STRENGTHENING COMMUNITY-BASED CARE
2024 REVISION

PART 3

CAPACITY BUILDING

TRAINING SESSIONS AND MATERIALS

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

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

STRENGTHENING COMMUNITY-BASED CARE

CAPACITY BUILDING

10 DAYS • 8 MODULES

GETTING STARTED

Key considerations for capacity building of Community Health Workers

The purpose of Getting Started Guide is to support program staff to plan the pilot of community-based care for survivors of sexual violence (SV), including intimate partner violence (IPV) in their community programming.

The Getting Started Guide is one component of the training tool package.

The training tool package also includes:

Community Health Workers Training – Facilitator's Manual

Community Health Workers Training – Participant Packet

Contents

Community-based approaches to caring for survivors of sexual violence and intimate partner violence

Community-based medical care for survivors of sexual violence

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, disasters, and displacement on families, communities, institutions, and economies.[1] 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. Violence 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 multiple UN Security Council Resolutions.[4]

History of the *Communities Care* training package

In 2009, the Women's Refugee Commission (WRC) and local partners conducted an evaluation in Myanmar with internally displaced persons (IDPs) to assess whether community-based delivery of services for SV survivors was safe, acceptable, and feasible in humanitarian settings. While the project established feasibility of the community-based model, its safety could not be assessed as no survivors presented to seek services during implementation. Evaluation findings underscored the importance of raising community awareness around the concepts of gender, gender-based violence (GBV), and the benefits of seeking care after SV. The study was published as "Piloting community-based medical care for survivors of sexual assault in conflict-affected Karen State of eastern Burma," in the May 2013 issue of *Conflict and Health*.[5]

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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; Elrha, *Small Arms Survey*, 2016. Elrha, Gender Based Violence Interventions: Opportunities for Innovation, 2016.

4 1325, 1820, 1888, 1889, and 1960 on Women, Peace and Security.

5 Tanabe M, Robinson K, Lee CI, Leigh JA, and Htoo EM. *Piloting community-based medical care for survivors of sexual assault in conflict-affected Karen State of eastern Burma*. Conflict and Health 2013 7:12.

Based on these evaluation findings, WRC and the UNICEF Child Protection, Health, and HIV/AIDS sections developed a broader training package for community-based management of survivors of SV to address the critical role that community health workers (CHWs) and other community-based service providers can play in addressing the medical and psychosocial survivors of SV in varied humanitarian settings. The training package was developed using the World Health Organization's (WHO) 2004 *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons* for CHWs to provide post-rape care where facility-based health services were not available or accessible. The effort was embedded within a larger package of interventions to address community norms around sexual violence. Entitled *Social Norms and Community-based Care in Humanitarian Settings: Building 'Good Practice' Approaches for Primary Prevention and Response to Sexual Violence Against Women and Girls Affected by Conflict*, the interventions were implemented in Somalia and South Sudan. While the initiative was successful in influencing social norms, UNICEF and Johns Hopkins University did not publish findings on the safety and efficacy of CHW provision of clinical care for survivors of sexual violence (as of 2021).[6]

Since these two pilots, more global guidance has emerged on sexual and reproductive health (SRH) in humanitarian settings, as well as task-sharing of related activities. First, the Inter-agency Working Group on Reproductive Health in Crises (IAWG) updated the *Inter-agency Field Manual on Reproductive Health in Humanitarian Settings* (IAFM) in 2018, which included updates to the Minimum Initial Service Package (MISP), the international standard of care for SRH interventions in acute emergency settings.[7] In 2019, WHO, the United Nations High Commissioner for Refugees (UNHCR), and the UN Population Fund (UNFPA) updated the 2004 *Clinical Management of Rape Survivors* to include IPV. IPV is of significant concern in humanitarian crises, as studies show that women who experienced conflict victimization were 5.9 times more likely to report experiencing IPV in the preceding year than women who had not experienced conflict victimization (95% confidence interval, 5.0-6.9).[8]

