or when people have been forced to flee their homes.

19 WHO, Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines, 2013.

20 WHO, Violence Against Women Prevalence Estimates, 2018, 2021.

- IPV also increases during epidemics and pandemics, when people are forced to stay in their homes, health and protection services are closed, and families are under a lot of stress – as we have seen all around the world during the COVID-19 pandemic.
- Conflicts, disasters, and displacement are very stressful for families and communities, especially if families are struggling to make enough money to survive, or are living in small spaces, or unfamiliar places. These stressors can lead to increases in IPV.
- These events can also change gender norms. For example, men may no longer be able to work and support their family—and therefore may feel that they are not able to fulfill societal expectations about what it means to "be a man." They may lose self-esteem, and feel badly. This stress can contribute to IPV. Another example is that communities and families may be separated, which can isolate women, and make them more vulnerable to IPV—they may not know where they can go for help.[21]
- Conflicts, disasters, and displacement also lead to increases in child marriage, and forced marriage. Women and girls who experience forced and child marriage are more vulnerable to IPV.
- All over the world during the COVID-19 pandemic, IPV increased, as families were locked down together and women and girls were struggling to get help or were unable to get away from their abuser. Many people lost their jobs, and stress levels were very high.

Explain:

- Many people ask why someone who is experiencing violence in their relationship does not leave.

Ask: Can you think of why a woman may not leave a partner who is violent to her? After one to two minutes, call on participants to share possible reasons that a woman does not end a relationship with a violent partner.

Then, explain to participants that a woman experiencing IPV may not leave because:

- She may not be able to take her children with her.
- She may not have a place to stay, or a way to support herself and her children.
- She may not want to end the relationship: many women love and care about their partner and may not want to end their relationship—they want the violence to stop, and to be safe.
- It may be against the law or prohibited in the community or country where she lives.
- She is at risk of violence, or even being killed by her partner, if she leaves. The most dangerous time for women experiencing IPV is when she tries to end the relationship.

Emphasize to participants that a person should not be judged for experiencing IPV. It is essential that service providers—including community health workers and volunteers—never blame or judge someone who reports IPV, or who they believe is experiencing IPV. **Emphasize to participants that it is never a survivor's fault that they are experiencing IPV.**

[21] International Rescue Committee, Private Violence, Public Concern: intimate Partner Violence in Humanitarian Settings Practice Brief, 2015.

Explain to participants that they will learn more about how they can support and provide care for women, girls, and any person experiencing IPV. **Emphasize that while IPV is most likely to happen to women and girls, by men, that people of all genders, including boys and men, can experience IPV, and that IPV takes place between same sex couples, too.**

Ask if participants have any questions before moving on to the next section.

3. Social norms and sexual violence, including intimate partner violence

3.1 What are social norms and how do they relate to gender and sexual violence?

DISCUSSION[22] (15 minutes)

1. First, ask participants to provide examples of social norms in their community. Call on several participants to share examples with the group.

Explain to participants:

- Social norms are rules and expectations about behavior that members in a group or community are expected to follow by other members in the same community.
- People follow social norms in order to be accepted and to avoid being punished for not following them.
- Social norms can tell people what behavior is expected of them or what behavior is forbidden.
- People follow social norms because they see others following them and believe other people think they should follow them, too.
- Some social norms apply to all members of a community, no matter who they are.
- Some social norms apply to only some people in a community, and are rules about how people belonging to that group should act.

2. Ask CHWs to raise their hands to share different community groups they belong to. As participants provide examples, it may be useful to list them on flip chart paper. After you have called on several participants, explain:
   - Some social groups are smaller, like a group of friends, or members of the same place of worship. Some groups are larger: like young men in a community, or older women in a community.
   - No matter if the social group is big or small, group members' behavior will be guided by the opinions and behaviors of other people in the group.
3. Ask participants to think about the examples of social groups on the flip chart, and brainstorm a few social norms that are generally approved of, a few social norms that are disapproved of, in one of the groups they listed above.

[22] Mackie G, Moneti F, Denny E, and Shakya, H. What are social norms? How are they Measured?, UNICEF/UCSD Center on Global Justice, Working Paper, 2014.

4. Next, ask participants to share what they think "social rewards" are. After you have called on several participants to share, explain to participants that people follow social norms to be accepted by a social group, including large social groups like communities, so they can meet their basic needs, including shelter, food, and safety, as well as friendship and belonging.
5. Then, ask participants what they think "social punishments" are. After you have called on several participants to share, explain to participants that people who do not follow social norms may be excluded, punished, or shamed by group members.[23]
6. Next, explain that often a person acts in a certain way because they think it is the action that another member of the social group would take, or because they think other members of the social group would approve of the action. Emphasize to participants that social norms guide people to behave in the way that is expected of them.

Ask if participants have any questions before moving on to the next section.

3.2 How are social norms linked to sexual violence and intimate partner violence?

ACTIVITY (20 minutes)

1. Explain to participants:
   - Sometimes, social norms continue even when they are harmful.
   - Sometimes a person follows a social norm they do not like, or does something they do not want to do, because they believe that other members of the social group approve.
   - It can be hard for someone to speak up when they think a social norm is wrong, because they are afraid of social punishments. This can hide the fact that many people in the community also do not approve of a behavior or practice. Because of this, harmful behaviors like SV may continue, even when many people in the group do not believe it is right.
   - It can be hard to know what other people really think about SV because in many communities there are social norms against talking openly about sex in any way. It is possible that many people in a group actually dislike SV but remain silent because they think that other group members support it.
   - Tell participants that gender roles and social norms are related. In many communities, men and women are expected to follow different social norms based on their gender.
2. Break participants into groups, and assign each group to "men" or "women." Give the groups three minutes to brainstorm examples of social norms for people of that gender, including children, in their community.
3. Then, ask participants to brainstorm social norms and gender roles for people of that gender related to sex, sexuality, and romantic relationships. Give participants five minutes.
   - While participants are brainstorming, set up two pieces of flip chart paper—with one labeled "men and boys" and one labeled "women and girls."

[23] Hechter, M and Opp, K "Introduction" in M Hechter and K Opp (Eds.), Social Norms, 2001.

- After five minutes, call on participants across groups to share one norm their group brainstormed, and write the norms on the flip chart paper. Continue calling on participants until the groups have shared all of their ideas.

4. Ask: How could these social norms relate to SV in your community? How do social norms relate to IPV? Facilitate discussion among the group for five to ten minutes. To prompt discussion, you can ask participants: How do these social norms about sex, sexuality, and romantic relationships reflect gender inequality?

5. End the activity by restating that social norms about men and women, and sex, sexuality and romantic relationships, reflect gender inequality, and can cause SV and IPV to be thought of as something that is normal, or cannot be avoided. Explain that participants will now play a game to further explore common norms related to gender and sexual violence and explore community attitudes that may be harmful for survivors.

GAME (20 minutes)[24]

1. Explain to participants that you will be doing an activity called "yes, no, maybe so."

   - Give each participant one "yes" card, one "no" card, and one "Maybe/I'm not sure" card.
   - You will read out a list of statements about SV and IPV.
   - After each statement, all participants should hold up the piece of paper saying whether they agree with the statement (yes), disagree with the statement (no) or aren't sure if they agree or disagree with the statement (maybe/I'm not sure).
   - Once the participant chooses their piece of paper and holds it up, have them close their eyes.
   - After everyone has held up their paper, ask participants to look around, and to reflect on one another's answers.
   - Be mindful of participants' responses, since this will help you better understand their perceptions about SV and towards SV survivors. Make a note to yourself of any participants who seem to agree with more of the statements, or any statements that many participants seem to agree with
   - After participants have looked around, read the corresponding follow-up to each statement.

2. Sometimes a woman is partially responsible for having been sexually assaulted because she went somewhere that was not safe, or she wore something that men found attractive.

   - The only person responsible for SV is the perpetrator. SV is never acceptable, no matter what a person wears or says, where they go or how they behave.
   - SV is about power and control, and men who assault are making the decision to do so. They are responsible for this decision.

3. A wife should always agree to have sex if her husband demands it, even if she does not want to.

[24] Adapted/excerpted from IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020; Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021; and Hesperian Foundation, *A Health Handbook for Women with Disabilities*, 2007; Women's Refugee Commission, Supporting Survivors of Violence: The Role of Linguistic and Cultural Mediators, 2021; Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2019.

- In many cultures, there is an expectation that the husband has more authority than his wife, and can therefore demand that his wife do things she does not wish to, including having sexual intercourse. Forcing her to have sex against her will is violence, even in the context of marriage.

4. If a woman agrees to have sex, it is not fair for her to change her mind.

   - Anyone can change their mind at any time before or during any sexual activity and say no, that they do not want to have sex anymore or that they want to stop. If a person does not stop, or forces someone to keep having sex after they have changed their mind, it is SV.

5. It is acceptable for an adolescent girl to marry an older man if her parents agree and approve of the man.

   - Each country has a legal age of marriage that often takes into account people's health and developmental stages of responsibility. Even if parents approve of the marriage, child marriage puts girls at risk of violence, having to leave school, isolation, poverty, and early pregnancy. Girls who become pregnant have higher risks of complications and death since their bodies are not yet mature, and their babies are also at higher risk of complications and death.

6. A woman will always say no to sex because she does not want to seem too eager for sex. It is therefore normal for the man to pressure his partner and push for sex.

   - It is never acceptable to pressure someone to have sex. Pressuring or coercing a person to agree to have sex when they do not want to is SV.

7. Having sex is an important part of proving or demonstrating masculinity.

   - While this can be a common notion, it is never acceptable to use the demonstration of masculinity as a reason to force sexual activity on someone.

8. If a man assaults a gay adolescent boy, it is not as serious as if he assaults a straight adolescent boy.

   - LGBTQIA+ youth and men may blame themselves if they experience SV, feel self-hatred and believe that they deserve it as a punishment for not conforming to society's expectations. Some service providers share these harmful beliefs. Any sexual act against a person's will is SV, *regardless* of the survivor's sexual orientation.

9. A woman who is selling sex cannot really be sexually assaulted.

   - Because someone is selling sex does not mean that they "cannot" be sexually assaulted, or that it is their fault if they are assaulted. Everyone has the right to say no to sex, or to change their mind about having sex—even when they are selling sex. Women selling sex are at a very high risk of SV. In many places, selling sex may be illegal, or thought to be shameful, which can make it harder for someone to report SV or to seek help.

10. If a girl consents to have oral sex, then she has also consented to have vaginal or anal sex.

    - This is not the case. Just because a person agrees to one sexual act, it does not mean that they consent to other sexual acts.

11. It is common for girls and women to lie about having been sexually assaulted.

    - This is not true. It is extremely rare for people to lie about experiencing SV.

12. If a woman's husband or boyfriend forces her to have sex, it is not as serious as when it is a man she is not in a relationship with.
    - This is not the case. SV is just as serious when it happens between two people in a relationship as when it happens between people who are not in a relationship. Many incidents of SV are committed by someone a woman knows. Anytime someone is forced to have sex against their will, it is SV—whether the attacker is a husband, boyfriend, teacher or a stranger.
13. It is best for families to keep IPV private, as it could cause other people in the community to judge them.
    - Violence is not just a family matter. Many women are hurt or killed. Sometimes, the violence happens in the family. Violence is a social and community health problem.
    - People experiencing IPV should not be judged, and should know where there are safe places in the community they can go for help, without fear of being shamed.
14. IPV and SV is part of normal life. It is just what happens in this community.
    - While it may feel this way, normalizing violence is not helpful for survivors or those at increased risk of experiencing SV or IPV. Addressing social norms openly and questioning whether this notion is helpful for society is one meaningful way of working towards change.
15. Sexual violence is more serious if the man uses violence and force, than if he uses pressure or threats.
    - SV is just as serious when a man does not use physical violence to force someone to have sex as when he does.
16. It is normal for men to discipline their wife or girlfriend using threats.
    - It is never acceptable for men to threaten their wives or girlfriends. This is emotional/psychological abuse, and is a form of IPV.
    - Nothing a woman does gives a man the right to threaten or hurt her, even if he thinks she deserves it—even if she herself thinks she deserves it.

After you have read the final statements, Ask: Would anyone like to share any reflections on this exercise? Was there anything about the statements that surprised you?

Conclude the activity by emphasizing that anyone can be a target of SV, and it is never the person's fault. Men and boys can also experience SV, and SV can also take place in same-sex relationships. Emphasize that SV is just as serious when it happens between two people in a relationship, and whether or not the perpetrator uses physical violence.

Ask if participants have any questions before moving on to the next section.

3.3 Why does gender-based violence happen, and what are some risks/ contributing factors?

DISCUSSION[25] (25 minutes)

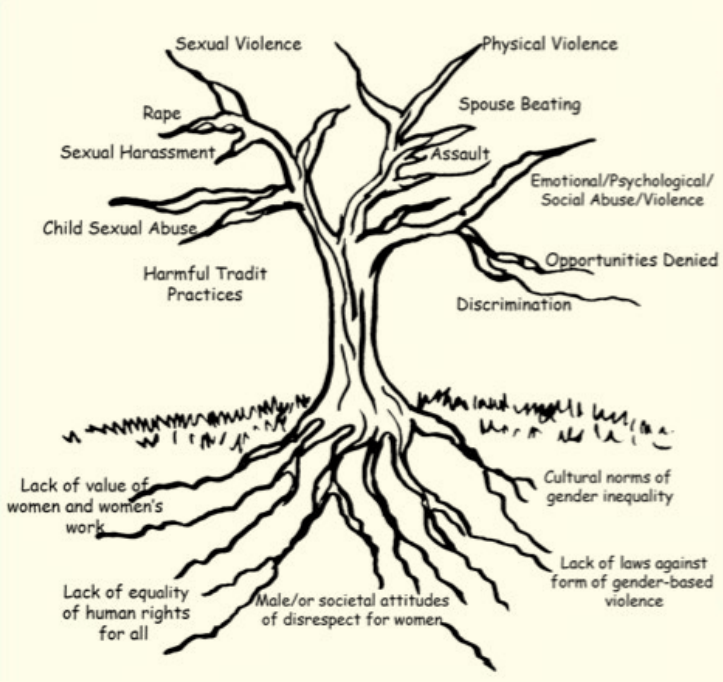
1. Go back to the tree diagram drawn on the flip chart. Draw roots to your tree diagram, and on the side of the flip chart, draw a rain cloud. Under the rain cloud, write, "weather and temperature." Explain to participants that the weather and temperature represent contributing factors. For example, weather and temperature can make trees grow larger and the roots stronger. In the case of GBV, contributing factors would be circumstances that can make GBV more common in a relationship, family, and/or community.
2. Ask participants to brainstorm examples of root causes of GBV. Ask participants to provide examples, and label different roots on the diagram.
3. Then, ask participants to brainstorm examples of contributing factors to GBV. As participants provide examples, list them on the side of the diagram, under the rain cloud.
4. Review participants' contributions, and add any examples of root causes and contributing factors that are missing (see the Facilitator's notes). Ask participants if they have any questions about any of the terms on the drawing.

[25] Krug E, Dahlberg L, Mercy J, Zwi A and Lozano R (Eds.), *World Report on Violence and Health, World Health Organization*, 2002.

Facilitator's notes

Root causes, including gender roles, can be:

- Male and/or society attitudes of disrespect or disregard towards women.
- Lack of equality of human rights for all.
- Cultural/social norms of gender inequality and discrimination.
- Lack of value of women and/or women's work.



Contributing factors depend on the situation and can be:

- Alcohol/drug abuse.
- Religious beliefs.
- Culture and traditional practices.
- Crises, including conflict, natural disasters, displacement, and epidemics or pandemics.

Adapted from: CARE, *Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series*, 2002; UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012; and International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2011.

5. Next, explain that there are many risk factors in the individual, family and community that can influence the chances of someone experiencing GBV, including SV and IPV. Risk factors affect individuals, relationships, families, schools, and other institutions and communities.[26]

[26] World Bank, *Gender-based violence, health, and the role of the health sector*, 2009.

Risk factors at the individual level include:

- Age—girls and young women are at a higher risk of GBV.
- Having experienced SV in the past or having experienced childhood sexual abuse.
- Poverty/socio-economic status.
- Having a disability—people with disabilities have a higher risk of experiencing GBV.
- Gender identity—transgender people have a higher risk of experiencing GBV, and may be targeted because of their gender identity.
- Sexual orientation—gay, lesbian, and bisexual people may be targeted for violence because of their sexual orientation.

Risk factors in relationships include:

- Women gaining education, or economic empowerment.
- Drug and alcohol use/drugs and alcohol in the home.
- Presence of weapons in the home.
- Poverty/stress over livelihoods.
- Child, early, or forced marriage.
- Power imbalances in relationships (sex worker/client; teacher/student; humanitarian aid worker/beneficiary).

Risk factors at the community and societal level include:

- Gender roles and gender inequality.
- Lack of safe spaces/organizations supporting women and adolescents.
- Social norms.
- High levels of poverty.
- High levels of unemployment.
- Weak laws and policies to prevent GBV and hold perpetrators accountable.
- Religious or cultural belief systems that support gender inequality and/or GBV, and oppose LGBTQIA+ people.
- Humanitarian crises, including conflict, natural disasters, displacement, and epidemics or pandemics.

Special considerations

Pregnant women: Some people are more likely to be abused than others. A woman's risk of experiencing IPV is highest when she is pregnant. The man may feel as though he is losing control because he cannot control the changes in her body. He may feel angry because she is paying more attention to the baby and less to him, or because she may not want to have sex with him. Many couples may also feel extra worried about money when they are expecting a new baby.

People with disabilities, including children, are also more likely to experience IPV and SV, as:

- They may be isolated, and face more challenges to notify someone, or to seek help.
- Some men may feel angry that they did not get a "perfect" woman.
- Men may think a woman with a disability is easier to control because she may be less able to defend herself.

More information about working with survivors with disabilities, including referrals for services for people with disabilities, is included in later modules.

Age and risks: Young women are thought to be more at risk of SV than older women. Certain forms of SV are very closely associated with a young age, in particular, child marriage, violence taking place in schools, and trafficking for sexual exploitation.

Gender identity and sexual orientation: LGBTQIA+ people may be targeted for SV because of their gender identity or sexual orientation. However, they may be even less likely to report violence or seek help because they may be shamed, blamed, and stigmatized. Same sex relationships are illegal in many countries.

From: Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2010; and WHO/World Bank, *World Report on Disability*, 2012; WHO/London School of Hygiene and Tropical Medicine, *Preventing intimate partner and sexual violence against women: taking action and generating evidence*, 2010. p.20.

6. Conclude by emphasizing that SV and IPV happen everywhere, and can be fueled by root causes and contributing factors, including risk factors.

Ask if participants have any questions before moving on to the next section.

3.4 What are some norms and attitudes that may be helpful for survivors of sexual violence?

DISCUSSION (20 minutes)

1. Note that it is important to remember that some social norms can also help people that have experienced SV, including IPV, in the community. Ask participants to brainstorm existing social norms in their community that offer empathy, compassion, and support to survivors. Write the norms down on a sheet of flip chart paper as participants speak.

2. Next, ask participants to pair up or to form small groups. Tell participants that they have ten minutes to discuss the following questions with their partner:

    - As a CHW, what can I do to promote social norms in my community that provide empathy, compassion, and support to survivors?

    - When I am providing care to a survivor, what can I do to ensure the survivor does not feel shamed or blamed?

After ten minutes, ask if any participants would like to share key points and ideas from their discussion with the larger group, and call on any participants who would like to speak.

3. As CHWs prepare to manage survivors of sexual violence in the community, emphasize that they should work to prevent stigmatizing attitudes towards survivors and never fuel them. Reinforce that:

    - The survivor is never to blame.

    - SV can happen to anybody.

    - SV is not about sexual attraction or seduction, but violence and control.

    - Acts of SV violate survivors' fundamental human rights.

4. Understanding sexual violence in the framework of human rights

4.1 What are human rights?

MINI LECTURE (20 minutes)

1. Explain to participants:
   - Human rights are rights that belong to all human beings, no matter what country they are born in, where they live, their gender, age, sexual orientation or gender identify, ethnicity, race, color, religion, language, or other status.
   - Human rights are based on respect for the dignity and worth of each person.[27]
   - Everyone is equally entitled to human rights, regardless of who they are.[28]
2. Ask participants: can anyone provide examples of different human rights? Call on participants to share their examples.
3. Tell participants:
   - SV violates survivors' human rights.
   - These human rights are protected by international law and by national law in many countries.
   - SV violates the following human rights of survivors:[29]
     - The right to life, and to be safe and free.
     - The right to be healthy, including mental health.
     - The right to not be tortured, or to experience cruel and degrading treatment.
     - The right to freedom of opinion and expression.
     - The right to education and personal development.
     - The right to be protected from neglect, cruelty, and exploitation.

[27] UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012.
[28] UN Office of the Commissioner for Human Rights, *What are Human Rights?* Last accessed 26 November 2012.
[29] International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2011.

4. Tell participants that you will share some scenarios of SV, and that you will ask them to describe how the scenario violates the survivor's human rights. After each statement, call on participants to share how the survivor's human rights are violated.
    - A girl is sexually assaulted on her way to collect firewood.
    - A teacher sexually abuses a student at school.
    - A husband physically and sexually abuses his wife.
    - A transgender woman is attacked by a man, and beaten and forced to have intercourse.
    - A humanitarian worker refuses to give food assistance to an adolescent boy unless he has sex with him.
    - A man forces his girlfriend to have sex with other men for money.
    - A man in a detention center is forced to have intercourse by officers detaining him.
5. Conclude by telling participants:
    - SV always violates the survivor's human rights, no matter who they are, or the type of SV they experienced.
    - All people have the right to be free from SV, and have the right to receive help, support, and care after they experience SV no matter who they are or where they live.
    - CHWs have the power and the important responsibility to help protect the human rights of survivors in their community.

Ask if participants have any questions before moving on to the next section.

SESSION 2.2 Addressing sexual violence in crisis settings

Session time	6 hours
Objectives	By the end of this session, participants will be able to understand: • Why sexual violence happens in conflict. • The health, emotional, psychological, and social consequences of sexual violence. • The health and other benefits for survivors seeking timely care.
Methods	• Mini lecture • Discussion • Game • Activity
Preparation	• Prepare lecture. • Print and cut HIV cards annexed to the end of the facilitator's guide for a game on how HIV can or cannot spread. Two sets will be required if you are dividing the participants into two groups. • Print and cut "Blanketed by blame" cards annexed to the end of the facilitator's guide.
Training aids, materials and handouts	• Flip chart and markers. • Sample condoms (male and female). • HIV cards (annexed to end of the facilitator's guide). • HIV flipbook (participants' packet). • "Blanketed by blame" cards (annexed to the end of the facilitator's guide). • Sample medicines (EC, antibiotics, etc.) for visual understanding. • Ball of string. • Scarves or sheets of newspaper.
Evaluation and assessment	• Game on how HIV can and cannot spread.
Additional resources	• Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021. • Partners in Health, *Accompagnateur Training Guide*, 2008. • CARE, *Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series*, 2002. • UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012. • Ipas, *Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences*, 2018.

1. Risks and vulnerabilities to sexual violence in crisis settings

1.1 What happens during a conflict, natural disaster, epidemic/pandemic, or displacement?

MINI LECTURE[30] (5 minutes)

Tell participants:

- This session focuses on SV in crisis settings, including conflict, natural disasters, epidemics and pandemics, and when communities are displaced – for example, in refugee camps.
- In this session, we will also have an opportunity to reflect on how the crisis this community is experiencing has affected SV.
- Armed conflict often destroys homes, fields, roads, hospitals, schools, and other important infrastructure. During armed conflict, ordinary people might be hurt or killed. People may be forced to leave their homes because it is not safe for them to stay, or because they cannot make a living.
- There is often a need for humanitarian assistance, but sometimes it can be difficult for humanitarian organizations to reach communities in need.
- Natural disasters also have a serious impact on communities. Hurricanes (also called cyclones), floods, and earthquakes are all examples of natural disasters. Many people may die, or be injured in a disaster. Disasters can make it impossible for people to make a living, and destroy homes, and other infrastructure. Families may be forced to separate.
- During and after conflict and disasters, families may be forced to flee, or seek safety in another country. After flight, communities might live in refugee camps, or camps in their country.

1.2 Why does sexual violence happen in crisis settings, and what are some additional risks/contributing factors?

DISCUSSION[31] (20 minutes)

ACTIVITY

1. Draw participants' attention back to the tree diagram. Ask: What are some of the additional risks and vulnerabilities that can contribute to SV during crises? Call on as many participants who wish to speak. Use a different color pen to record responses on the tree diagram.
2. Break participants up into small groups. Tell participants that they will have 5 minutes to reflect on the crisis their community is experiencing. Has the crisis impacted SV in their community? What about IPV? Have other types of GBV increased because of the crisis?

30 IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015.

31 Adapted from: CARE, Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series, 2002; UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012; and International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2011.

3. After small groups have finished discussing, tell participants:

   - Many types of GBV take place in crisis settings, and GBV increases—including SV, IPV, child, early or forced marriage, sexual exploitation, and trafficking.
   - When a crisis first strikes, and families are separated or fleeing, they might not have safe spaces to stay or a way to support themselves. Protection services may not yet be in place. This all increases risks of GBV.
   - During this time, the most common type of GBV is SV against women and girls, perpetrated by men.
   - During conflict, SV can be used as a strategy of warfare to spread fear, intimidate and humiliate individuals, families, and communities, and force people off their land. SV as a strategy of war is most commonly used against women and girls.
   - Increases of SV also put women and girls at a higher risk for unwanted pregnancy, unsafe abortion and STIs, including HIV.
   - Men and boys, transgender women and men, and gender non-conforming people also experience heightened risks of SV during humanitarian emergencies.[32]
   - Armed actors may also use SV against men and boys as a strategy of warfare.[33]

[32] Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2021.

[33] Women's Refugee Commission, *Sexual Violence against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh*, Italy, and Kenya, 2020.

Facilitator's notes

In crisis settings, women and girls have limited access to resources, including money, education, skills training, jobs, safe housing, transportation, information, decision-making, social networks, and influence. At the same time, women most often remain the primary caregivers for their families. This can increase risks of sexual and economic exploitation, trafficking, SV, and other types of violence.

Additional crisis-related factors:

- Chaos and breakdown of social norms and services, including law enforcement, social services, community norms or religious codes.
- Disruption of families and communities.
- Separation of children from their caregivers; presence of children without adults and child-headed households.
- Separation of persons with disabilities from their primary caregivers.
- High presence of armed actors.
- Sexual violence as a strategy of warfare.
- Climate of human rights violations, lawlessness, and impunity (free from punishment).
- Dependency on aid and resulting vulnerability, including needing to exchange sex to meet basic needs (sexual exploitation and abuse).
- Increases in child, early, or forced marriage.
- Temporary communities and shelters may not be safe, or may be overcrowded, in isolated areas, or lack services and facilities.
- Children may not be able to attend school.
- Camp leadership may be primarily made up of men: women's security issues are not considered in decision-making and planning.
- Loss of male power/role in the family and community; seeking to assert power through IPV.

Adapted from: CARE, *Moving from Emergency Response to Comprehensive Reproductive Health Programs: A Modular Training Series*, 2002; UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012; and International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2011.

4. Review participant feedback from the tree diagram and add any missing crisis-related risks and vulnerabilities, based on the Facilitator's notes. Ask if participants have any questions about any of the terms.

5. Conclude the discussion by telling participants:

   - SV happens in all cultures and communities, all around the world. However, the risk of SV increases in crises, when families and communities are separated, and institutions that keep people safe, like schools, churches, police, and health systems are weakened or destroyed.
   - It is important to remember that crises impact people differently. People can face higher risks of SV because of their gender, age, or other vulnerabilities. However, anyone can experience SV, and risk of SV increases for all people during emergencies.
   - It is also important to remember that SV is highly under-reported everywhere in the world, including in emergencies. Humanitarian responders must ensure that services are available for survivors.

Ask if participants have any questions before moving on to the next section.

1.3 Who is at risk of sexual violence in crisis settings?[34]

Ask: Who is at risk of experiencing SV in crises? Call on several participants.

Tell participants:

- Anyone can experience SV, no matter their gender, age, or sexual orientation.
- Although most SV in crises is against women and girls, the risk of SV increases for everyone during a crisis and when they have had to leave their homes.
- LGBTQIA+ people are at very high risk of SV, especially transgender people.
- People selling sex also face very high risks and levels of SV. People selling sex are at risk of violence from clients, but also from police and authorities, and can even be targeted for SV because it is assumed that they will be less likely to report it.[35]
- SV against men and boys has been documented in crises all over the world, including rape, sexual exploitation, and sexual abuse.
- Men and boys may also be targeted with types of SV based on their gender in places with armed conflict, including:
  - Being forced to witness SV against others, particularly women and girls in their families and communities.
  - Being forced to commit SV against others, including family and community members.
  - Injuries to their penis and testicles.
- People in prisons and jails in conflict setting are also at very high risk of SV, including men and boys.

[34] Women's Refugee Commission, *Sexual Violence against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh*, Italy, and Kenya, 2020.

[35] Women's Refugee Commission, *Sexual Violence against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh*, Italy, and Kenya, 2020.

- Persons from ethnic and religious minority groups are frequently at greater risk of violence and harassment, including SV. They may also face discrimination from service providers, and services may not be available in their language.[36]

2. Consequences of sexual violence for survivors and their community

2.1 What are the health consequences of sexual violence?

DISCUSSION (25 minutes)

1. Tell participants:
   - In this module, we will learn more about the health consequences of SV.
   - SV can cause serious and potentially life-threatening health problems. SV can cause death—if the perpetrator murders the victim, or if the violence leads to serious injuries.
   - In other cases, a survivor may become pregnant as a result of the attack and attempt to end her pregnancy in an unsafe way, which can cause death. SV survivors are also at a higher risk of dying by suicide.
   - In some settings, survivors may be killed by their families after the attack in the name of protecting the family's honor. [37]
   - All survivors, including men and boys and transgender people, can and do experience serious health consequences as a result of SV.
2. Ask: Can you think of other potential health problems a survivor can experience as a result of SV?
3. Draw leaves on the tree, and write each health problem on the leaves as participants share.
4. Review participants' contributions, and add missing health consequences to the tree diagram based on the Facilitator's notes. Key health consequences to include on the tree are in bold.
5. Men and boys and transgender survivors are at risk of many of the same serious health consequences, including for their mental health, as cisgender women and girls.
6. Note that more information on the mental health and social consequences of SV will be covered in later sections.
7. Conclude by explaining to participants that they will learn more about the acute physical and SRH consequences of SV in more detail.

[36] Women's Refugee Commission, *Sexual Violence against Men and Boys in Conflict and Displacement: Findings from a Qualitative Study in Bangladesh*, Italy, and Kenya, 2020.

[37] UNICEF, Caring for Survivors Training Pack, 2010.

Facilitator's notes

Other health problems may include:

Chronic physical

- Disability (physical, sensory, or cognitive/intellectual)
- **Chronic pain**
- **Chronic incontinence**
- Gastrointestinal issues
- Fatigue
- **HIV infection**

Mental health

- **Post-traumatic stress**
- **Depression**
- **Anxiety**
- Eating disorders
- Sleep disorders
- **Alcohol or drug use/ substance use disorders**
- **Self-harm/suicide**

Acute physical

- **Injury (cuts and wounds, broken bones, bruises, etc.)**
- **Shock**
- Infection of wounds

Sexual and reproductive health

- Injury to external and internal genital organs and anus/ colon, bleeding
- Traumatic fistula
- **Unwanted pregnancy**
- **Unsafe abortion**
- **STIs, including HIV**
- Chronic infection—urinary tract infections, pelvic inflammatory disease
- **Miscarriage**
- **Pregnancy complications**
- Sexual dysfunction
- Menstrual disorders

Special considerations

Physical consequences for men and boy survivors can include:

- Bruises, bleeding, swelling, sores or discharge in genitals, anus, or mouth.
- Pain, burning, and/or itching of the genitals or anus, or other signs of STIs.
- Trouble eating or swallowing.
- Pain during urination and/or bowel movements.
- Weight loss or weight gain.
- Bedwetting, incontinence, and soiling.
- Frequent stomach complaints with no identifiable diagnosis.

Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2021.

Special considerations

Physical consequences for young children can include:

- Pain, discoloration, sores, cuts, bleeding or discharge in genitals, anus, or mouth.
- Continuing or recurring pain during urination and/or bowel movements.
- Wetting and soiling accidents unrelated to bathroom training.
- Weight loss or weight gain.
- Lack of personal care.

Sexual abuse of a child is often different from sexual abuse of an adult in some important ways. For example:

- Physical force/violence is very rarely used; instead, the abuser tries to manipulate the child's trust and hide the abuse.
- The abuser is usually a known and trusted caregiver.
- Child sexual abuse often occurs over many weeks or even years.
- Incest accounts for about one third of all child sexual abuse cases.
- In most cases, children do not disclose abuse immediately for many reasons, including:
  - They do not think anyone will believe them.
  - Being scared of punishment or breaking up the family.
  - Shame and embarrassment.
  - Blaming themselves and feeling guilt.
  - Fear of what would happen to the abuser.

From: International Rescue Committee/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012, page 31; UNICEF, *Caring for Survivors Training Pack*, 2010; and WHO Guidelines for medico-legal care for victims of sexual violence, 2003, p. 76.

2.1.1 Acute physical injuries

Tell participants:

- "Acute physical injuries" means injuries to the body that happened during the SV.
- During an incident of SV, the perpetrator may be physically violent or use weapons. Sometimes, survivors have injuries to their bodies, including broken bones, cuts and wounds, burns, bruises, and swelling.
- Part of caring for SV survivors is looking for and treating these injuries, OR referring the survivor to a health facility where they can get the help they need. We will learn more about caring for physical injuries in later modules.
- Physical violence and using weapons can also cause injuries to the survivor's genitals and anus. This can include tearing, bleeding, and swelling.
- In some cases, SV can cause injuries to the organs inside someone's body. This is very serious. This is more likely to happen when there are multiple perpetrators, or when the perpetrator uses an object to assault the person.
- Sometimes, vaginal or anal assault of girls, women, and transgender men can cause an injury called a "fistula." A fistula is a tear or hole in the vagina or in the anus. This is a serious injury that can cause problems with leaking of urine and/or feces. Fistulas can also happen when a person is in labor for a very long time and does not get the medical help they needs. People with a fistula face high risks of IPV, and may be isolated and shamed by their partner, family, and/or community. It is possible for doctors to repair fistulas, and people with fistulas deserve compassion and support.
- Injuries to the genitals and anus increase the risk of the survivor getting an STI, including HIV.
- If a pregnant person experiences physical and sexual violence, it can cause them to have a miscarriage—or lose the pregnancy—or can hurt the baby while it is in the uterus.

2.1.2 Unintended pregnancy and unsafe abortion

Unintended Pregnancy:

- Vaginal assault can lead to pregnancy. Anal assault can also lead to pregnancy if the perpetrator ejaculates on or near the vulva.
- Some people believe SV cannot cause someone to become pregnant. This is not true. Even one incident of forced intercourse can cause a survivor to become pregnant.
- During an incident of SV, a perpetrator may not use a condom, which increases the risk of pregnancy or getting an STI.
- It is important to remember that trans men can become pregnant as a result of SV, and that prevention of unintended pregnancy is an important part of caring for trans men survivors.
- After SV, a survivor can use something called emergency contraception to prevent them from becoming pregnant. Emergency contraceptive pills are pills that can be taken up to five days after unprotected vaginal or anal intercourse to prevent pregnancy.

- Emergency contraceptive pills work best when taken within the first three days after unprotected sexual intercourse, but they can be taken up to five days after. If taken within three days, emergency contraceptive pills are up to 89% effective at preventing pregnancy.
- Copper intrauterine devices (IUDs) can also be used as emergency contraception, if they are inserted within five days.
- Providing emergency contraception is an important part of caring for SV survivors. We will learn more about emergency contraception in later modules.
- Emergency contraceptive pills are not the same thing as the abortion pill. Emergency contraceptive pills will not cause someone who is already pregnant to have a miscarriage.

Unsafe abortion:

- Survivors who become pregnant may not want to have a baby. They may decide they want to end the pregnancy and have an abortion.
- Remember: trans men can also become pregnant, have unsafe abortions, or go to a health facility to have an abortion.
- In most countries, it is legal for someone who is pregnant because of SV to have an abortion.
- Share with participants the legal status of abortion in the country where they are working.

Facilitator's notes

As part of preparing the training, you should identify the legal status of abortion in the country.

- It can be very hard for women and girls to go to a health facility to receive care and a safe abortion.
- Women and girls may not know that they can have a safe and legal abortion at a health facility, be unable to afford transportation or the procedure or medicines they need, or be afraid that someone will find out. Sometimes, partners and families prevent girls and women from being able to have an abortion, or health care providers will not help them.
- All around the world, women and girls have unsafe abortions when they cannot receive care from a health care provider and have a safe abortion.
- An "unsafe abortion" can mean several things. It can mean the abortion was provided by someone who is not trained and qualified, or in a place where it is not clean and safe to have a procedure, or done with dangerous or unclean methods. Dangerous methods could include being hit or kicked in their belly, falling down, or inserting something into their uterus through the vagina, like sticks, wire, glass, or knitting needles.

- Unsafe abortions are extremely dangerous: many maternal deaths are caused by unsafe abortion, as they can cause bleeding or infection, or injure the internal organs.[38] Every year, around 44,000 women and girls around the world die from an unsafe abortion, and millions more are injured.[39] Unsafe abortion is one reason that SV can cause deaths.
- If a girl or woman has had an unsafe abortion and is sick or having bleeding, it is very important that she see a health care provider to receive post-abortion care. Post-abortion care is lifesaving.
- Making abortion illegal does not stop women and girls from having abortions. Instead, it puts women and girls in very serious danger.
- Trained health care workers, including CHWs, have a very important role to play in protecting women and girls, and their health, rights, and well-being.
- Helping women and girls who want to have an abortion, or helping women and girls who have had an unsafe abortion to get the help they need, is an important part of providing care for SV survivors. We will learn more about this in later modules.

Ask participants if they have any questions before moving on to the next activity.

ACTIVITY (30 minutes)

Why did she die?[40]

Facilitator's notes

It is helpful to change the names and certain elements of the story to be more culturally, geographically, or organizationally appropriate for participants. As part of preparing for the training, you should collect any available data about unsafe abortion in their community to share with participants.

Tell participants:

1. In this activity, we will hear a story about a young woman named Beatrice, who lives in a community like yours, and who had an unsafe abortion.
2. A member of the facilitation team will play the role of Beatrice.
3. Ask participants to stand and form a half circle around the facilitator playing Beatrice.
4. Have the facilitator read Beatrice's story.
5. After Beatrice's story ends, ask participants the question, "Why did she die?" Have the facilitator hold the end of the ball of string.
6. As each participant answers the question "Why did she die?" take the ball of string to the person answering the question. Ask the person to wind the string around their waist and give the ball of string back to you. Bring the ball of string back to the volunteer.

38 World Health Organization, *Abortion: Key Facts*, 2021.

39 Ipas, *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences*, 2018.

40 Sourced and adapted from Ipas, *Abortion Attitude Transformation: A Values Clarification Toolkit for Humanitarian Audiences*, 2018.

7. Once each participant has responded (if you are facilitating for a small group; if it is a larger group, solicit 8-10 responses), the string will have formed a "web" that connects participants.
8. Tell participants: This web of string represents our responsibility to the woman, and all women in her situation.
9. Ask participants to return to their seats and tell them they will now discuss several questions to reflect on Beatrice's story.

Facilitate a discussion with the following questions:

- How does this story make you feel?
- What choices did Beatrice have?
- What could have been done to prevent her death? Who could have helped prevent her death?
- What information, resources, and health care services could have helped prevent this situation?
- What could you do, personally and professionally, to prevent deaths such as this one from occurring?
- What does this story tell us about our responsibility to ensure women have access to comprehensive medical care, including safe abortion care?

Close the activity by reinforcing for participants:

- Women and girls who do not want to be pregnant will have unsafe abortions if they cannot access the care they need from a trained health care worker.
- Women and girls can die or have permanent injuries from unsafe abortions.
- We can all help prevent these deaths and injuries and help women and girls, including survivors of SV, receive the medical care they need.

Script for Beatrice

My name is Beatrice. I am the eldest daughter in my family, and I support my family financially by assisting my mother with selling items to travelers on the road next to our village. I love school, and I dream of attending university one day.

My dreams were dashed the day one of the rebel groups stormed into our village. Men with guns came into our home. My parents told my siblings and me to run while they distracted the men, and we all lost sight of each other. Our village was in chaos, and I do not know what happened to my family. I was able to escape, and I eventually arrived at a camp that was set up for people forced to leave their homes like me. Although I am thankful for the people here who are helping me and the food and shelter they provide, our shelters do not offer much privacy, and I do not feel safe at night.

One night when I was alone in the shelter, I heard footsteps, and soon after, a man entered. I recognized him as the man who had been staring at me for weeks. He said I had been tempting him for too long. He forced himself upon me and continued to rape me for what seemed like forever. When I tried to call for help, he slapped me hard many times and said he would hurt me more if I did not stop talking. After a long time, I felt weak and went unconscious. When I finally came to, I hurt all over, but

was too ashamed of what happened to tell anyone. I thought I must have done something to make him think that he could do that to me.

Although I tried to push that horrendous night out of my mind, I felt more distraught with each passing day. I finally noticed that I was feeling sick. My parents and teachers had never talked to us about pregnancy, but because I had missed two periods, I was afraid that I was carrying a child. I felt so ashamed to tell someone, but I was sure I did not want to have that man's baby. I still hoped that one day I could go home and continue my studies. I went to the camp clinic and told the nurse that I might be pregnant. When she confirmed my pregnancy, I cried and said I did not want to carry the baby of this man. I begged for her help. Even though she was from my tribe, the nurse told me she could not help because she did not have the equipment, and anyway, abortion was against the law.

A few days later, I gathered my courage and asked a midwife in the camp for help. She told me the same thing. I had heard that there are pills that could help bring my period back, but I didn't know where to find them. When I told my secret to another girl, she said a friend had had the same problem, and she took care of it by drinking a mixture of medicine and cleaning supplies. Over the next few days, the girl and her friend helped me collect the medicine and supplies. I waited until I was alone, and I drank the mixture. I began to feel sick with a terrible burning in my belly. The last thing I remember, I was lying face down on the floor in my vomit, in agony and moaning for help. I was too young to die.

2.1.3 What are sexually transmitted infections?

MINI LECTURE[41] (20 minutes)

Ask:

- What do you know about sexually transmitted infections, or STIs?
- Have you heard of this term before?
- What types of STIs do you know of?

Facilitator's notes

Be prepared to stop and address any myths or misperceptions about STIs that participants share.

Explain to participants:

- Sexually transmitted infections (STIs) are infections that are passed from one person to another during sexual contact, including SV.
- All people, no matter their gender or age, can have an STI.
- Some common STIs are gonorrhea, chlamydia, human papilloma virus (HPV), trichomoniasis, syphilis, chancroid, herpes, hepatitis B, and HIV.
- Share with participants the STIs that are most common in their community (if known).

41 Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth and women's health*, 2010.

Facilitator's notes

Prior to this session, identify any STIs that are particularly common in the community. Chlamydia and gonorrhea are often the most prevalent.

Signs and symptoms of STIs

- If a person has any of these signs, they may have an STI:
  - Abnormal discharge from the vagina or penis, or anus, including discharge that is thick, bloody, cloudy, white, yellow, green, and/or bad smelling
  - Itching genitals or anus
  - Painful genitals or anus
  - Swelling of the genitals
  - Pain during urination
  - Warts, sores, bumps, or blisters on and/or around the genitals or anus
  - Pain in the pelvis or belly, or pain during sex
  - Bleeding during sex
- It is also very common to have an STI and have no signs or symptoms at all. Many people have STIs but do not know it. Even if someone has no signs or symptoms of infection, they can still pass the STI to other people.

How STIs can be passed between people

Ask: Can anyone share the different ways that STIs can be passed between people? After having called on several participants, explain:

- There are many myths and perceptions about STIs and how they can be passed between people.
- Oral sex, vaginal sex, and anal sex can all pass at least some types of STIs. It is possible to pass STIs when touching the genitals or anus with the hands, but this is much lower risk.
- STIs are not passed by hugging, shaking hands, or touching, or using the same toilet. Kissing is very low risk, as many STIs are not passed by saliva, and most STIs do not cause infections in the mouth.
- Only herpes can be passed by kissing, which may cause cold sores.
- People can reduce the chance of passing an STI to a sexual partner by getting tested and treated for STIs often, and by using condoms. We will learn more about testing and using condoms later in this module.

Health problems caused by STIs

- Untreated STIs can lead to very serious health problems, including pelvic inflammatory disease (infection of the uterus, ovaries, and/or fallopian tubes), infertility, and cancer.
- An untreated STI in a pregnant woman can cause a tubal pregnancy, where the baby starts to develop outside of the uterus and cannot survive. Tubal pregnancies can also lead to bleeding, injury, and death for the mother.
- Untreated STIs in pregnant women can also cause a baby to be born too early, too small, with a disability, sick, or dead.
- It is also possible for a mother to transmit some untreated STIs to her baby during birth.
- Some STIs, including syphilis, gonorrhea, and chlamydia, can cause illness to other parts of the body, including the eyes, joints, and brain (syphilis).
- A person who has one STI can more easily get another, including HIV, because they get infections more easily.

Treating STIs

- All STIs can be treated, which means that a health provider can give the infected person information and medicine to help them feel better, prevent serious health problems, and even lower the chance they will pass the STI to someone else.
- Only some STIs can be cured—this means that the infection is gone completely. Chlamydia, gonorrhea, syphilis, and trichomoniasis can be cured with antibiotic medicine. Even if someone has had one of these infections in the past and taken medicine, they can still be infected again in the future.
- HPV is very common. Young, healthy people may be able to clear the HPV virus on their own, but if the virus continues to infect a person, it can lead to cancer.
- Some other kinds of infections affecting the genitals are parasite infections: scabies, pubic lice, and crabs. These can be passed between people during sexual activity, but can also be passed between people in other ways, like sharing bedding and towels. These types of infections can be cured with medicine.

STIs and sexual violence

- Incidents of SV are often more likely to result in STIs than consensual sexual activity.[42]

Ask: Based on what we have learned about SV, why do you think survivors of SV face a higher risk of STIs? After calling on participants, explain:

- When a person experiences SV, they are less likely to be able to use a condom. This is also true of sexual forms of IPV.
- During SV, physical force may cause wounds to the genitals, anus, and/or mouth that increases the likelihood of getting an STI.

[42] The Advocates for Human Rights, Sexual Assault, HIV, and other STIs, 2006.

STIs in crisis settings

Tell participants that people, especially women and girls, transgender people, and people selling sex, may be at a higher risk of getting an STI in a crisis.

- This is because SV is common in crisis, including sexual exploitation, where someone with power coerces someone to have sex in exchange for goods they really need.
- During crises, more people may be selling sex to survive. People selling sex are less able to insist on using condoms in case they lose money. They are also at a high risk of SV, and are more likely to have sexual contact with someone with an STI.

Conclude by telling participants that preventing the transmission of STIs and/or treating an STI is an important part of caring for SV survivors. Participants will learn more about their role to support preventing and treating STIs for survivors in later sessions.

Ask participants if they have any questions before moving on to the next section.

2.1.4 What are HIV and AIDS?

Facilitator's notes

A flipbook is included in the participants' packet to help them raise awareness around HIV in their daily work. While an activity is devoted to learning how to use this tool, you may find it useful in your instruction, too.

MINI LECTURE[43] (20 minutes)

Ask: What do you know about HIV? Call on participants to share their knowledge of HIV.

Facilitator's notes

Be prepared to address any myths or misperceptions about HIV or AIDS that participants share.

Explain to participants:

- HIV is a tiny germ that attacks the immune system. HIV causes sickness and a disease called AIDS, an illness where people cannot fight off infections. If it is not treated, AIDS can cause death.
- Emphasize that it is possible to prevent the spread of HIV, and to treat a person with HIV so that they do not develop AIDS. However, once a person has HIV, it is not possible to cure them of HIV. We will learn more about preventing and treating HIV later in this session.

[43] Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth and women's health*, 2010.

- HIV lives in some of the body fluids of people who are infected with HIV: blood, semen, vaginal fluid, and breast milk.
- HIV does not live in saliva, tears, sweat, urine, or feces. HIV is not transmitted by kissing.
- The virus spreads when these fluids—blood, semen, vaginal fluid, or breast milk—get into the body of another person.

Ask: Do you know how HIV spreads?

Facilitator's notes

Be prepared to stop and address any myths or misperceptions about HIV or AIDS that participants share.

Explain to participants that HIV can be spread by:

- Vaginal and anal sex, if the person does not use a condom.
- In very, very rare cases, it is possible to transmit HIV when using a condom. This is most likely to happen if the condom is put on wrong, is expired, or is punctured.
- It is possible to pass HIV by oral sex, but less likely than vaginal or anal sex. If the person has a cut, wound, or sore in their mouth, or if they have semen in their mouth, the risk is higher.
- SV increases the risk of passing HIV because the survivor may not be able to use a condom, or because physical violence or force can cause injuries or wounds to the mouth, genitals, and anus.
- Reusing needles, or using dirty needles, by health providers or when injecting drugs.
- Using tools that pierce or cut the skin, such as razor blades.
- Infected blood that gets into cuts or an open wound of another person.
- A pregnant person with HIV can pass HIV to the baby during pregnancy, childbirth, or breastfeeding.
- In places where donated blood has not been tested for HIV, people can also become infected from blood transfusions, which is a process where doctors give donated blood to someone who has lost a lot of blood.

Facilitator's notes

When preparing for the training, you should be sure to identify the HIV prevalence in the community, and any information about HIV/AIDS in the community that is important to know.

Share with participants:

- The HIV prevalence in their community, including among women, men, boys, girls, and people with diverse SOGIESC.
- Primary transmission routes and drivers in their community, if known.

Facilitator's notes

Be sure to confirm that participants are familiar with condoms. If participants are unfamiliar with what a condom is, explain that it is a narrow bag of thin rubber placed on a penis during oral, anal, or vaginal sex to prevent pregnancy and protect against HIV and STIs. The bag traps the semen so that it cannot get into the person's body. Internal condoms that can be put inside the vagina or anus are also available in some settings. It is helpful to have both external and internal condoms to pass around to participants.

External condom **Internal condom**

From: Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth and women's health*, 2010.

Strongly emphasize to participants:

- HIV is not spread through everyday contact such as shaking hands, hugging and kissing, or living, playing, sleeping, or eating together. It is also not spread by food, water, insects, latrines, or sharing cups.[44] It is not possible to know by looking at someone whether they have HIV.
- People with HIV may not have any signs or symptoms for a long time, up to 10 years without any medications.
- People can take a blood test for HIV, but without this, most people do not know they have HIV until they are very sick.
- However, HIV can be passed to others at any time, even if the person living with HIV does not have any signs of illness.

[44] Hesperian Foundation, *Where There Is No Doctor*, 2011.

AIDS

- AIDS is an illness that develops when a person cannot fight infections. HIV eventually makes it difficult for the person to fight infections, and the person will begin to have health problems. When a person with HIV becomes very sick and illnesses become more difficult to treat, the person has AIDS.
- There are many different signs of AIDS. Often, they are the typical signs of other common illnesses such as diarrhea or flu, but they are more severe and will last longer.
- There are special medicines that people living with HIV can take called antiretrovirals (ARVs) to keep them healthy and control AIDS symptoms. If a person takes ARVs correctly, they can even keep them from passing HIV to others. A person taking ARVs is receiving antiretroviral therapy (ART). We will learn more about ARVs and ART later in the training. ART, medicines, and good nutrition can help people fight infections caused by HIV and allow them to live long, healthy, happy, and productive lives with their families and loved ones.[45]

2.1.5 Who is at risk for HIV and AIDS?

Tell participants:

- Any person can contract HIV, no matter their sex or gender, age, or sexual orientation. However, some people are at a higher risk for HIV.
- Using unclean needles is one of the ways that HIV can be passed between people. People who inject drugs have a very high risk of HIV because they may be sharing needles. This risk is even higher in places where injecting drugs is against the law.[46]
- Anal and vaginal sex are two of the primary ways that HIV is passed between people. Anal sex is higher risk than vaginal sex, because the rectum is more fragile than the vagina, and there is a higher risk for tears or injuries that can allow HIV to enter the body.[47]
- Women and girls, as well as men who have sex with men, have a higher risk for HIV. However, risk is also driven by social factors, including gender inequality and discrimination against LGBTQIA+ people. Men who have sex with men may not be able to get the services they need to protect themselves from HIV because of discrimination and poor treatment from health care providers, or because they are afraid someone will find out they have sex with men. This is especially true in places where same sex relationships are against the law.
- People who sell sex also have a much higher risk of HIV. In addition to higher risk of exposure due to more sexual partners, people selling sex may not be able to make their clients use a condom, have a higher risk of SV, and may not be able to get care and services because of stigma and discrimination. This is especially true in places where it is against the law to sell sex.[48]

45 Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth, and women's health*, 2010.
46 Avert, People Who Inject Drugs, HIV and AIDS, 2019.
47 Avert, Women and Girls, HIV and AIDS, 2020.
48 Avert, Sex Workers, HIV and AIDS, 2019.