Additionally, learning and good practices have emerged on working with CHWs for SRH activities at large.[9] Guidance recommends that any intervention provided by lay health workers should be perceived by recipients, lay health workers, and the health professionals who support them, as relevant, meaningful, and acceptable.[10] Recommendations focus on the need to ensure clear roles and responsibilities among different levels of the health system; robust and continuous training and supervision; drugs and commodities; changes in regulations to support enhancements to the scope of practice for lay health workers; and salaries and incentives that reflect such scope changes.[11,12]

In terms of SV specifically, articles have reviewed existing practices and the roles that CHWs have played in preventing and responding to SV and IPV at the community level. Serving as core resources of information, referrals, and follow-up, interventions have documented enhanced knowledge of

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6 Glass N, Perrin N, Clough A, et al. *Evaluating the Communities Care Program: Best Practice for Rigorous Research to Evaluate Gender-Based Violence Prevention and Response Programs in Humanitarian Settings*. Conflict and Health 2018, 12:5.

7 Inter-Agency Working Group on Reproductive Health in Crises. Inter-agency field manual on reproductive health in humanitarian settings. IAWG; 2018.

8 Falb KL, McCormick MC, Hemenway D, Anfinson K, and Silverman JG. *Violence against refugee women along the Thai-Burma border.* International Journal of Gynecology & Obstetrics 2013, 120:3.

9 Warren E, Post N, Hossain M, Blanchet K, and Roberts B. *Systematic review of the evidence on the effectiveness of sexual and reproductive health interventions in humanitarian crises*. BMJ Open 2015, 5:12.

10 IFRC, *International first aid and resuscitation guidelines*, 2020.

11 IFRC, *International first aid and resuscitation guidelines*, 2020.

12 Kok MC, Dieleman M, Taegtmeyer M, et al. *Which intervention design factors influence performance of community health workers in low- and middle-income countries? A systematic review.* Health Policy Plan 2015, 30:9.

SV and reporting among survivors.[13] CHWs have been appreciated as trusted, approachable, non-judgmental, and compassionate sources of critical health information and linkages to established services.[14] Despite these gains, studies document some of the challenges that can compromise the quality of services provided by CHWs for SV survivors, including lack of support from formal institutions; high workload; hindering community norms; safety concerns; and inadequate guidelines, resources, and training.[15] Reviews additionally identify the gap in literature around CHWs providing direct clinical care for survivors, and call on studies that robustly evaluate their effects on survivor outcomes.[16]

Since the original training tool was developed, the humanitarian system has increasingly recognized the unique needs, risks, and capacities of sub-populations, especially adolescents, persons with disabilities (PWDs), persons with diverse sexual orientation or gender identities or expressions, and sex characteristics (SOGIESCs), older persons (OPs), persons living with HIV/AIDS (PLHIV), persons engaged in sex work, and other historically marginalized communities has grown across the humanitarian system. While the original training tool incorporated guidance around caring for male survivors, child survivors, and survivors with disabilities, it is critical to conduct active outreach and engagement with all sub-populations to services are available and accessible to all crisis-affected populations in all their diversity. This revised training tool includes additional guidance to support CHWs to care for and address the unique needs of men and boys, PWDs, and people with diverse SOGIESCs.

What is new for clinical care for survivors of sexual violence?

This community-based care model is based on task-shifting/-sharing to empower CHWs to play a critical role in the clinical management of survivors of SV. The facility-based response in the 2004 WHO protocol encompassed:

- Collecting minimum forensic evidence with the survivor's consent if capacity exists for its use.
- Conducting a minimum medical examination with the survivor's consent.
- Providing a minimum care package of compassionate and confidential treatment that includes:
  - Treatment and referral for life-threatening complications
  - Presumptive treatment for STIs
  - EC to reduce the risk of pregnancy
  - Care of wounds

13 Abeid, M, Muganyizi, P, Mpembeni, R, Darj, E, Axemo, P. *A community-based intervention for improving health-seeking behavior among sexual violence survivors: a controlled before and after design study in rural Tanzania.* Global Health Action 2015, 8:28608.