- Transgender people, especially trans women, are at very high risk of HIV because of the extreme discrimination and exclusion they face. In many places, it may be very hard for trans women to support themselves, and they may rely on selling sex—which increases their risk even more.[49]

Emphasize to participants that all people have the right to support and services to protect themselves and their communities from HIV.

Women and girls

- Gender inequality is a large part of why women and girls have a higher risk of HIV.
- More than half of the people in the world living with HIV are women and girls, and girls and women between ages 10 and 24 are twice as likely to contract HIV as boys and men the same age.[50]
- Poverty, lack of access to education, lack of access to health services, and GBV, including IPV, all increase girls' and women's risk of HIV.
- Women and girls are often infected with HIV at a younger age than men. This is because young women and girls are less able to refuse unwanted or unsafe sex, and are often married to older men who may be more likely to have HIV.
- Women and girls often live with untreated STIs. Having an untreated STI increases a person's risk of HIV.
- Women get more blood transfusions than men because they may need a transfusion after bleeding during childbirth. This can expose them to HIV if the blood has not been tested.

Ask participants if they have any questions before moving on.

Be sure to answer all questions, and clarify any misconceptions about HIV or AIDS that were raised by participants at the beginning of this session.

GAME (20 minutes)

1. Divide participants into two groups.

2. Hand out the HIV cards found at the end of this guide, a blank sheet of flip chart paper (half a page will be enough), and tape to each group.

3. Ask each group to divide their flip chart paper into two, with one side for ways that HIV can be spread, and the other side for ways that it cannot spread.

4. Ask participants to determine whether the act drawn on each card can transmit HIV. If the act can transmit HIV, they should tape the card to the side where HIV can spread.

[49] Avert, Transgender People, HIV and AIDS, 2019.
[50] Avert, Women and Girls, HIV and AIDS, 2020.

5. Give participants 5 minutes to discuss and develop their poster. If they feel that any ways that HIV can be passed are missing from the cards, they can write or draw it on the appropriate side of the flip chart paper.

6. Have the groups present their poster, and facilitate a discussion to address any differences between the groups and any misunderstandings to ensure that participants understand how HIV can and cannot be spread.

Facilitator's notes

HIV can spread by:

- Anal or vaginal sex without using a condom (including sexual violence)
- Unsterile needles or tools that cut the skin
- Infected blood that gets into another person
- Infected mother during pregnancy,
- Childbirth, or breastfeeding
- Blood transfusions where blood has not been tested

HIV cannot spread by:

- Touching or hugging
- Kissing
- Sharing food or dishes
- Sharing a bed
- Sharing clothing
- Sharing latrines
- Insect bites

2.1.5.1 How do we know if someone has HIV?

MINI LECTURE[51] (5 minutes)

Explain to participants:

- Health providers can test a person's blood to learn if they have HIV.
- An HIV test is the only way to know if a person has been infected with HIV.
- Even if the person feels completely well, the person can still spread the virus to others.
- A negative HIV test means that a person is not infected with HIV, or that it is too soon for the test to work.
- After a person gets HIV, it can take a month to three months for the test to work.
- The HIV test can be helpful for survivors of SV, since they can learn how to protect themselves from HIV, or how to live a healthy life if they are HIV positive.
- We will learn more about HIV testing for SV survivors in later modules.

51 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

2.1.5.2 How can HIV be prevented?

MINI LECTURE[52] (10 minutes)

Ask: What can people do to protect themselves from HIV, and help prevent the spread of HIV in their community? Call on participants.

Explain that people can protect themselves from HIV by:

- Getting tested for HIV and other STIs, especially before and after having oral, anal, or vaginal sex with a new partner. It is also important for pregnant people to be tested, so they can prevent passing HIV to their baby if they test positive.
- Getting treatment for any STIs.
- Using condoms correctly. It is especially important to use condoms with any sex partner whose HIV status is not known, or who is living with HIV.
- Asking sexual partners about their HIV status, and when they were tested for STIs, and encouraging partners to get tested and STI treatment.
    - It is important to note that this may not be possible for people experiencing IPV, people selling sex, or people experiencing sexual exploitation and abuse.
- Avoiding piercing or cutting the skin with needles or other tools that are dirty and have not been sterilized. This includes the tools used for piercings, acupuncture, tattoos, scarring, or circumcision.
- Not reusing needles for injections, or ensuring needles are sterilized before being used.
- Not sharing razors.
- Not touching someone else's blood or wound without wearing gloves.
- Cleaning blood spills with disinfectant.

Tell participants that:

- There is also a special medicine that people can take after they have been exposed to HIV, or think they may have been exposed to HIV, that can prevent them from becoming infected. This is called post-exposure prophylaxis, or PEP.
- Part of providing clinical care for SV survivors is giving them PEP to prevent HIV. We will learn more about providing PEP, or referring survivors to a health facility for PEP, in a later session.
- We will learn more about how to protect ourselves and our clients from HIV when providing care in later modules.
- People living with HIV can also take steps to prevent passing it to others. People living with HIV can receive ART and see their health care provider when they need.

[52] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- If a person living with HIV becomes pregnant, they should see their health care provider to enroll in programs to prevent passing HIV during pregnancy, childbirth, and breastfeeding. This is called "prevention of mother-to-child transmission."
- It is very safe for people living with HIV to have babies: When all of the steps of prevention of mother-to-child transmission are followed correctly, it can reduce the risk of passing HIV to the baby to less than 5%.[53]
- It is important for everyone to protect themselves from HIV by practicing safer sex, using condoms consistently and correctly whenever they are able, and sterilizing (cleaning appropriately) tools and equipment.

Be prepared to stop and address any myths or misperceptions about how to prevent the spread of HIV that participants share, if not already covered in the discussion.

Facilitator's notes

Note that a handout for sterilizing equipment is available in the Participant's Packet, Advanced Module 8 (Handout 8.7 on preventing infection). This is only relevant for CHWs who will provide the highest level of care.

2.1.5.3 What are treatment options for persons living with HIV and AIDS? (Only include this section if ART is consistently available in the pilot site)

MINI LECTURE[54] (10 minutes)

Remind participants that:

- There is still no cure for HIV, but medications called "antiretrovirals" (ARVs) can help people with HIV live longer and have fewer health problems.
- If used correctly, ARVs fight against and control the HIV infection. The immune system becomes stronger and the person living with HIV is able to fight off infections and become healthy. The ARVs control the HIV infection to prevent the person from developing AIDS.
- HIV is not cured, however. Small amounts of the virus will always remain in the body.
- People living with AIDS can still receive treatment with ARVs to control symptoms, and treatment for many infections.
- Antiretroviral therapy (ART) must be done correctly. ARV must be taken every day at the same time to keep working well. If a person stolder people taking their ARVs, their HIV will grow strong enough to make them ill again. Afterwards, if they restart taking ARVs, their HIV may be more difficult to treat with the same medication. There are several possible combinations of medications to use.

53 World Health Organization, Mother-to-child Transmission to HIV, 2020.

54 Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth, and women's health*, 2010.

Ask if participants have any questions before moving on to the next section.

2.1.5.4 What are some of the consequences of HIV and AIDS for the individual and the family? (optional)

DISCUSSION*[55] *(25 minutes)

1. Next, participants will discuss some of the impacts of HIV and AIDS. Divide them into three groups and provide each group with a sheet of flip chart paper. Ensure that there is at least one person who can read and write who can serve as the scribe. Assign each group one of the following questions and ask them to brainstorm, writing their ideas on the flip chart paper:

   a. What do people in your community say, think, and feel about HIV, and about people living with HIV or AIDS?

   b. How does living with HIV or AIDS impact an individual?

   c. How is the family of a person living with HIV or AIDS impacted?

2. Tell participants they have 10 minutes to discuss, and will have 3 minutes to present what they brainstormed.

3. After 10 minutes, have each group present their discussion, beginning with the group discussing beliefs and attitudes about HIV/AIDS Ask all participants to reflect and share additional ideas. If needed, you can refer to the facilitator's notes, below, for additional suggestions for the impact of HIV on people living with HIV or AIDS, and their families.

4. Once all groups have finished presenting, Ask: What are some of the emotions that someone might feel when they learn they have HIV?

   After calling on participants who wish to speak, refer to the Facilitator's notes, below, to add any other feelings.

5. Conclude the discussion by emphasizing that there is no one way, or no right way, that people should feel when they learn they have HIV. People react to the news that they are HIV positive in different ways and may experience some or all of the emotions at different times. It is possible for people living with HIV to work through these feelings and live healthy, positive, fulfilling lives. CHWs have an important role to play in supporting people living with HIV, and helping communities learn more about HIV.

[55] Partners in Health, *Unit 10: Psychosocial Support and Effective Communication, Accompagnateur Training Guide*, 2008.

Facilitator's notes

Examples of consequences for each level are:

Individual

- **Physical and mental health:** The illness can make the person feel sick, or too weak to do regular activities. The person may struggle with their mental health.
- **Economic**: The person living with HIV/AIDS may lose their job or be unable to work because of discrimination or illness, which can lead to or worsen poverty.
- **Social**: A person may feel or be isolated or isolate themselves from others, and may be the target of gossip, teasing, shaming, rejection, verbal abuse, or violence. HIV-positive children may be teased by other children at school.
- **Spiritual**: A person with HIV/AIDS may lose faith.

Family

- **Social:** The entire family may become isolated from the community if the community thinks the family is shameful or "contagious."
- **Emotional and psychological**: If a person living with HIV or AIDS is not able to work and support their family, this can increase the burden and responsibility for others. This could result in children having to drop out of school in order to work, or children becoming the primary earners in their families. People may be worried or anxious about the health and well-being of their family member.
- **Economic**: People living with HIV or AIDS may not be able to contribute to supporting their household, and there may be more expenses for medical care and medicines, or to care for orphans and other children, which could lead to or worsen poverty.

Adapted from: Partners in Health, *Unit 10: Psychosocial Support and Effective Communication*, *Accompagnateur Training Guide*, 2008; Hesperian Foundation, "Chapter 17: HIV and AIDS," *Where Women Have No Doctor: A Health Guide for Women*, 2021.

Facilitator's notes

Examples of emotional and psychological consequences of HIV for individuals include:

- **Shock:** They cannot believe that they are HIV positive.
- **Denial**: They refuse to accept that they are HIV positive.
- **Fear:** They are afraid of the illness; afraid of what will happen to them or their children; afraid of stigmatization, discrimination, isolation, and rejection by others.
- **Loss:** They experience or fear loss of control, independence, ability to care for their family, respect from family and community, confidence, and self-worth.
- **Grief:** They grieve for loved ones who have died of AIDS, or possibly over their own future.
- **Shame or guilt:** They feel ashamed or guilty for having gotten HIV, for practices that led to getting infected (such as having multiple partners or using intravenous drugs), and for the effect it will have on loved ones, especially children.
- **Anger:** They are angry with themself or at the people who infected them, with a spiritual being (God), at society for the way people living with HIV/AIDS are treated. In some cases, this anger can lead to irresponsible sexual behavior.
- **Anxiety:** They are anxious about how the illness will progress and what will happen to them.
- **Low self-esteem:** They experience rejection by loved ones and the community; inability to work, care for family, or participate in social events.
- **Depression:** Signs include too much or too little sleep, overeating or not eating at all, feelings of hopelessness, irritability, not participating in social events and daily activities.
- **Suicidal thoughts:** Severe depression can lead to wanting to take one's own life.

Adapted from: Partners in Health, *Unit 10: Psychosocial Support and Effective Communication*, *Accompagnateur Training Guide*, 2008.

2.1.5.5 Why are people living with HIV/AIDS vulnerable in crisis settings? (additional risk factors)

ACTIVITY[56] (15 minutes)

1. Direct participants to rejoin their small groups. Tell participants that they will have 10 minutes to discuss two questions:
    - Think back to our discussion about why SV increases in conflicts and disasters, and when people have had to flee their homes. Why are people living with HIV/AIDS vulnerable in these situations?
    - In what ways have people living with HIV/AIDS in your community become more vulnerable since the emergency took place?
2. After 10 minutes, get participants' attention, but have them stay with their groups.
3. Conclude the activity by explaining:
    - Crises, such as natural disasters and conflicts, can have a serious impact on how communities function.
    - This means that medical and psychosocial support services to people living with HIV/AIDS may not be available.
    - During a crisis, it may be harder for a person with HIV/AIDS to take care of their health or find an HIV care and treatment program. They may not be able to eat nutritious food, get enough rest, or take steps to prevent infections.
    - Many people in crises, including people living with HIV/AIDS, may not be able to use condoms for safer sex.

2.1.5.6 What are some ways to reduce stigma against people living with HIV/AIDS in the community, and how can CHWs be agents of change?

DISCUSSION[57] (20 minutes)

1. Direct participants to spend another 10 minutes in their small groups discussing and brainstorming: What can we as CHWs do to help fight discrimination against people living with HIV/AIDS in our community?
2. After 10 minutes, have each group share their ideas with the full group. As participants speak, write down their ideas on flip chart paper.
3. After all groups have shared, tell participants that as CHWs, they can:[58]
    - Share accurate information how HIV is spread and how it is not spread to members of their community, especially when they treat people for other STIs.

56 Hesperian Foundation, "Chapter 17: HIV and AIDS," *Where Women Have No Doctor: A Health Guide for Women*, 2021.

57 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

58 Adapted from Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021; and Partners in Health, *Unit 10: Psychosocial Support and Effective Communication*, *Accompagnateur Training Guide*, 2008.

- Make sure people in the community, including adolescents and people with disabilities, know where to get tested for HIV, and how to access care and treatment when they need it.
- Include people living with HIV/AIDS in health education activities so they do not feel isolated.
- Encourage both men and women (including adolescents) to use condoms, even if they are already using another form of family planning to prevent pregnancy or space births.
- Wash hands with soap and water before and after giving all care; avoid touching bloody body fluids with bare hands; do not share anything that touches blood (including razors, needs, sharp instruments, and toothbrushes); and keep wounds covered.

4. Conclude the discussion by emphasizing to participants that showing compassion and empathy to people living with HIV/AIDS can also help others change their attitudes towards people living with HIV/AIDS.

5. Note that there is a flipbook about HIV/AIDS that CHWs can use in their awareness-raising sessions. Go through the flipbook with them, and demonstrate how it can be used. The text on the back of each page explains the pictures on the front of the page. Answer any questions participants may have.

Ask participants if they have any questions before moving on to the next section.

2.2 What are the emotional, psychological, and social consequences of sexual violence?

DISCUSSION (30 minutes)

1. Tell participants:
   - Now that we have learned about the physical health consequences of SV, we will learn more about the emotional and psychological health consequences, and the social consequences, for survivors.
   - In this discussion, we will reflect on how experiencing SV can make someone feel, and the consequences.

2. Divide participants into four small groups and provide each group with a sheet of flip chart paper and markers. Ensure that in each group, there is one participant who can take notes. Two groups will be asked to brainstorm "individual emotional and psychological consequences," reflecting on earlier training sessions. The other two groups will brainstorm "social consequences."

3. Give participants 5-7 minutes to brainstorm consequences, and write them on their flip chart paper. Then, have participants stay in their small groups and share back with the larger group and put their flip chart paper on the wall.

Facilitator's notes

Between groups, be sure that the following are addressed. If any of these are missing, participants should write them on their flip chart.

Consequences of sexual violence for the survivor can include:

Emotional and psychological consequences

Fear

Anger

Shame, self-hate, self-blame

Suicidal thoughts, behavior

Self-harming behavior

Withdrawal and hopelessness

Relationship and family problems

Post-traumatic stress disorder (PTSD)

Depression

Anxiety

Use of alcohol/drugs

Social consequences

Blaming the survivor

Loss of roles in society (e.g., earn income, care for children)

Rejection from family

Social stigma

Social rejection and isolation

Adapted from: UNICEF, *Caring for Survivors Training Pack*, 2010 and UNFPA, *Managing Gender-based Violence Programmes in Emergencies: E-learning Companion Guide*, 2012.

4. Then, ask participants to discuss the following in their small groups:

   - Think about your community—its cultural, social, and gender norms, as well as people's social and economic situation, and access to services and resources. How might survivors of SV face specific emotional, psychological, and social consequences in this community? Be sure to think not only of women and girls, but boys and men, transgender persons, and other people who might be most vulnerable or isolated.
   - How could experiencing SV during crises—during disaster and war, or when crossing a border—affect survivors, and what are the emotional, psychological, and social consequences they experience?

5. After 10 minutes, bring participants back together to the full group. Ask participants to share key points from their discussions. Call on all participants who wish to speak.

6. Then, explain to participants[59]:

- Psychological and emotional effects can be immediate and long term.
- Stress and trauma reactions are normal reactions to events like crises and SV—it is not the person who is defective.
- Feelings may be strongest right after a traumatic event and get better over time; however, they may persist.
- People are amazingly strong and resilient, and we all have ways of managing and responding to stress and distress.
- If the violence affects a person's ability to function, they may need help to recover.
- Everyone can benefit from psychosocial support.

7. Conclude the discussion by emphasizing to participants:

- SV can have very serious, significant emotional and psychological consequences. It can impact survivors' relationships with their partners and families, friends, and neighbors, and with their community. It can affect their experiences at school and at work, and their ability to care for and support their families.
- For many survivors, these consequences can be just as severe, or even more severe, than physical injuries. This means that ensuring survivors have access to mental health care, psychosocial support, and support services is just as important as providing clinical care for injuries and infections.
- This is an important part of our jobs as CHWs: providing support to survivors who we work with, and referring them for this care.

Ask participants if they have any questions before moving on to the next section.

59 UNICEF, Communities Care: Transforming Lives and Preventing Violence, 2020.

3. Health and other benefits for seeking timely care

3.1 What are the health benefits of seeking care?

Facilitator's notes

Before this module, gather the different medicines used for clinical management of rape so you can hold them up to show participants and pass them around.

MINI LECTURE (10 minutes)

Explain to participants:

- SV can have serious physical, emotional, psychological, and social consequences for survivors and their families and communities.
- However, by providing essential medical and support services, we can help reduce further harm.

Explain to participants that survivors can prevent further problems if they come for medical care. These include (if all are available):

- Medicine to prevent pregnancy— emergency contraception.
- Medicines to prevent or treat STIs—antibiotics.
- Medicines to prevent HIV—antiretrovirals called post-exposure prophylaxis, or PEP.
- Care to treat wounds.
- Injections/shots (vaccinations) to prevent consequences of infections such as tetanus ("lockjaw"[60]) and hepatitis B.
- Basic support for the survivor's emotional needs.
- Referral to higher-level medical care, and links to other support services, such as protection, psychosocial support, and legal assistance.
- Medical care and options if a survivor is found to be pregnant, including safe abortion care.

If medicines are available, hold them up to show to participants. You can also pass them around for participants to see.

60 Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2011.

3.2 What is timely care?

MINI LECTURE (5 minutes)

Explain to participants:

- Some of these medicines are time sensitive. This means that they need to be taken within a certain amount of time in order to work.
- This includes the medicines to prevent the survivor from becoming pregnant, and the medicines to prevent the survivor from contracting HIV.
- PEP, antiretroviral medicines to prevent HIV, must be given within three days, or (72 hours) after a person has been exposed to HIV.
- Medicine to prevent pregnancy—known as "emergency contraception" (EC)—must be given within five days (120 hours) after an unprotected sexual encounter. EC should be provided after vaginal and anal assaults for women, girls, and transgender men, even if the assailant did not ejaculate inside the vagina.
- Medicines to prevent pregnancy and HIV are most effective when they are given immediately after the incident. The more time that has passed, the less effective the medicines are, and it becomes less and less likely that the medicines will work to prevent pregnancy and HIV.
- **Timely treatment with medicine is therefore very important,** and can prevent further trauma, illness, and even death caused by HIV, unwanted pregnancies, and unsafe abortion.
- As CHWs, we will share information with communities about the importance and benefits of this timely care.

Note to participants:

- Other medical services for SV survivors are effective even after five days, and can help survivors even after a long time has passed since the sexual assault.
- This includes care for wounds and injuries, and for STIs and other infections.
- It is best that survivors receive these services as soon as possible after the assault, but it is still important to support survivors to access these services, even if a lot of time has passed.
- We will learn more about referring survivors for these services in later modules.

Ask: Think back to our earlier discussions about the health consequences of SV. Beyond preventing pregnancy and HIV, how does this timely care—PEP and EC—prevent trauma, illness, and death? Call on all participants who wish to speak.

- Ensure that participants have addressed:
  - Learning that they have HIV can cause a person to experience depression, anxiety, and post-traumatic stress.
  - It can also negatively affect people's relationships with their loved ones and community, and affect their ability to earn a living and care for their family.
  - Unintended pregnancy can lead people to have unsafe abortions, which can cause serious infections, injuries, and death.

Ask if participants have any questions before moving on to the next section.

3.3 What other services can survivors access if they would like?

MINI LECTURE[61] (10 minutes)

Tell participants survivors benefit from more than medical care. Services that can be helpful include:

- **Psychosocial support** to address survivors' immediate mental health and emotional needs. Psychosocial services offer ongoing psychological assistance through social workers and community services workers. Peer support groups and peer networks can also provide psychosocial support.
- **Specialized mental health services** for survivors to address their long-term mental health and emotional needs, or more specialized care for conditions such as depression or post-traumatic stress disorder.
- **Protection services** can help protect survivors from experiencing additional GBV risks and harms. These can include safe houses where survivors and their children can stay, or safe spaces or special programs where women, children, adolescents, or other populations, like People with disabilities, transgender people, and LGBTQIA+ youth, can go to receive services, participate in activities, and build relationships. Sometimes, community members can come together to develop their own protection strategies and protective circles. These can be in the form of community support groups such as women's groups, peer groups, drop-in centers, or other traditional places where survivors can feel welcome and protected.
- **Social support services**, such as livelihoods support and training for survivors to earn an income, learn a trade, or obtain a job. Education programs can also teach adults to read and write.
- **Legal/justice services** can include legal counseling, representation, and other court support to survivors, and monitors court cases and judicial processes where they exist. It may also include restorative justice processes where they exist. Legal services can also help survivors with divorce, or with custody for their children.

Such services are very important for survivors and their families. They can help protect survivors' physical and mental health and well-being and healing.

Ask participants if they have any questions before moving on to the next section.

Facilitator's notes

During project planning, partners will conduct a thorough community mapping of services and resources, including for diverse populations. As part of preparing for the training, it could be helpful to review the mapping, and identify several organizations and/or services to provide as examples in this activity.

[61] Global Protection Cluster, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, 2010.

ACTIVITY (optional, 30 minutes)[62]

Explain to participants that in this activity, they will work together to map their communities, and the resources they know of that could be helpful for diverse SV survivors.

1. Break participants into small groups. Provide each group with a sheet of flip chart paper and markers.

2. Explain to participants that they will be drawing a map of their community in order to identify places and people where survivors could go for different types of services and resources, as well as places that are not safe to go.

3. Instruct them to begin by thinking of a central reference point, such as a main road, marketplace, or the group meeting place.

4. Instruct participants to start at the central reference point and then begin drawing all of the major places they know (e.g., schools, religious buildings, markets, bars, sholder people, hospitals and clinics, bus stolder people, railroad tracks, roads, police stations). Circulate around to each group and encourage them to discuss other places they know, and ask them to draw these on their maps.

5. Next, direct participants to draw organizations, places, and people that provide social and medical services. This can include NGOs or UN agencies, reception centers, pharmacies, food or aid distribution points, safe spaces, community centers, including for specific populations such as LGBTQIA+ populations, etc.

6. Circle the different places on the map where survivors can receive different types of services and programs: medical care, legal assistance, counseling, mental health care and psychosocial support, education, livelihoods support, etc.

7. Next, ask participants to draw and/or write potential barriers and challenges survivors in their community could face to reaching the different service points, or reasons why survivors might not go for services. They can consider:

    - Is transportation available?
    - Is it located in a part of the community that is not very safe?
    - Are services expensive?

Prompt participants to reflect on diverse survivors: might adolescents, People with disabilities, LGBTQIA+ people, and people engaged in sex work face different barriers, or more barriers?

8. Have small groups pair off to present their maps to one another.

9. Conclude the activity by telling participants that they will learn more about the barriers survivors face to getting care and services in many communities, including communities in humanitarian settings.

[62] Adapted from Women's Refugee Commission, *I'm Here Approach*, 2019.

3.4 What are some barriers that survivors face to receive care?

MINI LECTURE

Tell participants:

- Survivors in communities all around the world can face barriers to getting the care and support they need. This is often especially true in cases of conflict, disasters, epidemics and pandemics, and displacement or migration.
- Survivors may not be aware of services, and may not have the information or tools they need (like a phone that can connect to the internet) to learn about services and where they can go.
- Survivors may not seek services because of stigma, or fear that other members of their family and community may find out about their experience.
- Adolescents and People with disabilities in particular may be unable to leave their homes or go places alone.
- People experiencing IPV, especially if they are living with their abuser, may not be able to leave their home or go for services without their partner finding out.
- Sometimes services are far away from survivors' homes, and they may not be able to get there safely or afford transportation.
- Sometimes services are only available at certain times that are not convenient for everyone. If services cost money, survivors may not be able to afford them.
- In some communities, especially for refugee and displaced and indigenous populations, services may not be available in the language that survivors can understand.
- Survivors in many communities face stigma and may be treated badly, or not be believed, when they come forward for services—including by nurses and doctors, police officers, and religious and community leaders. This may be especially true for LGBTQIA+ people, People with disabilities, and people who sell sex.
- In some communities, especially in humanitarian settings, services may not be available at all.

Persons with disabilities[63]

- Survivors with disabilities face all these barriers, just like survivors who do not have disabilities, but it can be even harder for them to find a way to care.
- The families of survivors with disabilities, and other community members, may not want or may try to stop a survivor with a disability from getting help. This can make it very hard for survivors with disabilities, as they may need support to reach facilities, communicate with providers, and pay for services if they are not free.
- Survivors with disabilities may be treated badly by providers and may not be believed because of their disability.

[63] Women's Refugee Commission, *"I See That It is Possible:" Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015.

- Providers may not know how to communicate with survivors with different types of disabilities, including people with speech and/or hearing impairments, or cognitive or intellectual disabilities.
- There is a risk that a provider will not respect the confidentiality and decisions of survivors with disabilities, because they believe they are not capable of making their own decision, or that they know what is best for the survivor. This is not survivor-centered care.
- Health providers and other people providing services may believe that People with disabilities are not able to participate in programs and activities.

Men, boys, and LGBTQIA+ people[64]

- Men and boys and LGBTQIA+ survivors also face many of these barriers, including not having enough money to pay for transportation, medicines, or services, and being afraid that someone will find out about their experience.
- Men and boys and LGBTQIA+ people may not know that it is important to see a health worker after experiencing SV, or that there are services are available in their community.
- This may be particularly true because many communities may not know or acknowledge that men and boys also experience SV or believe that it is more shameful for men and boys to experience SV.
- Persons in the LGBTQIA+ community may be directly targeted for SV based on their SOGIESC, as a result of severe stigma and discrimination.
- Men, boys, and LGBTQIA+ persons also face different barriers, including:
  - Same-sex relationships being against the law (in some countries), or laws exist that do not recognize male survivors.
  - Not enough health care providers who have been trained to care for men, boy, and LGBTQIA+ survivors.
  - Health care providers with negative attitudes, who do not believe men, boy, or LGBTQIA+ survivors, or who shame them.
- However, many humanitarian workers in different parts of the world have reported that they do not know how to care for men, boys, and LGBTQIA+ survivors, and that they need more training and information.[65]

People selling sex

Facilitator's notes

When discussing people who sell sex, it is important to be careful about the language used. Do not use language that is discriminatory or derogative. Although you may use certain terms like "prostitution" when naming laws or policies, it is important to use respectful, person-first language. This includes terms like "people selling sex" and "sex work." It is important to note that some people who sell sex describe themselves as sex workers, but other people do not. Follow the person's lead, and use the language they use to describe themselves.

64 Women's Refugee Commission, *Sexual Violence against Men and Boys*, 2020.

65 Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2019.

- In crisis situations, people may not have many choices for how they can support themselves. Many types of people will sell sex to make a living and to care for themselves and their loved ones: women and girls, men and boys, older persons, People with disabilities, and LGBTQIA+ people.
- People selling sex face barriers to receiving essential information and services, including care after SV. This is very serious: people selling sex are at very high risk for SV and experience extremely high levels of SV.
- Survivors who sell sex may not be able to come forward for care because of stigma and discrimination. They are often treated poorly or are abused by health care providers and authorities.
- In places where it is against the law to sell sex, survivors may not feel safe to seek care because of the risk of being arrested and even experiencing further SV from police and authorities.

Facilitator's notes

As part of preparing for the training, facilitators should determine the legal status of selling sex in their context.

Emphasize to participants that all survivors need and deserve compassion, clinical care, and support– not judgement or abuse—no matter their gender identity or expression, sexual orientation, age, disability status, or if they sell sex. All survivors have the right to receive this care.

Ask: How can we, as CHWs providing community-based clinical care for SV, help address these barriers in our community?

Have participants pair off and discuss together for 5-7 minutes. If, at 7 minutes, pairs are still actively discussing, allow for 3 more minutes.

Once pairs have finished, call on participants to share their ideas. Call on as many participants who wish to speak.

Ask if participants have any questions before moving on to the next activity.

ACTIVITY: "Blanketed by blame"[66] (1 hour)

Facilitator's notes

Before this activity, print the "Blanketed by blame" script, annexed to the back of this facilitator's manual and cut out each volunteer's script for them to read.

1. Explain to participants that in this activity, they will reflect on survivors' experiences when seeking care, and some of the barriers survivors experience.

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

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

4. As the facilitator, read:

> Maya is 35 years old. She has been married for 10 years. She has two children, ages seven and nine. Maya works in her host community at a garment factory sewing clothes for a big foreign company. Her husband Lee works for an automobile manufacturing factory. Soon after their younger child was born, Lee started beating Maya and eventually forcing her to have sex. This has continued for many years and has gotten worse. Lee's drinking has also gotten worse. One day when Maya had to stay late to sew clothes for a big order, the garment factory manager dropped her off at home. Lee saw them together and became jealous and very angry. He beat and raped her so badly that her arm got fractured, she had a big gash on her forehead, bruises everywhere, and a swollen black eye. Her children saw this and became very scared that something would happen to their mother. Maya could not take it anymore as she was afraid for her life and decided to take action. She approached her friends, family, a social worker in an NGO, a doctor, and the police.

5. One by one, have volunteers step forward, read the first, blaming statement from their script, and place the shawl or newspaper over Maya.

   The order is: friend, HER mother, neighbor, HIS mother, community health worker (female), priest/ religious leader (male), daughter, police, social worker, lawyer, doctor.

6. After each volunteer has put their shawl over Maya, Ask: "Maya, how do you feel?"

7. After Maya responds, have each volunteer step forward, remove the shawl or newspaper, and read the non-blaming statement.

[66] Activity is adapted from World Health Organization, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-Care Providers*, 2019; and the Inter-agency Working Group (IAWG) on Reproductive Health in Crises Training Partner Initiative, *Clinical Management of Sexual Violence Survivors in Crisis Settings*, 2021.

The order of volunteers is now reversed: doctor, lawyer, social worker, police, daughter, priest/ religious leader (male), community health worker (female), HIS mother, neighbor, HER mother, friend.

8. After the shawls have been removed, ask Maya how she is feeling.

9. Have the volunteers sit back down, and lead participants in a discussion of the following questions.

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

10. Conclude the activity by emphasizing to participants:

- Survivors are making important safety decisions all the time, and they are the experts on their situations.
- Survivors often have very few, if any, options for seeking support or escaping from violent situations. They face many barriers to accessing care.
- This includes stigma and social norms—survivors may not be believed, or they may be told that they are overreacting. This is especially true if SV and IPV are normalized in the community. Survivors may also be blamed or shamed when they seek help.
- Survivors are not to blame for what has happened to them. It is important to NEVER place any kind of blame on the survivor. We can remind others as well not to blame survivors for violence they experienced.
- As health providers, CHWs can help survivors in several ways on the path to healing.
  - They can reach out to survivors who they suspect are experiencing violence and share information about the care and support that is available.

  - They can listen to survivors' stories and show empathy for their feelings.
  - They can believe survivors' experiences and not blame them for the violence.
  - They can ask survivors about their needs and concerns, encourage them to look for options, support them to make decisions that are right for them, and respect their wishes and choices.
- Over the coming sessions, we will learn how to work with survivors to provide care with empathy and compassion.

Ask if participants have any questions before moving on to the next module.

SESSION 2.3 Health education to facilitate health-seeking behavior

Session time	2 hours
Objectives	By the end of this session, participants will be able to: • Identify key health education messages for CHWs to convey to individuals and communities about sexual violence. • Gain practice conveying health education messages in health consultations.
Methods	• Mini lecture • Role play • Activity
Preparation	• Prepare lecture.
Training aids, materials, and handouts	• Flip chart, markers, and pens. • Sexual violence flipbook (participant's packet).
Evaluation and assessment	• None.
Additional resources	• UNFPA, Addressing Violence against Women and Girls in Sexual and Reproductive Health Services: A Review of Knowledge Assets, 2010. • WRC/RHRC Consortium, Universal, adaptable IEC templates for sexual violence, 2011.

1. Key messages around sexual violence

1.1 What are the key messages that the community should know about sexual violence and the importance of seeking care?

Facilitator's notes

A flipbook is included in the participants' packet to help CHWs conduct health education around sexual violence in their daily work. While an activity is devoted to practicing with this tool, you may find it useful as you go through the messages below.

MINI LECTURE (10 minutes)

Tell participants:

- Part of your work as CHWs is to organize activities in the community to help people learn more about SV, including why it is important for survivors to seek care, and where they can go.
- You will also have the opportunity to share information about SV when working with community members as part of your day-to-day work.
- It is important to help community members, including survivors, understand that survivors are not to blame for what happened to them, and that they are not alone.
- We can help community members better understand the different physical, emotional, and social consequences of SV, which can help reduce stigma and shame.
- It is important that communities know that help is available, and that services are private and confidential.
- By sharing this information, we can help to create an environment where survivors feel able and safe to come forward to receive care and services.

CHWs can share messages with the community, including:

- *What* is SV?
- *Who* can experience SV?
- *Why* does SV happen?
- *What* are the consequences of SV?
- *What* should survivors do after experiencing SV?
- *What* should others do if they know someone has experienced SV?
- *What* are the benefits of survivors seeking health care as soon as they are able?
- *Where* can survivors go for services?

- *What* can survivors of SV expect if they seek health care?
- Health services are free, private, voluntary, and safe, and available 24 hours a day, 7 days a week.[67]

1.2 How should we share information about SV in the community?[68]

MINI LECTURE (10 minutes)

Tell participants:

- The way that CHWs deliver these messages is just as important as the information that is shared.
- It is important to be careful about how we share these messages with the community, to ensure that people are open to participating in activities and that we reach as many people as possible.
- It is important to be aware of words and phrases about SV that are taboo or stigmatized in the community—this can cause people to not want to participate in activities. This can be especially true of men and boy survivors, who might not be comfortable identifying their experiences as SV.
- When we are leading activities and discussions, it is important to use examples that show that all types of people can experience SV, including men and boys, LGBTQIA+ persons, and People with disabilities.
- This can help people understand that care is available and important for all survivors, not just women and girls—and encourage diverse survivors to come for services.
- It also helps to reinforce that all types of people experience SV, and it is not something that only happens to women and girls.
- When sharing information about the different services available in the community, it is important to highlight different services for different populations, including services for adolescents, boys and men, LGBTQIA+ people, People with disabilities, and people selling sex.
- It is important to avoid using stereotypes when working with communities. This includes gender stereotypes, stereotypes about LGBTQIA+ people, and stereotypes about religious or ethnic minorities.
- It is important to be aware of the language we use when we talk about SV committed by men and boys. If CHWs use language that men and boys feel is shaming or blaming them, they may not want to participate in activities. It is important to share that boys and men have the power to support survivors and work against SV in their communities.

Ask if participants have any questions before moving on to the next activity.

67 World Health Organization, *Clinical management of rape and intimate partner violence survivors*, 2019.
68 Women's Refugee Commission, *Supporting young male refugees and migrants who are survivors or at risk of sexual violence*, 2021.

ACTIVITY (30 minutes)

1. Explain to participants that they will be working together in small groups to develop messages with important information about SV to share with members of their community, based on what they have learned in the training.

2. Break participants into four small groups. Provide each group with a sheet of flip chart paper and markers. Ensure that each small group includes a participant who can take notes.

   Group 1: What is SV, and who can experience SV?

   Group 2: Why does SV happen?

   Group 3: What are some of the physical, emotional, and social consequences of SV? How can community members support survivors?

   Group 4: Where can survivors go after experiencing SV, and what are the benefits of seeking medical care as soon as possible?

   Give groups 20 minutes to work together to develop their messages.

3. Have each group present their messages to the full group.

4. After each small group presents, ensure that the following messages are included and shared:

Group 1: What is sexual violence, and who can experience sexual violence?

What is sexual violence?

- SV is when someone uses violence, threats, or pressure to make someone engage in sexual activity when they don't want to. It is SV, even if they don't succeed.
- SV can include all different types of sexual activity, even kissing and touching. There are many different types of SV, and some are more hidden than others and harder to talk about. This includes SV in families and relationships.
- If a person forces their partner to have sexual relations when they don't want to, it is SV—even if they are married. When SV happens between partners, this is a form of intimate partner violence.
- Most incidents of SV are perpetrated by someone the survivor knows.
- Sexual violence can also happen when someone uses their power or authority over another person to force or pressure them to engage in sexual activity. This is called sexual exploitation and abuse. For example, if a person refuses to pay someone their wages, or give them food aid, unless they have sex with them, this is sexual exploitation.

Who can experience sexual violence?

- Anyone can experience SV. This includes women and girls, men and boys, People with disabilities, and LGBTQIA+ people. SV happens to all types of people.
- People can experience SV at any age: this includes children and adolescents, and older people.
- Although SV happens to all types of people, some people are at higher risk for SV because they are more vulnerable, isolated, or have less power in the community. This includes women and girls, adolescents, People with disabilities, and LGBTQIA+ people. People who sell sex are also at a very high risk of SV.
- No matter what, the survivor is never to blame or responsible for what happened to them.

Group 2: Why does SV happen?

Why does sexual violence happen?

- SV is not about sexual desire—it is about power, control, and violence.
- SV happens in every community around the world.
- Risk of SV goes up, and SV becomes more common, when communities are experiencing conflict, disasters, and epidemics, and for people who are on the move. No matter what, the survivor is never to blame or responsible for what happened to them. The way someone dresses or behaves is never a reason for SV. No one deserves to experience SV.
- Nothing that a girl or woman does gives a boy or man the right to hurt her, even if they are her parent, guardian, or partner, or if he thinks that she deserves it.
- Anyone can be a target of SV, and it is never the person's fault. The only people who are responsible for SV are the perpetrators.

Group 3: What are some of the physical, emotional, and social consequences of SV? How can community members support survivors?

What are some of the physical, emotional, and social consequences of SV?

- SV can have serious, even life-threatening, consequences for survivors, but also for their children and other family members, and even the rest of the community.
- SV can cause injuries to a person's body, like bruises, burns, broken bones, and cuts, as well as injuries to a person's private parts. These injuries can cause infections and chronic pain or other long-term physical problems.
- SV can cause STIs, including HIV, and unintended pregnancy. This can lead people to have unsafe abortions, which is very dangerous and can lead to permanent injuries and death.
- SV has serious emotional and psychological consequences, even if the survivor is not physically injured. This includes depression and anxiety, post-traumatic stress disorder, shame and anger, and trouble eating and sleeping. These are normal responses to SV, and these consequences are just as serious as physical injuries. These feelings can last for a very long time.

- Survivors may also experience social consequences. They may struggle to care for their families, or to work, because of the emotional and psychological harm they are experiencing. They may become isolated and withdraw from their families and friends.
- Survivors may be blamed and stigmatized by their partner, families, and communities if others learn about what happened to them. This makes it harder for survivors to go for help and services.

How can community members support survivors?

- Everyone can play a role in supporting survivors and working against harmful attitudes and beliefs about SV.
- If someone tells you that they have experienced SV, you can support them by telling them that you believe them, that they are not to blame, and that they are not alone. There is no one "right" way to feel or behave after experiencing SV: many people will feel and behave in different ways after this experience. It is important not to judge or make assumptions about a survivor based on what they say, do, or feel.
- You can support the survivor by sharing information on seeking support from a CHW or the health facility for care as soon as they are able.
- If it is possible, it is best for survivors to receive care within three days of the SV, so they can take medicines to prevent them from getting an STI and from becoming pregnant. Do not tell people about the sexual violence the survivor has experienced without the survivor's approval. It is important to respect the survivor's privacy.

Group 4: Where can survivors go after experiencing SV, and what are the benefits of seeking medical care as soon as possible?

Where can survivors go after experiencing SV?

- Survivors can see a CHW or go to the health facility.
- It is best for survivors to receive medical care as soon as possible after the assault—within three days, if possible, so that medicines to prevent STIs and pregnancy are most effective.
- It is still good to go for care, even if more than five days have passed. The health worker can still help survivors with their health care needs, provide emotional support, and link them to other support services if they would like.

Facilitator's notes

As part of preparing to implement this program, program staff will identify ways that community members can reach CHWs to obtain care. You should share this information with CHWs during the training.

What are the benefits for survivors of seeking health care immediately?

- Seeking health care as soon as possible can help survivors prevent pregnancy and infections and receive counseling. Depending on when survivors come for services after experiencing SV, the health care worker can help them receive:
  - Medicine to prevent pregnancy
  - Medicines to prevent or treat infections
  - Medicines to prevent HIV
  - Wound care
  - Vaccinations to prevent illnesses such as tetanus ("lockjaw") and hepatitis B
  - Basic support to meet emotional needs
  - Link them to additional emotional and social support, protection, and legal assistance, if they would like.
- The earlier survivors come for care, the more likely they can prevent HIV (within 3 full days of the assault) and pregnancy (within 5 full days of the assault).
- Survivors of all genders can benefit from seeking care as soon as possible after an assault.
- Services are private, free, voluntary, and safe. The health care worker will treat survivors with dignity and respect.

MINI LECTURE (15 minutes)

Explain to participants:

- It is also important that community members know what they can expect to happen when they go to a health care worker to receive medical care for SV.
- While tier 2 and 3 CHWs will learn more about the different services that they can provide in later modules, all CHWs should be able to share information about what happens when a survivor goes to see a health care worker.

As you share each message, write the key points on another sheet of flip chart paper to be displayed next to the others.

- The health care worker will bring survivors to a private place to talk and comfort them.
- The health care worker will ask for their permission to provide care, including medicine.
- If the survivor has very dangerous or life-threatening injuries, the health care worker will arrange for them to go for emergency care right away.
- The health care worker will treat their wounds and injuries and talk to them about how to take care of themselves.
- Depending on when they seek care, the health care worker will give them medicines to prevent pregnancy and infections, including HIV, and tell them how to take the medicines.

- If there is anything the health care worker cannot treat or care they cannot provide, they will ask whether survivors would like a referral to a health facility.
- Before the survivor leaves, the health care worker can help them plan to get emotional support, make sure they have a safe place to stay, and other medical care or social support that they may like.
- Remember, services from the health care worker are private, free, and safe.

Then, explain to participants:

- In addition to sharing information about the benefits of seeking care, it is important to share information about possible consequences of going for services.
- In some places, there are rules or laws called "mandatory reporting." This means that when someone comes to them and tells them about SV, the health care worker has to report it to an authority—even if the survivor does not want to report it to the authority.
- This is not in line with a survivor-centered approach.
- We will learn more about mandatory reporting, and what exactly a health care worker should do when there are mandatory reporting requirements, in a later module.
- However, it is important that survivors understand when there are mandatory reporting requirements, so they can make an informed decision about how and where to seek care.

ROLE PLAY[69] (30 minutes)

1. Group participants in teams of 3-4 and have them practice conveying the messages to each other using their flip chart. Note that when they do this, it is important for them to emphasize community support and empathy towards survivors.

2. Let participants know they have 20 minutes to practice. Group members should ask questions to the presenter, since that will help everyone understand the messages. If they have any questions, they should ask you. You will be choosing one person to conduct a mock health education session (5 minutes) to the entire group.

3. Ask if any participants would like to volunteer to present the session. Compliment her/his skills and provide suggestions that would also be helpful for others.

4. Close this exercise by telling participants:

- It is very important that the information CHWs share with communities is true. We should only tell people about available services.
- Any messages must be linked to services that are available, so that the community's expectations can be met, and they will trust what CHWs say. If services are changed or improved, program staff will let CHWs know. If the program develops additional materials (such as posters, brochures, etc.), the resources will be shared with CHWs.

[69] IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015; and Médecins Sans Frontières, *Sexual & Gender Based Violence: A handbook for implementing a response in health services towards Sexual Violence*, 2011.

Ask participants if they have any questions before moving on to the next section.

Special considerations

Health education for people with disabilities:

Depending on their impairment, People with disabilities may miss out on health education messages, especially if they are not likely to seek health services. For example, people with visual impairments may be unable to access information in writing or pictures. People with hearing impairments may miss information that is only spoken. Often, persons with cognitive or intellectual disabilities are not directly targeted with information about SV. It is important to talk about SV with people with cognitive and intellectual disabilities, including to help them understand they have a right to be safe from abuse. Make sure they know they can talk to someone they trust if they are being touched or abused, and that they will be believed and be safe.

Adapted from Hesperian Foundation, *A Health Handbook for Women with Disabilities*, 2007.

MODULE 3

Principles of working with survivors of sexual violence

SESSION 3.1 Principles of working with survivors of sexual violence

Session time	2 hours
Objectives	By the end of this session, participants will be able to understand: • Learn key principles to working with sexual violence survivors. • Learn how to interact and communicate appropriately with survivors. • Understand informed consent and informed assent. • How to work with an interpreter (optional, CHWs 2 and 3 only).
Methods	• Mini lecture • Scenario • Role play
Preparation	• Prepare lecture.
Training aids, materials, and handouts	• Flip chart and markers. • Poster on key principles (handout [HO]). • Handout on working with People with disabilities.
Evaluation and assessment	• None
Additional resources	• UNICEF, *Caring for Survivors Training Pack*, 2010. • WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. • International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. • WHO, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007. • Women's Refugee Commission, *"I See That It is Possible:" Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015. • Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2019. • Women's Refugee Commission, *Working with Refugees Engaged in Sex Work : A Guidance Note for Humanitarians*, 2016.

1. Key principles of working with survivors of sexual violence

1.1 What are the key principles to working with survivors of sexual violence?

MINI LECTURE[70] (30 minutes)

Explain to participants:

There are guiding principles to working with survivors of SV. These are:[71]
Ensuring the survivor's physical safety.

- Guaranteeing the survivor's "confidentiality."
- Respecting the wishes, the rights, and the dignity of the survivor. If the survivor is a child, this also means considering what is best for the child.
- Treating survivors equally (non-discrimination).

When we use these guiding principles, we are using a survivor-centered approach.

Facilitator's notes

Before beginning this session, you can write key words for these principles—safety, confidentiality, respect, and non-discrimination—on a sheet of flip chart paper and display it throughout the remainder of the training.

- When we are providing care to a survivor, we must take steps to ensure their physical safety.
- Coming forward to receive care can put the survivor's physical safety and security at risk.
- If the survivor's abuser learns that they have come forward, or if their partner, members of their family, or other members of their community find out, the survivor may be at risk of more violence.
- When you are speaking with a survivor, you must find a private, safe place where you cannot be seen or heard.
- For some survivors, you may be able to speak with them at their home. But, for survivors experiencing intimate partner violence, their home is not a safe place.

[70] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

[71] Adapted from UNICEF, *Caring for Survivors Training Pack*, 2010.

Facilitator's notes

As part of preparing to implement this program, program staff will communicate with other organizations providing health and protection services in the community to establish referral pathways, and to raise awareness of the program. As part of these communications, program staff will identify locations in the community where they can safely meet survivors. You should share these locations with training participants.

- **Guaranteeing confidentiality** means that CHWs do not share the survivor's story or documents with others.
- Sharing information about a survivor and what happened to them without their approval can put their safety at risk. If other people, including the perpetrator, find out that the survivor has told someone about what happened to them, they could experience more violence.
- This may be especially true for survivors experiencing IPV: for many women and girls in abusive relationships, the most dangerous time for them is when they go for help, or when they are trying to leave their relationship.
- Breaking confidentiality can cause the survivor to face stigma and discrimination from the community. This can be especially true for LGBTQIA+ people.
- Confidentiality also protects the survivor's right to privacy.
- If CHWs need to share information with other service providers to organize a referral for other services, they can only do so if the survivor understands what this means and has given their approval in advance.
- This process of giving approval after understanding what the information may be used for is called "informed consent." (More to follow in section 3.)
- By guaranteeing confidentiality and only sharing information with informed consent, CHWs restore control to the survivor. They have the power and control to make decisions about what they would like to do.
- If service providers break confidentiality, a survivor may feel that they have been lied to. They may lose confidence in service providers, and not continue to go for help or services. If other people in the community learn that service providers have broken confidentiality, they might not feel safe to come forward if they need help in the future.
- Breaking confidentiality can also have negative consequences for the safety and security of service providers, including CHWs.
- Ensuring confidentiality means that when CHWs go home, they do not share the stories of survivors and what services were provided with anyone, even their partners or other family members.
- It is important to know that there are some cases in which the CHW cannot keep confidentiality. It is very important that the survivor, or in the case of a child, the child's guardian, understands when a CHW would have to tell someone else about what they have shared. This includes:
  - If there are mandatory reporting requirements
  - If the survivor is at risk of seriously hurting themselves, or seriously hurting someone else

  - If there is a situation of sexual exploitation or abuse by a humanitarian worker
  - If a child's safety is at risk, and telling someone else is in the best interests of the child.
- **Respecting the wishes, the rights, and the dignity** of the survivor means that every action CHWs take should be guided by the survivor's decisions, needs, and capacities. Obtaining informed consent is an important part of ensuring that CHWs respect the survivor's wishes, rights, and dignity.
- CHWs should not judge the survivor or their decisions or tell the survivor what they should or should not do.
- If a survivor feels that the CHW is pressuring them to do something they do not want to do, they may not feel comfortable continuing to receive help and services and may lose trust in service providers. If a survivors' wishes, rights, and dignity are not respected, they might feel ashamed, or blame themselves—which causes them even more harm.
- Survivors have a right to high quality care to help them heal physically and psychologically, regardless of their ability to pay.
- When caring for child survivors, the CHW must consider what is in the best interest of the child. We will discuss more about what "the best interests of the child" means later in this session.
- **Treating survivors equally** means that CHWs should treat every survivor equally, and with respect and dignity, regardless of:
  - The survivor's gender and gender identity
  - The survivor's sexual orientation
  - Where the survivor is from
  - What happened during the survivor's assault
  - How many times the survivor has come for services
  - The survivor's age
- **We must believe and support all survivors, without discrimination.**
- CHWs should never make assumptions about the survivor's behavior or ever judge or blame the survivor.
- It is important that we, as service providers who interact with survivors, are aware of and reflect on our own beliefs and biases about SV, and gender and sexual orientation—as we discussed in Module 2.
- By reflecting on our biases and beliefs, we can be sure that they do not influence the way we treat survivors.

In the Participants' Packet, there is a poster that lists these guiding principles. You can pin this to a wall or in your notebooks so that you see this every day.

Special considerations

Best interests of the child means that the child's physical and emotional safety are considered. CHWs should assess the positive and negative consequences of any actions with the child and their caregivers (as appropriate). The least harmful course of action is always preferred. All actions should ensure the child's safety and well-being. Any actions involving a child should therefore:

- Protect the child from potential or further emotional, psychological, and/or physical harm.
- Promote privacy and confidentiality within the limits of any mandatory reporting requirements.
- Address the evolving capacities of children by providing information that is appropriate to their age.
- Ensures the participation of children in decisions that impact their lives by soliciting their opinions and involving them in the design and delivery of care.
- Empower children and families.
- Examine and balance benefits and potentially harmful consequences.
- Promote recovery and healing.

From: IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse: Guidelines for health and psychosocial service providers in humanitarian settings*, 2012, page 98. WHO, *Responding to children and adolescents who have been sexually abused: WHO clinical guidelines*, 2017.

Ask participants if they have any questions before moving on to the next section.

2. Interacting with survivors

2.1 How should survivors be treated?

MINI LECTURE[72] (30 minutes)

Explain to participants:

- CHWs should treat all survivors with compassion, competence, and confidentiality. Treating survivors with **compassion** means creating a safe and supportive environment and caring for them with kindness and respect.
- **Competence** means having the required knowledge, skills, and qualifications to do the job well and help survivors begin to heal. This is important since CHWs can do more harm for survivors if they are not adequately trained.
- **Confidentiality**, again, means that whatever care CHWs provide to a survivor, or anything that a survivor tells a CHW, must NEVER be discussed with others without the survivor's permission.
- When you are working with a survivor, you must obtain consent at each point in the process. This includes obtaining their consent before you begin taking a history and starting an intake form, at every step in a physical exam, for each service you provide, and for each referral you make and for each service provider that you share information with. We will learn more about obtaining consent when providing care in later modules.
- When you begin working with a survivor, you should assure them that you will respect their confidentiality and privacy, and that you will not share or repeat anything that they tell you to anyone without their permission.
- You can explain examples of people that you might ask to share information with, like doctors, social workers, or case workers, when you are referring them for services.
- You should also explain very clearly, before the survivor shares any information with you, if there are mandatory reporting requirements that you must follow. You must explain what you are required to do with any information they share with you, and who you are required to share it with. We will learn more about mandatory reporting in a later module.
- It is important to **treat the survivor with dignity**. CHWs must show that they believe the survivor, that they do not question the story or blame them, and that they respect their privacy.
- CHWs should also **be caring and supportive** of the survivor. They should provide emotional support and show sensitivity, understanding, and willingness to listen to their concerns. It is important to acknowledge that it is hard for survivors to come forward for care, and that they are very brave.

[72] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

- Sometimes, survivors do not describe their experiences as "sexual violence" or "rape," and they may not refer to themselves as "victims" or "survivors." This can be especially true for men and boys, as they may believe that SV is something that only happens to women and girls. Listen carefully to the words the survivor uses to describe their experiences and use the same words when speaking with them. If the survivor uses language that is harmful or negative, instead you should use neutral words to describe their experience—for example, "when you were hurt" or "when they hurt you."
- Do not pressure survivors to share information or details about what happened to them that they do not want to share. In later modules, CHWs who will provide clinical care will learn how they can ask certain questions to get the information they need to help the survivor without forcing them to share other information.

Ask: Can anyone think of helpful phrases or words we can use when we are working with survivors to show compassion and support, that we believe them, and to build trust? As participants raise their hands and share ideas, write responses on sheets of flip chart paper to be posted. Call on as many participants as wish to speak.

After participants have shared their ideas, you should also read out the following phrases:

- "I'm glad you have come to me."
- "I believe you."
- (For adults, or with adults and adolescents if there are no mandatory reporting requirements) "What you share with me is private. I will not share any information that you tell me with anyone without your permission."
- "I'm sorry this happened to you."
- "You are safe here." (If this is true.)
- "How can I help you to feel safe here?"
- "It's OK to feel..."
- "You are not to blame."
- "It's not your fault."
- "You are not responsible for what happened."
- "What you are feeling is very normal for someone who has been through what you have."
- "You are very brave to talk with me, and I will help you however I can."
- "You are not alone."
- (For men and boys) "There are many men and boys who have experienced this."

2.2 How can CHWs communicate with a survivor?

MINI LECTURE[73] (10 minutes)

Explain to participants:

- It is important to communicate with a survivor without retraumatizing them (hurting them again) and in a way that helps them begin to heal.
- Survivors may choose not to share details of their experience. It is important that you do not pressure the survivor to tell you information that they do not want to share. You should only ask questions about what you need to know to care for the survivor.
- If the survivor, including People with disabilities and children and adolescents, has agreed to have a trusted person with them, it is important to speak directly to the survivor and not to the parent, caregiver, or an interpreter.
- You can express your interest and concern with your body by facing and looking at the survivor, as well as with your words.
- Do not interrupt or rush the survivor when they speak. Give time for them to communicate, especially if they have an intellectual impairment. Respect silence by waiting with attention and patience, or use supportive statements, such as "I know this is difficult for you" or "I am here to listen."
- Acknowledge their emotions with statements such as "I can see you are feeling (upset, sad, scared…)."
- Never discount the survivor's feelings by using phrases like "It is not that bad" or "Do not let it bother you."
- Support any of their feelings with statements like "It is normal to feel (upset, sad, scared, anxious…)" or "People who experience sexual assault often feel…"
- Do not ask "why" questions. They are often judgmental.
- Do not offer your opinions or advice. Give the survivor the information they need to make their own decision. More information will be covered in Module 4.

[73] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

2.3 What to avoid when communicating with a survivor

MINI LECTURE[74] (10 minutes)

Share with participants:

- When working with survivors, there are things that CHWs should avoid doing.
- Be sure to find a quiet, private room where the survivor will be safe and comfortable. Be sure that they have a place to sit down. Be sure you cannot be seen or heard, and will not be interrupted. Do not speak or share information with a survivor's parent, caregiver, or an interpreter, without their consent.
- Do not touch the person without their permission. This includes touching and holding their hands and shoulders or hugging them.
- It is important to be aware of your body language. Do not use inappropriate body language. This includes the tone of voice, looking away from the survivor, crossing one's arms, chewing gum, slouching, looking at your phone, being distracted, and so on.
- It is important to avoid talking about yourself or your views and feelings instead of focusing on what the survivor is saying. For example, "This once happened to me as well" or "I feel very angry when you tell me this."
- Do not rush the person, speak over them, or finish their sentences. Give the person time to speak and finish their sentences.
- Do not guess what the person is saying or jump to conclusions after a few sentences.
- Do not make assumptions about the person or judge the person. This includes views such as "It was her fault," "They deserved it," or "She shouldn't have gone there."
- Do not ask "why" questions. "Why" questions can make it seem as if you are blaming the survivor. For example, "Why didn't you tell anyone? Why did you go there?" are harmful statements.
- You should avoid asking leading questions such as "Are you worried about being pregnant?" Such questions may cause additional anxiety and do not provide space for the survivor to communicate in their own words.
- Do not make assumptions about the person.

ROLE PLAY (25 minutes)

- Divide participants into groups of 3-5. Explain to participants that they will be making up skits modeling positive and negative CHW communications.
- Assign half the small groups to plan a "positive communications" skit, and half to plan a "negative communications" skit. Ask groups to include at least 5 examples of positive or negative communication techniques in their skits. Give the small groups 15 minutes to plan their skits.
- Then have each small group present their skit to the rest of the participants.

[74] UNICEF, *Caring for Survivors Training Pack*, 2010.

2.4 What are some tips for working with survivors of diverse backgrounds (persons with disabilities, LGBTQIA+, children, men and boys)?

Tell participants:

- **First and most importantly, CHWs should use the survivor-centered approach and treat all survivors with compassion, empathy, and respect, no matter who they are.**
- It is very important that CHWs are prepared to support diverse survivors—you should know all the different referral pathways in your communities and the services that may be important for, or specifically serve, People with disabilities, men and boys, and LGBTQIA+ persons.

Working with men and boy survivors[75]

Ask: Think back to the discussions we had in earlier sessions. What are some of the vulnerabilities to SV that men and boys experience in crisis settings? Call on several participants.

Explain to participants:

- It is important to remember that men and boy survivors may approach CHWs differently than women and girl survivors.
- Men and boys may report with different signs and symptoms, including back and belly pain, or with vague symptoms like body aches and pains or headaches.
- If possible, ask the survivor if they would prefer to work with a man or woman health care provider. Do not assume what gender provider the survivor would like to speak to. If the survivor's preferred provider is not available, see if there is a trained chaperone/attendant of the preferred gender who can accompany the survivor, and if there is, ask the survivor if they would like that person to stay with them.
- Men and boys may not identify themselves as "victims" or "survivors," or describe their experiences as "sexual violence" or "rape."
- Adolescent boys may not say openly that they have experienced SV. They may talk about "something a friend experienced," or make statements like "he hurt me in a very personal way." It is important that CHWs are familiar with the different phrases or expressions that different types of people in the community use to talk about SV.
- Men and boys who have been tortured often experienced sexual torture, and they may prefer to use the term "torture" rather than SV or rape.
- CHWs should also understand that men and boys may have different emotional and psychological reactions to experiencing SV than women and girls.
- Men and boys who have experienced SV may be very angry or be considered violent and aggressive. It is important to understand that this is a normal reaction, and be prepared to offer support without judgement.

[75] Adapted from Women's Refugee Commission, *Supporting young male refugees and migrants who are survivors or at risk of sexual violence*, 2021; The Children's Society, Boys and Young Men at Risk of Sexual Exploitation: A Toolkit for Professionals, 2018; and Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2021.

- Men and boys may also have concerns about sexual orientation. In some communities, there may be common myths like "only gay man are sexually assaulted" or "if a man or boy is sexually assaulted, he will become gay." CHWs can address this by explaining that anyone can experience SV, regardless of gender or sexual orientation. You can explain that SV is about power, violence, and control, not about sexual desire, and that surviving SV does not mean anything about their sexual orientation.
- Some survivors may experience erections and/or ejaculations during SV. This is a normal bodily response that the survivor cannot control. It is important to reassure the survivor that this is normal and not something that can be controlled, and that it does not mean anything about the survivor's sexual orientation or that he "wanted" or "enjoyed" the SV.
- Note: this can also happen to women and girls, and it is just as important to emphasize to women and girl survivors that this is normal and beyond their control, and it does not mean that they "wanted" or "enjoyed" the SV.
- It also important to remember and recognize that women and girls can also perpetrate SV against men and boys. It is important to recognize and take seriously SV by women and girls against boys and men—even though in some communities, boys who have experienced SV from a woman or girl may be admired by other boys.

Working with survivors with disabilities[76]

Ask: What are some of the vulnerabilities to SV experienced by People with disabilities? Call on several participants.

Explain:

- Remember: people with disabilities often face higher risks for SV, and for IPV and GBV more broadly. They have the same right to receive services and care as other members of their community. As service providers, we must be sure to include People with disabilities in all our services and activities—not as something separate or different.
- Often, people assume they know best what a PWD needs. They may be just trying to help, but People with disabilities know their needs best, and have the right to make their own choices.
- Do not assume that you know what is best for a survivor with a disability. Do not assume what care a survivor with a disability will need, or what services and programs they will be interested in. It is important to take time to consult with survivors with disabilities, just as you do with survivors who do not have a disability.
- Avoid speaking about disability in a negative way (for example, saying that someone is crippled or saying that someone suffers from blindness). It is best to use neutral language, like saying that someone is blind or uses a wheelchair.
- Greet people with disabilities in the same way you greet people without disabilities and treat adults with disabilities the same way you treat other adults. As you learn more about the person, you can adapt how you communicate to meet their needs.

[76] Excerpted from Women's Refugee Commission, *Tool 4: Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015; and Women's Refugee Commission, *Tool 6: Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015.

- If the survivor has an interpreter or caregiver, speak directly to and with the person with disabilities—not to the interpreter.
- Whenever possible, place yourself at eye level with the survivor, if they are not the same height. For example, you could sit in a chair or on a mat.
- There is a handout in the participant's packet that you can keep with you when you are doing your work, so you can refer to it when you are working with survivors with different types of disabilities.

When we work with people with physical impairments[77]:

- Move at their speed. Do not walk ahead of them if they are moving more slowly than you.
- Do not lean on or move someone's wheelchair or assistive device without their permission.
- Discuss transportation options for activities and services. Consider what is going to be safest, most affordable, and the least amount of effort.
- Check that the space is accessible (including toilet facilities, etc.) and has enough room for people to move around, even if they are using a wheelchair, walker, or crutches.
- When arranging meetings with a participant who uses a wheelchair, provide space at the table for a wheelchair (i.e., move one or more chairs away) and ensure there is enough space for them to move around the room freely.

When we work with people who are deaf or hearing impaired:

- Find out how the person prefers to communicate by watching how they communicate with others, or using simple gestures to ask about different communication options. People with hearing impairments may use writing, lip reading, and/or sign language.
- Be sure to find out if there is a sign interpreter available, including a person's family member or caregiver, and including them in activities where appropriate.
- Get the person's attention before speaking by politely raising your hand.
- Speak clearly and do not cover your mouth or eat when talking to help with lip reading.
- Allow the person who is deaf or hearing impaired to choose the best place for them to sit in the room.

When we work with people with vision impairments:

- Always introduce yourself and any other people in the group or room by name.
- Tell the person if you are moving or leaving their space—don't just walk away.
- If the person has arrived at a new place, tell them who is in the room or group, and offer to describe the environment.

77 Women's Refugee Commission, *Tool 6: Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015.

- Ask the person if they would like assistance to go to a new place. Ask how they prefer to be assisted: some people prefer you to tell them clearly how to go and some people might want you to guide them and go with them.
- If you are asked to physically guide someone, offer your arm just above the elbow. This way, the person can walk a little behind you to follow you when you turn or step up or down steps.
- If a person uses a support pet or guide dog to assist them, do not distract or pet the animal.
- If you are using a visual aid, describe all pictures that are shown.

When we work with people with speech impairments:

- Plan more time for communicating with people with speech impairments.
- It is OK to say "I don't understand." Ask the individual to repeat their point, and then say it back to them to check that you have understood it correctly.
- Don't attempt to finish a person's sentences—let them speak for themselves.
- Try to ask questions that require short answers or yes/no gestures.
- If you have tried several ways to understand a person without success, ask if it is OK to communicate in a different way, such as through writing or drawing.

When working with people with cognitive or intellectual impairments:

People with intellectual impairments may experience difficulty in understanding, learning, and remembering. But we can make small changes to how we work to help them learn new things and participate in our activities.

- Communicate in short sentences, sharing information about one thing at a time.
- Give the person time to respond to your question or instruction before you repeat it. If you need to repeat a question or point, repeat it once. If this doesn't work, try again using different words.
- Allow people with intellectual impairments to ask questions.
- Make sure that only one person is speaking at any given time, and that the person with an intellectual impairment is not being rushed to answer.
- People with intellectual impairments may want some more time to think about decisions or to discuss their options with someone they trust.
- Identify quiet environments to have conversations in order to reduce distractions.

Working with LGBTQIA+ survivors[78]

Ask: What are some of the vulnerabilities to SV experienced by LGBTQIA+ people? Call on several participants.

Explain to participants:

- LGBTQIA+ people are at a very high risk for SV, and face many barriers to receiving care, including stigma and poor treatment from providers and criminalization of same-sex relationships.
- When working with LGBTQIA+ survivors, use the person's preferred names and pronouns. Examples of pronouns are she and her, he and him, and they and theirs.
- You should never assume a survivor's gender or sexual orientation. You can always ask the person what their pronouns are if you are not sure how you should refer to them.
- You should listen carefully for the language the survivor uses when referring to their body parts and use that same language when speaking.
- If you are unsure of a person's sexual orientation, you do not need to ask. Instead, you can ask the person what resources they think would be best for them.
- When completing intake forms, always write down information about gender and sexual orientation in a respectful way.
- Do not ask unnecessary questions about a survivor's sexual orientation or gender identity. Only ask questions that are necessary to inform the care that you provide.
- People have a right to choose whether or not they disclose to someone that they are transgender or their sexual orientation. If a survivor chooses not to share this information with you, this does not mean that someone is lying or deceiving you—it is a personal decision.
- You should not assume that the SV experienced was related to the person's gender identity or sexual orientation. Listen carefully to the survivor and do not make assumptions about their experience.

Working with survivors who sell sex[79]

- It is important to remember that people sell or exchange sex all over the world, and in all humanitarian settings. This includes not just women and girls, but also men and boys, LGBTQIA+ people, People with disabilities, and older persons.
- People who sell sex are at extremely high risk of SV and face many barriers to receiving care and services.
- When working with survivors selling sex, you should not judge the survivor, share your beliefs or opinions about sex work, or try to convince the survivor that they should stop selling sex. People who sell sex deserve the same care, compassion, and support that is provided to other survivors.

78 Excerpted from Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2021. Adapted from FORGE, *Practical Tips for Working With Transgender Survivors of Sexual Violence*, 2008.

79 Women's Refugee Commission, *Working with Refugees Engaged in Sex Work : A Guidance Note for Humanitarians*, 2016.

- It is not necessary to know whether or not a survivor is selling sex to provide good quality care to a survivor. Do not ask or pressure survivors to share if they sell sex or if the SV took place in the context of selling sex.
- You can share information about all available referral services, even if the survivor does not tell you that they are selling sex.
- Some people who sell sex identify themselves as sex workers. Others do not. You should listen carefully to how the survivor describes their experiences and use the same language when speaking with them.

2.5 How can interpreters be engaged if necessary?

MINI LECTURE[80] (10 minutes)

Facilitator's notes

As part of preparing for this program, program staff should identify if there are members of the community that may need interpreters (e.g., refugees who speak a different language) and identify organizations in the community that can provide interpreters if needed.

Explain to participants:

- In some cases, you might need to work with an interpreter to help a survivor.
- As with any service, the survivor's consent must be sought to use an interpreter. In cases where no interpreter other than a family member is available, CHWs should still ask for the survivor's consent and speak directly to the survivor. This is true for survivors with disabilities who is accompanied by a family member or caregiver.
- Tell the participants what organizations in the community can provide interpreters, and how they can contact an interpreter if one is needed.
- When working with an interpreter, you should ask the survivor what gender of interpreter they would prefer (if possible) and select an interpreter of the same ethnicity (if possible).
- It is important that you get permission from the survivor BEFORE you communicate with the interpreter.

If you are working with an interpreter, you should ask them to:

- Provide a literal or real translation as opposed to summarizing, "cleaning up," or simplifying the survivor's answers.
- Help CHWs keep a dictionary of words or phrases for which there might not be a translation.

[80] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

When working with an interpreter, the CHW should:

- Introduce themself and the interpreter to the survivor.
- Speak directly to the survivor, not the interpreter.
- Keep eye contact with the survivor, not the interpreter.
- Review the interpreter's notes with the interpreter after the interaction.
- Document that an interpreter was used on the intake form. (This will be discussed later.)

SCENARIO[81] (15 minutes)

1. Tell participants: We will now work through different scenarios of a CHW providing care for a survivor.

2. Read each scenario below. Then, call on participants to identify the mistake the CHW made.

3. Then, call on participants to explain how the CHW should interact with the survivor. What could they have done to better support the survivor?

4. Finally, read the explanation that follows each scenario.

Scenario: It is reaching the end of the work day, and you are feeling tired. An adolescent boy comes to you for help. When you are taking his health history, he hesitates to share information about what happened. You ask him several direct questions for details about what happened to him.

Explanation: It is very important that you never pressure or insist that a survivor shares information that they do not wish to share. You should only ask the questions that are essential to provide the appropriate clinical care, and identify the appropriate services for referral. The survivor should be allowed to speak and share information at their own pace, and that you do not rush the survivor. A survivor should not be made to repeat their story many times; if you are not in a position to provide care, do not probe for their story, but instead, suggest options for care that they can consider.

Scenario: A survivor has come to you for care after having been sexually assaulted by her husband. You tell her that you are very sorry about what happened to her, and that you will do everything you can to help her. You reassure her that it could be much worse, if it had been a stranger who assaulted her.

Explanation: It is very important you do not minimize a survivor's experience, or invalidate their feelings and experience. This can cause survivors to lose trust in you, and other service providers, and can serve as a barrier for them to seek help. People who are experiencing IPV often face dismissive treatment from service providers, who may believe that violence is less serious when it is perpetrated by a partner or family member, or that IPV is a private matter.

[81] Adapted from UNICEF, *Caring for Survivors Training Pack*, 2010.

Scenario: You are providing care to a survivor at the one month follow up visit. She initially presented for care 8 days after having been sexually assaulted by a soldier, and was not able to take EC. She takes a pregnancy test at the follow up visit, and finds that she is pregnant. She is shocked, states that she does not know what to do, and expresses concern that her husband will leave her, or she will be shamed, if the baby is the result of the SV and people find out. You assure her that it will alright, and that the best thing to do is to go to the health facility for safe abortion care, and no one will know.

Explanation: It is not the role of the CHW to share their opinions about what the survivor should do. Instead, you should assure the survivor that you will keep her confidentiality, and share all available information about the different services available to her. You can ask open-ended questions about how the survivor is feeling, and if she knows what she would like to do. If she does not know, you can share information about available services, including how far along in a pregnancy that safe abortion care is available.

Scenario: A woman who is deaf has come with her brother, who can hear. You can see that the woman is in distress, and you ask her sister what has happened. It turns out that the survivor can communicate by sign, and her brother can interpret for her.

Explanation: You should never speak to the survivor's family members, or interpreters, without first obtaining consent from the survivor. It is also very important to be sensitive to the possibility that a family member may be the perpetrator. Wherever possible, you should try to communicate with the survivor privately, where they can tell you if they would like someone else to be present. For survivors with disabilities, it may be best to see if there is a trained sign interpreter (e.g., through health or protection services in the community) available to assist you. You should always speak directly to and with survivors with disabilities, and children and adolescents, even if they are communicating through an interpreter or a family member is present. You can ask survivors with hearing impairments or speaking impairments how they prefer to communicate.

Scenario: A woman comes to you for help. She was beaten and sexually assaulted while selling sex. You provide PEP, EC, and presumptive treatment of STIs, and paracetamol, and care for her wounds. You encourage her to go to the police to report the attack. She tells you that she does not want to go to the police, as she has heard that they treat people selling sex very badly. You tell her that it would be much better and safer for her to stop selling sex. You tell her you can share information about livelihoods and education programs in the community.

Explanation: You should never try to pressure or influence a survivor to report the assault to the police, or other authorities. In many cases, reporting SV to the authorities can further traumatize the survivor. It is the role of the CHW to share information about how the survivor can access different services, including police or authorities, but not to try to influence their decision, or provide advice about what they should do. It is critical that survivors have control over the process of seeking and receiving care and services for SV. This is also true when working with a survivor who is selling sex. You should not express your opinions about selling sex, or try to discourage the survivor from selling sex. This can be perceived as judging the survivor, and blaming them for what has happened to them.

5. End the activity by emphasizing:

- It is essential to use the survivor-centered approach when working with all survivors.
- The survivor centered approach means:

- Ensuring the survivor's physical safety.
- Guaranteeing the survivor's confidentiality.
- Respecting the wishes, the rights, and the dignity of the survivor. If the survivor is a child, this also means considering what is best for the child.
- Treating survivors equally (non-discrimination).

- Using the survivor-centered approach is essential to create an enviornment in which the survivor feels safe and supported, and can choose how and which information to share without being pressured.

6. Ask participants if they have any questions before moving on to the next section.

Facilitator's notes

Tips on how CHWs can convey information about available services and referral options for the survivor will be covered in Module 4. Make sure to cover this module for CHWs to learn about what (and not just how) to communicate to the survivor.

3. Understanding informed consent

3.1 What is informed consent?

MINI LECTURE[82] (20 minutes)

Ask: What does it mean to obtain informed consent? What is required for someone to be able to provide informed consent? Call on participants.

Direct participants to locate the handouts with the sample scripts for **informed consent** and **informed assent** in their participant's packet.

Tell participants:

- Informed consent means giving the survivor all the available information they need to be able to make a decision about whether or not to disclose their experience, or seek a service. They must be able to understand both the benefits, and the possible consequences, of disclosing SV and seeking care.
- An important part of obtaining informed consent is to ensure the survivor understands the limits of confidentiality.

Ask: Who can recall the limits to confidentiality? Call on participants.

- Limits of confidentiality include:

82 UNICEF, *Caring for Survivors Training Pack*, 2010.

  - When the survivor has expressed that they want to seriously harm or kill themselves;
  - When the survivor has expressed that they want to seriously harm or kill someone else;
  - When the survivor is at risk of being hurt or killed by someone else;
  - If the survivor is in need of life-saving medical care; and
  - When there are mandatory reporting requirements that apply to the survivor.
- When obtaining informed consent, you should ensure the survivor is able to ask any questions they may have.
- You must share this information BEFORE beginning to provide care to the survivor. You must obtain informed consent for each service you will provide to the survivor.
- It also means informing the survivor that they may need to share their information with others who can provide services, but only with their permission.
- You must also obtain informed consent from People with disabilities. People with disabilities have the same rights to information, and to make decisions about what information they would like to share, and what services they would like to receive.
- In many communities, family members of People with disabilities or health workers may think that they know best what the PWD needs. While they may not mean any harm, this goes against the rights and dignity of People with disabilities.
- Working with sign interpreters, and using writing to communicate, are all good options for communicating with People with disabilities and obtaining informed consent.
- If a survivor has a cognitive or intellectual impairment, you must still obtain informed consent. However, you may need to follow different steps.
- You can use short sentences with clear and simple language. You should take your time, and make sure the survivor has time to ask questions.
- You can ask a survivor with a cognitive or intellectual impairment to tell you in their own words what they have learned and what they understand are their options.
- In some cases, People with disabilities may need additional support from someone they trust to understand the information and make decisions. If a PWD needs someone else to assist them to make these decisions, you must document this clearly on the intake form.
- You should still continue to speak directly to and with the survivor, and include the survivor in all discussions about them, respecting their safety, confidentiality, and dignity at all times.

Facilitator's notes

When seeking informed consent, typically, the limits to confidentiality are explained. These include:

- The existence of mandatory reporting laws and policies (see session 3.2).
- The need to protect a survivor's physical and/or emotional safety or to provide immediate assistance. This applies if the survivor is:
  - At risk of hurting or killing themself (suicidal).
  - At risk of being hurt or killed by someone else.
  - At risk of hurting or killing another person.
  - Injured and in need of immediate health care.
- If the survivor is a child, the child's parent/caregiver may need to be informed to provide permission for the child to receive care and treatment.

From: IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012.

Further, in situations where it is in the best interests of the child or adolescent, informed consent can be sought from the child or adolescent themselves.

3.2 What is informed assent?[83]

Explain to participants:

- **Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent.** To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give consent.
- Some survivors are not legally able to provide informed consent. This can include minors, and some people who have cognitive or intellectual impairments.
- In these cases, you must obtain informed assent from the survivor, before providing care. **Informed assent is the expressed willingness to participate in services.**
- Parents or legal guardians are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age.
- In some settings, older adolescents are legally able to provide consent, especially if they are married or are not under the care of a parent or guardian.
- For younger children who are by definition too young to give informed consent but old enough to understand and agree to receiving services, the child's "informed assent" is sought.

83 From UNICEF, *Caring for Survivors Training Pack*, 2010. WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

3.3 What is the difference between informing and advising?[84]

Ask: What is the difference between informing a survivor, and advising a survivor? Call on participants.

Tell participants:

- **Advising** means telling someone what you think they should do and how they should do it. It also means giving your personal opinion.
- Giving information means giving someone facts so they can make an informed decision about what to do.
- Giving advice is not recommended because it is not possible to know whether the advice given is the right advice for that person.
- **Informing** is helpful because it empowers the survivor to think about this information and to have control of their choices.
- It also shows that we respect the survivor's opinion and judgment.
- The information we provide when obtaining informed consent should be adapted to the age and capacity of the survivor.
- Telling a survivor what to do does not help them understand and follow their own choices. A survivor might feel they are not being listened to if they are told what to do.
- Survivors should be helped to make their own decisions about their own lives.
- We will learn more about and practice obtaining informed consent and informed assent as we continue through the training.

Ask participants if they have any questions before moving on to the next section.

[84] From UNICEF, *Caring for Survivors Training Pack*, 2010. WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

SESSION 3.2 Addressing policy and societal barriers to providing and accessing care (Level 2 and 3 CHWs 2 only)

Session time	1 hour 30 min (1 hour without optional activity)
Objectives	By the end of this session, participants will be able to: • Understand mandatory reporting requirements. • Address legal and policy barriers that may hinder survivors' access to services. • Apply the social norms perspective to address societal barriers preventing survivors from accessing care.
Methods	• Discussion • Mini lecture • Role play • Activity
Preparation	• Prepare lecture. • Know the legal, policy, and social barriers for survivors to access health care, especially any or believed need for mandatory reporting, a marriage certificate, husband's permission, a police report. • Know the program's protocols to address or overcome the barriers/ challenges.
Training aids, materials, and handouts	• Flip chart and markers.
Evaluation and assessment	• None.
Additional resources	• WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. • WHO, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007.

1. Understanding mandatory reporting requirements (optional; level 2 and 3 CHWs 2 only)

Facilitator's notes

Mandatory reporting is a requirement to report certain incidents of sexual violence to predetermined authorities, such as the police. **Before any work is undertaken with survivors of SV,** program staff must obtain and document information about any mandatory reporting requirements, including reporting mechanisms and investigation procedures in the setting. In some cases, such requirements and the local situation may lead programs to not collect certain types of information or have health staff not ask certain types of questions because of the potential risks to survivors and/or themselves.

Program staff should determine the procedure the program will take to any mandatory reporting requirements, and managing risks to survivors. The procedure should be in alignment with relevant organizational, national, and/or international ethical standards. CHWs should be trained on procedures for mandatory reporting requirements.

Prior to delivering this module, the facilitator should prepare materials to train participants on relevant mandatory reporting requirements and procedures in the pilot site.

From: UNICEF, *Caring for Survivors Training Pack*, 2010.

1.1 What is mandatory reporting and when does it apply? (optional)

MINI LECTURE[85] (30 minutes)

Explain to participants:

- In many countries, there are laws and/or policies that require health care providers, or other service providers and case managers, to report certain (or all) types of cases of SV, or cases that involve a certain type of survivor or perpetrator.
- Mandatory reporting requirements most often apply when the survivor is a minor (under the age of 18 in many settings), and when the perpetrator is a person in a position of power or authority – for example, if they are a humanitarian aid worker.

Ask: Why do mandatory reporting requirement go against the survivor-centered approach? Call on participants.

- These types of reporting requirements can create a challenge for health care workers. This is because the requirements conflict with principles such as respect for consent, confidentiality, and the need to protect the survivor.

85 International Rescue Committee/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012.

- Mandatory reporting may also raise safety concerns. Survivors may experience retaliation and/or further violence, including by the perpetrator. They may risk losing custody of their children or face other legal consequences.
- Where same-sex relationships are not allowed by law, men and persons with diverse SOGIESC may be hesitant or less likely to seek health services if mandatory reporting is required.

Clearly explain mandatory reporting requirements in the pilot site.

- As part of obtaining informed consent or informed assent, you must clearly explain any relevant mandatory reporting requirements – before you collect information from the survivor.
- This includes:
  - Who the report will be made to (the agency/person).
  - The information that will be in the report.
  - How the information will be reported (i.e., is it a written report, a verbal report).
  - The possible outcomes or consequences of the report.
  - The rights of the survivor and, in the case of minor, the rights of their parents or guardians during the mandatory reporting process.
- It is very important survivors, parents, and guardians understand what will happen after a mandatory report is made.

Clearly explain mandatory reporting procedures for the program that CHWs will be expected to follow.

1.2 What does it mean to act in the best interests of the child?[86]

Tell participants:

- Mandatory reporting requirements for child survivors can raise even more ethical and safety concerns.
- There may be instances where reporting the assault is not best for the child. For example, if it may put the child's safety in danger at home or within their community, especially if the perpetrator is a family or community member.
- Other times, services for children may not be available, creating additional risks for the child (separation from family, and so on). The local authorities may themselves be abusive, or there may be no system to properly manage the report.
- When you are providing care to child survivors, you must ensure that all your decisions, and all the care you provide, as in the best interests of the child.
- If you are providing care in a setting where:
  - There are not clear guidelines and procedures for mandatory reporting;

[86] International Rescue Committee/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012.

  - There are not working protection and legal services to respond to the report
  - Or, where reporting could further put a child's safety at risk at home or within their community.
- Then you must put the best interests of the child first. This includes when deciding whether or not to make a report. In these cases, you must contact your supervisor (or the appropriate program staff member) right away.
- When deciding whether or not to make a report, the program staff must consider:
  - Will reporting increase risk of harm for the child?
  - What are the positive and negative impacts of reporting?
  - What are the legal consequences of not reporting?
- Whatever is decided, it should be documented clearly – either the reason why it has been decided to report the case, or the safety and protection risks that rule out making the report.

Ask participants if they have any questions before moving on to the next section.

2. Barriers hindering access to care

Facilitator's notes

Before this session is introduced, make sure that you and the program have mapped policy or societal barriers that may hinder survivors' access to services, particularly health care. You should train CHWs on any protocols to help address or mitigate policy-related barriers. If there are no policy-related barriers, this session can be skipped.

2.1 What are the legal or policy barriers that may hinder survivors' access to services? (optional)

MINI LECTURE[87] (30 minutes)

Ask: Based on what we have learned so far, what are some examples of laws and policies that can make it harder for a survivor to receive services? Call on as many participants as wish to speak.

Explain to participants:

- In many places, there are laws and policies that make it harder for survivors access services.
- In some place, cisgender women may not be able to access health services without the permission of her spouse, or may not be able to receive health services, like contraception, without her husband's permission. In some places, cisgender women may need to have a marriage certificate to receive services.

87 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

- In some places, in order to receive services like EC, or more commonly, safe abortion care, the survivor may be required to first make an official report of the SV to the police.
- Sometimes, these rules are part of a country's laws. Sometimes, however, it may be the health facility or health provider that requires these permissions.
- In some cases, the health facility or provider may believe that these rules are part of the law, even if they are not. These types of misconceptions and myths make it harder for survivors to obtain services.
- In some places, same-sex relationships are against the law. This can prevent survivors with diverse SOGIESC from being able to seek care.
- These types of laws and polices go against survivors' human rights to the highest attainable standard of health, privacy and confidentiality, equality and non-discrimination, self-determination, and dignity and respect.
- All survivors – no matter their gender, age, race, status, or sexual orientation – have the right to access care without discrimination.

Clearly explain relevant laws and policies that impact survivors' access to services in the pilot site.

Ask: What are different ideas and strategies that we as CHWs can use to help address these policy barriers? Call on as many participants as wish to speak.

Clearly explain program protocols that address these barriers, including policies around nondiscrimination and not asking whether or not the survivor is married.

2.2 How can we address social and cultural barriers for survivors?

ACTIVITY (20 minutes)

1. Explain to participants:
   - In this activity, we will reflect on social norms, and the different social and cultural barriers that survivors face in our community. We will think about how we as CHWs can organize community outreach activities and provide clinical services and referrals to address these barriers.

2. **Ask:** What are some of the biggest social and cultural barriers that survivors face to seeking services in this community? Be sure to consider specific barriers that face different survivors (e.g., men and boys, and people with diverse SOGIESC). Call on as many participants as wish to speak.

   After participants have shared, ask the group to identify and agree upon the 4-5 most important barriers.

3. Break participants into small groups – corresponding to the number of key barriers. Assign each group to one barrier. Provide each group with flip chart paper and markers.

4. Tell participants that they have 10 minutes to come up with ideas for what CHWs can do in their work to address these barriers.

5. After 10 minutes, bring participants back together. Have small groups present their ideas to the full group.

6. Then, discuss as a group:

   - What suggestions are feasible to implement now in our program? What can we as CHWs do to implement these suggestions.
   - What suggestions require additional support (e.g., time, funds, or staff) to implement?

7. Close the activity by emphasizing to participants:

   - CHWs have an important role to play to help share information with communities about SV, and to model compassion and empathy for SV survivors in all their diversity.
   - Over the course of this program, we will work closely with diverse community members and groups to organize activities that best meet their needs.

2.3 How can we address barriers for people with disabilities when delivering services?[88]

ACTIVITY (20 minutes)

1. Explain to participants:

   - In this activity, we will think of how we can deliver services and raise awareness of SV in the community to include People with disabilities.

2. Break participants into groups of 3 to 4. Assign half of the groups to "Community awareness activities." Assign the other half of the groups to "Clinical care and referrals for survivors." Provide each group with markers and a sheet of flip chart paper.

3. Tell the participants that they have 10 minutes to think of:

   - One barrier that prevents People with disabilities from accessing services or participating in the activity identified.
   - One thing they could do to help to overcome this barrier.
   - One way in which People with disabilities could provide input or feedback in order to improve our program.

4. After 10 minutes, bring participants together in the full group to discuss:

   - What suggestions are feasible to implement now in our program? What can we as CHWs do to implement these suggestions.
   - What suggestions require additional support (e.g., time, funds, or staff) to implement?

[88] Adapted from Women's Refugee Commission, *"I See That It is Possible:" Building Capacity for Disability Inclusion in Gender-Based Violence Programming in Humanitarian Settings*, 2015.

5. After 10 minutes, conclude the activity by emphasizing to participants:

- People with disabilities have the same rights to access our services and participate in our activities as other members of the community. We must remove as many barriers as possible to ensure they can access our services and be included in our program activities.
- We will work with People with disabilities in our community to learn from them about how to ensure our services are accessible, and to build awareness of where and how survivors with disabilities can access services.
- Including People with disabilities in decision-making, and using their skills and capacities, will make our programs more inclusive and support the healing of survivors with disabilities in the community.

Ask participants if they have any questions before moving on to the next section.

MODULE 4

Recognizing survivors and facilitating referrals for sexual violence

4.1 Recognizing survivors of sexual violence

Session time	1 hour
Objectives	By the end of this session, participants will be able to: • Recognize people who may need immediate help (passive identification) • Create an enabling environment for someone who may have experienced sexual violence.
Methods	• Mini lecture • Demonstration
Preparation	• Prepare lecture. • Know possible private, quiet locations in the community where CHWs can interact with survivors.
Training aids, materials, and handouts	• Flip chart and markers • Providing psychological first aid (HO)
Evaluation and assessment	• None
Additional resources	• UNICEF, *Caring for Survivors Training Pack*, 2010. • IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009. • IFRC, *International first aid and resuscitation guidelines*, 2020. • Hesperian Foundation, *Where There Is No Doctor: A Village Healthcare Handbook*, 2021 • WHO, *Psychological first aid: Guide for field workers*, 2011.

1. Recognizing survivors of sexual violence and providing first line psychosocial support

1.1 What are some signs that a person is in distress?

Facilitator's notes

Prior to or during this mini lecture, you should write the danger signs below that indicate a survivor should be referred immediately on a sheet of flip chart paper, to be displayed during the training.

MINI LECTURE[89,90] (15 minutes)

Explain to participants:

- During this program, we will share information all throughout the community about how people can contact you for help if they have experienced SV.
- Sometimes, however, you might come into contact with people who you suspect may have experienced SV.
- Such persons may have torn clothes, physical wounds, or show emotional or behavior symptoms of having suffered severe trauma—such as anxiety and fear—as discussed in Module 2.
- You should not ask every person you work with if they have experienced SV. This is called "active screening," and it is not recommended.
- However, you can still passively identify survivors, especially if someone comes to you in pain, or distressed. In a few minutes, we will learn more about how we can create an environment where survivors feel safe and supported to talk with you.
- In some cases, someone who comes to you for help needs to go to the health facility right away, because they are experiencing problems that indicate their injuries are very serious, and they are in danger. This includes if the person is unconscious, or has:
  - Swelling and hardness of the belly.
  - Pain in the belly.
  - Severe pain anywhere else in the body (back, chest, arms, legs, or head).
  - Vomiting blood.
  - Bleeding from the bottom (the genital area, or anus).
  - Heavy bleeding from other parts of the body.
  - Possible object lodged inside vagina/anus.

89 UNICEF, *Caring for Survivors Training Pack*, 2010.

90 IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009.

  - Altered mental state or confusion.
  - Pale, blue, or gray skin.
  - In a small child, fast breathing or difficulty breathing.
- These conditions, especially if the person is bleeding heavily or becomes unconscious, are dangerous and will require immediate medical attention.
- Other possible signs of a person in shock or immediate distress include:
  - Skin feeling cold, moist, and clammy.
  - Fast breathing with small shallow breaths.
  - Feeling anxious, panicky, or restless, or feeling faint or dizzy.
  - Thirst or feeling sick and vomiting.
- The above conditions, especially if the survivor becomes unconscious, are dangerous and will require immediate medical attention.
- All CHWs should **refer people presenting with danger signs immediately to a higher-level health facility**. More information will be covered in Module 5.

1.2 How can CHWs provide first line psychosocial support?

Facilitator's notes

Before or during this mini lecture, you should write LIVES (Listening, inquiring about needs and concerns, validating, enhancing safety, and supporting) on a piece of flip chart paper to display during the training.

MINI LECTURE (30 minutes)[91]

Tell participants:

- If you think that someone may have experienced trauma, including SV, ask if you can go with the person to a private, quiet, and safe place. Then, you can ask if they need help.
- There is a technique called **LIVES** that can guide CHWs on how to speak with survivors using a survivor-centered approach, and the principles we discussed in Module 3: protecting survivors' privacy and confidentiality, treating all survivors equally and without discrimination, and respecting survivors' wishes, rights, and dignity.
- By using LIVES, we can provide first line psychosocial support.
- **The first part of LIVES is listening.** You should use good listening skills, and listen closely to what the survivor is saying with empathy, and without judging the survivor.

[91] WHO, *Clinical management of rape and intimate partner survivors: developing protocols for humanitarian settings*, 2019; Inter-Agency Working Group (IAWG) on Reproductive Health in Crises, *Clinical Management of Sexual Violence Survivors in Crisis Settings*, 2021.

- If the survivor does not want to talk, they do not have to. Simply being a quiet, supportive, respectful person by their side can be helpful. Remember you should not touch the survivor (hugging, putting your arm around them, holding their hand, without permission).
- For level 1 CHWs, you should keep your questions to a minimum to obtain consent to refer the survivor, so that the survivor does not have to tell their story over and over again.

Ask: Based on what we learned earlier, can anyone share examples of how CHWs can show good listening skills when working with survivors? Call on as many participants who wish to speak.

Then, tell participants:

- Good ways to listen to survivors include acknowledging how the survivor is feeling.
- Let the survivor talk and tell their story at their own pace. It is OK to have periods of silence. Give the survivor time to think and breathe.
- Encourage them to keep talking if they want through open-ended questions. For example, "Would you like to tell me more?"
- Stay focused on the survivor.

Now, tell participants:

- **The next part of LIVES is to carefully inquire, or ask, about the survivors needs and concerns.** These concerns can be emotional and psychological, physical and health concerns, safety concerns, and concerns about practical things like childcare, or having a place to stay. We will learn more about how we can help survivors with different needs in later modules.
- If you do not understand something the survivor has said, you can ask for clarification. For example, you could say, "Can you explain that again, please?"
- You can also ask "Is there anything you need? Is there anything you are concerned about?"
- Remember: it is important not to ask "Why" questions, as this can sound like you are blaming or judging the survivor. You should also not ask leading questions.
- **The next part of LIVES is validating.** These means the CHW should assure the survivor that what they are feeling is normal. You should keep an open mind when the survivor is speaking, without judging. You should accept what the survivor is telling you, and respect the survivor's feelings. You should not correct or challenge what a survivor says. You should assure the survivor that they are not to blame.

Ask: Based on what we learned earlier, can anyone share examples of how CHWs can validate survivors' experiences and feelings? What are some helpful things that CHWs can say? Call on as many participants as wish to speak.

Next, tell participants:

- Validating the survivor's experiences and feelings is important to build trust, and to let the know that they have a right to be safe, and to not experience violence.
- Good examples of things to say include:

- "It is not your fault. You are not to blame."
- "No one deserves to be hurt by their partner. It is never OK for someone to hurt their partner."
- "You are not alone."
- "Your life and your health are of value."
- "Everybody deserves to feel safe at home."
- "I am concerned this may affect your health."

Then, tell participants:

- **The next part of LIVES is enhancing safety:** A person who has experienced SV may lose their basic sense of security and trust in other people.
- CHWs can help rebuild trust and security by staying close, but avoiding touching and staying calm while the person is upset.
- Survivors have important safety concerns. If other people, including family members, the perpetrator, or members of the community find out about what the survivor has experienced, or that they have gone for help, they may experience more violence. This can be especially true for survivors experiencing IPV.

Ask: Based on what we have learned so far, can anyone share examples of how CHWs can protect survivors' safety? Call on as many participants as wish to speak.

Next, tell participants:

- One of the most important things you must do to protect the survivor's safety is to keep their confidentiality. Always work with survivors in safe, private places, where you cannot be seen or overheard.
- Only speak with survivors when you are alone, or if the survivor has asked for and/or agreed to have another person present. This includes children over the age of two.
- If a survivor tells you that they are worried about their safety, you must take this very seriously. You can also ask open-ended questions to learn more about if the survivor is safe.
- As part of identifying services to refer the survivor to, you should discuss services that offer safe shelter and other protection services in the community. For survivors experiencing IPV, this can include referrals to services that can help them create a safety plan to follow if the violence continues.

Then, tell participants:

- **The last part of LIVES is supporting the survivor.**
- We can support the survivor by helping them to get the services, information, and support that they need. We will learn more about making referrals in the next section.

Direct participants to refer to the handout in the participant's packet on **providing psychological first aid**.

Explain to participants:

- There are some important things that CHWs should NOT do when working with survivors.
- Remember: you should only ask questions to inform the care you provide. You should not ask detailed questions that force the survivor to relive painful events.
- This includes sharing your opinion, or trying to help the survivor to solve their problems.
- You should not try to convince or pressure a survivor to go for services that they have said they do not want to go to. For example, you should never try to convince a survivor that they should report the SV to the police.
- You should also not try to convince a survivor to leave a violent relationship.
- **Finally, it is not the responsibility of any health provider, including CHWs, to determine whether or not a survivor has been "raped."** That is a legal determination.[92] If the survivor discloses that they have experienced SV, CHWs should treat them using the same guiding principles, and show compassion, confidentiality, and competence, regardless of whether their experience meets the legal definition of rape in the setting.

Ask participants if they have any questions before moving on to the next section.

92 International Rescue Committee, *GBV Emergency Response & Preparedness: Participant Handbook*, 2011.

SESSION 4.2 Referring survivors for health care and other services

Session time	2 hours 40 minutes (2 hours 30 minutes without optional activity)
Objectives	By the end of this session, participants will be able to: • Learn what role CHWs can play in making confidential referrals. • Learn when and how to make confidential referrals. • Know what to share about health and support services for which referrals are available. • Know what to do when referrals are not available.
Methods	***MINI LECTURE*** • Discussion • Scenario • Role play • Activity
Preparation	• Prepare lecture. • Map who is doing what where to respond to sexual violence, including referral mechanisms. Complete referral table in facilitator's manual. • Prepare presentation on standard operating procedures (SOPs) for referrals in the site, if relevant. • Prepare handouts or other materials on the referral pathway and SOPs for participants. • Identify private and safe locations for client interactions. • Know how much basic first aid participants have learned to stabilize persons in life-threatening conditions for referrals.
Training aids, materials, and handouts	• Flip chart and markers • Addressing symptoms of shock (optional) • Controlling excessive bleeding (optional) • Providing basic first aid for burns (optional) • Providing basic first aid to survivors with a head, neck, or back injury (optional) • Providing basic first aid to survivors with injuries to bones, muscles, or joints (optional) • Offering basic life support (optional)

Evaluation and assessment	• Role play to demonstrate learned skills to identify and refer survivors.
Additional resources	• UNICEF, *Caring for Survivors Training Pack*, 2010. • IFRC, *International first aid and resuscitation guidelines*, 2020. • IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2008. • WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

1. Referring survivors for care

1.1 What is the role of the CHW in making referrals?

MINI LECTURE[93] (10 minutes)

Tell participants:

- CHWs play a very important role in enabling survivors of SV to receive life-saving health care and other support services.
- Even if they are only responsible for health education (CHWs 1), CHWs still serve as bridges for survivors.

Review again the basic expectations for CHWs in each category.

- Level 1 CHWs will play an important role in leading community outreach activities, to help members of the community learn more about SV, why it is important for a survivor to seek care as soon as possible, and where people can go for services.
- In addition to these activities carried out by Level 1 CHWs, Level 2 CHW can offer some basic, but very important, clinical services to survivors. While more details of their exact scope will be revisited in Module 5, CHW 2s will be referring survivors to the health facility for wound care that they cannot manage, and for tetanus or hepatitis B vaccines. They will also refer survivors to the health facility, or to Level 3 CHWs, for more advanced care, and for other important mental health, safety, support, and legal services.
- In addition to these activities carried out by Level 1 and 2 CHWs, Level 3 CHWs will provide additional, more advanced health services, especially if survivors may not be able to go to a health facility, or if the health facility cannot provide the care the survivor needs. However, Level 3 CHWs will also refer survivors for these different support services.

93 Global Protection Cluster, *Handbook for Coordinating Gender-based Violence Interventions in Humanitarian Settings*, 2019.

1.2 What are the services to which CHWs will be referring survivors?

Facilitator's notes

The table of available referrals, below, should have been completed by program staff. Services selected for referrals should have been assessed for quality and their ability to maintain confidentiality. Facilitate this activity based on what services are available and what referrals are expected of CHWs. If CHWs will not be encouraging or facilitating referrals to the police, for example, this should be omitted from the discussion.

Private and safe locations where CHWs can interact or provide care to survivors should also have been identified. Ensure the locations are not only for survivors of SV, but are also used for other private meetings with clients, to avoid being able to identify survivors.

DISCUSSION (30 minutes)

1. Present the completed table below on flip chart paper or another medium (handouts, for example).

Services	Yes	No	Who provides this service, and what specifically?	Where is this referral located?	Does this service meet quality standards?* (Y/N)	When are they open? (24/7)	Contact
Community mapping of all referral points conducted.			N/A	N/A	N/A	N/A	
Organization(s) and individual(s) are in place to facilitate GBV coordination meetings.			*List organizations and focal persons*	N/A	N/A	N/A	
GBV coordination meetings take place and are attended for coordination and communication.				N/A	N/A	N/A	
System(s) developed to track referral services.			*Describe system*	N/A	N/A	N/A	
Referral by CHW 1 to CHWs 2/3							
Referral to a mid/low level facility that can treat shock, wounds, pelvic inflammatory disease; provide intrauterine devices, etc. and any services that CHWs are not authorized to provide in this setting							
Referral to a mid/high level facility that has surgical capacity for fistula or rectal sphincter muscle tears, broken bones, etc.							

Services	Yes	No	Who provides this service, and what specifically?	Where is this referral located?	Does this service meet quality standards?* (Y/N)	When are they open? (24/7)	Contact
Referral for HIV prevention services (HIV testing, antenatal care, and prevention of mother-to-child transmission of HIV).							
Referral for HIV treatment services (antiretroviral treatment, pediatric treatment, etc.).							
Referral for post-abortion services (includes vacuum aspiration services for first trimester abortions; basic emergency obstetric care).							
Referral for safe abortion services to the full extent of the law.							
Referral for psychosocial support.							
Referral for specialized mental health services.							
Referral for shelter and protection, including community protection for survivors.							
Referral to police and/ or community-based or traditional justice mechanisms.							
Referral for legal assistance.							
Referral to community-based organizations that can support survivors (women's groups, adolescent and youth groups, organizations of People with disabilities, LGBTQIA+ support groups, etc.).							
Referral for other social support (rehabilitation, reintegration, income-generation, education, etc.).							

*Only those services/organizations that have been assessed for their quality (especially ability to maintain confidentiality) per existing standards should be engaged as part of the pilot's referral network.

2. For each service in the referral pathway, review with participants:
    - The responsible organization
    - The specific services provided by the organization/facility
    - Where the service is located
    - Whether or not the services are available 24 hours a day, 7 days a week, or the hours the service is available
    - The quality of the services. It is important that only services that meet quality standards be included in the referral pathway. If there are rumors about the services, it is important to address these with participants. If survivors have bad experiences with a service, it can discourage others from coming to seek care.
    - How survivors can access each service (by foot, car, bus, etc.) If the program has resources to support survivors' transportation, share this with participants.

3. It is important to identify which services, if any, CHWs will not refer for. For each service CHWs are not referring for, explain how survivors can still access the services (through case workers if they exist, for example).

1.3 How should CHWs refer survivors of sexual violence?

Facilitator's notes

The sections below have been written primarily for Level CHWs 1, although the information is also relevant for Level 2 and 3 CHWs who can provide health care. Referrals from Level 2 and 3 CHWs for additional health services they cannot provide is addressed in Module 5.

While this module will not go into detail about how to stabilize survivors before referring, optional handouts are available in the participants' packet for additional information:

- Addressing symptoms of shock
- Controlling excessive bleeding
- Providing basic first aid for burns
- Providing basic first aid to survivors with a head, neck, or back injury
- Providing basic first aid to survivors with injuries to bones, muscles, or joints
- Offering basic life support

Detailed information on each of these topics is available from IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009. If these topics are new, make sure to review infection prevention measures with CHWs. This information is available in Module 5, and as a handout.

MINI LECTURE[94] (20 minutes)

Explain to participants:

- When a survivor comes to you, the first step is to assess the survivor for any danger signs, which would mean the survivor needs to be referred right away. **If the survivor has any of these signs, the survivors must be referred right away!**
  - Swelling and hardness of the belly.
  - Pain in the belly.
  - Severe pain anywhere else in the body (back, chest, arms, legs, or head).
  - Vomiting blood.
  - Bleeding from the bottom (the genital area, or anus).
  - Heavy bleeding from other parts of the body.
  - Possible object lodged inside vagina/anus.
  - Altered mental state or confusion.
  - Pale, blue, or gray skin.
  - Skin feeling cold, moist, and clammy.
  - Fast breathing with small shallow breaths.
  - Feeling panicky, faint, or dizzy.
  - In a small child, fast breathing or difficulty breathing.
- If the survivor has a wound that is bleeding heavily, it is important to take steps to control the bleeding until the person reaches the health facility (or, depending on the setting, the ambulance arrives).
- You should cover the wound with a clean cloth, press down, and apply pressure on the wound or instruct the person to do so as they are able, until the person reaches the health facility.
- If there is an object sticking out of the wound, it should not be removed. It should be left there and CHWs should try to stop the object from moving with clean pads and bandages until the person reaches the health facility.
- If survivors are in stable condition, CHWs should still take action right away to refer the survivor, or to provide care. **Remember – services for survivors of SV are time sensitive!**
- When we are referring survivors, we use the same survivor-centered approach that we use when we provide direct services.

Ask: Can anyone recall and share the key principles of the survivor-centered approach? Call on participants.

94 UNICEF, *Caring for Survivors Training Pack*, 2010.

- The key principles for working with survivors are to ensure their physical safety, guarantee their confidentiality, respect their wishes, rights, and dignity, and to treat all survivors equally, no matter their identity. This is called non-discrimination.
- We should also use the same good communication skills when we refer survivors, as when we provide direct services.

Ask: What are good skills to use when we communicate with survivors? Call on as many participants as wish to speak.

- Remind participants that:
  - Be sure that you are in a quiet, private, safe place where you cannot be seen and overheard.
  - You must obtain informed consent and/or informed assent before you begin working with the survivor.
  - You must obtain permission from the survivor if you need to work with an interpreter, or if they want to have a support person or family member with them.
  - If the survivor, including People with disabilities and children and adolescents, has agreed to have a trusted person with them, it is important to speak directly to the survivor and not to the parent, caregiver, or an interpreter.
  - It is important to communicate with a survivor without retraumatizing them (hurting them again) and in a way that helps them begin to heal.
  - We should use LIVES when we work with survivors to provide first line psychosocial support.
  - You should assure survivors that you will keep what they tell you private and confidential, noting any exceptions to confidentiality, and that you will do everything you can to help them.
  - We should use good listening skills, and listen with compassion and empathy, and without judging the survivor or making assumptions about them, or their experience.
  - Let the survivor talk and tell their story at their own pace. Do not interrupt the survivor. It is OK to have periods of silence. Give the survivor time to think and breathe.
  - Remember: it is important not to ask "Why" questions, as this can sound like you are blaming or judging the survivor. You should also not ask leading questions.
  - Survivors may choose not to share details of their experience. It is important that you do not pressure the survivor to tell you information that they do not want to share. You should only ask questions about what you need to know to care for the survivor.
  - Another important part of LIVES is validating. You can acknowledge their emotions with statements such as "I can see you are feeling (upset, sad, scared…)."
  - Support any of their feelings with statements like "It is normal to feel (upset, sad, scared, anxious…)."

Ask: What should we be careful not to do when we communicate with survivors? Call on as many participants as wish to speak.

- Remind participants:
  - You should not discount the survivor's feelings by using phrases like "It is not that bad" or "Do not let it bother you."
  - Do not offer your opinions, or try to share advice.
  - You should not try to convince or pressure a survivor to go for services that they have said they do not want to go to.
  - You should also not try to convince a survivor to leave a violent relationship.

Explain to participants:

- When you are providing referrals to different services, it is important to provide all the information the survivor needs to make informed choices about what services they would like to receive.
- It is very important that we provide accurate information about what is and is not available, to manage survivors' expectations, and to not make false promises. You must never make promises that you cannot keep.
- When a survivor comes to a CHW, they are demonstrating that they trust the CHW can help them.
- You should always be very clear about what CHWs can and cannot provide, both when conducting community awareness raising activities, and when working with survivors.
- You should only tell survivors about the services that are available in their community.
- When discussing different available services, you should share information about what the service can offer, and its quality. This will help the survivor choose the care and support they would like.
- Share the information in a way that the survivor understands, and check whether the survivor has understood the information by having the survivor repeat in their own words what they heard.
- CHWs can also offer to accompany the survivor to different services, if the survivor wishes. The CHW can accompany the survivor to the health facility, and can also arrange to accompany them to other support services in the community. There may be other support people in the community, such as social workers and case managers, who can also accompany survivors to provide support. These arrangements should be carefully discussed to ensure the survivor's safety, including in cases where the survivor is experiencing IPV.
- It is very important that referrals are coordinated between different organizations! Once the survivor has decided which services they would like to received, the you should contact the appropriate focal points or case manager to prepare to receive the survivor.

1.3.1 Standard operating procedures (older people) (optional)

Facilitator's notes

As part of program planning and mapping the referral pathway, the implementing organization's staff should document any standard operating procedures (older people) for GBV referrals and case management in the pilot site. CHWs must be trained on how to organize referrals in accordance with older people.

Deliver presentation training CHWs on how to follow any relevant older people when providing care and referrals.

Ask participants if they have any questions before moving on to the next section.

1.4 What can be shared with survivors to refer them for health services?

Facilitator's notes

Prior to this session, the facilitator should work with program staff to prepare training materials on procedures for referrals between CHWs and the health facility, as well as procedures for referral to other health, psychosocial support, protection, and legal services. It is essential to train CHWs on the referral processes and pathways that will be used in the program.

MINI LECTURE[95] (15 minutes)

1. **Ask:** Think back to what we have learned about why it is important for survivors to seek care as soon as possible. If a survivor reports within **three full days, or within 72 hours**, of the incident, what are the services they can receive? Call on participants.

Then, tell participants: If the survivor comes for care **within three full days** (less than 72 hours) of the assault, they can receive the following services in a confidential manner:

- Antibiotics to prevent STIs.
- EC to prevent unwanted pregnancy (women, girls, and transgender men).
- Care of wounds.
- PEP to prevent HIV.
- Emotional care/basic psychosocial support.
- Tetanus toxoid vaccination.
- Hepatitis B vaccination.

2. **Ask:** What if the survivor presents **after three full days but within five full days** (72-120 hours)? Call on participants.

95 WHO, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2004.

Then, tell participants: if a survivor presents **after three full days but within five full days** (72-120 hours), they can receive all of these services – **except for PEP to prevent HIV.**

3. **Ask:** What if the survivor presents after five full days (more than 120 hours)? Call on participants.

   Then, tell participants: if a survivor presents **after five full days** (more than 120 hours), they can still receive:

   - Antibiotics to prevent or treat sexually transmitted infections (presumptive treatment of STIs).
   - Care of any remaining wounds.
   - Emotional care/basic psychosocial support.
   - Tetanus toxoid vaccination.
   - Hepatitis B vaccination.

   Additionally, survivors can always receive:

   - HIV testing and counselling.
   - Referrals for HIV treatment programs.
   - Pregnancy testing and counselling.
   - Safe abortion care to the full extent of the law (referral or medication abortion).

4. Draw the following table on a sheet of flip chart paper. Adapt the third column (**From where is this service available?**) to reflect your program/the pilot site (Level 2 CHW, Level 3 CHW, health facility)

Service	Up to when after the assault can a survivor receive the care?	From where is this service available? (To be adapted)
Antibiotics to prevent sexually transmitted infections (presumptive treatment of STIs)	Anytime	*CHWs 2 and 3; health facility*
Emergency contraception (pills) to prevent unwanted pregnancy	5 full days	*CHWs 2 and 3; health facility*
Post-exposure prophylaxis (PEP) to prevent HIV	3 full days	*CHWs 2 and 3; health facility*
Wound care (basic)	Anytime	*CHWs 2 and 3; health facility*
Emotional care (basic)	Anytime	*CHWs 2 and 3; health facility*
Tetanus vaccine	Anytime	*health facility (or CHW 3)*
Hepatitis B vaccine	Anytime	*health facility (or CHW 3)*
Safe abortion care	Anytime	*health facility (or CHW 3 for pregnancies up to 12 weeks)*

Explain to participants:

- We can help survivors, no matter when they present for care. However, there are benefits to presenting for care as soon as possible after an incident of SV – within three days, if possible, for EC and PEP, or within five days for EC.
- It is important that CHWs never pressure survivors to seek services, or to agree to receive care.
- However, you can share information with survivors about:
  - What services they can receive.
  - The health benefits of the services they can receive.
  - Where they can go to receive the service.
  - What to expect when they go to receive the survey.
- Level 2 and 3 CHWs will learn how to provide direct clinical services to survivors in Module 5, and can refer survivors to the health facility for higher-level care, as needed and with the survivor's consent.
- Level 1 CHWs can refer the survivor to higher level CHWs, and/or the health facility for higher-level care as needed – with the survivor's consent.
- If the survivor would like, level 1 CHWs can stay with the survivor, providing support as they wait for the higher-level provider – or, level 1 CHWs can also accompany the survivor to the health facility to provide support.
- **Remember! If a survivor presents with any danger signs, they must be referred immediately!**

Facilitator's notes

In some instances, a survivor may hesitate to seek health care, as they may believe that this will also require them to report the incident to the police or authorities – and that may not wish to do so. It is important to reinforce for survivors that (when there are no mandatory reporting requirements) health care and reporting to authorities or taking legal/justice action do not have to be linked. CHWs can share information with survivors about referrals to authorities and legal services if the survivor wishes, but the key message that CHWs , the most important health message to share is the benefits of seeking health care and where services can be accessed.

1.5 What should be shared with survivors to refer them to other support services?

SCENARIO[96] (20 minutes)

1. Explain to participants:

   - We can also organize referrals to other support services, including mental health and psychosocial support, protection, legal and justice, livelihoods, and other services that are available in the community. Remember! We must obtain consent from survivors for each service we refer to the survivor to.
   - In some settings, there may be case workers available who can work closely with a survivor over time, to help them access different services.
   - **Before we refer survivors to any service, we must ensure that service is good quality, confidential, and safe.**
   - Program staff have confirmed that all the services included in this program's referral pathway are safe and of good quality.

2. Tell participants: In this activity, I will share different scenarios. I will then call on participants, and ask you to share how you would approach organizing referrals in that case, keeping in mind what we have learned.

3. Read each scenario. Then, call on several participants. After participants have spoken, read the corresponding explanation.

Scenario 1: A survivor comes to you for help, saying that her uncle came over when no one was home and forced her to have sex with him. Her uncle does not always live with her, but he often spends the night at her house. The survivor expresses that she is worried for her safety. The nearest safe house is a day's walk away, and it is already getting late. You send her home for the night, and ask her to come back tomorrow so you can refer her to the safe house. You provide her with your contact information, so she can call you right away if she is concerned.

What do you think about this scenario?

Explanation:

- The survivor's safety is of the utmost importance. It is very important that you do not send the survivor to a home or place where they may not be safe.
- If the survivor is not safe at home, and there is not a safe house or shelter available nearby, you should work with the survivor to try to identify another place where they can stay, like a friend or relative's house.
- You should also take time to develop a safety plan with the survivor, or—with the survivor's consent—contact the program staff person who is responsible for safety planning.

[96] Adapted from UNICEF, *Caring for Survivors Training Pack*, 2010.

Scenario 2: A survivor is interested in receiving mental health care services.

What are the different steps you should take to arrange this referral?

Explanation:

- Share information about the different mental health and psychosocial support services available in the community, including what the service/program is, where it is located, and when they are open.
- Share any information about costs, if the services are not free.
- If relevant, communicate which information you will or will not need to share to arrange the referral.
- If relevant, obtain the survivor's consent to contact the service or services they select, to organize the referral.
- Offer to help the survivor to access the service, by calling the service, arranging transportation, or accompanying the survivor.

Scenario 3: You are assisting a young man who was sexually assaulted while selling sex. He has asked if you can help connect him with different livelihoods opportunities, as he is hoping to transition away from selling sex. You are aware of an organization nearby that has provided stipends to people who formerly were sex workers. However, you do not know very much about the organization.

What should you do?

Explanation:

- You should not refer a survivor to a service unless you are sure that the service is private, safe, and confidential, and offers good quality services.
- In this case, you should not refer the survivor to this service. You can share information about other livelihoods programs that are available.
- Another option could be to notify program staff of the organization, and request that they follow up to learn more about the organization and if the service should be included in the referral pathway. If the service is determined to be safe and private, you could then share this information with the survivor at a follow-up visit.

ROLE PLAY (20 minutes)

1. Divide participants into pairs. Direct participants to find the **sample scripts to obtain informed consent and informed to arrange referrals for adults, children, and people with cognitive or intellectual impairments** in their participant's packet.

2. Ask for a volunteer to role play with you, and read the script to model obtaining informed consent for participants. Take time to stop and identify each component of obtaining informed consent or informed assent as you go through the script.

3. Then, in each pair, direct one person to play the CHW and the other a survivor (adult, child, or person with a cognitive or intellectual impairment). Have the participant playing the CHW to use the script to go through the process of arranging a referral.

4. Circulate amongst the pairs.

5. After the first role play is complete, have participants circulate and switch roles, so that everyone has the chance to play the CHW at least one time.

6. Switch roles when the first role play is complete, but have the second CHW practice the script for a different type of survivor.

7. If time permits, ask for pairs of volunteers to demonstrate each script.

8. Emphasize to participants that it is very important that they are comfortable obtaining informed consent and assent, and that they should review and practice with the scripts often. Note to participants that they can refer to their script when working with survivors.

Ask participants if they have any questions before moving on to the next section.

Facilitator's notes

For participants with low literacy, you can consider organizing additional sessions, or working with participants with low literacy in a small group to ensure they have enough time to practice to ensure they are prepared to obtain informed consent.

The scripts call for CHWs to:

- Introduce themselves.
- Offer comfort and understanding.
- Explain what services are available, how they can help the survivor, and any risks.
- Ask the survivor if they have any questions.
- See if the survivor would like to be referred to any of the services.
- Agree upon how the survivor can access these services.

When obtaining consent, CHWs should be mindful to:

- Provide the survivor with information about all available services and their quality.
- Explain the information in a way that the survivor understands, and check whether the survivor has understood the information.
- Be clear about roles and the type of support and assistance they can offer.
- Not make promises they cannot keep.

1.6 What if no referral services are available? (optional)

Facilitator's notes

In some settings, referral services may not be available. You do not need to include this module if there are functioning referral services in the pilot site.

DISCUSSION[97] (10 minutes)

Explain to participants:

- In some settings, additional services for survivors may not be available – either because they are not offered, or because survivors face too many barriers to access the survivor.
- If this is the case, **you should be careful to not share information or promise services to the survivor if they are not available. This can create expectations that you cannot meet, causing disapointment or distress, or causing the survivor to lose trust in the CHW and the program.**
- You can share information about those services that are available.
- **Additionally, even in settings where protection services are limited or not available, you can should make every effort to ensure the survivor is safe.** You should ask the survivor about their safety and discuss their safety concerns. You can contact existing protection services or your program suwith the survivor's consent, and develop a safety plan with the survivor.

Ask participants if they have any questions before moving on to the next section.

Facilitator's notes

As part of program planning, program staff may have identified gaps in available services for survivors in the referral pathway, and have developed contingency plans. If this is the case, CHWs should be trained on these contigency plans.

[97] Adapted from UNICEF, *Caring for Survivors Training Pack*, 2010.

2. Putting this all together

2.1 How can critical skills be demonstrated?[98]

ROLE PLAY (40 minutes)

1. Explain to participants:
    - In this exercise, we will work on different role plays to practice all of the key skills that we have learned in this training.
    - I will break participants into small groups. Each group will be assigned a scenario, and will have 15 minutes to develop a skit to model the skills and steps the CHW should take in each scenario. In each group, one person should play the CHW, and one person should play the survivor.
    - In each skit, you should consider the following:
        - It is important to share information with survivors about the different health services they can receive, depending on how long is has been since the SV occurred, and to encourage the survivor to receive care from the CHW or the health facility as soon as possible – with their consent. Remember, you should never pressure or force a survivor to do something they do not wish to do.
        - It is important to model the survivor-centered approach, and use the LIVES approach to provide first line psychosocial support.
        - LIVES stands for: listening, inquiring about needs and concerns, validating, and enhancing safety.
        - You must protect survivors' confidentiality, and treat all survivors with compassion, dignity, respect, and non-discrimination.
        - It is essential to obtained informed consent throughout the process, and explain any limits to confidentiality and mandatory reporting requirements.
        - With the survivor's consent, you should share information about the different services that are available, and arrange for referrals as the survivor wishes.
2. Divide participants into three groups, and assign each group one of the scenarios below. Circulate amongst the groups as they develop their skits.
3. After 15 minutes, bring participants back to the full group.
4. After each group presents their skit, provide five minutes for participants to identify the key skills and steps being taken, and share feedback and suggestions. After calling on participants, be sure to read the "Key skills" under each scenario.

[98] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

Ask participants if they have any questions.

Scenario 1: Fatima comes to you with a minor health complaint, but she is distraught and disheveled. You think something more is bothering Fatima, but you are not sure what. The skit should model what the CHW should do next, what questions they should ask and how they should ask them, and what information they should share and how they can share. Fatima ultimately shares that her husband hurt her that morning, but she does not wish to share any more details.

Key skills

- Find a safe, private, comfortable place to talk where Fatima cannot be seen or overheard.
- Be compassionate and supportive when talking with Fatima. Do not pressure Fatima to share information that she does not want to share.
- The CHW should use LIVES, and make general statements, like: "Sometimes, people will come to see me after someone has hurt them. I can help people to access important health services from a safe, confidential provider, or other support services, if they would like. You do not need to tell me anything you don't want to."
- If Fatima agrees, the CHW should share information about the health services Fatima can receive based on when the SV occurred.
- If Fatima agrees, the CHW should share information about the different services that are available, and should make the appropriate referrals for services that Fatima would like to receive.
- The CHW should inquire about Fatima's safety, and should work with Fatima to make a safety plan if Fatima would like.

Scenario 2: Several days after Fatima has come to your to receive care, her sister Nadia approaches you because she is worried about Fatima, and heard that Fatima went to see you. Nadia asks: "Is everything alright with Fatima? Why did she come to you?" Nadia asks many questions. After you do not answer her right away, she becomes upset and angry. The skit should model how the CHW can respond to Nadia while protecting Fatima's confidentiality.

Key skills

- Do not disclose any information about Fatima – the CHW should not confirm that they saw Fatima, or share any information about Fatima's experience.
- Instead, the CHW should explain to Nadia that all services provided by CHWs are private and confidential and that the CHW cannot discuss whether or not any person in the community has received services from a CHW, and that people come to see CHWs for many different reasons.
- The CHW should be polite to Nadia, but firm.

Scenario 3: A 15-year-old boy named Omar comes to you two days after having been sexually assaulted. He is accompanied by his mother. The assault included oral and anal penetration, and he has several injuries and bleeding wounds, but is not exhibiting any danger signs. Omar and his mother are very afraid that the perpetrator will find out they have come for help, and he wishes to receive all available health services.

Key skills

- Find a private, safe, and comfortable location to talk with Omar where the CHW cannot be seen or overheard.
- Obtain Omar's permission to include his mother in the conversation, or not.
- Demonstrate use of LIVES, and provide compassionate, survivor-centered care without judgement or discrimination.
- Obtain informed consent and informed assent, as Omar is a minor, throughout the process.
- If Omar agrees, the CHW should share information about the health services Omar can receive based on when the SV occurred.
- If Omar agrees, the CHW should share information about the different services that are available, and should make the appropriate referrals for services that Omar would like to receive.
- The CHW should inquire about Omar's safety, and should work with Omar to make a safety plan if Omar would like.

STOP HERE if you are working with Level 1 CHWs and go to Module 6 to close the training. You should continue to Module 5 for Level 2 and 3 CHWs.

MODULE 5

Providing community-based care for survivors of sexual violence

SESSION 5.1 Refreshing key skills

Session time	2 hours 35 minutes
Objectives	By the end of this session, participants will be able to: • Understand the different treatments to be provided depending on the time the survivor reports. • Learn how to provide medicines accurately and safely. • Learn how to store medicines. • Review infection prevention measures. • Know how to complete forms and store them safely.
Methods	• Mini lecture • Discussion • Demonstration
Preparation	• Prepare lecture. • Know participants' skills giving medicines accurately and safely. • Learn about standard precaution/infection prevention measures used in the program, and adapt the participants' handout as necessary. • Understand information storage and handling procedures.
Training aids, materials, and handouts	• Flip chart and markers • Flowchart/algorithm on care for survivors of sexual violence (HO) • Table of medicines (HO) • How to give medicines accurately (HO) • How to give medicines safely (HO) • Preventing infection (Basic) (HO) • Intake form (HO) • Monitoring form (HO)
Evaluation and assessment	• None.
Additional resources	• Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021. • IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. • IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. • WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

1. Reviewing treatment options for survivors of sexual violence

1.1 What should happen when survivors report they have experienced sexual violence to the community health worker?

DISCUSSION (30 minutes)

1. Direct participants to refer to the **flowchart** in the participants' packet for care for survivors of sexual assault.

2. Explain to participants:

   - The flowchart is a decision tree for what type of health care CHWs should provide, depending on how soon after the assault the survivors seek care and what type of assault they experienced.
   - If the survivor complains about key symptoms that are danger signs, or presents with signs of a life-threatening emergency, they must be referred immediately to a higher-level health facility.
   - If the survivor does not have any danger signs, you can then follow the steps to go through the flowchart.

Ask: Who can remember the different danger signs that indicate a survivor must be referred to the health facility immediately? Call on participants. Ensure participants list all of the following:

- Swelling and hardness of the belly
- Pain in the belly
- Severe pain anywhere else in the body (back, chest, arms, legs, or head)
- Vomiting blood
- Bleeding from the pelvic area (vagina or anus)
- Heavy bleeding from other parts of the body
- Possible object lodged inside pelvic area (vagina/anus)
- Altered mental state or confusion
- Pale, blue, or gray skin
- In a small child, fast breathing or difficulty breathing
- Is unconscious

3. Go through each of the following scenarios with participants, and discuss all appropriate treatment options for each scenario.

   - If it has been less than three full days since the assault
   - If it has been less than five full days since the assault
   - If it has been more than five full days since the assault

Facilitator's notes

As a reminder, if a survivor presents themself within three days, or 72 hours, they can receive the following if indicated:

- Emergency contraception to prevent pregnancy.
- Antibiotics to prevent or treat sexually transmitted infections.
- Care of wounds.
- Basic psychosocial support.
- Post-exposure prophylaxis to prevent HIV.
- Tetanus vaccination.
- Hepatitis B vaccination.
- Follow-up care.

If a survivor presents themself within five days, or 120 hours, they can receive:

- All of the above, except PEP to prevent HIV.

If a survivor presents themself after five days, they can still receive:

- Antibiotics to prevent or treat sexually transmitted infections.
- Care of remaining wounds.
- Basic psychosocial support.
- Tetanus vaccination.
- Hepatitis B vaccination.
- Follow-up care.

WHO, UNFPA, UNHCR, Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings, 2019.

4. Draw the following table on a sheet of flipchart paper. Direct participants to follow along with the pictorial table in their packet. For each type of medicine or vaccination, review when it can be taken, and whether or not it must be cold.

Activity	Up to when should a survivor receive the medicines after the assault?	Does the medicine need to stay cold?
Antibiotics to prevent or treat sexually transmitted infections	Anytime	No
Emergency contraception (pills) to prevent unwanted pregnancy	5 days	No
Post-exposure prophylaxis to prevent HIV	3 days	No
Tetanus vaccine	Anytime (through referral if needed)	Yes
Hepatitis B vaccine	Anytime (through referral if needed)	Yes

4. Reassure participants know that each step in the **flowchart** will be discussed in detail over the course of the training.

Ask participants if they have any questions before moving on to the next section.

2. Reviewing key skills to providing health care to survivors

Facilitator's notes

The following sections on giving medicines accurately and safely are particularly useful for CHWs who may not be comfortable dosing medicines by age, weight, pregnancy status, or allergies. This knowledge will be helpful in interpreting the pictorial protocols that will be discussed in detail for each treatment. However, these sections can be shortened if CHWs have substantial experience, or if pre-packaged treatment packets will be used in the pilot, in which case CHWs will have little or no opportunity to determine dosing. **You should still review storage of medicines and infection control with all participants.** Corresponding handouts are available in the participants' packet. You should encourage all participants to following along using the handouts.

2.1 How can medicines be given accurately?

MINI LECTURE[99] (40 min)

1. Tell participants:
   - In order to be able to give medicines to survivors, you must know:
     - What the medicine is called.
     - In what forms the medicine comes.
     - How to take the medicine correctly (dose and frequency).
     - Whether the medicine is safe to give.
     - If the medicine causes side effects.
     - What happens if a survivor takes too much or not enough of the medicine.
     - What to do if the survivor is already pregnant, is breastfeeding, or has an allergy.
   - Medicines come in different forms. Tablets, capsules, and liquids are usually taken by mouth. Injections are given with a needle directly into a person's muscle, tissues, or under the skin. Creams or ointments that contain medicine are applied directly to the skin.
   - Many medicines, especially antibiotics, come in different weights and sizes. To be sure you give the survivor the right amount, you should check how many grams, milligrams, or micrograms each pill or capsule contains.
   - Now, I will share some information about measuring medicines that will help you to understand the treatment protocols. We will have plenty of practice as we work through the protocols.

[99] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- Draw the below amounts on flip chart paper, including what that means when cutting a tablet.

  1 tablet = one whole tablet 

  ½ tablet = half of a tablet 

  1 ½ tablet = one and one-half tablets 

  ¼ tablet = one quarter or one-fourth of a tablet 

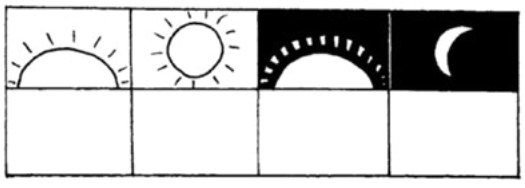
- Tell participants:
  - There are also different types of measurements. Medicine is usually weighed in grams (g) and milligrams (mg).
  - 1,000 mg = 1 g (one thousand milligrams makes one gram) Write this on the flip chart paper.
  - 1 mg = 0.001 g (one milligram is one-thousandth part of a gram) Write this on the flip chart paper.
- Tell participants:
  - Some medicines, particularly for children, are weighed in milligrams or even smaller amounts called micrograms (mcg or µcg).
  - 1 µcg = 0.001 mg (write th
  - This means there are 1,000 micrograms in a milligram.
- Next, tell participants:
  - Other medicines are measured in units (U) or international units (IU).
  - For liquid medicine given to children, amounts are in milliliters or cubic centimeters. A cubic centimeter is the same as a milliliter.
  - If the medicine does not come with a special spoon or dropper to measure liquid, household measures can be used.
- Draw on the flip chart:

  1 tablespoon = 1 Tb = 15 ml 

  1 teaspoon = 1 tsp = 5 ml 

- Then, tell participants:
  - Some medicines are also based on a person's weight, so that a survivor receives a certain amount of medicine for every kilogram they weigh.
  - If a scale is not available, CHWs should estimate how much the person weighs.
  - The treatment protocols for adults and children provide instructions on how to decide how much medicines CHWs should give.

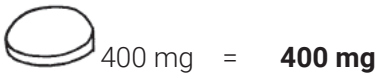
- Ask participants if they have any questions about the information about dosing medicines.
- Next, tell participants:
  - It is important for the survivor to take medicines at the right time. Some medicines should be taken only once a day, but others must be taken more often.
  - A clock is not needed. If the directions say, "1 pill every 8 hours," or "3 times a day," you can advise the survivor to take one pill at sunrise, one in the afternoon, and one at night.
  - If the instructions are "1 pill every 6 hours," or "4 times a day," the survivor should take one in the morning, one at midday, one in the late afternoon, and one at night.
- Draw the picture below on flip chart paper. Show how participants can use this to help survivors know what time to take what medicine.



DEMONSTRATION (15 minutes)

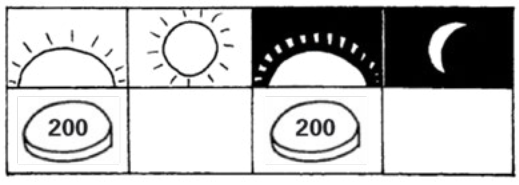
- Tell participants:
  - In this demonstration, we will practice filling out the time table and providing instructions for survivors using different types of medicines.
  - In this example, one medicine comes in two sizes: in a 200 mg pill, and in a 400 mg pill.
- Draw on flip chart paper:

- Tell participants:
  - The survivor needs to take 400 mg, by mouth as a single dose. You have 200 mg tablets. Therefore, the survivor needs to take 2 tablets.
  - If you have 400 mg tablets, the survivor only needs to take 1 tablet.
- Draw on the flip chart paper:



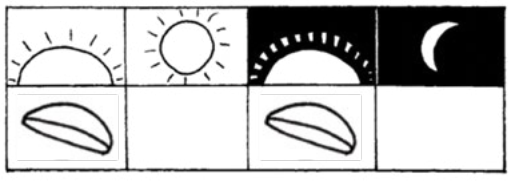
- Tell participants:
  - In this example, the survivor needs to take 200 mg of medicine 2 times daily. You have 200 mg tablets. What should you draw on the timetable? Call on participants, and then draw:


200 mg



- What about if the survivor needs to take 200 mg of medicine 2 times daily. You have 400 mg tablets. What should you draw on the timetable? Call on participants, and then draw:


400 mg



Ask if participants have any questions before moving on to the next section.

2.2 How can medicines be given safely?

MINI LECTURE[100] (15 minutes)

Explain to participants:

- There are important steps we need to take to ensure that we are giving medicines safely.
- Any time we give medicines to survivors, we must also give the survivor clear instructions. This includes instructing survivors:
  - On how to take it, including how much to take (dose), and how often to take it each day and for how many days.
  - To take all of the tablets for as long as advised. If they stop taking the medicine too soon, the problem may not have been cured and could become worse. It is very important for CHWs to inform survivors to finish all of the medicine.
  - On the side effects the medicine can cause, and how to address them.
  - On whether the medicines should be taken on a full or empty stomach.

100 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

  - On whether or not they can take medicines at the same time. The medicines that you can provide after someone has experienced SV can all be taken together.
  - To keep medicines in a cool, dry place and out of reach of children.
- It is also important to check that medicines are not expired before you give them to the survivor. You can usually find the expiration date in small print on the package or bottle.
- Doxycycline or tetracycline (antibiotics) especially should not be used after the expiration date has passed since they may be harmful.
- You should not give pills that are starting to fall apart or change color, or capsules that are stuck together or have changed shape.
- You should also tell survivors not to take more medicines than the amount they are told to take. Sometimes, people think that this will make the medicines work faster. This is not true and can be dangerous. If the survivor takes too much medicine at one time or too often, or if they take some medicines for too long, the medicine may harm them.
- More information on **how to give medicines accurately and using medicines safely** are available in the participants' packet.

Ask participants if they have any questions before moving on to the next section.

2.3 How should medicines be stored?

MINI LECTURE[101] (5 minutes)

Tell participants:

- It is important to store medicines properly, to make sure they will work.
- None of the medicines that level 2 CHWs will provide need to be refrigerated.
- However, you should keep medicines in a cool, dry place and out of reach of children. They should also be sheltered from dust and dirt.
- If you are given a medicine pouch or bag, they can store the medicines inside and keep the bag in a cool, dry place.
- **You should refill your supply of medicines through the health facility or program staff (as appropriate) BEFORE you have given out the last treatment.**

[101] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

2.4 How can infections be controlled when caring for survivors?

Facilitator's notes

Learn about standard precaution measures/infection control procedures for the program, and adapt the below and participants' handout as necessary.

MINI LECTURE[102] (10 minutes)

Tell participants:

- As healthcare providers, we must take steps for basic infection control when we are treating survivors.
- Infections are caused by germs that are too small to see. Every person carries germs, and any equipment and tools used to care for survivors will need to be cleaned of any germs.
- The four steps for basic infection control are:
  - Washing hands with soap and running water before and after giving care , especially after touching blood and other fluids from the survivor. If blood or body fluids splash into their eyes or mouth, rinse immediately with plenty of clean water.
  - Covering any cuts or open wounds on their hands, through bandages, gloves, or a clean plastic bag.
  - Avoiding any direct contact with blood by, for example, asking the survivor to put pressure on the wound themselves, and using plenty of cloth or dressing.
  - Cleaning blood spills on tables and floors, and appropriately disposing of dirty bandages and used cloth.
- If you prick or wound yourself when handling blood or body fluids, you should wash the area well with soap and clean water, and notify you supervisor or health facility staff right away.
- You should make sure you are protected against tetanus, too. If you have not had a tetanus shot in the last ten years, you may consider getting one.
- You can find a handout on **basic infection prevention** in your participant packet. An additional handout is also available for more advanced infection prevention, if you will be using tools that will need to be disinfected.

Ask participants if they have any questions before moving on to the next section.

[102] IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009. Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth and women's health*, 2021.

3. Completing the intake form

3.1 What is an intake form?

MINI LECTURE[103] (10 minutes)

Explain to participants:

- The **intake form** is a document where CHWs will note the care they provide to survivors.
- It is an important form to track the survivor's progress as they begin to heal.
- For security reasons, the form does not include any space to note the survivor's name or the perpetrator's name. You should not write any information that could identify the survivor on the form.
- If the survivor wishes to eventually report the assault to the police or the justice system, a copy of the intake form may serve as documentation that the survivor sought health care for SV.
- The original intake form should therefore be safely stored in the event that the survivor would like to use it.
- The survivor may also wish to keep a copy of the intake form for their records, although the safety of this should be discussed with the survivor. If the survivor requests a copy of the form, you should ask whether or not having the form at home could put them at risk – for example, if other people were to find the form. This is especially important for survivors experiencing IPV. You can talk with the survivor about where in their home they may be able to safely keep the document, where other people will not accidentally find it.
- The survivor has the sole right to decide whether and when to use this document.[104]

[103] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

[104] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Facilitator's notes

When health care providers care for survivors, a medical certificate is often provided that summarizes the survivor's history and findings with the specific purpose to use in court if the survivor chooses this option and legal justice is available. The intake form, which CHWs complete, is a medical record that serves to remind them about the history and care provided. While a medical certificate can serve as important evidence for future pursuance of legal justice, the medical certificate is beyond the scope of services that CHWs can provide. Protocol can instead be established in the pilot sites for CHWs to develop a duplicate copy of the intake form should the survivor request written information and the survivor understands any potential security risks to possessing such documentation.

Documentation of the survivor's medical history, and in particular on pre-existing symptoms or previous treatment for STIs, should be handled very carefully to avoid stigma and discrimination. All survivors, whether or not they report STI-like symptoms, will receive the same supportive treatment and counseling services. If medical documents are ever presented in court, the fact that a survivor was treated for a possible pre-existing infection or STI exposure may be used against them.

3.2 How are the intake forms and monitoring forms completed?

DEMONSTRATION[105] (10 minutes)

- Explain to participants:
  - In addition to the intake form, you will also a **monitoring form** since the intake form is particularly confidential.
  - This form will help the program see when survivors are reporting, what kind of care they are receiving, and what types of referrals they are requesting.
  - Once you complete an intake form, you are responsible for copying the information into the monitoring form so that the information from all survivors is on one form that can be submitted to program staff on a routine basis.
  - It is very important to write as neatly as possible! You need to be able to read you own writing, and program staff also need to be able to read what you wrote.
- Review the intake form with participants so that they know what it looks like. Let them know that they will go through each section as the treatment is discussed, and then they will practice filling out the form.
- Review the monitoring form so that they can see where each section of the intake form corresponds to the columns of the monitoring form. Point out also that the monitoring form does not note any identifying information (names of the survivor).

[105] UNICEF, *Caring for Survivors Training Pack*, 2010.

3.3 How should the intake forms and monitoring forms be stored?

Facilitator's notes

Before introducing this section, confirm with program staff that they have determined correct steps for data handling and storage. These include steps such as:

- Where will any intake forms, as well as other documentation, be stored?
- Who has access to the confidential information?
- If program monitoring is conducted in a central office, how will information about provided services be sent safely and confidentially to the centralized location for monitoring purposes?

MINI LECTURE[106] (10 minutes)

Tell participants:

- You must be sure to store and manage any information collected from survivors safely.
- All medical and health information related to the survivor should be kept confidential at all times, even from family members (unless the survivor is a child).
- Any information that is written about the survivor and what care has been provided—including the intake and monitoring forms—cannot be shared with anyone without the survivor's consent.

Review with participants where they should keep completed intake and monitoring forms, and procedures for reporting the data to program staff.

Ask participants if they have any questions before moving on to the next section.

106 WHO, *Ethical and Safety Recommendations for Researching, Documenting and Monitoring Sexual Violence in Emergencies*, 2007.

SESSION 5.2 Providing basic community-based health care to survivors of sexual violence in settings with minimal resources

Session time	9 hours 30 minutes
Objectives	By the end of this session, participants will be able to: • Prepare the survivor to receive treatment. • Take a health history. • Provide presumptive treatment for STIs. • Test for pregnancy (optional). • Provide options for counseling and medication abortion as needed. • Provide emergency contraception to prevent pregnancy. • Test for HIV (optional). • Provide post-exposure prophylaxis (PEP) to prevent HIV. • Provide wound care with basic first aid. • Provide supportive counseling. • Provide or refer for tetanus and hepatitis B vaccines. • Close the consultation.
Methods	***MINI LECTURE*** • Role play • Discussion • Case study • Activity • Scenario
Preparation	• Prepare training session and gather necessary materials. • Know and adapt treatment protocol handouts for STI prevention, EC, and PEP, as well as the table of weight-based treatment for antibiotics to the local context. • Know if/where referrals are available for tetanus and hepatitis B vaccines.

Training aids, materials, and handouts	• Informed consent scripts (HO) • Flowchart/algorithm on care for survivors of sexual violence (HO) • Questions on taking a health history (HO) • Intake form (HO) • Medicines for types of sexual violence (HO) • Monitoring form (HO) • STI presumptive treatment protocol (HO) • Table of weight-based treatment for antibiotics (HO) • Estimating pregnancy (HO) • Medication abortion (HO)	• Medication abortion for survivors (HO) EC treatment protocol (HO) • PEP protocol (HO) • Controlling minor bleeding (HO) • Cleaning a wound (HO) • Bandaging a wound (HO) • Providing basic first aid for burns (HO) (optional) • Providing basic first aid to survivors with injuries to bones, muscles, or joints (HO) (optional) • Offering basic life support (HO) (optional) • Infection prevention (Basic) (HO)
Evaluation and assessment	• Scenario/role play to bring learning altogether.	
Additional resources	• WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. • IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. • IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. • IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009. • IFRC, *International first aid and resuscitation guidelines*, 2020. • IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012. • Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021. • WHO, *Psychological first aid: facilitator's manual for orienting field workers*, 2013.	

1. Preparing the survivor

1.1 How should we prepare the survivor to receive treatment?

MINI LECTURE[107] (15 minutes)

Ask: Reflect on what we have learned so far about what CHWs must do before they begin to provide care to survivors. What are the steps we need to take to prepare the survivor? Call on as many participants as wish to speak.

Tell participants:

- Be sure to take the survivor to safe, private place where they will not be seen or overheard. They should be able to sit to be comfortable, and not be required to move from room to room.
- Introduce yourself.
- Reassure the survivor that everything that is discussed will be kept confidential, and that you will only share the survivor's information with others who can provide additional services if they agree. Explain any mandatory reporting requirements if applicable, and the circumstances in which you cannot keep confidentiality. You must do this before you begin collecting information.
- Offer comfort and understanding, using the LIVES approach.
- Reassure the survivor that they are in control of the pace, and what happens during the interaction.
- Do not force or pressure the survivor to do anything against their will. Explain that they can decline or refuse any part of the services, and at any time.
- Explain what is going to happen during each step of the process, including what types of questions you will and will not ask, and why you will ask those questions. Explain what types of care you can provide, and what types of services you can refer them to.
- Ask the survivor if they have any questions.
- Ask the survivor if they would like to have a specific person present for support. Try to ask this when they are alone, especially if the survivor is with a family member (e.g., their father) or their partner. The number of people allowed in the room should be limited to the minimum necessary. Police officers, members of the military, or other security personnel should NEVER be present in the room.
- Ask whether the survivor consents/agrees to receive help. Make sure the survivor has been informed of all possible information and options available, and any benefits and risks of what they will receive. If they consent to receive treatment, you should note this on the intake form.

[107] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. UNICEF, *Caring for Survivors Training Pack*, 2010.

Special considerations

If the survivor has a cognitive or intellectual impairment, CHWs should be especially sure to explain the process very slowly and clearly and in a language they can understand. CHWs should not skip the process of obtaining consent or assent, even if they assume that it is not necessary or that the survivor may have difficulty understanding. CHWs should clearly document the steps they took to obtain consent/assent in the notes section of the intake form, and any support from interpreters, caregivers, and/or support persons, that the survivor may have had in the decision-making process.

ROLE PLAY[108] (30 minutes)

1. Tell participants:
   - This exercise is an opportunity to practice obtaining informed consent and assent to provide direct care.
   - Obtaining informed consent or assent is more than just reading a script to a survivor. It involves helping the survivor understand what to expect when receiving health care and to answer any questions they might have.
   - This is an important and difficult skill to master, and requires practice.
2. Divide participants into pairs and distribute the informed consent scripts (handout). One participant will act as the CHW (provider) and the other will play the role of a survivor (adult, child, or person with an intellectual impairment). Tell participants they will role play the consent process. Where appropriate, the person portraying the survivor should ask for more explanation.
3. Move between groups throughout the room and offer suggestions or constructive comments. Make note of problems that many groups are having and the areas in which they do well. Then, have participants change roles.
4. After finishing the role play, ask participants to share how they felt as they played the role of provider and obtained informed consent. Was it difficult to explain? Do they have any questions? How did the "survivors" feel?
5. End the exercise by pointing out some of the positive points that you noticed during the exercise, as well as areas for improvement.

[108] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

Facilitator's notes

Make your comments general and do not identify specific groups or individuals as you share your observations. For example, if you noticed that in several groups the "provider" was speaking very fast and did not stop to ask the survivor if they had questions, you might say, "Remember how important it is during this process to engage the survivor. Some survivors will be too scared to ask questions. CHWs 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." When asking whether a survivor has questions, it is helpful to use phrases such as, "What questions do you have?" or "What questions may I answer for you?" This will keep the phrasing open-ended.

With survivors with disabilities, stress that it is important to talk directly to them (and not to their caregivers), explain the process in language they understand, and give them choices as with everyone else.

Adapted from: International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

2. Taking the survivor's history

2.1 How should the survivor's history be taken?

MINI LECTURE[109] (20 minutes)

Tell participants:

- In order to provide good quality care to survivors, you will first take a health history.
- This is where you learn more about the survivor's general health, what happened during the incident of sexual violence, current symptoms they are experiencing, and their past medical issues. Based on what you learn, you can then follow the **flowchart** on what care to provide.
- Before taking the history, you should review any documents or paperwork brought by the survivor, especially if they have been referred from another service. This will help make sure that you do not ask questions that have already been asked and documented by other people involved in the case. Having to tell the whole story over and over again to many people is re-traumatizing.
- When you take the history, you should use the survivor-centered approach and communications skills we have discussed, like:
  - Be patient and do not press for more information if the survivor is not ready to speak about their experience.
  - Ask survivors only relevant questions.
  - Do not discuss or ask about the survivor's sexual history, as this is not relevant to the care to be provided.
- **You should NOT be asking the survivor to undress,** especially their private areas, since this is not necessary for taking a history, and knowing whether or not a referral is needed.
- You should explain to the survivor what you are going to do at every step.

[109] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Special considerations

Working with child survivors: When communicating with a child survivor, you should take steps to build trust and creating a safe environment. You can help the child feel comfortable by allowing a parent or caregiver to accompany them, unless there is reason to believe that the adult is the perpetrator. Talk to the child in words they understand, and sit at their eye level. Assure them that they are not in any trouble. Allow them to use dolls or draw pictures to communicate.

The age and developmental stage of children should be considered when talking with children:

Infants and Toddlers (0–5 years old): Children in this age range should not be asked directly about their abuse. The non-offending parents/caregivers should be the primary sources of information about the child and suspected abuse.

Younger Children (6–9 years old): Children in this age range can be directly interviewed by the service provider, although, if possible, additional information should be gathered from trusted people in the child's life. The children may have a difficult time answering general questions, resulting in children saying, "I don't remember" or "I don't know" often, or they may give vague responses such as "The man did a bad thing," but fail to share more. Caregivers/parents or someone the child trusts can be involved as long as the child requests that the adult be present (and the adult is not a suspected abuser). Children benefit greatly from a mixture of both verbal and art-based communication techniques.

Younger and Older Adolescents (10–19 years old): Children and adolescents in this age range can be directly interviewed by the service provider. Open-ended questions can produce important information about SV. Caregivers/parents or someone the adolescent trusts can be involved as long as the adolescent requests that the adult to present (and the adult is not a suspected abuser). Adolescents have more capacity to communicate, but service providers should remember they are also still developing.

When working with child survivors:

- Ask the child if they would prefer to speak with a female or male CHW or interpreter or, if available, a trained CHW who identifies with the LGBTQIA+ community. In principle, female CHWs should speak with girl survivors.
- Listen actively and empathically to the child, and believe them when they speak.
- Be nurturing, comforting, and supportive.

- Reassure the child that they are not at fault for what has happened to them and that you believe them.
- Provide age-appropriate information in an age-appropriate manner and environment.
- Do no harm: Be careful not to traumatize the child further. Do not become angry with the child, force the child to answer a question they are not ready to answer, force the child to speak about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people.
- Tell the child why you are talking with them.
- Pay attention to nonverbal communication. A child may demonstrate feelings of distress by crying, shaking, or hiding their face, or changing their body posture. Be aware of the cues your body language is giving as well, to gain the child's trust.
- Respect the child's opinions, beliefs, and thoughts.

From: International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. Page 75; IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012. Page 74; WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. Page 37.

ROLE PLAY[110] (20 minutes)

- Tell participants:
  - In this activity, we will do a role play to practice and demonstrate active listening skills.
  - We will break into groups of three, with a speaker, a listener, and an observer.
  - When you play the speaker, you can talk about a real experience in your life, but you do not need to share anything private, or embarrassing. Sharing a real part of your life, however, will make this exercise more interesting and useful. Be sure to pause often to encourage the listener to respond, even though this may seem a little unnatural.
  - When you are the listener, practice active listening techniques. Acknowledge and confirm what the speaker says by repeating, "I heard you say…" Summarize to see if you understand correctly. Try to ask open-ended, non-judgmental questions, such as, "would you tell me more about that?" to obtain more information.
  - When you are the observer, you should concentrate on the person in the listener role, looking for as many active listening skills as possible. Then, you can share feedback at the end of the role play.
  - Each interview will last five minutes.
- Break participants into groups of 3.
- Have the small groups repeat the process, taking turns to play the different roles.

110 International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

2.2 What questions should be asked to a survivor when taking a health history?

Facilitator's notes

The questions below are the minimum questions to ask a survivor to ensure they receive the care that they need. A flow chart has been developed for this purpose, which accompanies the intake form. The intake form where the care provided is documented has been simplified to list only critical information. Note that neither the name of the survivor nor information on the perpetrator is collected for security reasons.

If capacity exists for a more detailed examination, the WHO history and examination form may be best to use. See Annex 4 of WHO, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

MINI LECTURE[111] (60 minutes)

Tell participants:

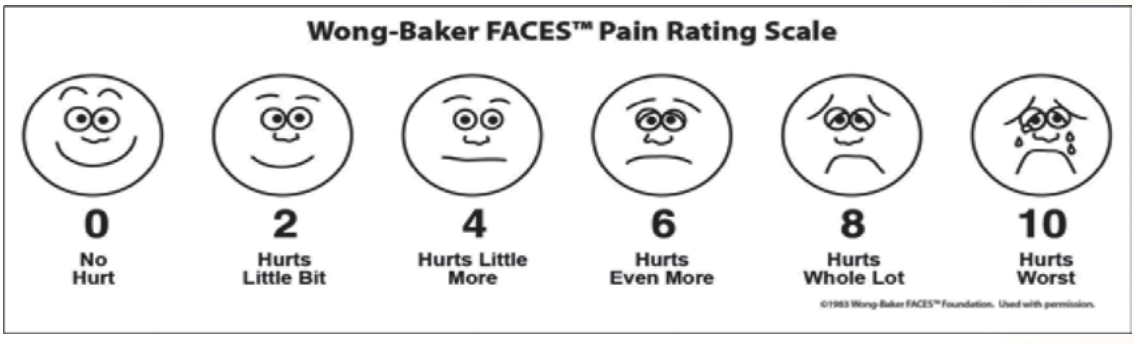
- Learning a survivor's basic health history will guide you to provide the appropriate care.
- There is a **handout of questions on taking a health history** for CHWs to follow in the participants' packet. Note that this handout is not a flowchart, but should serve as a guide to make sure CHWs do not skip a step.
- As you take the survivor's health history, you should make sure to record the relevant information on the **intake form** to avoid asking the same questions repeatedly.
- The health history includes:
  - Age.
  - Gender.
  - Vaccination status.
  - Medications and allergies.
  - Incident history.
  - Current signs and symptoms.
  - Other relevant information from the survivor's medical history.

[111] International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Direct participants to follow along on the form as you present each part of the form.

- **For age:**
  - Ask the survivor their age. Note this on the intake form.
  - Take note of the pubertal stage of the survivor and ask an adolescent girl if she has begun menstruating. If the survivor is a woman, adolescent girl, or transgender man who has reached puberty (including development of breast buds), they may be eligible to receive EC to prevent pregnancy.
- **For gender:**
  - Ask the survivor their gender and their pronouns, if the language uses different pronouns for different genders (such as she/he/they).
  - Write exactly what they say, even if it does not fit a pre-determined category. Possibilities could include: woman, man, transgender man, transgender woman, non-binary, gender-nonconforming, etc.
  - Do not question or judge the survivor if they use a gender that does not align with your perception of them.
- **For vaccination status:**
  - Ask the survivor if they have been vaccinated against tetanus and hepatitis B. Note this on the intake form.
  - A survivor who is fully vaccinated will not need to receive these vaccines.
  - A survivor who is not vaccinated or does not know their vaccination status can receive these vaccines if they are available. It will not harm the survivor to be vaccinated again.
- **For medications and allergies:**
  - Ask the survivor if they are currently taking any medications.
  - Also ask if they have any known allergies to medicines. Note these on the intake form.
  - If they do not know, ask if they have ever developed hives, itching, swelling, or trouble breathing after taking a medicine.
- **For the incident history, you will only ask questions to obtain information you need to provide appropriate care. This will include:**
  - The date of the incident.
  - If the survivor experienced physical violence.
  - What type of penetration the survivor experienced, if any.

- **For the date of incident:**
  - Ask the survivor what day and time they experienced sexual violence. Note this on the intake form.
  - If the incident was less than three days ago, they may be eligible to receive PEP to prevent HIV.
  - If it was less than five days, women, adolescent girls, and transgender men who still have ovaries and a uterus may be eligible to receive EC to prevent pregnancy.
- **For physical violence:**
  - Ask the survivor if they experienced any physical violence or injury.
  - Ask them where on their body they have experienced the physical violence.
  - They may require wound care or a tetanus vaccine if the violence resulted in broken skin.
- **For penetration:**
  - This is a very sensitive question, that should be asked very carefully.
  - Ask the survivor if they were penetrated vaginally, anally, or orally (through the vagina, anus, or mouth). Note this on the intake form.
  - They may require PEP to prevent HIV, antibiotics to prevent STIs, hepatitis B vaccine, and EC to prevent pregnancy (for women, adolescent girls, and transgender men with ovaries and a uterus).
- **For current signs and symptoms, you will be asking about pain and bleeding.**
- **For pain:**
  - Ask the survivor if they are experiencing any pain, and where the pain is located.
  - Ask them how severe the pain is on a scale of 0 (no hurt) to 10 (hurts worst) using the *FACES Pain Rating Scale* (below).[112]



[112] Wong-Baker FACES Foundation, *Nursing Care of Infants and Children*, 1983. Used with permission.

- A survivor who is experiencing some pain may receive anti-pain medication (paracetamol).
- **A survivor who is experiencing severe pain or any belly (abdominal) pain should be referred quickly to higher-level health care.**
- There are different possible causes of belly pain related to SV. This could be from internal injuries, if the SV was very recent.
- If the SV happened more in the past, it could be from a bladder infection, or pelvic inflammatory disease, if the survivor has an untreated STI.
- It could also be from complications from an abortion.
- It is very hard to tell the cause of belly pain without tests or special equipment.
- Any survivors with belly pain must be referred to the health facility right away!

- **For bleeding:**
  - Ask the survivor if they are experiencing any vaginal bleeding or discharge, or bleeding from the anus. **A survivor who reports vaginal bleeding or discharge, or bleeding from the anus, will need to be referred to a higher-level health facility.**
- You will also need to know some information about the survivor's medical history to provide appropriate care, including pregnancy and HIV status.
- You do not need to ask any questions about the survivor's sexual history.
- **For pregnancy:**
  - Ask the survivor if they are currently pregnant. Note this on the intake form. A survivor who is pregnant will not need to receive EC and must receive antibiotics that are safe to take during pregnancy to prevent STIs. A survivor who is not pregnant or is unsure whether or not they are pregnant can all receive EC.
- **For HIV status:**
  - Ask the survivor if they know their HIV status. Ask the survivor if they are HIV positive. Note this on the intake form.
  - A survivor who is HIV positive will not need to receive PEP.
  - If they are HIV negative or do not know their HIV status, they can receive PEP.

Special considerations

Adapting the history for a child survivor: When taking the history of a child survivor, take a few minutes to talk to the child in private, separate from their parent or caregiver – depending on their age, as noted above.

Questions for the child survivor include:

- Has something like this happened before?
- Is the person who did this someone you know?
- Did they say something bad would happen if you told anyone?
- Are you having symptoms like bleeding from your private area, burning when you pee, a smelly or colored fluid from your private area, or difficulty walking?
- Is there anything else you would like to talk about?

For girls, depending on age, you can ask about menstrual and pregnancy history. You should NOT ask about their sexual history.

If the child gives information that suggests they are being abused by a family member or parent, the CHW will need to ensure the child has a safe place to go (not home with the suspected abuser).

If the child reports symptoms suggestive of trauma, such as vaginal or anal bleeding, they should be referred for higher-level care. If the child reports symptoms suggestive of an STI, such as abnormal vaginal discharge or penile discharge, they should be treated for a presumed STI (see Advanced Module 8).

The CHW should NOT attempt to perform a genital exam, since this is beyond the scope of their role, and they can still provide care.

From: IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020. WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. Page 37.

Special considerations

Adapting the history for a male survivor

When taking a history from men and boy survivors, it may be helpful to know that their symptoms may be vague, such as body aches, generalized pains with no clear injuries, and headaches. Back pain may be a sign of sexual victimization due to genital, rectal, or abdominal trauma, physical or psychological trauma responses, or STIs. CHWs could keep an open mind, as survivors may not associate their experience with SV, but with torture or abuse. Other tips include:

- Offer the option of a man or a woman health provider, and never assume who the survivor would prefer to speak to. Where a provider of the preferred gender is unavailable, offer a trained chaperone of the preferred gender to accompany the survivor.
- To help reduce self-blame, reassure survivors that the assault was not their fault and that many other men and boys have also been victimized.
- Acknowledge the difficulty in seeking care and validate their courage in doing so.
- Use and reflect back the language and terms that the survivor uses (as appropriate); be sensitive to terms such as "sexual violence," "rape," "victim," and "survivor."

Women's Refugee Commission, *Addressing Sexual Violence against Men, Boys, and LGBTIQ+ Persons in Humanitarian Settings: A Field-Friendly Guidance Note by Sector*, 2021.

Special considerations

Adapting the history for people with diverse SOGIESCs

When taking a history from people with diverse SOGIESCs, the key factor that determines the course of treatment is whether or not the person has female reproductive anatomy: namely, a uterus and ovaries. Some people may be on hormone therapy to develop physical characteristics that align with their gender, but still possess the anatomy they were born with at birth. Others may have undergone surgical procedures to change their reproductive anatomy. As such, CHWs can politely Ask: Have you ever had surgery to remove or change any of your organs responsible for pregnancy? You can explain that you are asking to ensure you provide the best possible care, and reassure the survivor that all information they share with you will be kept confidential.

Whether or not a person of reproductive age is still menstruating does not have bearing on their care, as all persons with a uterus and ovaries should be given EC to prevent pregnancy.

As you go through the next section, draw the table below on flip chart paper. A similar **handout of medicines for types of sexual violence** is available in the participants' packet.

Activity	Sexual assault	Anal assault	Oral assault
Antibiotics to prevent or treat sexually transmitted infections	Yes	Yes	Yes, for gonorrhea, chlamydia, and syphilis No, for trichomoniasis
Emergency contraception (pills) to prevent unwanted pregnancy	Yes	Yes	No
Post-exposure prophylaxis to prevent HIV	Yes	Yes	Yes
Tetanus vaccine	Yes	Yes	No, unless there are wounds in/around the mouth or >10 years since last vaccine
Hepatitis B vaccine	Yes	Yes	Yes

Facilitator's notes

While EC is typically not necessary for anal assault, given that CHWs will not be asking detailed questions about the assault to determine the risk of sperm leaking into the vagina, the position of the assault or location of ejaculation; and survivors may not be familiar with their reproductive anatomy, EC should be provided in cases of anal assault in the pilot project.

For oral assault, presumptive treatment for trichomoniasis is not necessary. The tetanus vaccine only needs to be provided if there are wounds in or around the mouth, or if the survivor has not been vaccinated in 10 years.

While typically, survivors are asked whether or not they are using a method of family planning, CHWs will not be asking this question, due to added challenges to determine if EC is warranted, or if any risk of pregnancy exists. **As such, in this pilot, EC should be provided to all survivors of reproductive age with female anatomy, who have experienced vaginal or anal assault, even if they were using a method of family planning at the time of the assault.**

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019; and WHO/ILO, *Post-exposure Prophylaxis to Prevent HIV Infections, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infections*, 2007. Additional communications with UNFPA; October, 2013.

Facilitator's notes

While guidelines for clinical providers include a physical and genital exam, CHWs will NOT be trained in performing physical or genital exams as part of their intake or follow-up, as they will be referring survivors for higher-level care if they present with concerning symptoms, and they are also not responsible for collecting forensic evidence. Often, findings can be difficult to interpret and it will be difficult for the CHW to determine what to do with the information, which may cause unnecessary referrals that survivors may not desire, or place CHWs in a difficult position of figuring out if a finding is normal or abnormal. They can still provide first line care to survivors of SV and IPV where access to facility-based care may be challenging.

The exception for genital exams is CHWs 3 if they are the provider of last resort, if they have prior training in pregnancy-related care, and if they need to suture wounds or provide other emergency care. Genital exams in adults or children are not covered in this training.

3. Providing presumptive treatment for sexually transmitted infections

3.1 What are sexually transmitted infections?

MINI LECTURE (5 minutes)

Tell participants:

- Sexually transmitted infections (STIs) are infections that are passed from one person to another during sexual contact, including SV.
- All people, no matter their gender or age, can have an STI.
- Some common STIs are gonorrhea, chlamydia, human papilloma virus (HPV), trichomoniasis, syphilis, chancroid, herpes, hepatitis B, and HIV.
- Share with participants the STIs that are most common in their community (if known).
- If a person has any of these signs, they may have an STI:
  - Abnormal discharge from the vagina or penis, including discharge that is thick, bloody, cloudy, white, yellow, green, and/or bad smelling
  - Itching genitals or anus
- As a reminder, STIs are infections passed from one person to another during sexual activity,
- A survivor of SV is at risk for STIs if they experienced vaginal, anal, or oral penetration.

Ask: Can anyone share examples of common STIs? Call on participants.

- Common STIs include gonorrhea, chlamydia, syphilis, HIV, and trichomoniasis.

Ask: Can anyone share symptoms and signs of STIs? Call on participants.

- The signs of STIs include:
  - Abnormal discharge from the vagina or penis, including discharge that is thick, bloody, cloudy, white, yellow, green, and/or bad smelling.
  - Itching genitals or anus.
  - Painful genitals or anus.
  - Swelling of the genitals.
  - Pain during urination
  - Warts, sores, bumps, or blisters on and/or around the genitals or anus
  - Pain in the pelvis or belly, or pain during sex.
  - Bleeding during sex

- **Many people who have an STI will not have any signs or symptoms.**
- Even if someone has no signs or symptoms of infection, they can still pass the STI to other people.
- HIV will be discussed in more detail later.

3.2 How can sexually transmitted infections be prevented and what are the medicines to provide survivors?

Tell participants:

- **If a survivor had sexual contact with the perpetrator's genitals, either in or around their mouth, vagina, or anus, they are at risk of contracting an STI and should be offered medication, whether or not they have any signs or symptoms of an STI.**
- **The antibiotics will prevent any bacterial STIs the survivor might have been exposed to and treat any bacterial STIs the survivor might already have.**
- The antibiotics given to a survivor depend on the amount of time that has passed since the assault.
- Doses should be based on protocol and will differ depending on the survivor's age and weight, and whether the survivor's age and weight, and whether they are pregnant.
- The medication that is given to prevent STIs after an assault is a combination of the same medication that is given to treat some STIs, such as gonorrhea, chlamydia, and syphilis.

Special considerations

Some antibiotics are not safe for pregnant people. If the survivor is pregnant, they should be treated according to appropriate guidelines. Children will require very specific antibiotic dosages based on weight and age.

IAWG on RH in Crises, "Chapter 3: MISP," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

DISCUSSION*[113] *(30 minutes)

1. Direct participants to find the pictorial **STI presumptive treatment protocols for adults and children**, as well as the **table of weight-based treatment for antibiotics.**[114] Direct participants to follow along with the protocols in their These should be in the participants' packet.
2. Review the treatment protocol in detail, and encourage participants to ask any questions they may have, especially regarding doses for pregnant people or those with allergies to certain medications. Make sure participants understand how to read the protocols and tables.

[113] Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

[114] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

3. Tell participants:
    - You should always refer to the protocol when you are providing care to ensure the survivor receives the right antibiotics in the correct amount.
    - Survivors should always be given the shortest course of treatment. For example, if the survivor presents within 30 days of the incident, 400 mg of cefixime and 1 g (1,000 mg) of azithromycin by mouth can prevent gonorrhea, chlamydia, and syphilis.
4. Emphasize to participants that they should refer to the protocol every time they are providing care to ensure the survivor receives the right antibiotics in the correct amount.
5. Tell participants:
    - Survivors should always be given the shortest course of treatment. For example, if the survivor presents within 30 days of the incident, 400 mg of cefixime and 1 g (1,000 mg) of azithromycin by mouth can prevent gonorrhea, chlamydia, and developing syphilis.
    - Presumptive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV.
    - To reduce side effects such as nausea, the doses can be spread out and taken with food.
6. Review one example together:
    - You are treating a survivor under the age of 12, who weighs 34 kg.
        - the protocol states that a child less than 45 kg or younger than 12 should take "8 mg/kg by mouth, single dose" of cefixime to prevent gonorrhea. protocol states that a child less than 45 kg or younger than 12 should take "8 mg/kg by mouth, single dose" of cefixime to prevent gonorrhea.
        - According to the table of weight-based treatment for antibiotics, a 34 kg child would need 272 mg of the medicine.
        - The child can be given either one 200 mg tablet, or half of a 400 mg tablet.

 One 200 mg tablet **OR**  half of 400 mg tablet

Facilitator's notes

Refer to the local prevention protocols. If there is no local protocol, refer to the WHO protocol. All protocols and the table of weight-based treatment should be adapted before the training. If pre-packaged packets will be used, only review scenarios where CHWs may need to adapt the treatment, such as for children, men, or oral assault.

Since many people with STIs do not have symptoms, every survivor should receive the entire range of preventative antibiotics if they have had unprotected sexual intercourse, regardless of whether or not they have symptoms.

For oral assault only, the survivor should be given antibiotics to prevent gonorrhea, chlamydia, and syphilis. Treatment for trichomoniasis is not needed.

There is no presumptive treatment protocol for yeast infection, as this is considered a reproductive tract infection and not a sexually transmitted infection. Treatment is given if symptoms (itching and white curd-like discharge) appear. Presumptive treatment for herpes is also not recommended. Genital herpes is treated as soon as possible after lesions appear.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

ROLE PLAY (30 minutes)

1. Divide participants into pairs. Tell participants that they will be doing a role play to practice giving antibiotics to prevent STIs. Break participants into groups of 3 to 4, and provide participants with drugs for demonstration, and direct participants to refer to their protocols. Explain that you will provide several scenarios, and that the pairs will take turns giving the appropriate antibiotics.
2. Provide scenarios of a child, adult, and pregnant woman, arriving within 30 days and after 30 days, with and without signs of STIs.
    - A woman who is six months pregnant comes to you for services. She experienced SV two months ago, and she is having abnormal discharge and pain during urination.
    - An adolescent boy comes to you immediately after having experienced SV.
    - A man comes to you two weeks after having experienced sexual violence. He has no signs or symptoms of STIs.
    - A woman comes to you three days after having experienced SV.
    - A woman brings her child to you. She has just learned that her child experienced SV five weeks ago. The child weighs 30 kg.
    - A woman comes to you three weeks after having experienced SV. She is experiencing pain in her genitals, and pain and bleeding during sex.
3. 2. Provide the following scenarios:
    - A pregnant woman arrives the day after having experienced SV, including vaginal penetration.

- A man arrives for care, several months after having experienced an anal assault. He is having pain and itching around the anus.
- A child arrives one week after having experienced SV, including vaginal penetration.
- A woman arrives two weeks after having experienced SV. She is having pain when urinating, and abnormal vaginal discharge.
- A pregnant woman arrives after having experienced SV. The sexual assault took place two months prior, and she has no signs or symptoms of an STI.
- A man arrives for care immediately after having experienced SV.

4. Observe the role plays to ensure participants demonstrate skills in providing correct antibiotics and doses according to the protocol.

Ask participants if they have any questions before moving on to the next section.

4. Obtaining a pregnancy test and providing options counseling

4.1 To whom should a pregnancy test be offered?

MINI LECTURE[115] (10 minutes)

Explain to participants:

- A pregnancy test should be offered to all survivors with ovaries and a uterus, unless the survivor already has an established pregnancy. This includes women, transgender men, and adolescent girls.
- It should be offered to transgender men, even if they are taking hormone therapy and do not menstruate.
- It should be offered to girls who have not yet begun menstruating if they have begun to develop breast buds.
- Older women and older transgender men should also be offered the test if they have had any menstrual bleeding or spotting within the last 12 months, since they may not be post-menopausal.
- A pregnancy test should be offered to all survivors with ovaries and a uterus, unless the survivor already has an established pregnancy.
- It should be offered to girls who have not yet begun menstruating if they have begun to develop breast buds.

[115] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- It should also be offered to transgender men with a uterus and ovaries, even if they are no longer menstruating as a result of testosterone therapy.
- Older women should also be offered the test if they have had any menstrual bleeding or spotting within the last 12 months, since they may not be post-menopausal.
- **The pregnancy test should be offered at the initial presentation, but you do CHWs should not withhold EC if the test is not available. A pregnancy test is NOT required to provide EC.**
- If the survivor seeks care within five days of the assault, a positive pregnancy test is likely not a result of the assault, but from prior intercourse.
- CHWs should let survivors know that no test is 100 percent accurate: there could be a chance that the test is falsely positive or falsely negative.
- You should let survivors know that no test is 100 percent accurate; there could be a chance that the test is falsely positive or falsely negative. You can also inform the survivor where they can go for a blood test to confirm the test results.
- When providing counseling about the test, it is helpful to gain a sense of what the survivor would like to do about a pregnancy before the test shows its results.
- You can ask, "Do you have a sense of what you would like to do if the pregnancy test came back positive?"
- You can tell the survivor that you can share information about different services in the community.
- You should know the available options in the community to be able to connect them to appropriate supports and referrals, including for safe abortion care, and for maternal and newborn health services.

Facilitator's notes

Know the false positive and negative rates of the urine pregnancy test that is available in the project site. Also know how early in a pregnancy the test can detect pregnancy.

If the survivor has not had intercourse prior to an assault within the last five days, and the pregnancy test is positive, CHWs can repeat the pregnancy test. If it is still positive after EC, CHWs can refer the survivor to higher-level care. Some ovarian masses and cancers can cause increased markers of pregnancy; however, this is beyond the scope of what CHWs need to consider.

4.2 What if a survivor tests positive?

Facilitator's notes

It is essential to know what laws are in place around safe abortion care to the full extent of the law. In most countries, induced abortion is legally permitted in at least some circumstances. In many countries, abortion is allowed if the pregnancy threatens the physical and mental health of the woman and when the pregnancy results from rape or incest. Unintended pregnancies and unsafe abortions are major causes of maternal mortality. Global data show that unsafe abortion is present in countries where safe abortion care is not accessible to all women and girls.

If the country in which the pilot is being implemented requires survivors to go through specific processes to obtain an abortion in cases where the pregnancy is the result of rape or incest, it is important to document these requirements, and to train CHWs accordingly to ensure they can counsel and refer the survivor appropriately.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

MINI LECTURE[116] (20 minutes)

Direct participants to refer to the **handout on estimating pregnancy**.

Tell participants:

- If the pregnancy test is positive, it is important to establish how far along the pregnancy is in order to be able to offer all available options to the survivor.
- If a survivor has their menses regularly every 4 weeks, their pregnancy will start about 2 weeks after the first day of their last menstrual bleeding. To find out if this method can be used to estimate their due date, CHWs should ask the survivor three questions:
  - Has your monthly bleeding been mostly regular, once every 4 weeks (once every month)?
  - Was your last monthly bleeding normal for you (not unusually light or heavy)?
  - Do you remember the date of the first day of your last monthly bleeding?
- If the survivor answers "no" to any of these three questions, this method will not provide the correct estimate of pregnancy or due date.
- **However, what is important to establish at this time is whether the pregnancy is less than or greater than 12 weeks, since that would determine if you can provide safe abortion care for the survivor (depending on the pilot site), or if the survivor would need to be referred.**
- If it is not possible to determine whether the pregnancy is less than or greater than 12 weeks, the survivor should be referred to higher-level care for the uterus to be measured, or for an ultrasound if available.

[116] Hesperian Foundation, *A Book for Midwives*, 2021. Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

- If the survivor answers "yes" to all 3 questions, you can determine how pregnant they are at this visit, and the due date. A pregnancy lasts about 40 weeks or 280 days. This is about 9 calendar months, or 10 lunar months, from the last monthly bleeding.
- To figure out how pregnant the survivor is now, take the first day of the last menstrual bleeding and count the number of weeks that have passed between that day and this visit.
- If the pregnancy is less than 12 weeks and 0 days, the survivor is within the window to undergo a medication abortion if they so choose.
- If the pregnancy is between 12 and 14 weeks and 0 days, the survivor can undergo manual vacuum aspiration to terminate the pregnancy. This should be available at the health center.
- If the pregnancy is beyond 14 weeks, the possibility of termination will be based on whether a referral is available for dilatation and evacuation (D&E) or misoprostol-based methods.
- Depending on the setting, the available choices of a pregnancy are termination, carrying the pregnancy to term and raising the baby, or carrying the pregnancy to term and putting the child up for adoption.
- If the survivor desires a termination, CHWs will be expected to provide safe abortion care or a referral for that care, to the full extent of the law.
- If the survivor chooses to keep the pregnancy, they should be followed under routine antenatal care. You should provide the survivor with information about resources and services in the community for maternal and newborn health.

Inform participants on any processes or requirements for survivors who are eligible to obtain an abortion under the law in cases where the pregnancy is the result of rape or incest.

Ask participants if they have any questions before moving on to the next activity.

4.3 What if a survivor's preference for the pregnancy does not align with a CHW's faith or beliefs?

ACTIVITY: "Cross the line"[117] (45 minutes)

1. Tell participants:
   - This values clarification exercise is intended to help us reflect on our personal beliefs about induced abortion, and the provision of safe abortion care to the full extent of the law.
   - Remember: in this training, we treat one another with respect. This is a safe environment for all participants, regardless of their personal views.

2. Place a long piece of string in the middle of the room horizontally.

[117] Adapted from Ipas's "Cross the Line," *Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences*, 2018.

3. Explain to participants:

   - I will read a series of statements, and you should step entirely across the line when a statement applies to their beliefs or experiences.
   - There is no "in between," which means you must stand on one side of the line or the other.
   - There are no right or wrong answers.
   - Everyone should stand on the side of the line that best reflects their own beliefs and not feel pressured to move with the rest of the group.

4. Stand at one end of the line and start with a practice statement, such as: "Cross the line if you had coffee this morning."

5. Then, go through the "Cross the line if" statements below:

Cross the line if:

   - You were raised to believe that abortion should not be openly discussed.
   - At some point in your life, you believed abortion is wrong.
   - You have been asked to keep someone's abortion a secret.
   - You have ever felt uncomfortable talking about abortion.
   - You or someone you are close to has had an abortion.

6. Once some CHWs have crossed the line, give them an opportunity to observe who crossed the line and who did not. Invite participants to notice how it feels to be where they are.

7. Ask a CHW who crossed the line and then a CHW who did not to briefly explain their reasons for crossing or not crossing the line. If someone is the only person who did or did not cross the line, ask them what that feels like.

8. Invite all participants to move back to one side of the line.

9. Repeat the process for the following "Cross the line" statements:

   - You have ever heard a friend or family member talking in a negative manner about women who have had abortions.
   - You have heard the term "baby killers" applied to women who have abortions, or health care workers who provide safe abortion care.
   - You are concerned that if you facilitated a safe abortion, your safety will be at risk in this community.
   - You believe there is a medical need for safe abortion care to be available to women, in general.

10. Invite all participants to move back to one side of the line.

11. Repeat the process for the following "Cross the line" statements:

    - You are committed to addressing all of the main causes of maternal death, including unsafe abortion.
    - You have had to tell a woman she could not have an abortion.
    - You have had to tell a woman with an unwanted pregnancy as a result of sexual violence that she cannot have an abortion.

12. When you are finished, ask participants to take their seats. Facilitate a discussion with participants, using the following questions:

    - What did you learn from this activity? (or: What did you learn about your own and others' views on safe abortion care?)
    - Were there times when you felt tempted to move with the majority of the group? Did you move or not? How did that feel?
    - What does this activity teach us, in general, about the stigma and cultural norms related to safe abortion care?
    - How might stigma and cultural norms influence a woman's decision about terminating a pregnancy?
    - How might stigma and cultural norms influence the comfort of CHWs providing or supporting the provision of safe abortion care in in this project?

13. Summarize the key points from this activity by telling participants:

    - Not all of us may be comfortable with abortion care services, but regardless, we have a responsibility to ensure that all survivors can access safe services.
    - If you are uncomfortable or unable to provide a safe abortion service, be sure to refer survivors to a health facility that can provide a safe service.
    - We may feel afraid to talk about abortion work, but the bottom line is that safe abortion services save women's lives.

Facilitator's notes

If any safety concerns for CHWs are raised during the activity, try to tease out what the concerns are and brainstorm with CHWs on how they can be mitigated. Be sure to raise these issues with program staff, to minimize safety risks in the pilot.

4.4 How can referrals be made for safe abortion care to the full extent of the law?

DISCUSSION (20 minutes)

1. Review the referrals table developed during the mapping process. Identify the organization(s) where survivors can be referred for safe abortion care to the full extent of the law.

2. For each organization, discuss what services are specifically available, how CHWs will arrange and coordinate the referrals, any associated costs, and how survivors can physically access them.

4.5 What is options counseling?

ROLE PLAY[118] (20 minutes)

1. Tell participants:

   - Survivors can seek care any time after sexual assault. Survivors who present with a pregnancy at any gestational age should receive information about all options open to them, including safe abortion care or a referral for that care, to the full extent of the law. There may be cases in which a survivor presents with an incomplete abortion, and needs post-abortion care.
   - Options counseling is counseling for the survivor on the available options around the pregnancy for the survivor to make informed choices.
   - There are some special violence-related counseling considerations that you should be aware of, and sensitive to, when you are working with survivors. These include:
     - An unintended pregnancy may be the result of sexual violence or incest.
     - A spontaneous abortion could have been caused by physical abuse.
     - A woman may face further violence if her abortion or use of contraception is not kept confidential.
     - A woman may have been forced or coerced into having an abortion.
     - The pregnancy could have been wanted.
   - You must provide accurate and unbiased information about pregnancy options, including continuing the pregnancy and parenting, continuing the pregnancy and placing the child for adoption, and having an abortion. Survivors have the right to receive this information.

2. Group participants into groups of three, and have one person be the CHW, one the survivor, and the third an observer.

3. Inform participants:

   - In this role play, you will practice providing options counselling using the referral pathway for safe abortion care, and modeling the survivor-centered approach and good communications skills.

[118] Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

- After each scenario role play, they will switch roles. Each participant should play each role once. When you are observing, you should watch carefully, and be prepared to share feedback after the role play is done.
- The scenarios are:
  - The survivor wishes to terminate the pregnancy, and is eligible for a medication abortion.
  - (If a different organization provides manual vacuum aspiration) The survivor wishes to terminate the pregnancy, but is 13 weeks pregnant and will need to have manual vacuum aspiration.
  - The survivor wishes to continue the pregnancy, and to raise the baby.
  - The survivor wishes to continue the pregnancy, and to place the baby for adoption.

4. Move between the groups during the role play.

5. Ask if participants have any questions before moving on to the next section.

4.6 How can CHWs provide medication abortions? (Optional)

Facilitator's notes

Medication abortion should only be introduced and taught to CHWs if there is a back-up system of vacuum aspiration services through referral to a health facility, in case of failed or incomplete removal of uterine products.

Contraindications to medication abortion without access to a health facility include severe anemia, bleeding disorder, blood-clotting disorder, or adrenal failure.

Refer to participants' **handout on medication abortion**, as well as the **handout on medication abortion for survivors**, for this section.

IAWG on RH in Crises, "Chapter 8: Comprehensive Abortion Care," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. Ipas, *How to have an abortion with pills*, 2021.

MINI LECTURE[119] (45 minutes)

Tell participants:

- The recommended abortion methods in the first trimester are manual or electric vacuum aspiration, or medications with mifepristone followed by misoprostol.
- Where mifepristone is not available, misoprostol can be used alone, although it is less effective than when combined with mifepristone or vacuum aspiration. Without mifepristone, the survivor will need to take more misoprostol pills, the process tends to be longer, and they may experience more side effects.
- Sharp curettage/dilation and curettage should no longer be used to end a pregnancy.

[119] Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018; and Ipas, *How to Have an Abortion with Pills*, 2021.

- People who are seeking abortion care may be under severe emotional stress or physical discomfort. Abortion is stigmatized in many communities, and breach of confidentiality could place the survivor at particular risk.
- As with all services, you must ensure privacy and confidentiality, share accurate and complete information with the survivor to help them understand their options, and obtain informed consent for treatment.

The **mifepristone/misoprostol regimen** is:

- Up to 10 weeks of gestation: Give 200 mg orally of **mifepristone**. After 24-48 hours, give 800 micrograms of **misoprostol** buccally (in the cheek), sublingually (under the tongue), or vaginally for one dose.
- 10-12 weeks of gestation: Give 200 mg orally of **mifepristone**. After 36-48 hours, give 800 micrograms of **misoprostol** vaginally, then 400 micrograms vaginally or sublingually (under the tongue), every 3 hours for a maximum of 5 doses of misoprostol.

If **only misoprostol is available**, the regimen for pregnancies up to 12 weeks is:

- Misoprostol 800 micrograms (four 200 microgram pills) **vaginally** every 3-12 hours for a maximum of 3 doses.

OR

- Misoprostol 800 micrograms (four 200 microgram pills) **sublingually** (under the tongue) every 3 hours for a maximum of 3 doses.

Tell participants:

- It is very important that survivors understand what to expect during and after a medication abortion. You must communicate clearly what will happen, how they might feel, and how the survivor can assess whether their abortion is complete. This counselling can help survivors to feel more confident and prepared for their abortion experience.
- The pills should cause bleeding and cramping, and the survivor may see clots. Their bleeding may be more than their normal monthly bleeding. Everyone will experience bleeding and cramping differently.
- All survivors undergoing medication abortion should also be offered pain control with non-steroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen or diclofenac.
- They can take this before or after they take the misoprostol.
- Applying a heating pad or hot water bottle to the lower belly may also help with discomfort.
- A medication abortion was likely successful if the survivor experienced bleeding and cramping and they no longer have symptoms of pregnancy.
- **If the survivor experiences no bleeding or has little bleeding within 4–5 days after taking the 4 pills, it may mean the medicines did not work and they are still pregnant.**
- You can share the following questions with survivors, so they can assess if their abortion is complete:

  - Did you have cramping after you took the abortion pills?
  - Did you have bleeding after you took the abortion pills?
  - Did you pass tissue or see blood clots after you took the abortion pills?
  - Did any pregnancy symptoms you had before taking the pills go away after taking the abortion pills?
- If the survivor answered "yes" to most of these questions, it is likely that their abortion was successful.
- **If they answered "no" to any of these questions, they should follow up with a CHW or the health facility. It is important to make sure their abortion is complete (see section on post-abortion care).**
- If the survivor would like to confirm that they are no longer pregnant with a pregnancy test, they should **wait until four weeks after taking the abortion pills.** A pregnancy test may still have a positive result for up to four weeks after an abortion.
- Survivors who are considering an abortion, either with medication or with a vacuum aspiration at a health facility, should be counseled on post-abortion contraception. You should share the following with the survivor:
  - Ovulation can occur as early as 10 days after an abortion, resulting in pregnancy even before menses returns.
  - All contraceptive methods, including an IUD or hormonal methods, may be started immediately after an uncomplicated vacuum aspiration.
  - Hormonal methods, including implants, oral contraceptive pills, and injectables, may be started on the same day as the first dose of the medication abortion drug.
  - IUDs can be used when the woman is no longer pregnant.
- You should also offer post-abortion contraceptive methods to survivors before they leave.
- Level 2 or 3 CHWs trained in Depo-Provera injections can provide the injection at this time.
- If the survivor declines a contraceptive method but does not wish to become pregnant, you can consider sending the survivor home with EC, if it is safe to do so.

Ask participants if they have any questions before moving on to the next section.

Facilitator's notes

Routine follow-up after medication abortion with mifepristone followed by misoprostol or vacuum aspiration is not necessary. However, **because of lower efficacy, follow-up after induced abortion with misoprostol-only is recommended**. In all cases, if there are complications, the woman should go to a health facility immediately. If the woman desires follow-up care, she may be scheduled approximately two weeks after the procedure.

IAWG on RH in Crises, "Chapter 8: Comprehensive Abortion Care," *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

5. Providing emergency contraception to reduce the risk of pregnancy

5.1 Who is at risk for pregnancy after sexual violence and what are the consequences of pregnancy?

MINI LECTURE (5 minutes)

Ask: Who is at risk of becoming pregnant as a result of SV? What are some of the possible consequences of a survivor becoming pregnant as a result of SV? Call on participants.

Tell participants:

- Women, transgender men who have ovaries and a uterus, and adolescent girls who are menstruating OR who have developed breast buds are all at risk of becoming pregnant as a result of sexual violence, if they are not already pregnant and if they experienced vaginal or anal penetration with a penis.
- Unwanted pregnancy after SV can result in serious problems for the survivor, such as the spouse or family disowning the survivor, or the survivor being considered unsuitable for marriage. Social stigma may drive the survivor to seek an unsafe abortion, which has the risk of illness and possibly death.

5.2 What is emergency contraception and how is it provided to female and transgender male sexual violence survivors?

MINI LECTURE[120] (20 minutes)

Direct participants to follow along with the protocols in their participant's packet.

- Emergency contraception (EC) is a medicine that can prevent a woman, girl, or transgender man from becoming pregnant after having unprotected sexual intercourse.
- The medicine works by stopping the egg from being released for fertilization and may prevent the sperm and egg from meeting.[121]
- A female or transgender male survivor of sexual violence who is of reproductive age (menstruating women, or adolescents who have developed breast buds) and presents for care within 5 days (120 hours) after vaginal penetration or anal penetration should receive EC to prevent unintended pregnancy.
- EC is not needed for survivors who experience only oral assault.

120 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; HO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

121 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

Special considerations

Adolescent girl survivors are eligible for EC as soon as they have developed breast buds or other secondary sexual characteristics, even if they have not yet started menstruating. There are cases where the first ovulation results in pregnancy.

Transgender male survivors are eligible for EC if they still have ovaries and a uterus. They should still be given EC even if they are no longer menstruating as a result of testosterone therapy. A person taking testosterone may still ovulate and be at risk of pregnancy.

Explain to participants:

- **A pregnancy test is not required to provide EC pills.** If someone is pregnant but does not know that they are pregnant, they can still take the EC pill and it will not harm the pregnancy.
- EC is NOT a method of abortion.
- If the survivor knows they are pregnant, the CHW does not need to give EC pills because they will have no effect.
- If the survivor is not sure, EC should be provided.

There are three oral EC regimens that can be used:

- The **ulipristal acetate regimen:** 30 mg single dose. It should be taken within 5 days (120 hours) of unprotected intercourse. It is more effective than progestin-only pills in the 73-120 hours after unprotected intercourse. It is also more effective with fewer side effects than the combined hormonal pills.
- The **levonogestrel-only (progestogen-only) regimen**: 1.5 mg of levonogestrel in a single dose. It should be taken within 5 days (120 hours) of unprotected intercourse; efficacy is greatest when used closer to the time of sexual intercourse. It is more effective and has fewer side effects than the combined hormonal pills.
- The **combined estrogen-progestogen regimen**: one dose of 0.1 mg ethinyl estradiol plus 0.5 mg of levonogestrel taken 12 hours apart. It is less effective and with more side effects than progestin-only EC pills and ulipristal acetate.

Tell participants:

- Common side effects are spotting or bleeding a few days after taking the EC pills, nausea, headache, abdominal pain, breast tenderness, dizziness, and fatigue. These are generally short-lived.
- If vomiting occurs within two hours of taking a dose, the dose should be repeated.
- This information should be shared with the survivor, to ensure they know what to expect after taking the medicine, and what to do if they vomit.

- There are pills that have been made to serve as EC, but they are not always available. If designated EC pills are not available, EC can be provided using regular oral contraceptive pills. The number of pills to take depends on the amount of estrogen or progestogen each pill contains. See **protocol handout 5.15** on how many pills are needed.

Facilitator's notes

Progestin-only EC pills are safe for all women, transgender men, and adolescents of reproductive age, even for those who are advised not to use combined oral contraceptives for ongoing contraception (such as those with bleeding disorders), as the dose of hormones is relatively small and the pills are used for a short time.

EC pills are safe and effective in preventing pregnancy if taken more than once, even within the same menstrual cycle and there are no lifetime limits on the number of times a person can take progestin-only EC pills. Progestin-only EC pills do not need to be taken more than once in a 24-hour period if unprotected sexual intercourse occurs more than once during that timeframe.

For the combined hormonal pills, each dose must contain estrogen (100–120 mcg ethinyl estradiol) and progestin (0.50–0.60 mg levonorgestrel (LNG) or 1.0–1.2 mg norgestrel). The first dose should be taken as soon as possible after unprotected intercourse (preferably within 72 hours but as late as 120 hours, or 5 days) and the second dose should be taken 12 hours later.

If the survivor vomits within 2 hours after taking EC pills, they should take another dose as soon as possible. If they are taking combined pills for EC, they can take antiemetic medicine (meclizine hydrochloride) 30 minutes to 1 hour before the EC pills to reduce nausea.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019, pages 23-24.

CASE STUDY (5 minutes)

1. Provide participants with this case study:

   A 25-year-old woman comes to you four days after vaginal assault. She tells you that she is not currently pregnant or taking contraceptives. What would you do?

   a. Tell her it is too late to take EC pills
   b. Offer her EC pills.
   c. Require her to take a pregnancy test before taking EC pills.

2. Ask participants to raise their hands if they think the answer is A. Repeat for B and C.

3. Discuss why B is the answer, including:

   - This woman of reproductive age (15-49 years) reported within five days of the assault.

- A pregnancy test is not required for a woman to take EC.
- The ulipristal acetate regimen would be the most effective regimen, since the survivor reported after 72 hours (3 days).
- However, if this option is not available, the survivor can receive the progestin-only or combined hormonal regimens.

4. Provide participants with this case study:

   A 23-year-old transgender man comes to you three days after vaginal assault. His pronouns are "he/him." He tells you that he is on testosterone therapy, but he still had his ovaries and uterus. He cannot remember when he last menstruated. What you do?

   a. Offer him EC pills.
   b. Tell him that since he identifies as a man, he does not need EC pills.
   c. Tell him that since he is on testosterone therapy and is not menstruating, he is not at risk of pregnancy.

5. Ask participants to raise their hands if they think the answer is A. Repeat for B and C.

6. Discuss why A is the answer, including:

   - A transgender man who has ovaries and a uterus is still at risk of pregnancy, even if he is on hormonal therapy.
   - The survivor can be given any of the three methods since he presented within the 3-day (72 hours) window.

DISCUSSION (10 minutes)

1. Distribute the EC treatment protocol.[122] Review the protocol in detail with participants.

2. Ensure participants understand the protocol, and encourage them to ask any questions they may have.

3. **Emphasize that participants should refer to the protocol (Handout 5.15) whenever they are providing care to ensure the survivor receives the appropriate EC regimen.**

[122] Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

Facilitator's notes

You should know what EC regimens are available in the setting and what will be used in the project before this section is introduced. If pre-packaged EC pills are not available locally, EC can be provided using regular oral contraceptive pills. Make sure this information is conveyed so that CHWs can provide EC.

EC should be provided in cases of anal assault, given the small risk of sperm leaking into the vagina, and that the CHWs will not ask detailed questions about the position of the assault, location of ejaculation, or knowledge of the survivor regarding her reproductive anatomy.

ROLE PLAY (15 minutes)

1. Divide participants into small groups to practice giving EC. Ask participants to find the treatment protocols in their package. Hand out EC pills for demonstration.

2. Provide scenarios of an adolescent girl, adult woman, pregnant woman, and transgender man, arriving within 120 hours and after 120 hours of sexual violence.

3. Observe the role plays to ensure participants demonstrate skills in providing correct treatment according to protocol.

Facilitator's notes

If a survivor is taking certain medications for tuberculosis or AIDS (e.g., rifampicin or efavirenz), the effectiveness of oral hormonal contraceptives can be reduced. The survivor will need to take a double dose of EC pills to have therapeutic effect. However, this would be beyond the scope of what the CHW will be able to determine, unless the CHWs are actively involved in DOTS therapy for these survivors.

If copper-bearing IUDs are available through referral health facilities, you can mention what they are and how they work.

IUDs and sexual violence: Survivors who seek care within five days after sexual violence may be able to receive a copper-bearing IUD if they have not had additional unprotected sex in their current menstrual cycle. An IUD is a small object that is inserted into the uterus by a specially trained health worker. It can stay in the uterus for up to 12 years before it must be removed and replaced. It is more effective at preventing pregnancy than EC pills.

IUDs do not protect against STIs, including HIV. If a survivor has an STI, the IUD can lead to more serious complications, such as pelvic inflammatory disease (PID). PID can lead to infertility. If an IUD is used as EC, the survivor must take antibiotics to prevent STIs.

IUDs should not be recommended to survivors who are already pregnant, or those unable to get to a health facility where it can be inserted or removed by a trained health worker. IUDs can be used safely by women who are breastfeeding.

Side effects of copper-bearing IUDs can include light bleeding during the first week after getting an IUD. Some women have longer, heavier, and more painful periods, but this usually older people after the first three months.

When a woman wants to stop using an IUD, it must be removed by a trained health worker. A woman can become pregnant as soon as the IUD has been removed.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

6. Conducting HIV counseling and testing

Facilitator's notes

An HIV test should only be offered if PEP is available, and treatment for HIV is available in the setting. A positive test should be referred for HIV treatment and care. An HIV test is NOT needed to begin PEP.

6.1 Who is at risk for HIV?

MINI LECTURE (5 minutes)

Ask: Who is at risk for HIV? Call on participants.

Tell participants:

- Survivors of all ages and genders may be at risk for HIV if they experienced vaginal, anal, or oral penetration.
- HIV infection is spread through blood and body fluids. Survivors often have tissue injuries (breaks in the lining of the vagina or anus) due to the violent nature of the act and are at increased risk for HIV infection.
- CHWs should assess the risk for HIV when learning whether the survivor experienced vaginal or anal penetration, so that the survivor is not asked the same questions again and again.

6.2 What does the HIV test look for?

MINI LECTURE[123] (5 minutes)

Tell participants:

- When HIV enters the body, the body begins to make proteins called antibodies to fight the virus. These antibodies usually show in the blood 2 to 4 weeks after the exposure.
- The HIV test looks for these antibodies in the blood.
- An HIV test is the only way to know if a person has been infected with HIV. It is not a test for AIDS.
- A positive HIV test means that a person is infected with the virus and their body has made antibodies to HIV.
- Even if a person feels completely well, they can still spread the virus to others.
- A negative HIV test means 1 of 2 things:
  - A person is not infected with HIV.

[123] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- OR
  - A person was recently infected, their body has not yet made enough antibodies to HIV to be detectable on a test.

Facilitator's notes

Know the type of test available for CHWs to use. It is likely to be a rapid test. You should be familiar with how it works, how long after infection it can accurately test, how much time it takes for the results to be available, and the rate of false positivity or false negativity of the test. You should also identify where in the community survivors can obtain confirmation of their HIV status through a blood test.

6.3 What should be conveyed when providing HIV counseling and testing?

MINI LECTURE[124] (15 minutes)

Tell participants:

- An HIV test should always be voluntary and adhere to the 5 Cs:
  - Consent.
  - Confidentiality.
  - Counseling.
  - Correct test results.
  - Connection to care, treatment, and prevention services.

Write each of the 5 Cs on a sheet of flipchart paper.

- When providing counseling, you must ensure the survivor understands what the test entails and the advantages and disadvantages of knowing the result, so that the survivor can make an informed decision on whether they would like to be tested.
- The advantages of knowing the test results are that if the test is negative, the survivor can begin to take PEP if they present within 72 hours of the assault.
- The advantages of knowing a positive result are that the survivor can be referred to treatment services and can be connected to support services for those who are living with HIV/AIDS in the community.
- If the result is positive, and it has been within 2 weeks of the sexual assault, the survivor was likely infected with HIV prior to the assault.
- The disadvantages of knowing the test result are that the survivor may experience further distress.

[124] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- The survivor may also experience blame, social stigma, and discrimination, if other people in the community learn about their test result. **Keeping test results confidential is of the utmost importance.**
- It is important to inform the survivor that there is a possibility that the test result is falsely positive OR falsely negative.
- It is also important to tell the survivor that, if they are presenting within 2 weeks of the assault, the test may not yet be effective, as it can take time for the test to be able to be accurate. You should encourage the survivor to receive HIV testing again, as part of follow up care or at a health facility later on.
- If the test is positive, give space for the survivor to process their emotions. It is normal for survivors to be shocked or to be in denial. Work with the survivor to:
  - Identify next steps to confirm their test result.
  - Decide who, if anyone, to tell about their HIV status.
  - Explain how they can stay as healthy as possible, including ART if it is available to them.
  - How they can practice safer sex.
  - Refer them to care and treatment.

7. Providing post-exposure prophylaxis (PEP) to prevent HIV

Facilitator's notes

This section should only be covered if the provision of PEP is warranted in the context and CHWs will be initiating PEP. The current WHO guidance is that only nurses and above can initiate PEP, although CHWs can play a role in encouraging patients to continue taking the entire 28-day dose and helping to manage side effects. See WHO, Task Shifting: Global Recommendations and Guidelines, 2008, for more information.

If HIV testing will be made available for survivors (not required for PEP provision), the program should have determined where survivors can access ARVs.

7.1 What is HIV post-exposure prophylaxis (PEP) and how does it work?

MINI LECTURE[125, 126] (10 minutes)

Tell participants:

- HIV post-exposure prophylaxis, or PEP, is a medication that can reduce the risk of HIV transmission after sexual violence if given promptly.
- PEP must be started within 72 hours or 3 days after a survivor experiences vaginal, anal, or oral assault. PEP should be started as soon as possible. PEP is more effective the sooner it is started.
- PEP consists of antiretroviral (ARV) drugs given for 28 days. The most common drugs are tenofovir (TDF) and lamivudine (3TC) or emtricitabine (FTC).
- The WHO also recommends a third drug such as dolutegravir.
- Refer to your protocol and note that the amount of medicine or dosage is adjusted for children based on their age and weight.
- To ensure survivors have access to the full course, they may be given the full 28-day course at the initial visit, with instructions to complete the entire course.[127]

Special considerations

Pregnant women and children may be eligible to receive PEP. The dose is adjusted for children based on age and weight (see treatment protocols).

From: IAWG on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

Facilitator's notes

Nevirapine (NVP) should not be used for PEP due to the high risk of toxicity that can lead to a higher likelihood of PEP discontinuation. Refer to the local treatment protocol, including for children based on age and weight. If there is no local protocol, consult the WHO protocol. This includes WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, 2016, and WHO/ILO, Post-exposure prophylaxis to prevent HIV infection: *Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection*, 2007.

125 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

126 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

127 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

7.2 Who should receive PEP?

MINI LECTURE[128] (5 minutes)

Explain to participants:

- All survivors who experience vaginal, anal, or oral penetration should be offered PEP if they present within 72 hours, or 3 days, after the assault. Other risk factors that would warrant the provision of PEP include:
  - The survivor has been exposed to bodily fluids (e.g., blood, blood-stained saliva, genital secretions, rectal fluids) through wounds or tears in other mucous membranes.
  - The survivor was unconscious or does not remember what happened.
  - The perpetrator is known to be an injecting drug user.
  - The survivor was assaulted by multiple perpetrators.
- Survivors should be asked if they would like voluntary counseling and testing (VCT) for HIV to learn their HIV status.
- However, HIV testing is not required for PEP. Do not delay starting PEP while waiting for an HIV test result.
- Survivors who cannot or do not wish to undergo HIV testing should be offered PEP if they present within 72 hours of the assault.
- **There are situations when PEP is not indicated, even within 72 hours.**
  - **If a survivor is living with HIV.** However, a short PEP treatment is not expected to do harm in someone who does not know their HIV status and who is actually HIV positive.
  - The perpetrator is known not to have HIV. If there is any doubt, PEP should still be offered.
- **Pregnancy is not a contraindication for PEP.** The possible effects of the drug on the fetus are not known in pregnancies less than 12 weeks.

7.3 How can survivors manage side effects of PEP?

MINI LECTURE[129] (5 minutes)

Explain to participants:

- Adherence is an important element of PEP since it must be taken once or twice daily for 28 days.
- About half of people who take PEP experience side effects, such as nausea, tiredness, weakness, loss of appetite, and flu-like symptoms.

[128] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

[129] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- For most people, the side effects decrease in a few days. They can be relieved with ordinary pain relievers such as paracetamol.
- The symptoms will also go away once the survivor older people taking the medication. The symptoms are not dangerous. PEP should be taken with food to reduce nausea and vomiting.
- It is important to complete the full course of PEP to ensure protective efficacy.
- It is very important to prepare survivors, and ensure they know what to expect when taking PEP.

7.4 What if the survivor is already known to be HIV positive (provision of co-trimoxazole and referral for ART)?

MINI LECTURE[130] (10 minutes)

Tell participants:

- If a survivor is known to be HIV positive, and is not taking antiretroviral therapy, they should be referred for HIV treatment immediately.
- Co-trimoxazole prophylaxis is a lifesaving, simple, well tolerated intervention for HIV-positive people. It is an antibiotic to prevent pneumocystis pneumonia and toxoplasmosis in adults and children with HIV, as well as other infectious and parasitic diseases.
- Co-trimoxazole prophylaxis is recommended for HIV-positive adults, pregnant women, adolescents, children, and infants.
- Survivors can be given the medication as they are referred for more comprehensive HIV/AIDS services.

Facilitator's notes

In settings where malaria and/or severe bacterial infections are highly prevalent, co-trimoxazole prophylaxis should be initiated regardless of CD4 cell count or clinical disease severity. Review available HIV/AIDS treatment in the community and ensure CHWs know where and how to send patients for ARVs.

130 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

CASE STUDIES (15 minutes)

1. Read the following case study:

   A 41-year-old survivor comes to you two days after being attacked by multiple assailants who assaulted her vaginally and anally. She is experiencing bleeding from her anus.

   Question: What would you do?

   a. Offer her PEP.
   b. Tell her it is too late to take PEP.
   c. Require her to take an HIV test before offering PEP.

   Call on participants.

   Then, explain: The answer is A. Due to the nature of the assault (vaginal and anal penetration, broken skin, multiple assailants), the survivor is at risk for HIV infection. She has come to you within 72 hours so is eligible to receive PEP. HIV testing is not required to give PEP.

2. Read the following case study:

   A 25-year-old survivor with an intellectual impairment is brought to you by her caregiver. She was assaulted vaginally by her neighbor three days ago.

   Question: What would you do?

   a. Offer her PEP. Ask if she would like to be tested for HIV.
   b. Offer her PEP. It is not likely that she needs or would want to have an HIV test, as it is unlikely she is sexually active.
   c. Require her to take an HIV test, and then offer PEP.

   Call on participants.

   Then, explain: Answer: A. Due to the nature of the assault (vaginal penetration), the survivor is at risk for HIV infection. She has come to you within 72 hours so is eligible to receive PEP. Persons with disabilities should be treated in exactly the same manner as those without visible disabilities.

3. Read the following case study:

   A 16-year-old survivor comes to you five days after being assaulted vaginally by her uncle.

   Question: What would you do?

   a. Still offer her PEP.
   b. Encourage her to take an HIV test now and/or in 3 months and let her know where support, care, and treatment services are available if needed.
   c. Do not mention the possibility that the survivor could have HIV since it will be too much for them to cope with.

Call on participants.

Then, explain: Answer: B. Since it has already been more than three days since the incident, PEP will not be effective. However, knowing her status can help the survivor access support, care, and treatment services, and enable her to stay healthy.

4. Read the following case study:

A 44-year-old survivor comes to you two days after oral penetration with the perpetrator's penis. The survivor is HIV positive, and knows his status, but is not on any antiretroviral medications for HIV.

Question: What would you do?

a. Give PEP since the survivor presented within three days of the assault.
b. Do not give PEP since the survivor was not vaginally or anally assaulted.
c. Do not give PEP, since the survivor is known to be HIV positive. Offer co-trimoxazole prophylaxis and refer to an HIV program instead.

Call on participants.

Then, explain: Answer: C. Oral penetration also carries risks of HIV transmission, hence PEP is warranted. However, this survivor has known HIV, so they would not need PEP. They can be given co-trimoxazole prophylaxis and refer to an HIV program immediately to begin HIV/AIDS treatment.

DISCUSSION (20 minutes)

1. Direct participants to the PEP protocol in the participant's packet.[131] Review the protocol in detail with participants.

2. Ensure participants understand the protocol, and encourage participants to ask any questions they may have.

2. Ask participants:

   - Are there any barriers to providing PEP?
   - What is the dose for an adult survivor?
   - What is the dose for a child survivor?

3. Emphasize to participants that they should refer to the protocol whenever they are providing care to ensure the survivor receives the appropriate PEP regimen.

4. Ask if participants have any questions before moving on to the role play.

ROLE PLAY (30 minutes)

1. Divide participants into groups of three to practice giving PEP.

2. The scenarios to practice are:

   - Child survivor arriving within three days of the sexual assault.
   - Child survivor arriving after three days of the sexual assault.
   - Adult survivor arriving within three days of the sexual assault.
   - Adult survivor arriving after three days of the sexual assault.

Participants should rotate between playing the role of the CHW, the survivor, and the observer.

3. Observe the role plays to ensure participants demonstrate skills in providing correct treatment according to the patient's history and treatment protocol.

4. Ask participants if they have any questions before moving on to the next section.

[131] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

8. Providing basic first aid to manage wounds

8.1 What types of wounds can CHWs address?

MINI LECTURE[132] (5 minutes)

Explain to participants:

- Sometimes, survivors can present with wounds and injuries on other parts of their bodies due to violent physical assault.
- CHWs can provide basic first aid for minor wounds and bleeding.
- It is important to remember that if a survivor is bleeding from the vagina or anus, they must be referred to the health facility right away.
- A wound will not require stitches if the edges of the skin come together by themselves.
- **If survivors have clean wounds where the edges of the skin do not come together by themselves, they need to be referred within 24 hours (one day) to a higher-level health facility.**
- Dirty wounds that require stitches will also need to be referred as soon as possible.

8.2 How can minor bleeding be controlled with basic first aid?

ROLE PLAY[133] (15 minutes)

1. Direct participants to refer to the **Controlling Bleeding** handout in their participant's packet.

2. Explain to participants:

- Remember, if there is an object sticking out of the wound, you should not remove the object. If there is severe bleeding, the survivor should be referred immediately.
- To control minor bleeding; the following steps should be followed:
  - Cover the wound with a clean cloth.
  - Avoid direct contact with the person's blood.
  - Wear gloves if they are available. If there are no gloves, use a plastic bag as a barrier.
  - Press down and apply pressure on the wound. Apply the bandage firmly enough to stop the bleeding but not so tight as to cut off circulation.
  - Instruct the survivor to apply pressure to the wound.

[132] IFRC, *International first aid and resuscitation guidelines*, 2020; Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2020.

[133] IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009. Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2020.

- Give emotional support by explaining what is happening and giving reassurance.
- If the bleeding does not stop, press on the wound more firmly and apply more bandages. Do not remove the first dressings.
- Wash hands with soap and water after giving object lodged inside them should be referred to higher-level care immediately.

3. Group survivors in pairs and have them demonstrate bleeding control. Distribute cloth and bandages to practice. If a model is available, they can practice on the model instead.

4. Remind participants that any severe bleeding should be referred, and if an object is sticking out of the wound, they should not remove it. They should leave it there and try to stop the object from moving with clean pads and bandage before the survivor is referred to a higher-level health facility.

8.3 How can wounds be cleaned and bandaged with basic first aid?

MINI LECTURE[134], [135] (10 minutes)

Explain to participants:

- For any wounds that do not require a referral to a higher-level health facility, you should clean any tears, cuts, and abrasions from the wound and remove dirt and dead or damaged tissue.
- When cleaning the wound, you should be careful to clean out all of the dirt. You should lift up and clean under any flaps of skin, but do not rub the wound to get out the dirt. You can use clean tweezers, a clean cloth or gauze to remove bits of dirt, but they should always be boiled first to be sure they are sterile.
- Any dirt that is left in a wound can cause an infection. If possible, the wound should be squirted with cool boiled water in a syringe or suction bulb.
- After the wound has been cleaned, you can dry the area around the wound and apply a thin layer of antibiotic cream if available. You can then place a piece of clean gauze or cloth to cover the top. It should be light enough so that the air can get to the wound and help it heal.
- If the survivor has a dirty wound and has never had a tetanus injection, you should offer a tetanus injection or refer them to a health facility for the injection, and provide antibiotics to prevent infection. You can also consider giving paracetamol for pain relief.
- You should wash your hands with soap and water after giving care.

ROLE PLAY (15 minutes)

Using the instructions in the participants' handouts, group participants in twos and have them practice **cleaning and bandaging a wound**.[136]

134 IFRC, *Volunteer manual for community-based health and first aid in action manual (CBHFA)*, 2009..
135 Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2020
136 Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2020

Facilitator's notes

Additional handouts (optional) are available in the participants' packet on:

- Providing basic first aid for burns.
- Providing basic first aid to survivors with injuries to bones, muscles, or joints.
- Offering basic life support.

These skills are beyond the scope of this training; however, they may be useful if CHWs need to organize referrals.

9. Providing supportive counseling

9.1 How can survivors be emotionally supported?

MINI LECTURE[137] (15 minutes)

Facilitator's notes

Health care for survivors includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, use of drugs, risk-taking behavior, and family rejection. Even though trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to psychosocial or mental health services in the community if they exist.

Explain to participants:

- As most survivors of SV never tell anyone about the incident, if the survivor has confided in you, it is a sign that have trust in you and your ability to help them.
- Your compassionate response to the survivor's disclosure can have a positive impact on their recovery.
- You should provide non-intrusive, practical care. You should listen, but not force the survivor to talk about the incident. You should NOT push the survivor to share more information than they wish to share. You should only ask the questions you need to provide care.
- Survivors are at increased risk of negative emotional and psychological consequences, including:
  - Feelings of guilt and shame
  - Uncontrollable emotions, such as fear, anger and anxiety
  - Anxiety and depression
  - Post-traumatic stress disorder
  - Nightmares
  - Suicidal thoughts or attempts
  - Numbness
  - Use of drugs or alcohol
  - Sexual dysfunction
  - Unexplained physical problems
  - Social withdrawal
- It is important to validate the survivor's experience of a serious physical and emotional event.

[137] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- It is very important to emphasize that:
  - They are NOT to blame. No person is ever at fault or responsible for experiencing SV, no matter who they are, what they were doing, or where they were.
  - SV is the responsibility of the perpetrator.
- You can tell them that there is no wrong way to feel or react after experiencing SV, and that survivors can experience a wide range of different emotions and reactions. Their feelings and experience are valid.
- You can also communicate that there are resources available to support them, and that can help them with their emotions and mental health and wellbeing.
- You can share that it may be helpful for survivors to confide in a trusted loved one, family member, or friend for support – but you should not force or pressure survivors to disclose their experience to others.
- Sometimes, the survivor may have experienced involuntary orgasm during the assault, which causes further distress and trauma. CHWs should reassure them that if this occurred, it was the body's reaction, and was completely involuntary and beyond their control.

Special considerations

Men and boy survivors may be even less likely than women to report SV, due to stigma and lack of information and awareness of services. While the physical effects differ, men and boys also experience psychological trauma. Further, when a man is anally assaulted, pressure on the prostate can cause an erection and even orgasm. Reassure the survivor that if this occurred, it was the body's reaction and was beyond their control.

From: WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

9.2 Reviewing basic psychosocial support

MINI LECTURE[138] (15 minutes)

Explain to participants:

- As discussed in prior sections, first-line support helps to address the survivor's immediate emotional and practical needs, and may be offered whether or not the survivors chooses to access health services and psychosocial support.
- Most survivors who have been exposed to violence experience symptoms of emotional distress. These symptoms can vary greatly: there is no right or wrong way to react after having experienced SV.
- These reactions are normal and common in people who have gone through a traumatic and frightening experience.

[138] Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

Ask: Who can share the different components of LIVES? Call on participants.

Remind participants:

- Psychological first aid includes:
  - Listening, without judgement.
  - Inquiring about needs and concerns.
  - Validating emotions and experiences.
  - Enhancing safety.
  - Supporting access to care and services.

Ask: Who can share techniques for how CHWs can use and demonstrate good listening skills when working with survivors? Call on participants.

Ask: Who can share examples of what CHWs can do to inquire about survivors' needs and concerns? Call on participants.

Ask: Who can share techniques to validate survivors' emotions and experiences? Call on participants.

Ask: What are key steps that CHWs must take to protect survivors' safety? Call on participants.

Ask: What can CHWs do to support survivors to access services? Call on participants.

10. Referring for tetanus and hepatitis B vaccinations (optional)

Facilitator's notes

This section should only be included if the tetanus toxoid vaccination or the hepatitis B vaccines are available from a higher-level health facility.

10.1 What is tetanus and who is at risk for tetanus infection?

MINI LECTURE[139] (5 minutes)

Explain to participants?

- Tetanus is a serious disease caused by germs entering a wound.
- A person with tetanus may experience headache, difficulty swallowing, stiff neck, jaw spasms, tense or rigid body, painful muscle contractions or spasms, or convulsions.
- Without treatment, which is often not available in low-resource settings, a person with tetanus can die a painful death.
- The disease can be prevented through immunization.
- **A survivor of SV who presents with breaks in the skin or mucous membranes may be at risk for tetanus infection.**
- **Tetanus vaccine is not needed for survivors who experienced oral assault only, unless there are wounds in or around the mouth, or they have not been vaccinated in the last 10 years.**

10.2 What is the tetanus vaccine and how does it work?

MINI LECTURE[140] (5 minutes)

Tell participants:

- The tetanus vaccine is given as an injection in the upper arm for adults or buttocks for children. There are three doses. The second dose is typically given 4 weeks after the first dose, and the third dose is given 6 months to one year after the first dose.
- **CHWs should ask the survivor if they have received the full three doses of the tetanus vaccine.**

139 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

140 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- **If they have not or do not know, note on the intake form to offer the injection, or refer the survivor to the health facility with their consent, no matter how long it has been since the incident.**

Special considerations

Tetanus vaccination is safe for pregnant women and children.

If the survivor presents months or years after the assault, the tetanus vaccine would be given for future protection, since the incubation period for tetanus is 3-21 days. CHWs should still refer the survivor to a health facility if they would like to receive the vaccine.

From: WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

10.3 What is hepatitis B and who is at risk?

MINI LECTURE[141] (2 minutes)

Tell participants:

- Hepatitis B is a common and serious infection that may cause problems such as liver failure, liver disease, and liver cancer.
- **Survivors of sexual violence who have been exposed to the assaulter's blood or body fluids through vaginal, anal, or oral penetration may be at risk for hepatitis B infection.**

10.4 What is the hepatitis vaccine and how does it work?

MINI LECTURE[142] (5 minutes)

Tell participants:

- The hepatitis B vaccine is given by an injection in the thigh for children under 2 years of age or in the upper arm for adults and older children. There are three doses. The second dose should be given 1 month after the first dose and the third dose 4-6 months after the first dose. However, doses will vary with the product.
- **Unvaccinated or inadequately vaccinated survivors should be offered the hepatitis B vaccine.**
- **Ask the survivor if they have received the full three dose of the hepatitis B vaccine. If the survivor has not or does not know, note on the intake form to refer the survivor to the health facility for the injection with their consent.**

141 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

142 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Special considerations

Guidance varies on the hepatitis B vaccine, and up to how many days it should be given after an assault. The Inter-agency Field Manual still lists within 14 days of assault, while the WHO guidance no longer includes an end point. If the survivor presents months to years after the assault and has not received the full three doses, they can still receive it for future protection from liver disease. CHWs should still refer the survivor to a health facility if they would like to receive the vaccine.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018; WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Hepatitis B vaccine is safe for pregnant women and children.

11. Closing the consultation

11.1 How should CHWs close the consultation?

MINI LECTURE[143] (10 minutes)

Explain to participants:

- It is important to share information with survivors at the end of your consultation. Some of the information that you should share will be covered in more detail in later modules.
- At the end of the visit, you should:
  - Reassure the survivor again that the assault was not their fault, and that it is normal to experience a range of different emotions and response.
  - Provide treatment counseling, including clear and simple instructions for medications and wound care (see section 11.2).
  - Encourage the survivor to get tested for HIV from the health facility, if testing was not offered at this visit (see section 11.3).
  - Discuss ways that the survivor can protect themself and their partner(s) from further health consequences (see section 11.4).
  - Decide together what referrals the survivor would like or need (more health services, psychosocial, protection, legal, social, etc.) (see section 11.5).
  - Discuss the survivor's safety, and make sure the survivor has a safe place to go and is aware of protection services in the community (see section 12.6).
  - Encourage a follow-up visit in two weeks, preferably one week if the survivor is taking PEP (sooner if the survivor is a person with an intellectual or psychosocial impairment to provide ongoing opportunities for them to ask questions or clarify health matters) (see section 11.7).

143 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- Then, you should review the intake form to see that it is complete. If an interpreter or caregiver was present, CHWs should make a note of this on the form (see section 11.8).
- You should also ask if the survivor wishes to have a record of their visit. If the survivor does wish to have this documentation, it is very important that you discuss possible safety issues, and identify how the survivor can safely and privately store the record (see section 11.9).
- Then, you should be sure to provide space for the survivor to ask any questions they may have.

11.2 How can treatment counseling be provided?

DISCUSSION (30 minutes)

1. Ask: Who can share the different information we must share with survivors, any time that we provide and medications or treatment? Call on participants.

2. Remind participants that they must explain to the survivor:

   - What and how to take medications, including how much to take (dose) and how often to take it each day and for how many days.
   - To take all of the tablets for as long as advised. If they stop taking the medication too soon, the problem may not have been cured and could become worse.
   - Side effects the medication can cause and how to address them.
   - Whether the medications should be taken on a full or empty stomach.
   - Whether to avoid taking other medications at the same time since some medications can stop other medications from working or will cause problems when taken together.
   - To keep medications in a cool, dry place, and out of reach from children.
   - It is also important to share information about different follow up that might be needed to different medications and treatments, and what the survivor should look for to know if they need to follow up with the CHW.

3. Remind participants: **For each treatment or medication you provide, you must obtain informed consent!**

3. Explain to participants:

When offering antibiotics to a survivor to prevent STIs, the following messages should be provided:

- **Treatment:**
  - Medications called "antibiotics" can prevent STIs that they might have been exposed to or treat any infections they might already have, even if they have no symptoms.
  - Go over how the medications should be taken and note that the antibiotics must be taken for the full course to be effective.

- **Side effects:** Some antibiotics can cause nausea or an upset stomach. To reduce side effects, the medications can be taken with food.[144]
- **You should also caution the survivor that:**
  - If no PEP is given to the survivor, CHWs should explain that condoms must be used during sexual intercourse until the antibiotic regimen is complete in order to prevent transmitting STIs to any partner.
  - If PEP is given, condoms must be used for 3 months after PEP is started, or until HIV tests, taken 3 and 6 months after the assault, are negative.
  - These points about condom use are especially important for adult survivors who are in a relationship where sexual intercourse is still expected from them, despite the incident (such as between a married couple, if one of the partners does not know about the assault).
- **Follow-up:** Pelvic Inflammatory Disease (PID) may develop if an STI is not cured. PID may lead to infertility if it is not treated.
- A survivor who develops signs of PID (severe belly pain, fever, green or yellow bad-smelling discharge, or bleeding from the vagina) should go to a higher-level health facility for treatment.

Messages to give a survivor taking EC to prevent pregnancy are:

- **Treatment:** EC is a medication that can prevent pregnancy if taken within 5 full days of unprotected sexual intercourse. The sooner it is taken the better.
- Go over how the medicine should be taken.
- **Side effects:** EC may cause mild nausea. The survivor can take the pills with food to prevent nausea.
- EC may also cause vomiting. If the survivor vomits within 2 hours after taking EC, they should take another dose. If vomiting occurs more than 2 hours after taking EC, they do not need to repeat the dose.
- **Caution:** EC pills do not prevent pregnancy from sexual intercourse that takes place *after* the pills are taken.
- **Follow-up:** EC is not always effective at preventing pregnancy. Menstruation should occur around the time when it would normally be expected, but may be up to a week early or late.
- If the survivor has not had their monthly bleeding within a week after it was expected, they should return for a pregnancy test.
- Spotting or slight bleeding is common with the levonorgestrel regimen, and this should not be confused with normal menstruation.

Messages to give a survivor taking PEP to prevent HIV are:[145]

144 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018.

145 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018. WHO/ILO, *Post-exposure Prophylaxis to Prevent HIV Infections, Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infections*, 2007.

- **Treatment:** Medications can reduce the risk of HIV infection if they are taken within 3 full days of the assault, the sooner the better.
- The medications are taken for a full 28 days. It is important to remember to take each dose. It can help to take the treatment at the same time every day, such as at breakfast and/or dinner (depending on frequency of dosing).
- Taking the pills at regular intervals ensures that the level of the medication in the blood stays about the same.
- Some PEP medications need to be taken with food.
- In the case of a missed dose:
  - With once-daily regimens, the survivor should still take it, if it is less than 12 hours late. If it is more than 12 hours late, they should wait and take the next dose at the regular time.
  - With twice-daily regimens, if a dose is missed, the survivor should not take two doses at the same time.
- **Side effects**: About half of the people taking PEP may experience some type of side effect. PEP may cause tiredness, weakness, loss of appetite, nausea, and flu-like symptoms.
- These side effects are temporary and some can be relieved with ordinary pain relievers such as paracetamol.
- The symptoms are not dangerous.
- PEP should also be taken with food to reduce nausea and vomiting.
- If the side effects are too hard to manage, the survivor should go to a higher-level health center.
- **Caution**: Survivors should use condoms every time they have sexual intercourse for the next 3 months, or until the follow-up HIV test is negative.
- **Follow-up**: Even with side effects, it is very important to take the medicines every day for 28 days. Survivors are recommended to be tested for HIV at 3 and 6 months after taking PEP.

For survivors who have had minor wounds treated, messages are:

- **Treatment:** Minor wounds can be treated with basic first aid. The survivor can take paracetamol for pain relief as necessary.
- **Follow-up**: Change the gauze or cloth every day and look for signs of infection. Go to the health center if the wounds look red, hot, or painful to touch after some days.

For survivors who have experienced minor tears and cuts to their genitals, CHWs can advise basic care. This includes informing survivors to:[146]

- Soak the genital area three times each day in warm water that has been boiled and cooled.
- Pour water over the genitals while passing urine to help with burning when urinating. Drinking a lot of liquid makes the urine weaker, so it will burn less.

[146] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- Watch for signs of infection, such as heat, yellow liquid (pus) from the torn area, a bad smell, and pain that gets worse. If any of these signs are present, they should go to a health facility.
- Wait to have sexual intercourse until the genitals no longer hurt and any tears have healed. For many women, having sex makes them think about the assault. They should not be pressured into having sexual intercourse.[147]

For survivors who are found to be less than 12 weeks pregnant and are having an abortion with pills:[148]

- An abortion with pills uses a combination of the medications mifepristone and misoprostol. If mifepristone is not available, misoprostol can also be used alone. You should share only the information about the regimen the survivor is using, so as not to cause confusion.
- **Treatment:**
  - **Mifepristone and misoprostol combination:**
    1. Swallow 200 mg of mifepristone with water.
    2. Wait 1-2 days.
    3. Place 4 misoprostol pills (200 micrograms each, so 800 micrograms total) either under the tongue, between the cheek and gums (2 pills on each side of the mouth), or vaginally. After 30 minutes, swallow any remaining pieces of pills with water if taken in the mouth.
  - **Misoprostol-only regimen:**
    1. Place 4 misoprostol pills (200 micrograms each, so 800 micrograms total) under the tongue for 30 minutes. After 30 minutes, swallow any remaining pieces of the pills with water.
    2. Wait 3 hours and then repeat Step 1.
    3. Wait 3 more hours and then repeat Step 1. In total, the survivor will take 12 pills from start to finish.
- **Side effects:** To reduce pain and cramping, the survivor can take ibuprofen/paracetamol before or just after taking the misoprostol pills.
- Common side effects include nausea, vomiting, headache, or fevers and chills. When side effects occur, most go away in a few hours.
- **Caution**: If the survivor has any of the following symptoms, they should go to a health facility:
  - Heavy bleeding or soaking more than 2 sanitary pads per hour for 2 hours in a row, especially if the survivor feels dizzy, lightheaded, and increasingly tired.
  - Unusual or bad-smelling vaginal discharge, especially if they also have severe cramps or abdominal pain.
  - Any of the following the day after they take the misoprostol: fever; severe belly pain; feeling very sick with or without fever; or persistent severe nausea or vomiting.

147 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

148 Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. 2018; and Ipas, 2021.

- **Follow-up:** If a survivor does not experience much or any vaginal bleeding in 4-5 days, they should contact the CHW for post-abortion care or referral to a health facility for vacuum aspiration.
    - If a survivor is concerned that they are still pregnant after taking the pills, they can ask themselves the following questions.
- Did the survivor have cramping after they took the abortion pills?
- Did the survivor have bleeding after they took the abortion pills?
- Did the survivor pass tissue or see blood clots after they took the abortion pills?
- Did any pregnancy symptoms they had before taking the pills go away after taking the abortion pills?
    - If the survivor answered "yes" to most of these questions, it is likely that their abortion was successful. If a survivor would like to confirm that they are no longer pregnant, they will need to wait 4 weeks before repeating a pregnancy test, since the test may still be positive for up to 4 weeks after an abortion.

4. When you provide medications to survivors, you should fill out a pictorial **form for survivors** that notes how often and for how long to take the medicines. The form is available in the participants' packet. It is important to discuss with the survivor how they can safely store this form to protect their safety and privacy, and to inquire if they have any safety concerns about having this pictorial form at their home.

Ask participants if they have any questions before moving on to the next role play.

ROLE PLAY (25 minutes)

1. Group participants into pairs and have them practice treatment counseling and completing the pictorial medication form. The pairs should switch roles (CHW and survivor) once they are finished. Participants should refer to their **treatment protocol** handouts for dosing per age and weight.

2. Walk around the room to provide guidance as necessary. Pay close attention to whether participants are asking for the survivor's agreement/approval for each treatment and medication offered.

3. Ask participants if they have any questions before moving on to the next section.

11.3 How can survivors be encouraged to seek HIV counseling and testing? (Optional)

Facilitator's notes

This section should only be presented if HIV counseling and testing is available at the health facility.

MINI LECTURE[149] (10 minutes)

Explain to participants:

- Remember, and HIV test is NOT required to offer PEP.
- However, you can encourage survivors to go to the health center for an HIV test if one could not be immediately offered at the time of the initial visit.
- If the survivor tests negative for HIV, they should continue taking PEP and can be tested again after 3 and 6 months to make sure that PEP has worked.
- As discussed in an earlier section, there are advantages and disadvantages to knowing one's HIV status.
- If the survivor is negative, they can learn how to protect themselves to stay negative and prevent HIV infection.
- If the survivor tests positive, they can:
  - Prevent spreading HIV to their partner or their baby.
  - Learn how to protect themself from future STIs and other infections.
  - Have their partner get tested and receive treatment.
  - Get care and treatment early to prevent health problems.
  - Make changes in their day to day lives, so that they can stay healthy.
  - Get support from people living with HIV/AIDS in the community.
  - Plan for their and their family's future.
  - The disadvantages of knowing the test results are that they may feel anger and despair, and blame themselves or others.
- You can reassure the survivor that they do not need to tell the result to anyone, not even to the CHW.
- If they are interested in getting tested, refer them to the health facility, and let them know where they can access HIV support, care, and treatment services.
- **It is very important to emphasize that they should NOT delay starting PEP while waiting for a test result.**

Ask participants if they have any questions before moving on to the next section.

11.4 What are ways that survivors can protect themselves and their partners from further health consequences?

DISCUSSION[150] (10 minutes)

Tell participants:

- Survivors of SV may or may not wish to disclose their experience to their partner.

149 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.
150 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- A survivor must **never** be forced to tell a partner about their treatment. This is also true for survivors who have experienced IPV.
- They may worry that their partner will leave them, act out violently, or accuse them of being unfaithful.
- It can be challenging for survivors to take steps to protect their and their partner's health, without sharing their experience and treatment with their partner. It is very important to be sensitive to this when sharing information with survivors. The survivor is the expert on their situation, and what is and is not safe or possible for them.
- You can share the following strategies with survivors:
  - Use an internal or external condom each time the survivor has oral, anal, or vaginal sex.
  - Avoid sexual intercourse at all for three months. If the survivor does not have sexual intercourse, they will not be able to transmit or be exposed to STIs. Some survivors find this the best option; however, for many survivors, this choice is not possible or desirable.
  - Have sex in ways that avoid getting the partner's body fluids in the vagina or anus, such as using their hands. Oral sex is not recommended since there is still a small risk of transmitting STIs and HIV – however, it is lower risk than anal or vaginal sex.
- You can also offer to discuss how the survivor might be able to talk about using condoms with their partners. Survivors may be concerned that their partner will not trust them, or will accuse them of being unfaithful, if they ask their partner to use a condom.
- These strategies can include:[151]
- **The survivor can practice talking with the CHW or a trusted friend, first.** Then, they can practice what they want to say.
- **Do not wait until right before sex to talk about it.** The survivor can approach their partner to talk about using condoms at a time when both partners are feeling positively towards one another, and their relationship. It can be harder to talk about if a couple is preparing to have sex.
- **Focusing on safety:** The survivor can share with their partner that they have learned more about STIs and HIV, and that using condoms can help keep them safe because it is possible to have an STI without knowing it, and HIV can be passed between people in different ways.
- **Use other people as examples.** Sometimes learning that others in the community are using condoms can help influence the partner to do so, too. The survivor can share that they have learned that many couples in their community are using condoms for safety.
- **The survivor can be prepared to try and respond to their partner's concerns.** In addition to questions or concerns about trust between partners, partners' concerns about condoms could include:
  - Sex not feeling as good, or condoms being uncomfortable
  - condoms are inconvenient, and "ruin the moment"
  - Condoms cost money

[151] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- In response to these concerns, the survivor could consider suggesting that they try condoms out for a few weeks, to see if they get used to using them.
- The survivor can also try an internal condom, which is worn inside the vagina or anus. These condoms can be inserted up to 8 hours before sex, and so do not require partners to stop immediately before sex. Some people also find that internal condoms do not dull sensitivity as much as external condoms that fit tightly on the penis.
- If asked why they would want to start using condoms now, the survivor can share that they have learned more about condoms and their benefits, and that it seems like it could be a good idea, to protect one another.
- The survivor can also share information about condom distribution points in the community, where people can get free condoms, if there are any available.

11.5 How can additional referrals be decided?

Facilitator's notes

Refer to Module 4, sections 1.2 and 1.3 for detailed information on providing referrals.

Explain to participants:

- When working with survivors, it is important to discuss the full range of services available, using the referral pathway.
- You should use the same skills we practiced during Module 4, using LIVES and applying the survivor-centered approach.
- Be sure to record information about referrals on the intake form.

11.6 How should the survivor's safety be evaluated?

Facilitator's notes

If it is not safe for a survivor to return to their home or dwelling, it is important to make appropriate referrals for shelter or safe housing, or work with the survivor to identify a safe place that they can go to (such as a friend's home; women- and girl-friendly safe space, or a church). These situations should be anticipated and discussed during the process of establishing referral networks and pathways.

WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

MINI LECTURE[152] (5 minutes)

Explain to participants:

- In addition to referring survivors for health services, you also have a role to play to link survivors to protective services if they have safety and security concerns.
- Survivors who have experience SV in the context of IPV, or who are residing with the perpetrator, may not feel safe to go home. They may be at risk of further violence, or escalating violence.
- It is therefore very important to talk with the survivor about their situation, and if they feel safe to go home. It is very important to be aware of signs that could indicate that a survivor is at risk of escalating violence at home.
- They should therefore ask how the survivor sees the situation, and whether or not they feel safe going home.
- It is not possible to eliminate a survivor's risk of violence completely; however, it is possible to enhance their safety, even if only slightly.
- This involves assessing their immediate risks of violence, exploring options and available resources, and identifying concrete steps.
- **If the survivor is worried about their safety, take them seriously.**
- If the survivor seems unsure about whether or not they are safe to go home, you can ask different questions to learn more about their situation.
- You can also ask about places in their community that are safe and not safe. If there are places in the community that are unsafe, you can discuss strategies for how the survivor can avoid that place, or to plan to go to that place with friends and family members for support and protection.
- If the survivors feel unsafe or are unable to find the means to go home safely, with the survivor's permission, you should contact relevant protection services (safe spaces, women's groups, etc.) to arrange for services to protect the survivor's safety.

[152] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- You should also share information about referrals for protection services beyond shelter and safe housing, including women's groups and other community groups.

11.7 Special considerations for survivors experiencing IPV

Tell participants:

- Survivors experiencing IPV are at risk of continued violence if they return home, but they may not have other options for places to go. They may also not wish to end the relationship, or not be able to end the relationship.
- Remember: it is never appropriate to judge or blame survivors of IPV for remaining in their relationships. Survivors of IPV face many barriers to leaving abusive relationships, including custody of their children.
- Survivors of IPV are at greatest risk of violence and murder when they are attempting to end a relationship.
- **CHWs should NEVER force an IPV survivor to leave an abusive relationship, or try to pressure the survivor to leave the relationship.**
- An abusive partner may further harm or even kill the survivor.
- Instead, your role is to help the survivor with safety planning, so that survivors can consider their options and plan accordingly.
- **Survivors who answer "yes" to any of the following questions may be at an especially high immediate risk of violence.**
  - Has the violence happened more often, or become worse, over the past six months?
  - Has the person (husband, boyfriend, etc.) ever used a weapon or threatened you with a weapon?
  - Has the person ever strangled or "choked" you, or obstructed your breathing?
  - Has the person ever threatened to kill you? Do you believe the person could kill you?
  - Has the person ever beaten you when you were pregnant?
  - Is the person violently and constantly jealous of you?
  - Does the person make threats about what they will do if you try to leave?
  - Have you recently left the relationship, or attempted to leave the relationship?
- These are serious indicators that the survivor is at a very high risk of serious violence, including murder.
- If the survivor answers yes to any of these questions, you should communicate that you are very concerned about their safety, and that you want to be sure that they have a plan to be safe.
- You can ask the survivor if they are currently working with any case managers, or other protection services.

- If the survivor is at high risk of recurrent violence, or if they have other safety concerns, CHWs can review the following to develop a safety plan.
    - **Safe place to go:** If you need to leave your home in a hurry, where could you go?
    - **Planning for children:** Would you go alone or take your children with you? Is there a safe person who can care for you children, if you have to go to the safe place by yourself?
    - **Transport:** How would you get there?
    - **Items to take with you:** Would you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential? Can you put these items together in a safe place or leave them with someone, just in case?
    - **Financial:** Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
    - **Support of someone close by:** Is there a neighbor you can tell about the violence, who can call the police or call for help, and/or assist you if they hear sounds of violence coming from your home, or if you reach them in the event of violence?
- **Survivors who continue to live in violent relationships need more comprehensive safety planning and specialized support. Typically, safety planning and case management are specialized skills that are conducted by trained social workers, psychologists, and others.** If these persons exist, refer survivors to them for more comprehensive, longer-term support.

Ask if participants have any questions before moving on to the next section.

11.8 What should be shared about the follow-up visit?

MINI LECTURE[153] (5 minutes)

Explain to participants:

- All survivors of sexual violence will benefit from follow-up care.
- Survivors should return for follow-up care in two weeks (preferably one week if taking PEP), then at 1 month, 3 months, and 6 months if feasible.
- It is important to explain to the survivor what will happen during follow up visits, and why it is important for survivors to have follow up visits if possible.
- During a follow up, you will ask the survivor how they are feeling, how wounds or injuries are healing, and how they are doing with any medicines they are taking (e.g. are they having any side effects?).
- You should ask the survivor if they have any questions about the care they have received, and next steps.
- You can also help the survivor with referrals to other support services, if they wish.

153 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- If the survivor agrees to a follow-up visit, decide on a time and a safe place to meet. Note this information on the intake form.
- If the survivor is taking PEP and/or prefers to meet earlier, then you should plan to do so.
- You should also emphasize that the survivor is welcome to reach out to you at any time if they have questions, or if they need anything.

Ask participants if they have any questions before moving on to the next section.

11.9 What should CHWs discuss about the intake form?

DISCUSSION (15 minutes)

1. There are important steps you must take to prepare the intake form for referrals:
   - If you will be referring the survivor to the health facility, make a copy of the intake form for them to give to the health provider. This is very important! This will help the provider know what care has been provided so that they do not ask unnecessary questions.
   - However! In some situations, and in some settings, it may not be safe for the survivor to be the person responsible for taking the intake form to the health facility. For example, if they are not going to the health facility right away, or if there is a risk they could be stopped by security personnel.
   - In these cases, it may be best for you, or another program staff person, to be responsible for transferring the records. **Any decision must be made with the survivor's consent.**

2. There is also very important information that you should be prepared to share with survivors about the intake form:
   - You must explain to the survivor what you will do with their original intake form.
   - You should tell the survivor that:
     - The intake form does not contain any information that could be used to identify them (for example, their name or where they live). You can show them this clearly on the intake form.
     - The original intake form will be stored safely in a locked cabinet, and that they can request a copy at any time.
     - When they come back for a follow-up visit, the same form will be used.
     - If they would like to take home a record of the visit at this time, they can be given a copy of the intake form.
     - You should also tell them that basic information about the care the CHW has provided – without any identifying information – will be safely shared with the program, to monitor the program and so that the program can provide the survivor with any follow up care they would like over the coming months.

3. You should also explain to the survivor that, if they would like, they can also have a copy of the intake form to take with them. However, it is very important that you discuss the benefits AND the possible risks:

- The benefits could be that even if they were to move homes, they would still have a record of the visit.
- A possible risk is that if someone were to find the form, it could put their safety and privacy at risk. This is especially true for survivors of IPV, or survivors who share a home with their abuse.
- If someone were to find the form and to tell others in the family or community, this could also pose risks for the survivor.
- If the survivor does not wish to have a copy of the intake form, or feels it is not safe to have a copy, you should remind them that they can always request a copy or see the intake form from the program at any time.

4. If the survivor requests a copy:

- Make the survivor an exact copy of the original.
- Make sure to keep the original, and note at the bottom of the intake form that a copy of the record has been given!
- You can also discuss with the survivor where in their home they can safely keep the intake form, so they have a plan in place when they leave.

Ask participants if they have any questions before moving on to the next section.

11.10 After the survivor leaves, what should CHWs do?

MINI LECTURE (5 minutes)

Tell participants:

- You should transfer the information from the intake form to the monitoring form as soon as possible.
- It is better for you to transfer the information soon after the consultation, so that the interaction is still fresh in you mind.
- It is important that the monitoring form has no mistakes, since the information recorded on the form is what program staff will use to monitor the success of the pilot program.
- Once you have transferred the information, you should file the original intake form and any other relevant documents in a locked cabinet and follow the program's data handling processes.

Direct participants to their copies of the monitoring form.

- Review each column of the monitoring form with participants, so that they understand how to transfer the information from the intake form and keep their notation consistent.
- Remind participants to triple check what the information on the monitoring form is complete and correct!

Review with participants, in detail, the data handling processes that will be used in the pilot program.

Ask participants if they have any questions before moving on to the next section.

12. Putting this all together

12.1 How can critical skills be demonstrated?

Facilitator's notes

For this exercise, you should make copies to give to participants/ so that they can practice using the form as they review the scenarios. There are several different ways to complete this exercise. Depending on the participants and amount of time available, you can choose to review all scenarios as a group, or divide participants into smaller groups and have them go through one scenario each to present to the larger group. This exercise can also be done as a role play in pairs, where one person plays the CHW and the other the survivor. If you use role plays, participants can practice obtaining consent, taking a history, providing care, and planning next steps. Treatments should follow local protocols. **If possible, it is best to have participants complete the exercise as role plays, and that all participants have the chance to role play the CHW for each scenario.**

Scenarios[154] (1.5 hours)

1. Explain to participants:

- For each of the following scenarios, you will need to use the information provided about the incident of SV, the amount of time since the incident occurred, and the survivor's sex, age, and weight to determine what care should be provided.
- You will need to indicate which doses of medicine to be given.
- You will practice using the health history and intake forms, and writing the appropriate information down.
- You will also need to determine what information should be shared with the survivor as part of counselling, and the appropriate services you can refer the survivor to.
- You will practice using the survivor-centered approach and providing frontline psychosocial support (LIVES), obtaining informed consent/assent, providing counselling, and making referrals.

Ask participants if they have any questions before moving on to the scenarios.

154 International Rescue Committee, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2020.

Scenario 1: A 36-year-old cisgender woman comes to the CHW three days after being sexually assaulted (vaginal penetration with a penis) by someone she does not know. She states she wants all available treatment. She says she has no allergies that she knows of, and does not have belly (abdominal) pain or bleeding. She does not think she is currently pregnant, since her last monthly bleeding was 2 weeks ago. She does not know her HIV status. You have no dedicated emergency contraception; however, you do have a combined oral contraceptive with 0.05 mg of estrogen estradiol (EE) and 0.25 mg of levonorgestrel (LNG).

Response

Care	Dose (follow local protocol)
Antibiotics to prevent sexually transmitted infections	• Give 400 mg of cefixime and 1,000 mg of azithromycin by mouth as single doses to prevent gonorrhea, chlamydia, and syphilis.
Screening tests (pregnancy, HIV)	• Urine pregnancy test is not necessary unless the survivor requests; since the assault took place 3 days ago, it would be too early for it to show. • Provide voluntary counseling and testing for HIV or, if not available, encourage the survivor to go to the health facility for HIV testing and counseling.
Emergency contraception (pills) to prevent unwanted pregnancy	• Give 2 tablets of EE and LNG for the first dose. • Advise the survivor to take 2 tablets of EE and LNG after 12 hours.
Post-exposure prophylaxis to prevent HIV	• If HIV negative, give 28-day supply of combined tenofovir (300 mg)/lamivudine (300 mg), and dolutegravir (50 mg). One tablet of each medication should be taken once a day for 28 days. If HIV testing is not available, still give PEP.
Wound care (basic)	• None.
Other medical care (medication abortion, vaccines, etc.)	• Administer or refer the survivor to a health facility for a tetanus vaccine and hepatitis B vaccine.
Emotional care (basic)	• Basic counseling.
Referral (HIV, safe abortion >12 weeks, vaccines, other health, protection, psychosocial, social, etc.)	• Refer as needed for protection, psychosocial, and other support services.
Follow-up care	• Advise the survivor to come back in 2 weeks, preferably in 1 week, since giving PEP. Repeat pregnancy test at 2 weeks. • Follow up at 1, 3, and 6 months. Repeat pregnancy test at 1 month, STI testing if survivor has symptoms, and HIV test at 3 and 6 months. Also give remaining tetanus vaccines (1 and 6 months) and hepatitis B vaccines (1 and 6 months).

- If the survivor asks about sexual relations after the assault, CHWs should advise that they should wait until their genitals no longer hurt and any tears have healed. For many women, having sex makes them think about the assault. If possible they should not be pressured into having sex.[155]
- Survivors can be reminded to use condoms to protect against infections, especially if they are not sure if their partner(s) has an STI.
- As discussed, survivors who are taking PEP should be encouraged to use condoms every time the survivor has sex until the follow-up HIV test is negative.

[155] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- Referral services that may be beneficial are psychosocial support, mental health services, and any other support they may like. These should be discussed and planned with the survivor's consent.

Scenario 2: A 5-year-old boy is brought for care one day after being sexually assaulted by his uncle (anal penetration with a penis). He weighs 15 kg. He is crying and is in pain. His mother states she wants all available treatment. She states he has no allergies that she knows of.

Response

Care	Dose (follow local protocol)
Antibiotics to prevent sexually transmitted infections	• Give 120 mg of cefixime and 300 mg of azithromycin by mouth as single doses to prevent gonorrhea, chlamydia, and syphilis.
Screening tests (pregnancy, HIV)	• Urine pregnancy test is not indicated. • Provide voluntary counseling and testing for HIV or, if not available, encourage the survivor's caregiver to take the survivor to the health facility for HIV testing and counseling.
Emergency contraception (pills) to prevent unwanted pregnancy	• None. Not applicable.
Post-exposure prophylaxis to prevent HIV	• Give 28-day supply of zidovudine 100 mg capsules (84 capsules) and lamivudine 150 mg tablets (28 tablets). Advise that one capsule of zidovudine should be taken three times a day. Half a tablet of lamivudine should be taken twice a day. • Test for HIV, or if testing capacity is not available, encourage mother to take the child to the health facility for HIV testing and counseling.
Wound care (basic)	• Refer to the health facility since the boy is reporting pain. He can be given paracetamol to manage the pain.
Other medical care (medication abortion, vaccines, etc.)	• Administer or refer the survivor to a health facility for a tetanus vaccine and hepatitis B vaccine.
Emotional care (basic)	• Provide basic counseling and referral to psychosocial support/mental health services.
Referral (HIV, safe abortion >12 weeks, vaccines, other health, protection, psychosocial, social, etc.)	• Refer as needed for child protection and other support services, with the caregiver's consent..
Follow-up care	• Advise the mother to bring the boy back in 2 weeks, preferably 1 week. • Follow up at 1, 3, and 6 months. Offer STI testing if survivor has symptoms, and HIV test at 3 and 6 months. Also give remaining tetanus vaccines (1 and 6 months if needed, although refer to local guidance) and hepatitis B vaccines (1 and 6 months).

- A five-year-old child should not be asked directly about the assault. Instead, CHWs should ask the mother what happened.
- Never restrain or force a frightened child to do anything against their wishes. Restraint and force are often part of sexual abuse, and if used by those attempting to help, this will increase the child's fear and anxiety, and worsen the psychological impact of the violence.
- What is best for the child should be considered at all times, especially the child's physical safety. Any referral and follow-up plans must be made with this in mind.
- CHWs should know how to address mandatory reporting requirements (inform those who will report) and discuss this issue with the caregiver.

Scenario 3: An 11-year-old girl is brought to the clinic by her aunt, who is her guardian. She reports multiple sexual assaults by a group of five soldiers four days ago. Her aunt is very concerned about HIV. She wants all possible treatment given to the girl. The girl's weight is 35 kg. She shows signs of breast development. The girl reports bleeding from her bottom.

Response

Care	Dose (follow local protocol)
Antibiotics to prevent sexually transmitted infections	• Give 280 mg of cefixime and 700 mg of azithromycin by mouth as single doses to prevent gonorrhea, chlamydia, and syphilis.
Screening tests (pregnancy, HIV)	• Urine pregnancy test is not necessary: since the assault took place 5 days ago, it would be too early for it to show. • Provide voluntary counseling and testing for HIV or, if not available, encourage the caregiver to take the survivor to the health facility for HIV testing and counseling with her assent.
Emergency contraception (pills) to prevent unwanted pregnancy	• Give one dose of ulipristal acetate 30 mg, or, if not available, one dose of levonorgestrel 1.5mg. EC can be given to an adolescent who has developed breast buds, even if she has not begun menstruating.
Post-exposure prophylaxis to prevent HIV	• PEP is not indicated since the survivor presented after 72 hours (3 days) since the incident.
Wound care	• Refer to the health facility for bleeding from her genitals. Give pain relief, such as paracetamol.
Other medical care (medication abortion, vaccines, etc.)	• Administer or refer the survivor to a health facility for a tetanus vaccine and hepatitis B vaccine
Emotional care	• Provide basic counseling and referral to psychosocial support/mental health services.
Referral (HIV, safe abortion >12 weeks, vaccines, other health, protection, psychosocial, social, etc.)	• Refer as needed for child protection and other support services.
Follow-up care	• Advise the survivor to come back in 2 weeks, preferably 1 week. • Follow up at 1, 3, and 6 months. Repeat pregnancy test at 1 month, STI testing if survivor has symptoms, and HIV test at 3 and 6 months. Also give remaining tetanus vaccines (1 and 6 months) and hepatitis B vaccines (1 and 6 months).

- Since the assault took place >72 hours ago, ulipristal acetate is a more effective regimen. However, if only levonorgestrel only tablets are available, they can be given, as can combined oral contraceptive pills.
- CHWs should be careful working with younger adolescents. Similar considerations on the best interest of the child need to be made.

Scenario 4: A 28-year-old transgender man comes to the CHW two days after being sexually assaulted (vaginal penetration with a penis). They state that they would like all available treatment. They say they have no allergies that they are aware of, and do not have belly pain or bleeding. They are not on any hormone therapy, and have not had any surgeries in the past.

Response

Care	Dose (follow local protocol)
Antibiotics to prevent sexually transmitted infections	• Give 400 mg of cefixime and 1,000 mg of azithromycin by mouth as single doses to prevent gonorrhea, chlamydia, and syphilis.
Screening tests (pregnancy, HIV)	• Urine pregnancy test is not necessary since the assault took place 2 days ago, it would be too early for it to show. However, the survivor is still at risk of pregnancy since they have a uterus and ovaries. • Provide voluntary counseling and testing for HIV or, if not available, encourage the survivor to go to the health facility for HIV testing and counseling.
Emergency contraception (pills) to prevent unwanted pregnancy	• Give 1 tablet of levonorgestrel 1.5 mg.
Post-exposure prophylaxis to prevent HIV	• Give 28-day supply of combined Tenofovir (300 mg)/lamivudine (300 mg), and dolutegravir (50 mg). One tablet of each medication should be taken once a day for 28 days.
Wound care (basic)	• None.
Other medical care (medication abortion, vaccines, etc.)	• Administer or refer the survivor to a health facility for a tetanus vaccine and Hepatitis B vaccine.
Emotional care (basic)	• Basic counseling.
Referral (HIV, safe abortion >12 weeks, vaccines, other health, protection, psychosocial, social, etc.)	• Refer as needed for protection and other support service.
Follow-up care	• Advise them to come back in 2 weeks, preferably 1 week, since they are taking PEP. • Follow up at 1, 3, and 6 months. Repeat pregnancy test at 1 month, STI testing if survivor has symptoms, and HIV test at 3 and 6 months. Also give remaining tetanus vaccines (1 and 6 months) and hepatitis B vaccines (1 and 6 months).

Scenario 5: A 22-year-old cisgender woman comes to the CHW 7 weeks after being sexually assaulted by an unknown man. She is concerned that she may be pregnant since has not had her monthly bleeding since two weeks before the assault. She typically has her menses every month; the last one was normal for her. She does not have any physical pain, and reports she has not experienced any abnormal vaginal discharge. If she is pregnant, she would not like to remain pregnant.

Response

Care	Dose (follow local protocol)
Antibiotics to prevent sexually transmitted infections	• Provide presumptive treatment
Screening tests (pregnancy, HIV)	• Offer urine pregnancy test. • Provide voluntary counseling and testing for HIV, or, if not available, encourage the survivor to go to the health facility for HIV testing and counseling.
Emergency contraception (pills) to prevent unwanted pregnancy	• Not indicated since beyond 120 hours since assault.
Post-exposure prophylaxis to prevent HIV	• Not indicated since beyond 72 hours of the assault.
Wound care (basic)	• None.
Other medical care (medication abortion, vaccines, etc.)	• Estimate how far along the survivor's pregnancy is. Since the survivor was assaulted 2 weeks after her last menses, she is likely 9 weeks pregnant and eligible for medication abortion. • Since pregnancy is less than 10 weeks, give 200 mg orally of mifepristone. After 24-48 hours, give 800 micrograms of misoprostol buccally (in the cheek), sublingually (under the tongue), or vaginally for one dose. • Provide post-abortion care contraceptive counseling and give any methods that are available. • Administer or refer the survivor to a health facility for a tetanus vaccine and hepatitis B vaccine.
Emotional care (basic)	• Basic counseling.
Referral (HIV, safe abortion >12 weeks, vaccines, other health, protection, psychosocial, social, etc.)	• Refer as needed for protection and other support service.
Follow-up care	• Advise the survivor to come back in 2 weeks. If the pregnancy has not terminated in 4-5 days after taking the abortion medication, the survivor should seek out the CHW. • Follow up at 1, 3, and 6 months. Repeat pregnancy test at 1 month, STI testing if survivor has symptoms, and HIV test at 3 and 6 months. Also give remaining tetanus vaccines (1 and 6 months) and hepatitis B vaccines (1 and 6 months) if the course was started.

- Since the survivor is presenting seven weeks after the incident, she will likely show signs of STIs, if she has them. **Not all survivors will present with symptoms, even if they are infected, however.** CHWs can prescribe presumptive treatment or syndromic management (see Advanced Module 8) if the survivor has symptoms such as pain, itching, sores, or discolored or foul-smelling vaginal discharge.
- 10-12 weeks of gestation: Give 200 mg orally of **mifepristone**. After 36-48 hours, give 800 micrograms of **misoprostol** vaginally, then 400 micrograms vaginally or sublingually (under the tongue), every 3 hours for a maximum of 5 doses of misoprostol.
- If the pregnancy is between 12 and 14 weeks and 0 days, the survivor can undergo manual vacuum aspiration to terminate the pregnancy. This should be available at the health center.
- If the pregnancy is beyond 14 weeks, the possibility of termination will be based on whether a referral is available for dilatation and evacuation (D&E) or misoprostol-based method.
- If it is not possible to estimate how far the pregnancy is due to the survivor not having reliable menses, she will need to be referred to a health center if the pregnancy is likely more than 12 weeks. However, even if the survivor does not recall the exact first date of her last menstrual bleeding, if it has been less than 12 weeks since her last menses, she can be considered for medication abortion if the site permits.
- If only misoprostol is available, the regimen for ending pregnancies up to 12 weeks is:
  - Misoprostol 800 micrograms (four 200 microgram pills) vaginally every 3-12 hours for a maximum of 3 doses.
  - Misoprostol 800 micrograms (four 200 microgram pills) sublingually (under the tongue) every 3 hours for a maximum of 3 doses.
- If the survivor is concerned she will not know if the abortion was successful, ask her to consider the following questions:
  - Did you have cramping after you took the abortion pills?
  - Did you have bleeding after you took the abortion pills?
  - Did you pass tissue or see blood clots after you took the abortion pills?
  - Did any pregnancy symptoms (e.g., nausea, morning sickness) you had before taking the pills go away after taking the abortion pills?
- While any wounds that the survivor sustained may have healed by the time she presents, the CHW may consider giving the tetanus vaccine if she has never been vaccinated or has not been fully vaccinated. Similarly with the hepatitis B vaccine, as these can still be protective for the survivor moving forward. The availability of supplies and access should help determine whether these are reasonable vaccines to provide.

After the participants have completed all the scenarios, have them practice transferring information from the intake forms to the monitoring form.

Ask participants if they have any questions before moving on to the next section.

SESSION 5.3 Providing follow-up care to survivors of sexual violence

Session time	• 3 hours (2 hours 30 minutes without optional activity)
Objectives	By the end of this session, participants will be able to: • Understand what follow-up care is offered to survivors at 2 weeks, 1 month, 3 months, and 6 months. • Learn ways that CHWs can help survivors in the healing process. • Learn how to provide post-abortion care, and when to refer to higher-level care.
Methods	***MINI LECTURE*** • Scenario • Case Study • Discussion
Preparation	• Prepare lecture. • Know if pregnancy tests are available and how soon they can detect pregnancies. • Know the legal indications for safe abortion care.
Training aids, materials, and handouts	• Flip chart and markers. • Intake form (HO) • Monitoring form (HO)
Evaluation and assessment	• None.

Additional resources	• WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. • IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. • IRC, *Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool*, 2008. • WHO, *Guidance on couples HIV testing and counselling—including antiretroviral therapy for treatment and prevention in serodiscordant couples: Recommendations for a public health approach*, 2012.

1. Providing follow-up care

1.1 What is follow-up care?

MINI LECTURE (10 minutes)

Explain to CHWs that during the follow-up visit, CHWs will:

- Ask the survivor how they are doing with the medications, and any side effects they are experiencing. (See section 1.2.)
- If the survivor has additional health problems, assess per skills taught in Module 5 on whether they will need to be seen by a higher-level health provider.
- If they have not already been tested, ask if the survivor wants to take an HIV test. If they agree, refer them to the health center. This is always optional.
- Encourage partner referral for STI and HIV testing and treatment as necessary. (See sections 1.2.1-1.2.2.)
- See whether or not the survivor may be pregnant and provide counseling as necessary. (See section 1.3.)
- Assess the survivor's emotional state and ensure they have appropriate psychosocial and mental health support. (See section 1.5.)
- Ask the survivor if any support services have been helpful (if referrals were made and completed).
- Decide together what additional referrals the survivor would like, including health services, psychosocial, mental health, protection, social, and legal support. Referrals should follow the same processes as previously discussed.
- Discuss new or existing safety concerns.
- CHWs should document the care they provided and any issues of concern on the intake form. If the survivor requests a copy for their records, give them a copy, weighing the security risks.

1.2 How should CHWs follow up with survivors on their treatment?

MINI LECTURE[156] (15 minutes)

When CHWs ask the survivor how they are doing with the medications and any side effects they are experiencing, they should also:

- Remind survivors to finish the full course of antibiotics to prevent or treat STIs.
- If the survivor is taking PEP, remind them to complete the 28-day treatment regimen.

[156] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- If the survivor has been tested for HIV, ensure they are following the instructions they received at the health facility. If HIV positive, the survivor should no longer be taking PEP. (See section 1.2.1-1.2.2 on how to discuss HIV testing with their partner.)

If the survivor did not take an HIV test, CHWs should encourage them to be tested.

CHWs can ask a survivor if they have noticed any of the following common symptoms and signs of an STI, such as:

- Unusual vaginal discharge (liquid) in terms of amount, smell, or color.
- Itching of the vagina.
- Pain while passing urine.
- Pain during sex.
- Lower belly pain.
- Rash, sores, or ulcers in the genital areas.

If the survivor has symptoms of an STI, it could be because the medicine did not work or they have a new infection from a partner(s) who also has an STI. CHWs should **refer cases of treatment failure or recurrent STI infection** to a higher-level health facility. Messages to provide survivors for relief from the discomfort of some STIs are:

- Wear underclothes made of cotton.
- Wash underclothes once a day and dry them in the sun.
- Sit in a pan of clean, warm water for 15 minutes, 2 times a day.
- If it is painful to pass urine, pour clean water over the genital area while passing urine.

Facilitator's notes

Advanced Module 8 has information on syndromic management of STIs as well as partner notification and management strategies for STIs.

1.2.1 How can partners be encouraged to get treated/tested for STIs and HIV?

MINI LECTURE[157] (10 minutes)

Tell participants:

- Remember! Someone who has treated for an STIs, or has taken antibiotics to cure gonorrhea, syphilis, or chlamydia, can be affected again in the future!
- A survivor who is treated for an STI may be reinfected, if their sexual partner(s) is not treated.
- The sexual partner may or may not have symptoms and, if left untreated, could continue to (re-) infect their partners.
- It is also possible that the survivor's partner already has an STI, and that they could pass it to the survivor if the partner does not also get treatment.
- "Partners" include survivor's current sexual partner(s), and all partners within the last three months.
- Many people living with HIV do not have signs and symptoms of the infection.
- Even if a survivor takes medication to prevent HIV transmission after an assault, it is possible that this medication does not work. Therefore, they should use condoms for three months with all partners for every act of sexual intercourse (vaginal, anal, and ideally oral) until a repeat HIV test is obtained to confirm their HIV status.
- In other cases, a survivor might test positive, and wish to learn what their partner's HIV status is, too.
- This can be a difficult issue for partners to talk about and survivors should never be forced to share information about their health or treatments with anyone else (including partners), especially if doing so could put their safety at risk. This is of particular concern for survivors experiencing IPV.
- You can discuss with the survivor whether or not they think it is safe and appropriate for them to go with their partner to the health facility, so they can both be tested and treated for any STIs, and learn their HIV status. This can help them work together as a couple to plan for their health and their future.

[157] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

1.2.2 What are the benefits of couples HIV testing and counseling over individual testing?

DISCUSSION[158] (15 minutes)

1. Draw two columns on a sheet of flip chart paper. Label one column: "Couples HIV counselling and testing." Label the other column" "Individual HIV counselling and testing."

2. Ask participants: What are the benefits of HIV couples counseling and testing, where appropriate? Call on as many participants as wish to speak. Write down participants' responses in the appropriate column.

3. After you have called on participants, compare their responses with the left column on the table below. Add anything that has been missed.

4. Then, go through each of the corresponding statements under "Individual HIV counselling and testing." Add each statement to the table as you go.

5. Before moving on, emphasize to participants: it will not be safe or possible for all survivors to try to have their partner come with them for HIV treatment and testing. Survivors should never be forced to share information about their health or treatments with anyone else (including partners), especially if doing so could put their safety at risk. This is of particular concern for survivors experiencing IPV.

• Couples HIV counseling and testing	• Individual HIV counseling and testing
• Partners learn each other's HIV status.	• Survivor learns only their own HIV status.
• Counselor can help ease the tension and diffuse blame.	• Survivor is faced with the burden of disclosing to their partner.
• Partners hear information together, enhancing likelihood of shared understanding.	• Only one person hears the information.
• Counseling messages are based on the results of both members, and can be tailored to positive concordant (both partners HIV positive), negative concordant (neither partner HIV positive), and discordant (one partner HIV positive, one partner HIV negative) couples.	• Counseling messages take into account only one person's status.
• The counselor creates a safe environment and can help couples talk through issues they may not have disclosed before.	• There is no moderated opportunity for couples to talk through difficult issues.

[158] Table from K4Health, *Couples HIV Counselling and Testing: A Trainer's Manual*, 2009.

- Treatment and care decisions can be made together.
- Treatment and care decisions are more likely to be made in isolation.

GAME[159] (10 minutes)

1. Have participants stand up and gather in the center of the room. Tell participants: Now, we're going to play a game to exploring myths and misperceptions about disclosing HIV status.

2. Read each statement below and ask participants if they think it is true or false. Those thinking "true" should go to the right side of the room; those thinking "false" should go to the left. Once all participants have moved, read the fact. Then, ask participants if they have reflections, questions, or thoughts.

   Statement 1: If one partner is HIV positive, the other partner must also be positive.

   Answer: False

   Fact: Partners in a relationship can have different HIV status. One partner's HIV status does not determine the other partner's HIV status, and just because one partner is infected, it does not necessarily mean the other partner is, too. The only way to find out is through an HIV test.

   Statement 2: If one partner is HIV negative, their partner cannot have HIV.

   Answer: False

   Fact: As stated above, couple members can have different HIV status. One partner's HIV status does not determine the other partner's HIV status.

   Statement 3: If someone learns they are HIV negative, after their partner learns they are HIV positive, it is a protection from God.

   Answer: False

   Fact: The HIV-negative partner can become infected at any time if they do not take measures to lessen risk.

   Statement 4: If you have being having unprotected sex with someone living with HIV, you might as well continue, as you probably already have HIV.

   Answer: False

   Fact: Although HIV may not have transmitted in previous exposures, every new exposure poses a risk of HIV transmission. It is never too late to take measures to lessen risk.

[159] Myths and facts adopted from K4Health, *Couples HIV Counselling and Testing: A Trainer's Manual*, 2009.

1.3 What should CHWs do if a survivor learns they are pregnant? (Optional)

Facilitator's notes

Know in advance if urine pregnancy tests are available in the pilot site, and how soon they can detect pregnancies. Also know the legal indications for safe abortion care, which may include rape, preserving the mental and physical health of the pregnant person, and in cases of fetal defect.

Prior to the training, you should prepare to train participants on how to use the urine pregnancy tests available in the pilot site. You can prepare a flip chart paper to clearly show the signs that mean the test is positive or negative.

MINI LECTURE (5 minutes)

Tell participants:

- You can administer a pregnancy test if survivors report that their menstrual period is late, and they agree to be tested.
- If the test is positive, you can counsel the survivor on the different options and services available to them in their community. You should begin counselling by asking the survivor if they know what they would like to do.
- If safe abortion care services are available in the community, you should share this information with the survivor. In some settings, while safe abortion care may be legal in cases of sexual violence, even if it is restricted under other circumstances. Remember: you must share information about safe abortion care, and make referrals for safe abortion care, no matter your personal beliefs about abortion.
- You should also share information about any maternal and newborn health services, and adoption services available in the community.

1.4 What if a survivor has an incomplete medication abortion?

MINI LECTURE[160] (20 minutes)

Tell participants:

- A survivor may present after attempting a medication abortion, but has been unable to pass the contents of the uterus after 4-5 days of taking the mifepristone or misoprostol. This is called an incomplete abortion.
- Such survivors may report minor bleeding or camping.
- If you suspect an incomplete, and the survivor does not have signs of infection (see below), and the pregnancy is less than 13 weeks, you can give another dose of misoprostol:
  - Misoprostol 600 micrograms (three 200 microgram pills) by mouth as a single dose.

[160] Hesperian Foundation. "Emergency care for problems after miscarriage or abortion," A Handbook for Midwives. 2021; and Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

OR

- Misoprostol 400 micrograms (two 200 microgram pills) under the tongue as a single dose.

- While misoprostol is very safe, on rare occasions, it can cause too much bleeding or an incomplete abortion.
- If the uterus does not empty completely, the survivor should be referred to the health center as soon as possible for vacuum aspiration or other methods.
- The pregnancy may also not be in the uterus but in the surrounding organs (fallopian tubes) (a tubal pregnancy, or ectopic pregnancy), which may be the cause of an incomplete abortion with additional misoprostol.
- Similar to counseling around providing safe abortion care, for women who have undergone post-abortion care, you should counsel survivors on post-abortion contraception:
  - Ovulation can occur as early as 10 days after an abortion, resulting in pregnancy even before their monthly returns.
  - All methods, including an IUD or hormonal methods, may be started immediately after uncomplicated vacuum aspiration.
  - Hormonal methods, including implants, oral contraceptive pills, and injectables, may be started on the same day as the first dose of the medication abortion drug.
  - IUDs can be used as soon as the person is no longer pregnant.
- You should provide the available contraceptive methods that the survivor desires before the survivor leaves.
- If you are trained in Depo-Provera injections, you can provide the injection at this time.
- If the survivor declines contraception but does not wish to become pregnant in the near future, you can send them home with EC pills.

Facilitator's notes

Routine follow-up after treatment of incomplete abortion (PAC) with misoprostol is not necessary. If there are complications, the woman should go to a health facility immediately. If the woman desires follow-up care, she may be scheduled for an appointment approximately two weeks after taking the misoprostol.

Inter-Agency Working Group on Reproductive Health in Crises. *"Chapter 8: Comprehensive Abortion Care" from* Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2018.

1.5 What is a survivor has had an unsafe abortion?

MINI LECTURE[161] (30 minutes)

Ask: Who can recall what it means for someone to have an unsafe abortion? Call on participants.

Tell participants:

- If a survivor has attempted to terminate their pregnancy under unsafe or unsanitary conditions, they may be at risk of serious complications that could result in death.
- Someone who has had an unsafe abortion may experience vaginal bleeding, pain, and fever or chills, and may need treatment for incomplete abortion.
- Other people who have had an unsafe abortion may have more severe complications. Someone suffering more severe complications may present with shock, severe bleeding, severe infection (sepsis), and injury inside the belly. They may also need treatment for an incomplete abortion.
- Warning signs of an incomplete abortion are:
  - **Tissue coming out of the vagina**. Pieces of tissue may be coming out of the vagina, or the lower belly (uterus) may still feel enlarged because of tissue inside.
  - **Infection**. The survivor might have a fever, a bad smell coming from the vagina, or pain in the belly.
  - **Heavy bleeding** from the vagina.
- **If a survivor is bleeding a lot after an abortion, especially if the blood is bright red and has clots, it means the blood is fresh and flowing. They are in danger and could go into shock or even die. They must be referred immediately.**
- While facilitating the referral to a higher-level facility for emergency care, the CHW can help the woman's uterus contract by applying pressure to the lower belly with their hand while the survivor is lying down or squatting. If there is tissue in the uterus, the survivor may be able to push it out by bearing down, as if they are having a bowel movement or pushing out a baby.
- Survivors may also have an internal injury from an abortion. This is most often caused by a sharp tool making a hole in the uterus. The object may cause harm to other organs inside the body, such as the ovaries, intestines, or bladder.
- When a survivor has internal injuries, they may have bleeding inside the belly that remains in the belly, or they may bleed from the vagina or the anus. Signs of internal bleeding include:
  - Belly feels stiff and hard with no sounds or gurgles inside.
  - Very bad pain or cramps in the belly.
  - Fever with chills or shivering.
  - Nausea and vomiting.

[161] Hesperian Foundation. "Emergency care for problems after miscarriage or abortion," A Handbook for Midwives. 2021; and Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 8: Comprehensive Abortion Care" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

  - Pain in one or both shoulders.
  - Shock.
- **Survivors presenting with signs indicating internal bleeding must be referred to a health facility immediately.**
- While facilitating the referral, you can treat the survivor for shock, but they should not be given any food or drink by mouth (other than any medications and a little water to swallow), since they will likely need urgent surgery.
- Warning signs of infection are:
  - High temperature, above 38°C (100.4°F) or low temperature, below 36 °C (96.8°F).
  - Fast pulse, over 100 beats a minute.
  - Feeling chills and shivering.
  - Swollen, hard, or painful belly.
  - Bad-smelling fluid coming from the vagina.
  - Feeling ill or weak.
- Shock is usually either hemorrhagic or septic.
- Hemorrhagic shock is the result of severe blood loss, which may be caused by an incomplete abortion, uterus that fails to contract, or injury to the vagina, cervix, uterus, or belly.
- Septic shock is the end result of infection, which may come from an incomplete abortion, infection of the uterus, or an injury inside the belly that has become infected.
- To review, symptoms of shock include:
  - Feeling faint, dizzy, weak, or confused.
  - Pale and has a cold sweat.
  - Fast heartbeat, over 100 beats a minute.
  - Fast breathing.
  - Sometimes loss of consciousness.

You should write the symptoms of shock down on a sheet of flip chart paper, to be displayed during the training.

Tell participants:

- **For survivors presenting with any signs of shock from infection or bleeding, you should stabilize the survivor, and refer them for emergency, higher-level care immediately to remove retained products from the uterus, receive IV antibiotics if they have an infection, and IV fluids.**
- As you prepare for the referral, you can help the survivor by:

- Having the survivor lie with their feet higher than their head, and their head turned to one side.
- If the survivor does not have signs of internal bleeding, you can give fluids, such as water or a rehydration drink.

- **Survivors who have attempted an unsafe abortion with a non-sterile object (wire, wood, etc.) should also be referred to a higher-level facility since their risks of developing infection, sepsis, and shock are very high. Such survivors also need a tetanus vaccine if they have not received one in the last 10 years.**

Facilitator's notes

The Hesperian Foundation has more information on managing unsafe abortions, including manual removal of retained products. This is beyond the scope of the training, however.

Hesperian Foundation, "*Emergency care for problems after miscarriage or abortion*." *A Book for Midwives*, revised 2021.

Ask participants if they have any questions before moving on to the next section.

1.6 What are other ways CHWs can support the survivor during follow-up care?

ACTIVITY*[162] *(15 minutes)

1. Tell participants that in this activity, they will brainstorm different ways that CHWs can support survivors when providing follow-up care. Group participants in groups of three to five.

2. Tell participants:

- There are different ways you can support the survivor to identify positive coping mechanisms.
- It may be helpful to identify the key challenges the survivor is facing. You can ask:
  - What is your biggest worry these days? What are your most serious problems right now?
  - How are these problems or worries affecting you?
- Listen carefully, as survivors may identify worries and problems that could be addressed by different services and programs in the community, that you could refer the survivor to if they would like.
- You can ask the survivor how they are feeling, and how they are doing. You can also ask how the survivor is coping with their feelings and problems, each day.
- If the survivor agrees, you can share different coping strategies.

[162] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

3. Tell participants that they have five minutes to brainstorm different positive coping strategies in their small groups. They can reflect on the different activities they use to cope with their own challenges, and strategies that can help people to manage stress and anxiety.

4. After five minutes, bring the groups back together. Ask participants to share the different strategies and ideas they have come up with. Call on all participants who wish to speak.

5. Conclude the activity by sharing with participants:

- If the survivor wishes to discuss coping strategies, it is very important to be thoughtful, supportive, and non-judgmental. Not all coping strategies work for all people.
- You should also be sensitive and non-judgmental to negative coping mechanisms, and that survivors have experienced a serious trauma. Survivors may be using alcohol or drugs, and experiencing depression, anxiety, and PTSD. Survivors may be sleeping more than normal, or not sleeping very well. They may be eating more or less than normal. They may be isolated.
- You can encourage survivors to:
  - Continue activities, especially ones that they used to find interesting or pleasurable.
  - Engage in relaxing activities - walk, sing, pray, spend time out of doors or in nature, play with children).
  - Spend time with friends, family, and loved ones they enjoy spending time with.
  - Find time to engage in physical activity – walking, stretching, dancing, biking.
  - Meditate, or spend time focusing on their breathing.
  - Try to maintain a regular sleep schedule.
- If a survivor mentions using self-prescribed medications, alcohol, or illegal drugs to try to feel better, you can tell the survivor that what they experienced was very serious, and that this is a common response. You can tell the survivor that this can affect their health, and offer to share information and referrals about mental health and psychosocial support services.
- You can also ask the survivor to reflect on what is going well, and how they have coped with difficult situations in the past. Positive coping can also include building on their strengths, and abilities.

SCENARIOS (35 minutes)

1. Tell participants: We will now work on different scenarios, where survivors have raised different challenges and concerns during follow-up visits.
2. Read each of the following scenarios, and multiple-choice options. Ask participants to raise their hand to provide the answer, and to explain why. After the participant has responded, read the answer below.

Scenario 1: A survivor returns to you one week later complaining of vomiting after taking PEP. What advice would you give them?

a. Tell them to stop taking PEP.
b. Tell them to continue taking PEP with food and anti-nausea medication.
c. Explain to them that this means they are HIV positive.

Answer: B. Nausea and vomiting are common side effects of the medications used for HIV PEP. Survivors should be encouraged to complete the regimen. CHWs should encourage the survivor to take PEP with food to reduce nausea and vomiting. If nausea and vomiting still occur, CHWs can provide anti-nausea medication if it is available. It is important that the person complete the full 28-day treatment regimen in order for PEP to be effective at preventing HIV.

Scenario 2: A survivor finds out they are HIV positive after undergoing HIV testing and counseling. They share their status with you, and they do not know what to do. What advice will you give them?

a. Counsel them to let them know they can stop taking PEP and can access support, care, and treatment services as available.
b. Tell them to continue taking PEP, as it could still help.
c. Explain that if they tested positive now, they must have gotten HIV before the assault, so you are not able to help them.

Answer: A. The ways that you can help survivors living with HIV is by helping them:[163] [164]

- Decide who to tell that they have HIV, and how.
- Find the support of others who are also living with HIV.
- Get the care and treatment they need early from the health center, including preparing for and taking ART.
- Get the support they need from their family, friends, and loved ones.
- Understand how to stay healthy for as long as possible, by eating nutritious foods and getting enough rest.
- Plan for their future.
- Learn how to be sexual in a safe way, through using condoms.

[163] Hesperian Foundation, *A Book for Midwives: Care for pregnancy, birth and women's health*, 2020.
[164] Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

If the survivor is found to be HIV positive, they should stop taking PEP.

Scenario 3: A 21-year-old woman came for care two weeks after the assault. You did not give her EC since it was more than five days since the incident. During the follow-up care, she tells you that she has missed her period, and that she is likely pregnant. What advice will you give her?

a. Explain that you are not able to help her, as she came for care too late to take EC.
b. Give emotional support and share information about the options available to the survivors.
c. Give emotional support, share information about available options, and tell her what you would do in her situation.

Answer: B. Emotional support and clear information are needed to ensure that survivors understand the choices that are available if they become pregnant:[165]

- In many countries, the law allows for termination of a pregnancy as the result of rape. Where safe abortion services are available, let the survivor know where and how they can access this if they so choose.
- There may be adoption or foster care services in the area.
- If the survivor wishes to have the baby, you should offer to share information about maternal and newborn health services, and other available services for pregnant people, babies, and families in their community.
- Encourage survivors to seek support from someone they trust, such as a religious leader, family member, or friend.

1.7 How can CHWs address survivors' emotional needs?

Ask: Think back to what we learned in the earlier modules. What are the different emotional, psychological, and social consequences that survivors may experience after SV? Call on as many participants as wish to speak.

Tell participants:

- The survivor's emotional, mental health, and psychosocial needs are extremely important. The emotional, psychological, and social impacts of SV will often last much longer, or more impactful for the survivor, than any physical consequences of the assault.
- It is important to be mindful and pay attention to signs of how the SV may be affecting the survivor's mental health and wellbeing. This includes noticing the survivor's:
  - Overall appearance (e.g., taking care of themselves)
  - Behavior (e.g., agitation)
  - Facial expression, mood (e.g., crying, anxious, without expression)
  - Body language (e.g., posture, eye contact)

[165] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

  - Speech (e.g., fast, slow, silent) and information they share with you about their mental health and wellbeing.

- You can ask general questions about how the survivor is feeling, and how they are doing. You should emphasize that the information they share with you is private and confidential, except when there are perceived risks to the survivor (e.g., suicide or self-harm) or to others, or if there are any relevant mandatory reporting requirements. General questions to ask include:
  - How have you been feeling? How have you been doing?
  - Have you been having any difficulties or challenges day to day?
  - Are these affecting your life, such as relationships with family and friends, or your work or other activities? How so?

CASE STUDY[166] (1 hour)

1. Tell participants:
   - In this activity, we will examine different case studies with statements that survivors might share with you.
   - We will first identify which common emotional or psychological reactions the survivor is expressing/experiencing (e.g., fear, denial, depression, anxiety).
   - Then, we will discuss the key messages that we can share with the survivor and how we can help them cope.

2. Read each statement. Then, ask participants to identify what the emotional or psychological reaction is. Call on several participants. Then, read the consequence statement.

3. Then, share the coping information with the participants.

Statement #1: "I'm constantly scared. A sudden noise, an angry voice, moving bushes, and I am afraid. I am also afraid that my husband will divorce me if he finds out, and my family will take my children."

Consequence: FEAR.

- During SV, many survivors fear for their lives. Often, this fear is a direct result of the perpetrator's threats.
- After the violence, a survivor may be fearful of the dark, being alone, or going out by themself.
- They may experience fear caused by the possibility of pregnancy or STIs, or live in fear of running into their assailant again.
- They can also be fearful of the possible consequences of people finding out about their experience, including being isolated or rejected.

166 UNICEF, *Caring for Survivors Training Pack*, 2010.

Coping mechanisms:

- All of these fears are very real concerns and you must take the survivor's fears seriously, and take steps to protect the survivor's safety, and help them to feel as secure as possible.
- These fears are normal, rational responses.
- If the survivor has come for care within three days, you can reassure them that the health services they have received to prevent pregnancy, HIV, and STIs will help to protect their health. This may help reduce fears about the health consequences of SV. You can also emphasize that the survivor can always reach out with any questions and concerns, and you will help them to receive care.
- If the survivor reports after five days, talk through the health and support services in the community that they can access if and when they would like to do so.
- In all cases, you should share that you will protect their privacy and confidentiality (noting any exceptions).

Statement #2: "I feel so tense and jumpy."

Consequence: ANXIETY.

- Survivors of SV often experience severe anxiety that may show as physical symptoms, such as difficulty breathing, muscle tension, nausea, stomach cramps, or headaches.
- They are often easily startled.

Coping mechanisms:

- It is important to validate the survivor's feelings, and emphasize that what they are feeling is normal after what they have experienced.
- For many survivors, these feelings will ease over time.
- You can offer to share different techniques and strategies that may help the survivor to cope with their anxiety, if they wish.

Facilitator's notes

Examples of relaxation techniques that can be taught to both adults and children include slow breathing. You should share this technique with participants, so they can share it with survivors.

Slow breathing technique: This technique has the person focus on their breathing so that they breathe deeply and slowly. Breathing in this manner can help to relax the body. Controlled breathing can help to reduce feelings of tension or anxiety, and by concentrating on breathing patterns, the survivor can distract themself from unpleasant thoughts or images. The instructions to share with the survivor are:

- I am going to show you how you can breathe in a way that will help relax your body and mind. It will take some practice before you feel the full benefits of this breathing technique.
- The reason this strategy focuses on breathing is because when we feel stressed, our breathing becomes fast and shallow, making us feel more tense.
- You can do these exercises whenever you are stressed or anxious or cannot sleep. Provide the following instructions and demonstrate the steps and/or practice them together:
  - Sit with your feet flat on the floor. Put your hands in your lap. You may close your eyes or keep them open.
  - Relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
  - Now place one hand on your belly and the other hand on your upper chest. Think about your breath.
  - Slowly breathe out all the air through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon. Demonstrate this breathing—try and exaggerate the pushing out and in of your stomach.
  - Continue to breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out. Demonstrate by counting slowly for breathing in and out.
  - Keep breathing like this for about two minutes. As you breathe, try to feel the tension leave your body.

IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012.

Statement #3: "I want to kill him. I hate him, everything, everyone."

Consequence: ANGER/HOSTILITY.

- Anger is a difficult emotion for most people, but it is a common reaction and emotion that survivors experience after SV.
- Culturally, women and children are often discouraged from expressing anger, and it is most frequently directed at someone other than the person who has caused harm.
- Survivors may also be angry at the response they received from others with whom they shared their experience.

Coping mechanisms:

- If a survivor expresses anger towards you, it is important to remain calm, neutral, and supportive. Remember: the survivor's emotions and reactions are normal responses. Do not take this personally.
- If the survivor agrees, you can share information about different positive coping mechanisms (e.g., walking, deep breathing, playing with children, spending time with loved ones). These mechanisms may help the survivor over time.

Statement #4: "I feel like I don't have anyone to talk to who understands and supports me. I can't tell anyone around me about this."

Consequence: LONELINESS/ISOLATION.

- Survivors often experience feelings of loneliness, isolation, and despair if they are unable to share their experiences with others.
- However, it is normal for survivors to avoid talking about their experiences, since remembering the violence is painful, or they fear that others cannot understand them or they fear being stigmatized or isolated by friends or family.
- However, many survivors never forget their experiences, and these are relived in nightmares and flashbacks. Survivors may experience PTSD.
- This results in a state of fear that can prevent survivors from healing.

Coping mechanisms:

- You can serve as a "safe person" in whom survivors can confide.
- Assure survivors their confidentiality and refer them to support groups and other safe places where they can share their concerns and begin to recover.
- It is very important that survivors are listened to in a compassionate, nonjudgmental way, and they understand that they are not alone and can receive help.
- Ensuring that survivors have the opportunity to share their concerns with people who are understanding and respectful will help restore their dignity and help them heal.
- This is also why it is important to sensitize the community about the causes and consequences of SV, to reduce stigma in the community.

Statement #5: "I feel so helpless. Will I ever be in control again?"

Consequence: POWERLESSNESS/LOSS OF CONTROL.

- Because all forms of SV involve a survivor losing power and control, it is very important that you do what you can to help the survivor regain a sense of control.

Coping mechanisms:

- By explaining procedures and options, and by respecting and supporting their choices, you can assist the survivor to regain a sense of control.
- Supporting the survivor's choices, rather than advising the survivor or telling them what to do, is one of the most important and difficult skills of caring for survivors. By helping them find solutions to problems they face, you can help survivors regain a sense of control.

Statement #6: "I feel I am going crazy—one minute I feel nothing, then suddenly I feel really angry."

Consequence: MOOD CHANGES.

- After the assault, survivors' emotions may swing from intense emotional pain to complete lack of feeling (numbness).
- They may feel depressed, restless, confused, or angry.
- Having uncontrollable emotions may make them believe they are psychologically unstable.
- Among the most commonly misunderstood reactions is emotional numbness, which is a common response to a terrifying event.
- Those around survivors often misunderstand this response as an indication that the survivor is calm and relatively unharmed. However, in reality, this is a way of coping with the overwhelming experience.

Coping mechanisms:

- You can support survivors by explaining that intense mood changes are common and normal responses to extremely stressful events, and that for many people, this gets better over time.
- It is important to recognize that numbness or a lack of feeling is a normal reaction and, not a sign that the person was not impacted by what happened.
- Severe and persistent lack of feeling is an indicator for referral to mental health services.

Statement #7: "I'm OK. I'll be alright. I don't need any help."

Consequence: DENIAL.

- Following the initial shock of the assault, or even months later, survivors may deny that they were ever assaulted.
- They try to ignore what happened in an attempt to regain stability. Some survivors may feel that if they were not penetrated, they were not sexually assaulted, or that it was not as serious.
- Survivors may also express other statements that minimize or deny their experience.

Coping mechanisms:

- Denial is a strong action to protect oneself. Therefore, a survivor should NEVER BE PRESSURED to explain what happened or share any details.
- By listening and showing that you care and believe them, you can create a safe environment in which the survivor can begin to build trust and share as much as they feel is appropriate.
- This is very important, as it creates opportunities for the survivor to learn about or be referred for mental health and psychosocial support services that can help them to heal.

Statement #8: "I feel as if I did something to make this happen. If only I hadn't..."

Consequence: GUILT/BLAME.

- Survivors may feel that they could have avoided the assault by acting differently.
- These types of reactions are often strongly linked to the myths about SV that exist in the community that frequently blame the survivor rather than the offender.
- The behavior and reactions of friends, family, neighbors, and police may reinforce the survivor's own feeling that they "asked for it" or should have done something to prevent the assault.
- The survivor may also feel guilty if they believe they brought shame to their family and themself.
- Similarly, if the survivor believes they could have resisted more forcefully, they may also feel at fault.

Coping mechanisms:

- One of your roles is to raise awareness in the community that the offender is always responsible for sexual violence, never the survivor. Nothing a survivor does is "asking for it."
- Under all circumstances, you must reinforce that the survivor is not to blame and that it is the offender who is at fault.
- However, it may take time for the survivor to accept this. You should acknowledge and accept the survivor's feelings of guilt and self-blame, while you reassure the survivor that they are not responsible.

Statement #9: "I feel so dirty, like there is something wrong with me now. What will people think? I feel as if people will be able to know that I have been raped, just by looking at me."

Consequence: EMBARRASSMENT/SHAME.

- Many survivors feel very ashamed and embarrassed. They often feel dirty and, in some way, "marked for life."
- This reaction may prevent survivors from speaking out about the violence.
- Cultural norms that stigmatize and discriminate against survivors often reinforce these feelings.

Coping mechanisms:

- Providing opportunities for survivors to talk about their feelings, and question these beliefs, is important for their healing.
- Confidentiality and privacy are particularly important in order to help the survivor feel comfortable and safe to share their experiences.
- Stressing that shame and embarrassment is a normal reaction can help the survivor to accept and address these feelings. Helping the survivor recognize the situations in which they face stigma and discrimination is also helpful.

Statement #10: "I feel I can't do anything anymore...I'm disgusted by myself. I'm just worthless."

Consequence: LOSS OF SELF CONFIDENCE.

- The experience of SV may cause the survivor to think about how they cannot always protect themself no matter how hard they try. They have experienced a loss of control.
- The assault is not only an invasion of the survivor's physical self, but it also affects emotions, thoughts, and social interactions. The experience of assault raises many issues that can destroy self-confidence and beliefs about the world. Therefore, it is not surprising that survivors often experience low self-esteem.

Coping mechanisms:

- To facilitate the healing process, you can help survivors work towards building a new sense of confidence.
- This confidence can begin with the realization that surviving the violence took incredible strength and hard work.
- Every action the survivor takes (e.g., seeking help, sharing their story, etc.) should be recognized as a step towards taking control and regaining confidence.
- It is essential to focus on the positive aspects of the ways the survivor tries to help themselves.

Statement #11: "Suddenly people in my community won't talk to me—my neighbors stopped helping me, and the kids at the school tease my children."

Consequence: STIGMA AND DISCRIMINATION.

- A common problem for survivors is the stigma and discrimination they experience after SV. This can take many forms, including neighbors and other community members excluding the survivor from activities; verbal or physical abuse towards the survivor and/or their family and children; and discrimination in access to services such as social services and education.
- This can deepen the survivor's emotional distress (shame, isolation, depression, etc.), as well as make it more difficult for them to access services.

Coping mechanisms:

- If a survivor is experiencing stigma and discrimination, it is important to help the survivor to identify where they can receive social support (e.g., identifying neighbors who are supportive or social support networks).
- You can provide information on services that are sensitive to survivors, and if these do not exist, to provide them with accurate information about existing services and the benefits and risks involved.

Statement #12: "How am I going to go on? I feel so tired and hopeless, and nothing seems to interest me anymore."

Consequence: DEPRESSION.

- Many survivors of experience depression, such as losing the will to live and interest in daily activities, and experiencing numbness, loss of appetite, difficulty sleeping, and fatigue.

Coping mechanisms:

- Survivors showing signs of severe depression (e.g., thoughts about wanting to kill themselves and self-harming behavior) should be referred immediately to available mental health services. A survivor is considered at imminent risk of suicide or self-harm if either is present:
  - Current thoughts, plans, or recent attempt(s) of suicide.
  - A history of thoughts or plans for self-harm in the past month, or acts of self-harm in the past year, and current signs of being extremely agitated, violent, distressed, or uncommunicative.
- You can share information about positive coping mechanisms with survivors, as well as available mental health and psychosocial support services.

Statement #13: "I can't stop thinking about the attack. I have nightmares when I sleep, and sometimes during the day, I feel as if it is happening over again."

Consequence: FLASHBACKS AND NIGHTMARES.

- Memories of the violence often return without warning.
- Nightmares are common among survivors.
- Sometimes, flashbacks occur during the day and will be so real that the survivor feels as if they are re-living the assault.
- Flashbacks and nightmares can be indicators of PTSD.

Coping mechanisms:

- You can explain to a survivor that what they are experiencing is called a flashback.
- Reassure the survivor that flashbacks are a normal response to violence and will decrease with time. They represent a response that, like nightmares, will decrease as the recovery process continues.
- If a survivor experiences a flashback while talking, encourage them to take slow, gentle breaths. Tell the survivor that they are remembering, but not experiencing the violence. Help the survivor look around the room and realize where they are, that they are in a safe place and no one will hurt them. This reaction is normal.
- Techniques to help with flashbacks can be to focus attention on items in front of them: the color and texture of fabric, the feeling of where they are sitting or standing. Focus on identifying, naming, and describing what they can see, hear, and touch in the present moment.

Special considerations

Reactions in children across age and developmental stages:

Infants and Toddlers (ages 0–5): It is common for young children to exhibit behaviors from when they were younger after they experience sexual violence. This means that children may lose certain skills or behaviors they previously could do (for example, bladder control), or they may go back to behaviors they had outgrown (thumb-sucking). Similarly, young children often want to cling to familiar adults, including caregivers to whom they feel close. They may also resist leaving places where they feel safe or be afraid to go to places that may bring back memories of a frightening experience. Major changes in eating and/or sleeping habits are common, and young children may complain of physical aches and pains that have no medical reason.

Younger Children (ages 6–9): Younger children may also show regressive behaviors, such as asking adults to feed or dress them, or they may report unexplained physical problems just as young children do. This results in younger children showing emotions ranging from sadness, fear, anxiety, and anger to feelings of shame and guilt.

Adolescents (ages 10–19): Older children have a better understanding of the meaning of sexual abuse and they have more advanced thoughts and beliefs about what they experience and what they think are negative consequences. As a result, older children may begin to avoid their friends and refuse to go to school, or they may begin to behave aggressively. They may also be unable to concentrate, resulting in a drop in how they perform in school.

In general, adolescents tend to place more importance on their friends and "fitting in." This can complicate their efforts to understand sexual abuse. Adolescents may be reluctant to discuss their feelings or may even deny any emotional reactions to sexual abuse, partly because of their desire to fit in and avoid shame and stigma. Adolescents, especially older adolescents, are more likely to show traumatic responses similar to adults.

From: IRC/UNICEF, *Caring for Child Survivors of Sexual Abuse*, 2012. Page 32.

1.8 How should CHWs end the follow-up visit?

MINI LECTURE (5 minutes)

Tell participants:

- As with the initial consultation, you should take steps to secure the survivor's safety, and confirm with the survivor what additional referrals they would like.
- You should inform the survivor that they are welcome to come back anytime they would like. You should inform the survivor that follow up visits are especially important at one month, three months, and six months. However, sooner is also fine.
- As with any visit, you should document the care you provided and any issues of concern on the follow-up section of the intake form. If the survivor requests a copy for their records, give them a copy, and follow the same procedures for deciding how to safely store the document as you do during other visits.
- Once the survivor leaves, you should note on the monitoring form that the follow-up visit was undertaken, and safely store both the original intake and monitoring forms according to protocol.

2. Following up at one month

2.1 What should be addressed at the one-month follow-up visit?

MINI LECTURE[167] (10 minutes)

Tell participants:

- The one-month follow-up visit serves the purpose of connecting with the survivor, continuing with care, and linking them to available resources as appropriate.
- You can ask general questions about how the survivor is feeling:
  - How do you feel?
  - Are you having any difficulties coping with daily life?
  - To what extent are your difficulties affecting your life, such as relationships with family and friends, or your work or other activities?
- As with the initial follow-up visit, you should share all appropriate information about confidentiality, and any exceptions, including mandatory reporting.
- Other follow-up items at the one-month visit are: STIs, mental health, and planning for further follow-ups.
- You can also provide pregnancy testing, options counselling, referrals for safe abortion care, and contraceptive services (depending on the pilot site/CHW capacity).

[167] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

STIs:

- Give the second tetanus and hepatitis B vaccines, if needed. Remind the survivor of the 6-month dose.
- Ask the survivor about symptoms of STIs. These include:
  - Abnormal discharge from the vagina or penis, or anus, including discharge that is thick, bloody, cloudy, white, yellow, green, and/or bad smelling
  - Itching genitals or anus
  - Painful genitals or anus
  - Swelling of the genitals
  - Pain during urination
  - Warts, sores, bumps, or blisters on and/or around the genitals or anus
  - Pain in the pelvis or belly, or pain during sex
  - Bleeding during sex.
- Treat for STIs based on symptoms. (see Advanced Module 8).
- Test for syphilis, gonorrhea, chlamydia, and trichomoniasis if testing capacity exists, even if presumptive treatment was provided near the time of exposure.

Mental health:

- As with prior visits, you should continue to use LIVES and the survivor-centered approach to provide basic psychosocial support.
- You should assess the survivor's emotional state and mental health status.
- Survivors are at an increased risk of a range of serious psychological and mental health consequences:
  - Feelings of guilt and shame, anger, anxiety, fear, and/or numbness
  - Nightmares
  - Post-traumatic stress
  - Depression
  - Anxiety
  - Eating disorders
  - Sleep disorders
  - Alcohol or drug use/substance use disorders
  - Self-harm/suicide
  - Chronic pain, or unexplained body pain
  - Isolation and social withdrawal.

Ask: What are different strategies, techniques, and statements you can use to provide psychosocial support to the survivor? Call on as many participants as wish to speak.

- You can ask the survivor if you can share information about available mental health and psychosocial support services.
- For concerns of PTSD and self-harm or suicidal behaviors, you should refer the survivor to available mental health services with their consent.
- PTSD is a diagnosis made at least one month following a traumatic incident. PTSD is likely if a survivor presents with the following symptoms:
  - **Re-experiencing symptoms:** Repeated and unwanted recollections of the violence, as though it is occurring in the here and now (e.g., through frightening dreams, flashbacks, or intrusive memories accompanied by intense fear or horror).
  - **Avoidance symptoms:** Deliberate avoidance of thoughts, memories, activities, or situations that remind the survivor of the violence (e.g., avoiding talking about issues that are reminders of the violence or avoiding going back to places where the violence happened).
  - **A heightened sense of current threat:** Excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements (e.g., being "jumpy" or "on edge").
  - The survivor has **considerable difficulty with daily functioning** in personal, family, social, educational/ school, occupational/work, household/domestic, or other important areas of daily life (ask about each of these different aspects/activities).
- Before you close the visit, you should schedule the three month follow up visit. You should confirm a method that you can be in touch with the survivor in a safe way.
- You should document the care you provided and any issues of concern on the follow-up section of the intake form. If the survivor requests a copy for their records, give them a copy, and follow the same procedures for deciding how to safely store the document as you do during other visits.
- Once the survivor leaves, you should note on the monitoring form that the follow-up visit was undertaken, and safely store both the original intake and monitoring forms according to protocol.

3. Following-up at three months

3.1 What should be addressed at the three-month follow-up visit?

MINI LECTURE[168] (10 minutes)

Tell participants:

- The three-month follow-up visit serves many of the same purposes of the one-month follow-up visit.
- However, at 3 months, HIV testing may be able to accurately test for HIV infection due to the sexual assault.
- You can also provide pregnancy testing, options counselling, referrals for safe abortion care, and contraceptive services (depending on the pilot site/CHW capacity).

STIs:

- Offer HIV testing and counseling.
- Make sure that pre- and post-test counseling is available, and refer for HIV prevention, treatment, and care.
- If laboratory testing is available, retest for syphilis.
- If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.

Mental health:

- You should follow the same procedures to provide basic psychosocial support, assess the survivor's emotional state and mental health status, and refer the survivor for mental health and psychosocial support services.

Planning:

- Schedule the 6-month follow-up appointment in 3 months (i.e., 6 months after the SV, and 3 months after the 3-month follow-up appointment).
- Remind the survivor of the 6-month dose of the tetanus and hepatitis B vaccines, if needed.
- As before, you should:
  - Confirm a method that you can be in touch with the survivor in a safe way.
  - Document the care you provided and any issues of concern on the follow-up section of the intake form. If the survivor requests a copy for their records, give them a copy, and follow the same procedures for deciding how to safely store the document as you do during other visits.
  - Note on the monitoring form that the follow-up visit was undertaken, and safely store both the original intake and monitoring forms according to protocol.

[168] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

4. Following-up at six months

4.1 What should be addressed at the six-month follow-up visit?

MINI LECTURE[169] (10 minutes)

- The six month visit fulfills many of the same functions as the prior follow up visits.
- You should offer HIV counseling and testing if not done before. Make sure that pre- and post-test counseling are available and refer for HIV prevention, treatment, and care, as needed.
- Give the third dose of the tetanus and hepatitis B vaccines, if needed.
- If presumptive STI treatment was not given, evaluate for STIs and treat as appropriate.
- Assess the survivor's emotional state and mental health status, and refer for mental health and psychosocial support services.
- It is important to note to the survivor that although you will not be scheduling further follow up visits, they can reach out to the program for follow-up care, service referrals, or for other needs or concerns they may have.
- As before, you should:
  - Document the care you provided and any issues of concern on the follow-up section of the intake form. If the survivor requests a copy for their records, give them a copy, and follow the same procedures for deciding how to safely store the document as you do during other visits.
  - Note on the monitoring form that the follow-up visit was undertaken, and safely store both the original intake and monitoring forms according to protocol.

Ask participants if they have any questions before moving on to the next section.

DISCUSSION (15 minutes)

1. **Ask:** What are some barriers we may encounter to providing follow-up care? Are there limitations to the follow up care we can provide?
   - Call on as many participants as wish to speak.
2. **Ask:** Are there any strategies or approaches we can use to help address these barriers?
   - Call on as many participants as wish to speak.
   - Ask participants share ideas, write them on a sheet of flip-chart paper.

[169] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

MODULE 6

Self-care for community health workers

SESSION 6.1 Self-care for community health workers

Session time	2 hours and 30 minutes
Objectives	By the end of this session, participants will be able to: • Recognize different forms of stress. • Identify ways to deal with stress and understand how social and organizational support can help reduce stress related to working with survivors. • Apply strategies for self-care.
Methods	• Mini lecture • Discussion • Exercise
Preparation	• Prepare lecture.
Training aids, materials, and handouts	• Flip chart and markers. • Blank sheets of paper.
Evaluation and assessment	• None.
Additional resources	• UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators*, 2010. • IASC, *Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing Risk, Promoting Resilience and Aiding Recovery*, 2015. • WHO, *Psychological first aid: facilitator's manual for orienting field workers*, 2013.

1. Stress related to working with survivors of sexual violence

1.1 What causes stress?

DISCUSSION (30 minutes)

1. Pass around blank paper and pens or markers to participants.

2. Draw a table similar to the example below on flip chart paper. Ask participants to copy the table on their papers.

3. Explain to participants:

   - Working with survivors of SV and being regularly exposed to stories of SV can be very difficult.
   - It is therefore very important that we learn how to care for ourselves and each other.
   - Before discussing self-care, we can brainstorm the things in life that cause stress (stressors) and things that relieve stress, feels good, and/or give strength (resources). Some stressors and resources are beyond our control, while others we can influence through our actions and activities.

4. Ask participants to think about things that cause stress in their daily life and work, and activities or resources that make them feel good. They will need to distinguish between what they can control and what they cannot control. They should write or draw these stressors and resources in the table. Under the table, ask participants to write or draw the signs and symptoms they experience when they are stressed.

	What gives me stress? **Examples of major stressors**	***What gives me strength?*** ***What makes me feel good?*** **Examples of resources**
What I can control:	• Thinking about work at home. • Wanting everything to be perfect, wanting to help everybody. • Worrying over my children.	• Meeting with friends and neighbors. • Taking a long walk. • Playing with my children. • Being able to help survivors of sexual violence.
What I cannot control:	• The ongoing conflict in my home area. • The high number of cases of sexual violence in my community.	• Seeing a positive change in the way community members engage with survivors.

My "personal signs of stress": e.g., sleeping badly, having a headache/stomach ache, being easily irritated, etc.[170]

[170] Adapted from UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators*, 2010.

5. Give participants 5-10 minutes to fill in their table.

6. Bring the group back together. Ask for volunteers to share examples from their tables of stressors, resources, and signs of stress. Call on as many participants as wish to speak. As participants share examples, write these in the table on the sheet of flip chart paper.

7. **Ask:** What is the difference between having control, and not having control, over stessors and resources? Note that very often, stressors we cannot control have a bigger impact than those we can control.

8. When the matrix on the flip chart is completed, circle/underline stressors (and resources, if any) that are related to working with survivors of SV. Ask participants: are there other stressors and resources we might experience in our work with survivors that are not in the table? Call on as many participants as wish to speak.

9. Conclude the discussion by emphasizing that it is important to be aware of the stressors to which CHWs are exposed, and to recognize possible signs of stress.

1.2 What are the different forms of stress?

Facilitator's notes

Stress is an immediate, physical, social, and psychological response to a change in the situation around people. It is an "alarm-reaction" when people are faced with something that might be a threat. This threat might be a change in the internal or external environment to which people have to adapt and with which people have to cope. Every person reacts differently to stress. People have different limits. Not everyone feels stress in the same situation.

Adapted from UNICEF, Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators, 2010.

MINI LECTURE[171] (10 minutes)

Explain to participants:

- There are different forms of stress. Stress is a normal and natural physical and psychological response designed to protect, maintain, and make life better.
- It encourages people to get up in the morning, accomplish tasks, and seek out new work and enjoyable relationships.
- If the ways of managing stress are healthy, stress can be positive. However, long-lasting stress or frequent high levels of stress reduces people's ability to control and address it effectively, and people can begin to feel helpless.
- A main source of stress is day-to-day stress. Much of this stress is positive. As long as people feel that they can control the stressors, they are OK.
- However, a high level of stress can have a very negative impact on people's work and life.

171 UNICEF, Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators, 2010.

- Long-lasting stress (cumulative stress) is the most common for workers in conflict settings. It occurs when a person suffers from exposure to a number of different stressors for long periods of time. The causes are usually a combination of personal-, work-, and event-related stressors.
- When this type of stress is not well managed, there is risk for overload, which is the point at which stress overcomes people's ability to manage. Overload can lead to burnout. Burnout can be caused by:
  - Working long hours without any support or recognition.
  - Working with and for survivors but not having the resources to provide the care needed.
  - Working in dangerous or insecure settings.

Ask: What are different signs that someone is experiencing burnout? Signs can be physical, emotional, and behavioral. Call on as many participants as wish to speak.

Refer to the facilitator's notes to ensure participants have listed all the key signs of burnout. You can share any signs that participants did not share.

Facilitator's notes

Signs of burn out can include :

Physical reactions:

- Chronic fatigue
- Sleeping problems
- Frequent headaches
- Ulcers/stomach problems
- Loss of appetite

Emotional reactions:

- Depression
- Anger
- Irritability
- Feeling frustrated or feeling "trapped"

Thoughts:

- Having very negative thoughts about own performance or in general
- Becoming very cynical
- Starting to focus on one's own failures and/or the failures of others

Behaviors:

- Not showing up at work
- Working very hard and long hours
- Increased use of alcohol or drugs, or cigarettes
- Being in constant fights with colleagues or family/friends

From: UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack*, 2010.

MINI LECTURE[172] (10 minutes)

Tell participants:

- There are two types of stress that can impact people greatly and lead to extreme distress.
- One is stress that comes after experiencing an event that overwhelms people's ability to cope. Such events are usually sudden, violent, and unexpected. This is called **critical incident stress.** Critical incident stress is common for first line responders like humanitarian workers, police, firefighters, and paramedics.
- Examples of incidents that can bring about critical incident stress are:
  - Becoming a victim of or witnessing violent incidents, such as military conflict or violence by security forces, terrorist attacks, robbery, or threats, or serious accidents or disasters.
  - Caring for and working with survivors of a crisis, or in the midst of crisis.
  - Being faced with the sudden loss of a peer.
- The second type of stress is called secondary trauma, or vicarious trauma. This can happen when someone is repeatedly exposed to the trauma that other people have experienced.
- For example, when CHWs listen regularly and with empathy to stories of SV, they can become affected and begin to suffer from signs of stress that are somewhat similar to those of survivors.
- Signs of these two types of stress can be:
  - Taking work "home." This means that even when people are not at work, when they are home or with their families, they are unable to stop thinking about work.
  - Finding little interest or pleasure in doing things that once brought joy or happiness.
  - Feeling down, sad, or blue.
  - Trouble falling asleep or staying asleep, or sleeping too much.
  - Feeling tired or having little energy.
  - Poor appetite or overeating.
  - Muscle, bone, or joint pain.
  - Faintness, dizziness, or weakness.
  - Feeling strong emotions during or after working with a survivor.
  - Feeling suddenly scared for no reason.
  - Feelings of being overwhelmed or helpless, like there is no way to cope with what is happening around them.

[172] UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators*, 2010.

- Feelings of incompetence, such that they can no longer accomplish what they once did well.
- Trouble concentrating.
- Moving or speaking slowly that other people have noticed, or being more fidgety or restless more than usual.
- Not feeling happy or sad, just muted or without feeling.
- Thoughts that they would be better off dead, or thoughts of hurting themselves in some way.
- Feeling nervous, anxious, or on edge.
- Not being able to stop or control worrying.
- Worrying too much about different things.
- Trouble relaxing.
- Feeling afraid, as if something awful might happen.
- Disturbing thoughts of survivors, their families, and extremely stressful events through dreams, nightmares, daydreaming, repeating images, or real mental replaying of survivors' experiences.
- Anger at survivors, their families, the system, themselves, and/or at staff/society.
- Overreacting to small events, especially at home.
- Having fantasies about hurting someone because they have hurt or been violent towards someone else.
- Haunting memories of their own terrifying events.
- Emotional detachment (no feeling, no emotion, loss of humor) to those to whom they are close.

It is important to recognize the signs of different forms of stress, so we know when we need to take special care for ourselves, and others.

Facilitator's notes

Different cultures express distress in different ways. This does not imply that particular groups of people do not experience stress. Some cultures teach that showing emotion is negative and somehow shows a weakness of character. In such cultures, people under stress may not cry or cry very little, or do not show their feelings very much. It should never be assumed to mean that they are not experiencing stress, but rather that they have a very high threshold for showing emotion because of how they were raised or how their culture judges the display of emotion.

Every person is also different and experiences stress in their own way. What is stressful for one person might not have the same impact on someone else. People can react differently when faced with the same situation of stress or the same incident. Therefore, never make assumptions about a person's reactions or behavior.

From: UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack: General and Psychosocial Modules for Facilitators*, 2010.

2. Coping with stress

2.1 How can I manage and recover from stress?

Facilitator's notes

Prior to the training and beginning service delivery, program staff should identify mental health and psychosocial support services in the community that CHWs can access for support and care. You should share information about these services, and how CHWs can access them, during this session.

MINI LECTURE[173] (15 minutes)

Ask: What are different ways we can manage our stress, and support one another, as we do this work? Call on as many participants as wish to speak. As participants share ideas, write them on a sheet of flip chart paper.

Tell participants:

- Additional ways to manage stress include:
  - Thinking about what has helped you cope in the past and what you can do to stay strong.
  - Trying to take time to eat, rest, and relax, even for short periods of time.
  - Finding time for physical activity, including exercise.

[173] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

  - Trying to keep reasonable working hours, and setting boundaries between work and person time.
  - Considering, for example, dividing the workload among others, working in shifts, and taking regular rest periods.
  - Remembering that you are not responsible for solving all problems. You can only do what you can to help people help themselves.
  - Minimizing intake of alcohol, caffeine, or nicotine (smoking), and avoiding nonprescription drugs.
  - Checking in with fellow peers to see how they are doing and having them check in with you. Find ways to support each other.
  - Talking with friends, loved ones, or other people you trust for support.
- It is also important to take time for rest and reflection. This can help to manage and recover from stress. This can include:
  - Talking about your experiences with a supervisor, colleague, or someone else you trust.
  - Accepting what you are able to do to help others, even in small ways.
  - Learning to think about and accept what you did well, what did not go very well, and the limits of what you could do in the situation.
  - Taking some time, if possible, to rest and relax before beginning work again.
- If you find yourself experiencing with upsetting thoughts or memories about survivors' experiences, feel very nervous or extremely sad, have trouble sleeping, drink a lot of alcohol or take drugs, it is important to seek support from someone you trust.
- You should speak to a supervisor or health professional if you experience these signs for more than one month.
- There are resources and programs that can help support CHWs and other professionals who care for people who have experienced trauma. It can be helpful to use these services, even if you are not experiencing signs of secondary trauma. It can help you to manage stress and care for your mental health on an ongoing basis.
- If you ever have thoughts of wanting to harm yourself or others, you should seek professional help right away.

DISCUSSION (30 minutes)

1. Divide participants into groups of 3 to 5 participants.

2. Tell participants: For the next 10 minutes, in your small groups, discuss and reflect on different strategies that can help you to manage and recover from stress in your work. You can also think of strategies that are specific to your culture and community, such as relaxation techniques, mindfulness strategies, cultural and recreational activities, religious activities, and so on.

3. After ten minutes, bring the group back together. Ask small groups to share back on ideas that they brainstormed. As groups present, write their ideas down on a sheet of flip chart paper.

4. Once each group has presented, tell participants:

    - Individual strategies to balance stressors are very helpful, but social support or organizations can also be helpful to cope with stress. These can include support from other CHWs, self-care groups, staff meetings, support from leadership, and so on.

5. Direct participants back to their small group. Tell participants they have ten minutes to brainstorm and reflect on the support that it would be helpful for the program to provide and organize for CHWs.

6. After ten minutes, bring the group back together. Ask small groups to share back on ideas that they brainstormed. As groups present, write their ideas down on a sheet of flip chart paper.

7. Share any existing support networks, services, etc. that are available in the community, or will be organized for CHWs.

3. Planning for self-care

3.1 How is a self-care plan developed?

EXERCISE (30 minutes)

1. Ask participants to look again at the stressor/resource table they filled in earlier.

2. Tell participants: We are going to work on developing self-care plans to address the stressors we have identified, and to help us prepare to manage the stress we experience in our work, and care for ourselves. These self-care plans can include individual strategies, culture-specific coping mechanisms, and social and organizational support. I will read a series of guiding questions as we develop these plans.

3. Read the following guiding questions:[174]

   - What activities would help you relax, find distance from your work, and not to take work home?
   - What can you change so that uncontrollable stressors in your life become controllable?
   - How can you deal with the uncontrollable stressors?
   - Where can you seek social support? Who would you go to share experiences related to caring for survivors of sexual violence, while maintaining full confidentiality about survivors?
   - What organizational changes or changes in your surroundings would help you deal with stress? How can our organization best support you? What can you do to begin making changes?

4. Invite participants to store their self-care plan at home or in the office. Encourage participants to review their self-care plans on a regular basis, to add to the self-care plan, and to take time to assess their stress and check in with themselves on a regular basis over the course of their work.

[174] UNICEF, *Caring for Survivors of Sexual Violence in Emergencies Training Pack*: General and Psychosocial Modules for Facilitators, 2010.

MODULE 7

Summary, next steps, and closing

SESSION 7.1 Next steps

Session time	30 minutes
Objectives	By the end of this session, participants will be able to: • Plan next steps
Methods	• Discussion • Exercise
Preparation	• Prepare lecture.
Training aids, materials, and handouts	• Flip chart and markers. • Blank sheets of paper.
Evaluation and assessment	• None.
Additional resources	• None.

DISCUSSION (30 minutes)

1. Tell participants:
    - Congratulations on all you have learned and achieved in this training!
    - Over the course of this training, we have learned:
        - The role that CHWs can play to care for survivors of SV.
        - How CHWs can work with our community to raise awareness about gender-based violence, and the importance and benefits of seeking care after SV.
        - How CHWs can refer survivors for care with their consent.
        - [If Modules 5 and 6 (and the Advanced Module) were covered, this can also include directly providing medical care to survivors of SV.
    - Now, we will reflect on how we can go forward, and put what we have learned into practice.

2. Break participants into four groups. Tell participants: In these groups, you will discuss how you can implement what we have learned over the course of the training. Together, you should consider:
    - Who needs to be aware of the program, and the services that CHWs have been trained to provide?
    - What are the first steps you will take, as the program begins?
    - What help and support will you need to begin your work?

    Give participants 10 minutes in their small groups.

3. After ten minutes, pair groups. Give the groups 5 minutes to exchange their ideas.

4. Conclude the discussion by reviewing next steps and program logistics. This should include:
    - How CHWs and the program will coordinate.
    - How CHWs will obtain supplies.
    - Supervision plans.
    - Procedures for delivering and storing program and monitoring data.

SESSION 7.2 Post-test and clinical assessment

Session time	30 min (Modules 2-4) 1 hour (Module 2-4; 5-6) 1 hour 15 min (Module 2, Advanced) 45-60 minutes/person for clinical assessment
Objectives	By the end of this session, participants will be able to: • Have an indication of how much they learned during the training.
Methods	• Individual work. • Clinical assessment (CHWs 2 and 3).
Preparation	• Determine a clinical assessment schedule for CHWs 2 and 3 so that they are not all waiting to have their turn.
Training aids, materials, and handouts	• Post-test for literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed). • Post-test for non-literate CHWs (Modules 2-4) (annexed).
Evaluation and assessment	• Post-test for literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed). • Post-test for non-literate CHWs (Modules 2-4) (annexed). • Clinical assessment for CHWs 2 and 3.
Additional resources	• None.

Facilitator's notes

Be sure to give participants with low literacy the pictorial version of the test. When administering the post-tests, you can take participants using the pictorial version aside in a small group, and administer the test verbally. Be sure that participants understand each question, and the answer choices. Have participants circle the appropriate picture/image as their response to the questions.

POST-TEST

1. Explain to participants:
    - To end the training, we will take a post-test – using the same test we used as a pre-test at the beginning of the training.
    - Answer the questions as best you can, using what you have learned.

2. Distribute the written test. Ask participants to write their names at the top of each page.

3. Tell participants they have [depending on test] to complete the test. Let participants know when time begins, and collect the tests at the end of the time. Give participants updates on time (e.g., at halfway, and when they have ten minutes left).
    - 30 minutes
    - 1 hour for full test
    - 1 hour 15 minutes for advanced test)

4. Assist non-literate participants to complete the pictorial post-test in a small group.

CLINICAL ASSESSMENT (Level 2 and 3 CHWs only) (45-60 minutes each)

Facilitator's notes

The clinical assessment is only relevant for level 2 and 3 CHWs. The test should be administered individually. You will administer the test using the case study on the "CHW clinical assessment tool." Follow the prompts, and have the CHW take you through the care they would provide for the survivor, based on the experiences and symptoms they are reporting. A detailed checklist is available for you to mark whether the CHW has applied each key skill. Each "Yes" receives 1 point, and more than 46 total points in total (80%) is a passing score.

If the CHW does not pass the clinical assessment, they should receive additional training and support before being able to retake the assessment.

1. Take participants one by one to a private room and administer the clinical assessment tool. Instructions are noted on the tool itself. CHWs can bring their treatment protocols and job aids with them, but not the module summaries.

2. Mark on the checklist whether or not the CHW has applied a key skill. Make sure that all rows are marked with a "Yes," "No," or "Not applicable."

3. Note comments as you go, and when the CHW has finished, give them feedback on the scenario. Correct any mistakes or misunderstandings.

4. Tally the "Yes," points, and let them know if they have passed the test.

5. If the CHW does not pass the assessment, inform the CHW that they will need to have additional training before retaking the assessment, to address any areas where they need additional preparation before providing care to survivors.

SESSION 7.3 Closing and workshop evaluation

Session time	1 hour 30 minutes
Objectives	By the end of this session, the facilitator/program staff will have: • A sense of how participants found the training.
Methods	• Discussion
Preparation	• Marked post-test.
Training aids, materials, and handouts	• Return participants' marked tests to them. • Final training evaluation form.
Evaluation and assessment	• None.
Additional resources	• None.

Review of post-test and clinical assessment (1 hour)

1. Bring participants together to review the post-tests and clinical assessments. Return pre- and post-tests to participants.

2. Go through each question on the test, and the correct answers. Encourage participants to ask any questions they may have, and discuss questions together to ensure they understand the content of the test. Be sure to spend extra time on questions that many participants seemed to have difficulty with, and to explain the correct answers (and, why other answers are wrong).

3. Share with participants:

    - What they know very well;
    - Where they have made progress;
    - What skills/knowledge will need more training and support (even with passing scores).
    - How the program will facilitate ongoing training and support for key skills and knowledge as they move forward.

4. Review the clinical assessments in detail with level 2 and 3 CHWs. Be sure to spend extra time on knowledge and skills that many participants seemed to have difficulty with, and to explain, step-by-step, the correct steps and services the CHW should follow in each case. Encourage participants

to ask any questions they may have, and discuss questions together to ensure they understand the content of the test.

5. Collect tests and assessments back from participants, to be stored by the program.

Passing scores for post-tests are as follows:

- CHW 1: At least 70 per cent on the Module 2–4 post-test
- CHW 2:
  - At least 70 per cent on the Module 2–4 post-test
  - At least 80 per cent on the Module 2–6 post-test
- CHW 3:
  - At least 70 per cent on the Module 2–4 post-test
  - Average of 80 per cent on the Module 2–6 and Advanced Module 8 post-tests

Passing scores for the clinical assessment to be administered at the end of the training are as follows:

- CHW 2: 80 percent
- CHW 3: 80 percent

Closing and workshop evaluation (30 minutes)

Facilitator's notes

In some cultural contexts, participants may not feel comfortable providing verbal or direct feedback on the training or program. The facilitator should also be sensitive to any power dynamics for participants – for example, if CHWs' supervisors are present, power dynamics or cultural norms between people of different genders, etc. Do not pressure participants to share or discuss feedback, if they do not volunteer or if they seem uncomfortable.

1. Close the workshop by bring participants together, and facilitating a group discussion using the following questions:
   - Was there anything that you learned in the training that surprised you, or that you did not expect to learn?
   - What do you think were the three most important knowledge or skills you learned during the training?
   - What were the most challenging knowledge and skills to learn?
   - What worked well (teaching methods, activities, etc.) during the training? What could be done differently to help participants learn as much as possible during the training?

- If you were to organize the training in the future, what would you do differently? What would you do the same way? This could include: training timing and scheduling, learning methods and activities, assessments and evaluations, or any other thoughts or ideas you might have that you wish to share.

2. Present participants with certificates of completion, if the program will be issuing these certificates.

3. Distribute the training evaluation form to all participants. Explain to participants that it is anonymous (they do not have to write their name). Ask participants to complete the evaluation, to help program staff improve the training for future participants.

4. Bring participants with limited literacy aside, to assist them to complete the evaluation. First, explain where they should circle: very well, well, poorly, or not at all. Then, read each question, and give participants time to select their response.

5. Thank participants for their time and efforts, and for participating and sharing their experiences and knowledge with the group.

6. Collect the evaluation forms before participants leave.

MODULE 8 ADVANCED

(Level 3 CHWs only)

Providing advanced community-based care for survivors of sexual violence

ADVANCED SESSION 1: Providing advanced care to survivors of sexual violence

Session time	6 hours 15 minutes
Objectives	By the end of this session, participants will be able to: • Provide tetanus toxoid/immunoglobin to prevent tetanus. • Provide vaccines to prevent hepatitis B. • Manage sexually transmitted infections, including among partners. • Treat allergic reactions and allergic shock.
Methods	• Mini lecture • Discussion • Case study • Role play
Preparation	• Prepare materials for demonstration and lectures in advance. • Learn whether a cold chain, tetanus and hepatitis B injections are available, and whether CHWs can administer injections. • Adapt intake, health history and monitoring forms to note the provision of additional services. • Adapt protocols for STI treatment to local context. • Adapt the infection prevention handout according to the program's protocol
Training aids, materials, and handouts	• Flip chart and markers. • Reproductive anatomy (HO) • Hepatitis B and tetanus vaccination protocols (HO) • Preparing a syringe for injection (HO) • Knowing where to give an injection (HO) • Managing STIs (HO) • STI treatment protocol (HO) • Treating partners for STIs (HO) • Being prepared to treat allergic reactions and allergic shock (HO) • Preventing infection (advanced) (HO) • Medications, syringes, needles, model for demonstration
Evaluation and assessment	• None

Additional resources

- IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.
- WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Facilitator's notes

The advanced module is only relevant in settings where CHWs have additional skills and experience, and level 3 CHWs will be part of the program. Programs may also establish a cadre of level 3 CHWs in settings where they are providers of last resort, given lack of possible referrals to higher-level health facilities.

1. Providing tetanus toxoid/immunoglobin to prevent tetanus

Facilitator's notes

Only cover this section if the tetanus toxoid vaccination is available in the setting and level 3 CHWs have been trained in providing injections. This vaccination requires a cold chain and adherence to infection prevention standards. If tetanus toxoid will be provided, but CHWs have inadequate training on providing injections, consult training resources for additional information, and ensure CHWs demonstrate capacity in providing injections before training them to provide tetanus toxoid.

1.1 What is tetanus and who is at risk for tetanus infection?

MINI LECTURE*[175] *(5 minutes)

Ask: What is tetanus? Who is at risk for tetanus infection? Call on participants.

Explain to participants:

- As discussed in Module 5, tetanus is a serious disease caused by bacterial entering a wound.
- The disease can be prevented through immunization. A survivor of SV who presents with open wounds or cuts may be at risk for tetanus infection.

[175] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Facilitator's notes

Make sure the intake and monitoring forms have been adapted to include the provision of tetanus and/or hepatitis B injections, so that CHWs can see where they need to indicate the care provided.

1.2 What is the tetanus vaccination and how does it work?

MINI LECTURE[176] (10 minutes)

Tell participants:

- A survivor of SV who presents with breaks in the skin or mucous membrane and has not been fully vaccinated against tetanus, or if their vaccination status is uncertain, is at risk of tetanus.
- If the survivor has not been fully vaccinated with three or more doses, or the number of doses they have received is unknown, vaccinate immediately, no matter how long it has been since the incident.
- If the survivor has **clean wounds and they sustained them less than 6 hours ago, or if the wound is minor:**
  - Give tetanus toxoid if the survivor has received fewer than three doses, or the number of doses they have received in the past is unclear.
  - Do not give tetanus toxoid if the survivor has received three or more doses unless the last dose was **more than 10 years ago.**
- If the survivor has wounds other than a clean wound that was sustained less than 6 hours ago, or if the wound is not a minor wound (i.e., **for all other wounds**):
  - Give tetanus toxoid if the survivor has received fewer than three doses, or the number of doses they have received in the past is unclear.
  - Do not give tetanus toxoid if the survivor has received three or more doses unless the last dose was **more than 5 years ago.**

[176] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Facilitator's notes

Tetanus toxoid is available in several different preparations. Anti-tetanus immunoglobin (anti-toxin) is expensive and needs to be refrigerated. It is not available in many low-resource settings. Refer to the local treatment protocol, especially if tetanus immunoglobin will be provided rather than the tetanus toxoid vaccine. If there is no local protocol, refer to the WHO protocol.

If the survivor presents months or years after the assault, the tetanus vaccine would be given for future protection, since the incubation period for tetanus is 3-21 days. CHWs can weigh their present supply and the ease at which the survivor can receive remaining doses, to determine whether to give the vaccine to the survivor. If the survivor requests and the CHW's supply is limited, they should be referred to the health facility.

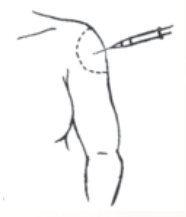
Special considerations

Tetanus vaccination is safe for pregnant women and children. For children under 7 years old, DTP (diphtheria, tetanus toxoid, and pertussis vaccine) or DT (diphtheria and tetanus toxoid) is preferred to tetanus toxoid alone. For people 7 years and older, Td (tetanus and diphtheria) is preferred to tetanus toxoid alone.

From: WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Tell participants:

The tetanus vaccine is given intramuscularly (IM) using a syringe and needle into the upper arm for adults or buttocks in children.



- Different syringes, needles, and injection sites must be used for each injection that is given in one day (that is, if you are giving more than one injection when caring for the survivor).[177]
- You must provide the following information to the survivor when you give the tetanus vaccine:
  - Survivors who receive the tetanus vaccination should complete the vaccination schedule.
  - The second dose should be given 4 weeks after the first dose.
  - The third dose should be given 6 months to one year after the first dose.

DISCUSSION (10 minutes)

1. Ask participants to take out the **tetanus vaccination protocol** (handout or local protocol) from their packets.[178]

[177] Images and guidance from Hesperian Foundation, *Where There Is No Doctor*, 2020.

[178] WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

2. Review the protocol in detail, and encourage participants to ask any questions they may have.

3. Emphasize to participants that they should refer to the protocol every time they are providing care to ensure the survivor receives the correct vaccination.

Ask participants if they have any questions before moving on to the demonstration.

DEMONSTRATION (30 minutes)

1. Direct participants to find the handouts on **how to prepare a syringe for injection**, **where to give an injection, and advanced infection prevention** in their participant's packet.

2. Demonstrate **how to prepare a syringe for injection** and **where to give an injection** using step-by-step instructions. Direct participants to the corresponding pictures in the handouts. [179]

3. Review infection prevention procedures in detail. Be sure to cover safe storage of needles and syringes, and safe disposal.

Ask participants if they have any questions before moving on to the role play.

ROLE PLAY (45 minutes)

1. Divide participants into pairs to demonstrate the tetanus vaccination. Provide participants with protocols, tetanus vaccine suspension, syringes, needles, and a model for demonstration.

2. After the first partner has modeled providing the tetanus vaccination, direct pairs to change roles so that all participants have a chance to practice.

3. Circulate among participants, and observe the role plays to see that participants demonstrate skills in providing the vaccination according to protocol. Provide feedback as necessary.

Ask participants if they have any questions before moving on to the next section.

2. Providing vaccines to prevent hepatitis B

Facilitator's notes

Only cover this section if the hepatitis B vaccination is available in the setting and CHWs have been trained in providing injections. This vaccination requires a cold chain and adherence to infection prevention standards. If the hepatitis B vaccine will be provided, but CHWs have inadequate training on providing injections, consult additional training resources on providing injections. Ensure CHWs have demonstrated capacity to provide injections before training them to provide the hepatitis B vaccination.

[179] Hesperian Foundation, *A Book for Midwives*, 2021.

2.1 What is hepatitis B and who is at risk?

MINI LECTURE[180] (5 minutes)

Ask: What is hepatitis B, and who is at risk? Call on participants.

Explain to participants:

- As discussed in Module 5, hepatitis B is a common and serious infection that may cause liver failure, liver disease, and liver cancer in up to 40% of patients who are infected.
- Survivors of SV who have experienced vaginal, anal, or oral penetration and were exposed to the assaulter's blood or body fluids may be at risk for hepatitis B infection.

2.2 What is the hepatitis B vaccination and how does it work?

MINI LECTURE[181] (15 minutes)

Explain to participants:

- Unvaccinated or inadequately vaccinated survivors should be offered the hepatitis B vaccine.
- The recommended dose varies by product. The hepatitis B vaccine is commonly available in the form of the pentavalent vaccine (DTP-Hib-HepB).
- You should refer to local protocol for preparation and dose.

Special considerations

Hepatitis B vaccine is safe for pregnant women and children. The dose and administration site should be adjusted for children.

From: WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

180 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

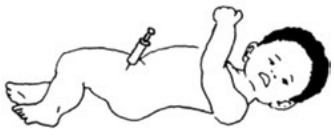
181 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

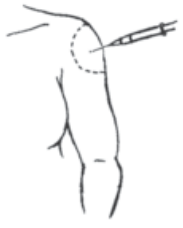
Facilitator's notes

Refer to the local treatment protocol for preparation and dose. If there is no local protocol, refer to the WHO protocol. Guidance varies on the hepatitis B vaccine, and up to how many days it should be given after an assault; for example, the Inter-Agency Field Manual notes within 14 days of the assault, while the WHO no longer lists an end point. If the survivor presents months to years after the assault and has not received the full three doses, they can still receive it for future protection from liver disease. CHWs can weigh their present supply and the ease with which the survivor can receive remaining doses, to determine whether to give the vaccine to the survivor. If the survivor requests the vaccine and the CHW's supply is limited, the survivor should be referred to the health facility.

From: WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Tell participants:





- The hepatitis B vaccine is given by intramuscular injection in the thigh (children <2 years) or in the upper arm (adults and older children).[182]
- Injection in the buttock is not recommended, as it is not as effective.[183]
- There is important information you must share with the survivor when you provide the hepatitis B vaccination:
  - A survivor who receives the hepatitis B vaccination should complete the vaccination schedule.
  - Depending on the product, the second dose should be given 1-2 months after the first dose.
  - The third dose should be given 4-6 months after the first dose.
- The survivor may experience redness and tenderness at the vaccination site.

DISCUSSION (10 minutes)

1. Ask participants to take out the **hepatitis B vaccination protocol** from the participant's packet.[184] Give participants time to review the protocol and ask questions.

2. Review the protocol in detail, and encourage participants to ask any questions they may have.

3. Emphasize to participants that they should refer to the protocol every time they are providing care to ensure the survivor receives the correct vaccination.

182 Images and guidance from Hesperian Foundation, *A Book for Midwives*, 2021.

183 MSF Spain, *Sexual & Gender Based Violence: A handbook for implementing a response in health services towards sexual violence*, 2011.

184 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

DEMONSTRATION (15 minutes)

1. Direct participants to find the handouts on **how to prepare a syringe for injection**, **where to give an injection, and advanced infection prevention** in their participant's packet.

2. Demonstrate **how to prepare a syringe for injection** and **where to give an injection** using step-by-step instructions. Direct participants to the corresponding pictures in the handouts. [185]

3. Review infection prevention procedures in detail. Be sure to cover safe storage of needles and syringes, and safe disposal.

Ask participants if they have any questions before moving on to the role play.

ROLE PLAY (45 minutes)

1. Divide participants into pairs to practice giving the hepatitis B vaccine. Provide them with the hepatitis B vaccine suspension, syringes, needles, and a model for demonstration.

2. After the first partner has modeled providing the hepatitis B vaccination, direct pairs to change roles so that all participants have a chance to practice.

3. Circulate among participants, and observe the role plays to see that participants demonstrate skills in providing the vaccination according to protocol. Provide feedback as necessary.

Ask participants if they have any questions before moving on to the next section.

3. Managing sexually transmitted infections (syndromic management)

Facilitator's notes

The information below describes basic syndromic management approaches to treating STIs. While instructions have been tailored so no observation is required (treatment based on self-reports), if you feel participants need to better understand the reproductive anatomy, refer to the relevant **anatomy handout** in the participants' packet.

For any treatment, refer to the local treatment protocol. If there is no local protocol, refer to the WHO protocol.

[185] Hesperian Foundation, *A Book for Midwives*, 2021.

3.1 How can STIs be managed and how is treatment provided?

MINI LECTURE[186] (45 minutes)

- Sometimes a survivor may have certain signs or symptoms of an STI. Many STIs, including gonorrhea, chlamydia, syphilis, and trichomoniasis, can be treated with antibiotics.
- The antibiotics used will depend on local guidelines and the drugs that are available. If left untreated, STIs can lead to chronic pain, pelvic inflammatory disease, pregnancy complications, and infertility.
- Many STIs can be identified and treated based on typical symptoms and signs. A syndrome is a group of symptoms a survivor reports.
- As discussed earlier, CHWs can ask a survivor if they notice any of the following common symptoms and signs of an STI, such as:
  - Abnormal discharge from the vagina or penis, or anus, including discharge that is thick, bloody, cloudy, white, yellow, green, and/or bad smelling
  - Itching genitals or anus
  - Painful genitals or anus
  - Swelling of the genitals
  - Pain during urination
  - Warts, sores, bumps, or blisters on and/or around the genitals or anus
  - Pain in the pelvis or belly, or pain during sex
  - Bleeding during sex
- If someone does not have signs or symptoms of an STI, that does not mean that there is no infection. STIs are often present without symptoms, especially in women and transgender men.
- We will now review a table that explains the signs and symptoms for the main STI syndromes and their most common causes. It also presents guidelines for how we can provide care and support anyone with these symptoms.[187] This table is also available in the participants' packet as a handout on managing STIs.

As participants follow along, review the table in detail. Encourage participants to ask any questions they may have.

[186] Inter-Agency Working Group on Reproductive Health in Crise, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

[187] Table adopted from: WHO, *Training Modules for the Syndromic Management of Sexually Transmitted Infections, 2nd edition*, 2007, Page 6; and WHO, *Sexually Transmitted and Other Reproductive Tract Infections*, 2005.

Syndrome	Symptoms (Survivor reports)	Signs	Common Causes	Management
Vaginal discharge	• Unusual vaginal discharge (in terms of amount, smell, or color) • Vaginal itching • Pain while urinating • Pain during sex	• Abnormal vaginal discharge (in terms of amount, smell, or color)	• Trichomoniasis • Gonorrhea • Chlamydia • Yeast infection	• Treat with antibiotics for trichomoniasis, gonorrhea, and chlamydia per **STI treatment protocol handouts.** • Conduct a syphilis test if available. If the result is positive or if a syphilis test is not available, also treat with antibiotics for syphilis. • If discharge is white with reported curd-like appearance, and presence of itching, also treat for possible yeast infection. • Refer to higher-level health facility when possible if discharge is reported as yellow, green, or very bad-smelling (may be a sign of pelvic inflammatory disease). • Consider referral to higher-level facility if fever, pregnancy, or abnormal vaginal bleeding (bleeding between periods or heavy bleeding) is also present.
Lower abdominal pain	• Lower belly pain • Pain during sex	• Vaginal discharge • Tenderness when lower belly is touched • Fever	• Gonorrhea • Chlamydia • Other anaerobic bacteria	• Treat with antibiotics for trichomoniasis, gonorrhea, chlamydia per **STI treatment protocol handouts.** • Conduct a syphilis test if available. If the result is positive or if a syphilis test is not available, also treat with antibiotics for syphilis. • Refer to higher-level health facility when possible, especially if fever, pregnancy, abnormal vaginal discharge, or bleeding (bleeding between periods or heavy bleeding) is present. • Also refer to higher-level facility for severe reports of pain in lower abdomen.
Genital ulcer	• Genital sore	• Genital ulcer	• Syphilis • Chancroid • Genital herpes	• Treat with medications per **STI treatment protocol handouts.** • Also treat with antibiotics for trichomoniasis, gonorrhea, chlamydia per STI pictorial treatment guideline handouts.

Tell participants:

- Anyone who is experiencing signs and symptoms of STIs and their related syndromes should be treated immediately, according to the guidelines outlined on the **STI treatment protocol** for adults and children.

Special considerations

Pregnant people, children, and men and transgender women: Some antibiotics are not safe for pregnant people. If a person is pregnant she should be treated according to appropriate guidelines. Children will also require very specific antibiotic dosages based on weight and age.

Men and transgender women who report discharge from their penis, pain during urination, and/or urinating more frequently than usual may have an STI. Gonorrhea and chlamydia are the most common causes of these symptoms and should be treated according to protocols. Men and transgender women may follow the same medication dosing guidelines for treatment of STIs as non-pregnant adult women.

From: Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

Explain to participants:

- As with all services, there is important information we need to provide to participants when offering antibiotics to a survivor for **managing STIs**:[188] [189]
  - Condoms must be used during sex until the antibiotic treatment regimen is complete in order to prevent transmitting an STI to the partner.
  - Antibiotics must be taken for the full course to be effective.
  - Pelvic inflammatory disease (PID)—inflammation of the pelvis—may develop if an STI is not cured. PID may lead to infertility if it is not treated. A survivor who develops signs of PID (severe abdominal pain, fever, green or yellow bad smelling discharge, or bleeding from the vagina) should go to a higher-level health facility for treatment.
  - Survivors should also go to a higher-level health facility if symptoms get worse or no improvement is seen after a week of treatment.
  - If the survivor has signs of PID, or if their symptoms do not improve or get worse, and they are not comfortable or able to go to the health facility, they can reach out to the CHW for support with referrals.
  - To get relief from the discomfort of some STIs, survivors can try the following:
    - Wear underclothes made of cotton.
    - Wash underclothes once a day and dry them in the sun.
    - Sit in a pan of clean, warm water for 15 minutes, 2 times a day.
    - If it is painful to pass urine, pour clean water over the genital area while passing urine.

188 Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 9: Sexually Transmitted Disease" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*,

189 Hesperian Foundation, *Where Women Have No Doctor: A Health Guide for Women*, 2021.

- Anyone who is treated for an STI may develop another infection if sexual partners are not treated. The sexual partner may or may not have symptoms and, if left untreated, could continue to spread infection. Partners include current partner(s) and all partners within the last two to three months.

DISCUSSION [190] (30 minutes)

1. Direct participants to find the handouts on **STI treatment protocols** for adults and children.[191] This should be in the participants' packet.

2. Review the protocols in detail. Encourage participants to ask any questions they may have, especially regarding doses for pregnant people or those with allergies to certain medicines.

3 . Emphasize to participants:

- You should refer to the protocol every time they are providing care to ensure the survivor receives the right treatment.
- Survivors should always be given the shortest course of treatment.
- Just because the survivor is being treated for STI-like symptoms, this does not mean that they definitely have an STI. However, it is safest to treat for STIs according to the reported symptoms, just in case these medications can help them feel better.

Ask participants if they have any questions before moving on to the next section.

190 Inter-Agency Working Group on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

191 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

Facilitator's notes

Refer to the local treatment protocol and disease prevalence data. If there is no local protocol, refer to the WHO protocol. All **treatment protocol** handouts should be ready before the training.

Patterns of genital ulcer disease vary in different parts of the world, but genital herpes, chancroid, and syphilis are most common. If a genital ulcer is noted or reported, treatment appropriate to local causes should be given. For example, in areas where both chancroid and syphilis are prevalent, survivors with genital ulcers should be treated for both conditions.

Generally, if a survivor reports a genital ulcer or sore, treatment for syphilis and chancroid should be given. Treatment for herpes simplex virus (HSV2) may be considered in areas where the prevalence of HSV2 is 30% or higher.

If a survivor reports only small, numerous, blister-like lesions, then treatment for HSV2 should be given. Note that treatment for herpes is expensive and may not be available in low-resource settings.

A handout is available on how to respond to survivors that develop an **allergic reaction or allergic shock** to medicines. While not mandatory, this information may be helpful, especially if CHWs are providers of last resort.

From: IAWG on RH in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

3.2 How should sexual partners be managed for STI treatment referral?

MINI LECTURE[192] (20 minutes)

Explain to participants:

- A survivor who is successfully treated for an STI will begin to feel better, but may return later with another infection.
- The following questions will help determine whether this is due to a problem with the treatment (treatment failure) or a new infection (re-infection):
  - Treatment failure: Did the survivor take all of the medicine? Did the survivor stop taking their medication as soon as they began to feel better?
  - Re-infection: Did the partner receive treatment? Did the survivor and partner(s) use condoms or abstain from sex after starting treatment?
- The survivor's sexual partners may or may not have symptoms and, if left untreated, could spread infection to others in the community.
- Partners may include current partners(s) and all partners within the last three months.

[192] Inter-Agency Working Group on Reproductive Health in Crises. *"Chapter 9: Sexually Transmitted Disease" from Inter-agency Field Manual on Reproductive Health in Humanitarian Settings.* 2018.

- We will now review a table that explains partner notification management strategies based on the major signs and symptoms a survivor may report. This table is also available in the participants' packet as a handout for **treating partners for STIs.**

As participants follow along, review the table in detail. Encourage participants to ask any questions they may have.

Signs and Symptoms	Possible Explanations	Partner Management
Genital sore or ulcer	STI very likely	Treat partners for syphilis and chancroid
Urethral discharge (men) Pain and burning during urination	STI very likely	Treat partners for gonorrhea and chlamydia
Lower belly pain Pain during sex	Pelvic inflammatory disease, often STI, but other causes possible	Treat partners for gonorrhea and chlamydia
Vaginal discharge (in terms of amount, smell, or color)	Non-STI infection most likely	No partner treatment unless relapse (then give treatment for trichomoniasis)

Facilitator's notes

Not all reproductive tract infections are sexually transmitted. Therefore, CHWs must be careful not to expose someone stigma as having an STI when the diagnosis is not clear. For instance, the symptom of vaginal discharge may be the result of an infection that was not contracted through sex, such as a yeast infection or bacterial vaginosis. Attempting to notify and treat partners in this situation would be unnecessary as partners do not need treatment, and notifying them may be damaging to their relationship. Isolation and stigma, violence, abuse, distrust, and separation are all possible consequences of partner notification if not managed correctly.

From Inter-Agency Working Group on Reproductive Health in Crises. "Chapter 9: Sexually Transmitted Disease" from *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018.

Tell participants:

- Remember! Survivors may not be able to safely talk about their symptoms or treatment with their partner. Survivors may be at risk of their partner leaving them, accusing them of being unfaithful, or violence and abuse. This is especially true for survivors experiencing IPV.
- The survivor is the expert on their situation, and what is and is not safe or possible for them. You must never pressure a survivor to share information with their partner, families, or others.
- It is important to listen carefully to the survivor's fears or concerns, and to emphasize that the survivor does not have to tell their partner- or anyone else – about their treatment if they do not feel comfortable doing so.
- If the survivor agrees, you can share different strategies for avoiding STI transmission between partners, and discussing condom use with their partners.
- You can share the following strategies with survivors:
  - Use an internal or external condom each time the survivor has oral, anal, or vaginal sex.

  - Avoid sexual intercourse at all for three months. If the survivor does not have sexual intercourse, they will not be able to transmit or be exposed to STIs. Some survivors find this the best option; however, for many survivors, this choice is not possible or desirable.
  - Have sex in ways that avoid getting the partner's body fluids in the vagina or anus, such as using their hands. Oral sex is not recommended since there is still a small risk of transmitting STIs and HIV – however, it is lower risk than anal or vaginal sex.
- Survivors may be concerned that their partner will not trust them, or will accuse them of being unfaithful, if they ask their partner to use a condom.

Ask: Who can remember different strategies for survivors to talk about using condoms with their partners? Call on participants.

Tell participants:

- **The survivor can practice talking with the CHW or a trusted friend, first.** Then, they can practice what they want to say.
- **Do not wait until right before sex to talk about it.** The survivor can approach their partner to talk about using condoms at a time when both partners are feeling positively towards one another, and their relationship. It can be harder to talk about if a couple is preparing to have sex.
- **Focusing on safety:** The survivor can share with their partner that they have learned more about STIs and HIV, and that using condoms can help keep them safe because it is possible to have an STI without knowing it, and HIV can be passed between people in different ways.
- **Use other people as examples.** Sometimes learning that others in the community are using condoms can help influence the partner to do so, too. The survivor can share that they have learned that many couples in their community are using condoms for safety.
- **The survivor can be prepared to try and respond to their partner's concerns.** In addition to questions or concerns about trust between partners, partners' concerns about condoms could include:
  - Sex not feeling as good, or condoms being uncomfortable
  - Condoms are inconvenient, and "ruin the moment"
  - Condoms cost money
- In response to these concerns, the survivor could consider suggesting that they try condoms out for a few weeks, to see if they get used to using them.
- The survivor can also try an internal condom, which is worn inside the vagina or anus. These condoms can be inserted up to 8 hours before sex, and so do not require partners to stop immediately before sex. Some people also find that internal condoms do not dull sensitivity as much as external condoms that fit tightly on the penis.
- If asked why they would want to start using condoms now, the survivor can share that they have learned more about condoms and their benefits, and that it seems like it could be a good idea, to protect one another.
- The survivor can also share information about condom distribution points in the community, where people can get free condoms, if there are any available.

Ask participants if they have any questions before moving on to the role play.

ROLE PLAY (20 minutes)

1. Divide participants into pairs to practice discussing how a CHW may support a survivor who is concerned about telling a partner of their treatment for a possible STI. One participant will act as the survivor and the other participant will be the CHW.

2. Share the following information for the role play:

   Survivor: You have been noticing an unusual vaginal discharge, and strong odor in your underclothes. The CHW has explained that you may have an STI, and has offered you treatment. You and your partner do not use condoms during sex. You are afraid that if you tell your partner you may have an STI, they will leave you or hurt you.

   CHW: The survivor is very anxious and concerned about talking about STIs with their partner, and asks for your advice about what to do.

3. Give pairs 5 minutes to carry out the role play.

4. After 5 minutes, rotate participants to new pairs – so they will now play the other role. Give participants 5 minutes.

5. Bring the group back together to discuss.

   Ask: What kinds of advice did the CHWs provide? Was any of the advice more helpful than other suggestions? Was there any advice that did not seem to be helpful?

   Call on as many participants as wish to speak.

6. Conclude the role play by emphasizing that survivors should never be pressured to disclose their experiences or treatments with anyone else if they do not feel comfortable. Disclosing an STI could put survivors at risk of violence and abuse.

Ask participants if they have any questions before moving on to the next section.

4. Preparing to treat allergic reactions and allergic shock

4.1 What are signs of allergic reactions and allergic shock?

MINI LECTURE[193] (10 minutes)

Tell participants:

- Some medicines, especially antibiotics like penicillin and ampicillin, can produce an allergic reaction, usually within 30 minutes after an injection.
- An allergic reaction can turn into allergic shock, which is an emergency.
- **To prevent allergic reaction and allergic shock, before giving an injection, you should Ask: "Have you ever had a reaction to this medicine, like hives (red blotches on the skin), itching, swelling, or trouble breathing?"**
- If the answer is yes, you should not use that medicine in any form, or any medicine from the same family of medications.
- Whenever you inject medicines, they should watch for signs of an allergic reaction and have medicines for treating them nearby. We will learn more about these medicines in the next section.
- Signs of mild allergic reactions are itching, sneezing, hives, or rash.
- Signs of moderate to severe allergic reactions are itching, hives, swollen mouth and tongue, or difficulty breathing.

4.2 How should allergic reactions and allergic shock be treated?

MINI LECTURE[194] (20 minutes)

Direct participants to find the handout on **treating allergic reactions and shock** in the participant's packet.

Explain to participants:

- Treatment for mild allergic reaction is to give survivors diphenhydramine by mouth three times a day until the signs disappear.
- Diphenhydramine can cause drowsiness.
- Pregnant or breastfeeding people may find the discomfort of a mild allergic reaction better than the risks of taking an antihistamine.
- Treatment for moderate to severe allergic reactions involves injecting epinephrine immediately under the skin.

193 Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2021.
194 Hesperian Foundation, *Where There Is No Doctor: A village health care handbook*, 2021.

- Diphenhydramine or cetirizine can also be given by mouth or by injection into a muscle to help with rash and itchiness.
- If the survivor has difficulty breathing or continued swelling of the mouth and tongue, they need to be referred to the health center immediately.
- Treatment for allergic shock requires injection of epinephrine immediately under the skin. It can be repeated at 5- to 15-minute intervals if symptoms do not improve. The person should be referred to a higher-level health facility immediately, since there is a risk that the signs will return in several hours.

DISCUSSION (10 minutes)

1. Review the handout on treating allergic reactions and shock in detail. Encourage participants to ask any questions they may have.

2. Emphasize to participants that they should refer to the protocol every time they are providing care to ensure the survivor receives the correct treatment.

3. Ask participants if they have any questions before moving on to the demonstration.

DEMONSTRATION (10 minutes)

1. Demonstrate how to give an injection under the skin through following the instructions in the handout. If participants have not covered intramuscular injections, also review the relevant information in the tetanus and hepatitis B vaccination sections.

2. If not already covered when discussing how to administer the tetanus or hepatitis B vaccinations, review infection-prevention procedures as detailed in the **advanced infection prevention** handout. Be sure to cover safe storage of needles and syringes, and safe disposal.

ROLE PLAY (20 minutes)

1. Divide participants into pairs to practice responding to allergic reactions and allergic shock. Provide them with the relevant drugs, syringes, needles, and a model for demonstration.

2. After the first partner has modeled treating allergic reactions and shock, direct pairs to change roles so that all participants have a chance to practice.

3. Circulate among participants, and observe the role plays to see that participants demonstrate skills in providing treatment according to protocol. Provide feedback as necessary.

4. Ask participants if they have any questions before closing.

ANNEXES

Registration Form and Attendance Sheet

Location: _____ Training dates: _____

Name	Signature	Village	Pretest Score	Post-test Score	Difference pre/post	% Change

Prepared by: _____ Verified by Program Manager: _____

Daily participant evaluation form

Date: _____

1. What did you enjoy most about today?

_____

_____

_____

2. What did you learn today that you will use when you go back home?

_____

_____

_____

3. What is the most valuable thing you learned today (any knowledge or skill)?

_____

_____

_____

4. Was there anything you did not understand during today's sessions?
   Please give an example of what you did not understand.

_____

_____

_____

5. What other specific comments or questions do you have?

_____

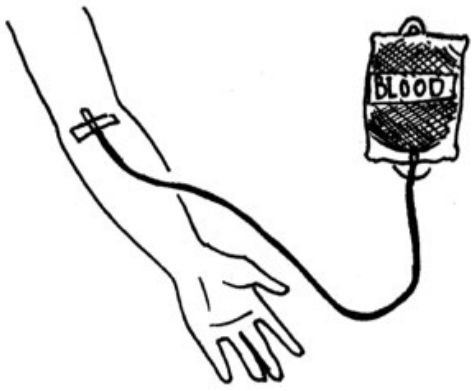
_____

_____

Thank you!

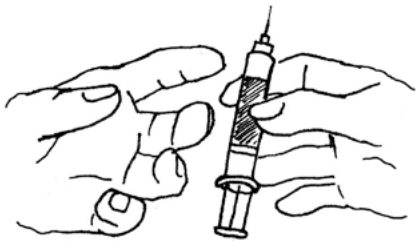
HIV cards

sex without a condom



blood transfusion

pregnancy, childbirth or breastfeeding



unsterile needle or tools

infected blood that gets into a cut

hugging

HIV CARDS (continued)

kissing

sharing a meal

sharing clothes

insect bites

sharing a bed

sharing a latrine

Blanketed by blame

Volunteer statements

BLAMING STATEMENT 1. Friend—Anita

Maya tells her closest friend, Anita, about the abuse. Anita: "Are you telling me that wonderful husband of yours loses his temper and even hits you? I cannot believe that! He is always so kind and happy. You must have done something to make him angry." (After reading the statement, step forward and cover Maya with the shawl/newspaper.)

EMPOWERING STATEMENT 11. Friend—Anita

Anita: "I am so glad you told me about this. Breaking the silence is the first step. What he is doing is not acceptable. You do not deserve this. I will stand with you, Maya." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 2. Maya's Mother—Grace

Maya calls her mother, Grace. Grace: "Try harder Maya. You were always the most stubborn one of all your sisters. Their marriages are all fine. They always listen to their husbands. Why did you have to go and work at that factory of yours? You must have neglected your husband. That is why he must be angry." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 10. Maya's Mother—Grace

Grace: "Maya, you have tried so hard, and he did not. Your stubbornness is your strength. If I was in your shoes, I don't know if I would have struggled for so long." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 3. Maya's Neighbor

The neighbors have heard her screams and sobs, and the police sirens. Neighbor: "The walls are pretty thin, Maya. People in the building are talking. These late shifts at work must be so frustrating for your husband. The poor guy was telling me that he has to now cook dinner on Wednesdays and Thursdays." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 9. Maya's Neighbor

Neighbor: "Maya, we can help out by watching the children when you have to work late. Let them come over to our apartment. We will cook their favorite noodles. When you come home, there will be some for you, too." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 4. HIS (Lee's) Mother—Sandra

Maya's mother-in-law Sandra lives close by, but she is often out of town visiting her other children. Sandra: "Do not whine, Maya. You are the one neglecting my son. Do you know how many times a day I must text him and make sure he is OK? You are always at that factory. Besides, who will believe you now? Do you remember those lies you told about my husband? That he tried to rape you." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 8. HIS (Lee's) Mother—Sandra

"I have worried for the longest time that Lee learned his abusive ways from his father. I will advise Lee that he must get help. And I am so sorry that I pretended not to notice that my husband was sexually harassing you." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 5. Community Health Worker—Miriam

The community health worker has often heard Maya and Lee fighting when she visits their home to talk about health. Miriam: "Maya, you should make peace with Lee. Is it good for your children to see the two of you fighting? Why don't you just listen to him and not argue back? He is such a good man. He is always laughing and talking to everyone in this neighborhood." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 7. Community Health Worker—Miriam

Miriam: "Maya, you do not deserve to be treated this way. This is abuse and it is bad for your health and for the children's health. I have heard about this NGO organized by women that helps women who face violence. Let me see if I can find out more and give you information. In the meantime, here is some medicine to help the pain in your arm. They will help with the pain you have in your arm." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 6. Priest/Religious Leader

In desperation, Maya confides in the priest/religious leader in her place of worship. She hopes that he will talk to Lee. Priest: "Maya, marriage is not a contract you can walk away from because you don't like the terms. It is a lifelong promise. If you pray harder, things will work out." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 8. Priest/religious leader

Priest: "I'm here to support you, Maya. I talked to Lee to remind him it is also his duty to be a caring spouse and father instead of terrifying you and the children. God does not condone a human beating another human." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 7. Child—Maya's Daughter

Maya's 7-year-old daughter hides under the blankets whenever the violence begins. Daughter: "Mama, why don't you cook better so Papa won't get angry at you? Why can't we leave here?" (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 5. Child—Maya's Daughter

Daughter: "Mama, Papa's so mean to you, he's scaring me. Why doesn't he stop?" (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 8. Police

The neighbors hear her screams and call the police. By the time the police come, Lee has left the house to go drinking with his friends. Police: "Hey lady, why is there so much commotion? The neighbors are complaining. You should not fight so much with your husband. The poor man is always working hard to take care of his family. If you want to file a complaint, you can. But, let me tell you, it is not our job to come between a husband and a wife. This is your private matter and you should sort it out within the family." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 4. Police

Police: "I have arrested your husband, Maya. We can keep him overnight. If you wish to file for a restraining order, you can do that, and this will help you stay safe. We will drive by to check that you are OK tomorrow. For tonight, you and your children are safe, so rest easy." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 9. Social Worker

Maya's son brings home a brochure from school. Maya sees it is for an NGO that helps women and calls them. A social worker answers the call. Social Worker: "We have many programs for women like you. Here is a number for a lawyer who can help you, if you agree to leave your husband. But if you do not leave your husband, it will be difficult to help you." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 3. Social Worker

Social Worker: "I can give you some information about what options you have, Maya. But it is best not to make a big decision when you are in a crisis. Tell me, what would be most helpful to you right now and then we can discuss some options so that you can decide what you would like to do. How does this sound to you?" (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 10. Lawyer

The lawyer hears her story, asks a few questions, and then responds. Lawyer: "These kinds of cases are very difficult. It will cost you a lot of money and time. Have you thought about your children? What will happen to them without their father? I will need a witness or someone else who can verify that you are telling the truth about your husband beating you and forcing you to have sex. Besides, once you got married, you have legally agreed to have sex whenever he wants." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 2. Lawyer

Lawyer: "No one deserves to be treated like this, Maya. While it is the case that the law does not recognize forced sex by your husband as a crime, physical abuse is recognized as a crime. You have several options. First, think about whether you want to file a temporary restraining order. This could give you some time to think about what you want to do and what is best for you and your children. I can help you in this process." (After reading the statement, step forward and remove the shawl/newspaper.)

BLAMING STATEMENT 11. Doctor

After two days, Maya's arm still hurts and she is unable to work. She goes to the local clinic. The doctor examines her and tells her there is a fracture. Doctor: "Your x-ray shows you have a fracture. We will need to put your arm in a cast. It will heal in a few weeks. Did you say this happened because you fell down the stairs? Well, you need to be more careful next time. Now, do not cry. You can see I am very busy. There is no time for all this emotional stuff. Please go to the nurse. She will get your arm into the cast and then you can be on your way." (After reading the statement, step forward and cover Maya with a blanket.)

EMPOWERING STATEMENT 1. Doctor

Doctor: "Maya, I can see from your x-ray that you have a fracture. I also see several bruises that are beginning to fade. Once we put your arm in a cast, it will heal in a few weeks. I can give you some pain medicine so that you are more comfortable. However, I am concerned about your health, and I am wondering if everything is OK in your home. I see many women facing problems like you. They trust me to share more about what is happening in their lives. If you feel comfortable, you can do so as well. I will not tell anyone else. Has Lee done something to hurt you?" (After reading the statement, step forward and remove the shawl/newspaper.)

Treatment Protocols[195]

(All tables from 2018 *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* or 2019 WHO Clinical Management of Rape and IPV Survivors)

STI presumptive treatment in ADULTS	WHO Protocol[196] *Circle drug used in pilot setting*	Notes	Local drugs and dosaging if different from WHO to be used in pilot setting
Gonorrhea	**cefixime** 400 mg orally, single dose or **ceftriaxone** 125 mg intramuscularly, single dose		
Chlamydial infection	**azithromycin** 1 g orally, in a single dose *(This antibiotic is also active against incubating syphilis within 30 days of exposure)* or **doxycycline** 100 mg orally, twice daily for 7 days (***contraindicated in pregnancy***)		
Chlamydia infection in pregnant women	**azithromycin** 1 g orally, in a single dose *(This antibiotic is also active against incubating syphilis (within 30 days of exposure)* or **erythromycin** 500 mg orally, 4 times daily for 7 days or **amoxicillin** 500 mg orally, 3 times daily for 7 days		
Syphilis	**benzathine benzylpenicillin*** 2.4 million IU, intramuscularly, once only *(give as two injections in separate sites)* or **azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)* *(This antibiotic is also active against chlamydial infections)*	**If the survivor presents within 30 days of the incident, **benzathine benzylpenicillin** can be omitted if the treatment regimen includes **azithromycin 1 g as a single dose,** which is effective against incubating syphilis as well as chlamydial infection.* *If the survivor presents more than 30 days after the incident, **azithromycin 2 g as a single dose** is sufficient presumptive treatment for primary, secondary and early latent syphilis of < 2 years duration and also covers chlamydial infections.*	
Syphilis, patient allergic to penicillin	**azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)* or **doxycycline** 100 mg orally, twice daily for 7 days *(contraindicated in pregnancy)* *Both azithromycin and doxycycline are active against chlamydial infections*		

195 IAWG on Reproductive Health in Crises, *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*, 2010.

196 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. IAWG; 2010.

STI presumptive treatment in ADULTS	WHO Protocol[196] *Circle drug used in pilot setting*	Notes	Local drugs and dosaging if different from WHO to be used in pilot setting
Syphilis in pregnant women allergic to penicillin	**azithromycin** 2 g orally as a single dose *(for treatment of primary, secondary and early latent syphilis of < 2 years duration)* or **erythromycin** 500 mg orally, 4 times daily for 14 days Both azithromycin and erythromycin are also active against chlamydial infections	**If the survivor presents within 30 days of the incident,* ***benzathine benzylpenicillin*** *can be omitted if the treatment regimen includes* ***azithromycin 1 g as a single dose,*** *which is effective against incubating syphilis as well as chlamydial infection.* *If the survivor presents more than 30 days after the incident,* ***azithromycin 2 g as a single dose*** *is sufficient presumptive treatment for primary, secondary and early latent syphilis of < 2 years duration and also covers chlamydial infections.*	
Trichomoniasis	**metronidazole** 2 g orally as a single dose or **tinidazole** 2 g orally as a single dose or **metronidazole** 400 or 500 mg orally, 2 times daily for 7 days *Avoid metronidazole and tinidazole in the first trimester of pregnancy*		

STI presumptive treatment in CHILDREN and ADOLESCENTS	Weight or age	WHO Protocol *Circle drug used in pilot setting*	Notes	Local drugs and dosaging if different from WHO to be used in pilot setting
Gonorrhea	<45 kg	**ceftriaxone** 125 mg intramuscularly, single dose or **spectinomycin** 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose or **cefixime** 8 mg/kg of body weight orally, single dose		
	>45 kg	Treat according to adult protocol		
Chlamydial infection	<45 kg	**azithromycin** 20 mg/kg orally, single dose or **erythromycin** 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days		
	>12 years	Treat according to adult protocol		
	>45 kg but <12 years	**erythromycin** 500 mg orally, 4 times daily for 7 days or **azithromycin** 1 g orally, single dose		
Syphilis		**benzathine penicillin*** 50,000 IU/kg IM (up to a maximum of 2.4 million IU), single dose	**If the survivor presents within 30 days of the incident,* ***benzathine penicillin*** *presumptive treatment for syphilis can be omitted if the treatment regimen includes* ***azithromycin,*** *which is effective against incubating syphilis as well as chlamydial infection.*	
Syphilis, patient allergic to penicillin		**erythromycin** 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days		
Trichomoniasis	<12 years	**metronidazole** 5 mg/kg of body weight, orally, 3 times daily for 7 days		
	>12 years	Treat according to adult protocol		

Emergency contraception	Pill composition	Common brand names *Circle drug used in pilot setting*	First dose: Take as soon as possible, up to 120 hours	Second dose: Take 12 hours later	Local drugs and dosaging if different, to be used in pilot
Levonorgestrel only ECPs	1.5 mg LNG	NorLevo 1.5 (in RH Kits), Escapelle, Plan B One-Step, Postpill, Pregnon 1.5, Vikela, Postinor 1	1 tablet	0 tablets	
	0.75 mg LNG	Postinor 2, Levonelle-2, NorLevo 0.75, Pregnon, Next Choice	2 tablets	0 tablets	
Levonorgestrel only OCPs	30 mcg	Microlut, Microval, Norgeston	50 tablets	0 tablets	
	37.5 mcg	Overette	40 tablets	0 tablets	
Ulipristal acetate ECPs	30 mg UPA	Ella, ellaOne	1 tablet	0 tablets	
Ulipristal acetate	5 mg	Fibristal	6 tablets	0 tablets	
Combined OCPs	EE 50 mcg plus LNG 250 mcg or NG 500 mcg	Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovidon, Ovral, Ovran, Tetragynon, E-Gen-C, Neo-Primovlar 4	2 tablets	2 tablets	
	EE 30 mcg plus LNG 150 mcg or NG 300 mcg	Lo/Femenal, Microgynon, Nordete, Ovral L, Rigevidon	4 tablets	4 tablets	
	EE 20 mcg plus LNG 100 mcg or NG 200 mcg	Loette	5 tablets	5 tablets	

PEP for adults and adolescents over 10 years (over 30 kg)				
Three-medication regimen recommended	**Dose/tablet**	**Dosage**	**Duration**	**Local drugs and dosaging if different, to be used in pilot**
Lamivudine + Tenofovir	300 mg/300 mg	1 tablet once daily	28 days	
Plus				
Dolutegravir	50 mg	1 tablet once daily	28 days	

Recommended Two-drug Combination Therapies for HIV-PEP (persons <40 kg)				
Weight or age	**WHO Protocol[197]** ***Circle drug used in pilot setting***	**Prescribe** *Discard a bottle of syrup 15 days after opening*	**28 day supply**	**Local drugs and dosaging if different, to be used in pilot**
Children <2 years or 5-9 kg	**Zidovudine (ZDV/AZT) syrup*** 10 mg/ml plus **Lamuvidine (3 TC) syrup** 10 mg/ml	7.5 ml twice a day plus 2.5 ml twice a day	420 ml (Five 100 ml bottles or three 200 ml bottles) plus 140 ml (Two 100 ml bottles or one 200 ml bottle)	
Children 10-19 kg	**Zidovudine (ZDV/AZT)** 100 mg capsule plus **Lamuvidine** (3 TC) 150 mg tablet	1 capsule three times a day plus ½ tablet twice a day	84 capsules plus 28 tablets	
Children and adolescents 20-39 kg	**Zidovudine (ZDV/AZT)** 100 mg capsule plus **Lamuvidine** (3 TC) 150 mg tablet	2 capsules three times a day plus 1 tablet twice a day	168 capsules plus 56 tablets	

Mifepristone and misoprostol regimens for abortion up to 12 weeks (IAFM)

Gestational age	Mifepristone dose	Misoprostol dose, route, and timing
Up to 10 weeks	200 mg orally	After 24-48 hours, 800 mcg buccally, sublingually, or vaginally, for one dose.
10-12 weeks	200 mg orally	After 36-48 hours, 800 mcg vaginally, followed by 400 mcg vaginally or sublingually every 3 hours for a maximum of 5 doses of misoprostol.

Misoprostol-only regimens for abortion up to 12 weeks (IAFM)

Dose	Route	Timing
Misoprostol 800 mcg (four 200 mcg pills) OR	Vaginal	Every 3-12 hours for a maximum of 3 doses.
Misoprostol 800 mcg (four 200 mcg pills)	Sublingual	Every 3 hours for a maximum of 3 doses.

Misoprostol for incomplete abortion up to 13 weeks uterine size (IAFM)

Dose	Route	Timing
Misoprostol 600 mcg (three 200 mcg pills) OR	Oral	Single dose.
Misoprostol 400 mcg (two 200 mcg pills)	Sublingual	Single dose.

[197] Reproduced and adapted from Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings*. IAWG; 2010.

Communities Care: Transforming Lives and Preventing Violence

Community Health Worker Training

Final Training Evaluation

Date: _____ Location of training: _____

Please circle the response that best matches how you feel about each question.

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 survivors of sexual violence?

   very well well poorly not at all

3. How well did the training meet your need to understand how to communicate with survivors of sexual violence?

   very well well poorly not at all

4. How well did the training provide specific information on the management of caring for persons with diverse needs (such as child survivors, men and boys, persons with SOGIESC)?

   very well well poorly not at all

5. How much will the training change how you care for survivors of sexual violence in the future?

   very well well poorly not at all

6. How did the training change your attitude toward survivors of sexual violence?

   very negatively somewhat negatively did not change

   somewhat positively very positively

7. How would you rate the exercises used in the training?

   very well well poorly not at all

8. How would you rate how the training was facilitated?

   very well well poorly not at all

9. Please note any comments or suggestions. THANK YOU!

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