14 Gatuguta A, Katusiime B, Seeley J, Colombini M, Mwanzo I, and Devries K. *Should community health workers offer support healthcare services to survivors of sexual violence? A systematic review.* BMC International Health and Human Rights 2017, 17:1.

15 Gatuguta A, Colombini M, Seeley J, Soremekun S, and Devries K. *Supporting children and adolescents who have experienced sexual abuse to access services: Community health workers' experiences in Kenya.* Child Abuse & Neglect 2019, 104244; and Gatuguta A, Katusiime B, Seeley J, Colombini M, Mwanzo I, and Devries K. *Should community health workers offer support healthcare services to survivors of sexual violence? A systematic review.* BMC International Health and Human Rights 2017, 17:1.

16 Gatuguta A, Colombini M, Seeley J, Soremekun S, and Devries K. *Supporting children and adolescents who have experienced sexual abuse to access services: Community health workers' experiences in Kenya.* Child Abuse & Neglect 2019, 104244; and Gatuguta A, Katusiime B, Seeley J, Colombini M, Mwanzo I, and Devries K. *Should community health workers offer support healthcare services to survivors of sexual violence? A systematic review.* BMC International Health and Human Rights 2017, 17:1.

- Supportive counseling
- Referral to social support and psychosocial counseling services

In addition, the protocol outlined the components of comprehensive treatment of SV:

- PEP to reduce the risk of HIV transmission
- Tetanus toxoid/Tetanus immunoglobin to prevent tetanus
- Vaccines to prevent Hepatitis B

The 2019 *Clinical Management of Rape and Intimate Partner Violence Survivors* update no longer distinguishes between minimum and comprehensive care. Instead, the guidance includes:[17]

- Listening, inquiring about needs and concerns, and validating
- Obtaining informed consent and preparing the survivor
- Taking the history
- Performing the physical and genital exam
- Providing treatment to:
  - Treat physical injuries or refer
  - Prevent tetanus
  - Prevent pregnancy
  - Prevent HIV
  - Prevent STIs
  - Prevent Hepatitis B (no longer within 14 days of assault)
- Enhancing safety and referring for additional support
- Assessing mental health and providing psychosocial support
- Providing follow-up care

The 2019 update also includes identification and care for survivors of IPV:[18]

- Identifying whether a person may be experiencing IPV
- Listening, inquiring about needs and concerns, and validating
- Providing clinical care
- Enhancing safety and referring for support

17 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

18 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.

- Assessing mental health and providing psychosocial support
- Documenting the visit

The 2018 IAFM has additionally updated guidance that includes:[19]

- Supportive communication
- History and examination
- The medico-legal system and forensic evidence collection, where feasible and when needed
- Compassionate and confidential treatment and counseling, including:
  - Emergency contraception
  - Pregnancy testing, pregnancy options information, and safe abortion care (SAC) /referral for SAC, to the full extent of the law
  - Presumptive treatment of STIs
  - PEP to prevent HIV transmission
  - Prevention of Hepatitis B and human papillomavirus (HPV)
  - Care of wounds and prevention of tetanus
  - Referral for further services, such as other health, psychological, and social services

As detailed in Annex II below, existing research and guidance demonstrate that most of the individual components of WHO's 2004 minimum clinical care package for survivors can be safely provided at the community level. Numerous studies have also documented the safety and feasibility of CHWs providing intramuscular and subcutaneous injectable contraceptives, and WHO supports CHWs to provide Depo Provera with robust monitoring, supervision, and evaluation.[20] WHO now also approves trained and supervised lay providers to independently conduct safe and effective HIV testing using rapid diagnostic tests.[21]

Activities that remain in the purview of higher-level health cadres include initiation and prescription of antiretroviral therapy for HIV—inclusive of PEP—and management of second line and third line antiretroviral therapy. However, WHO recommends pilot studies with evaluation and outcomes research to establish whether these tasks could, in certain circumstances, be undertaken safely by non-physician clinicians.[22] Further, this training tool is intended to support the community-level provision of post-rape care as a *package* of care delivered by CHWs, in settings where facility-based care or higher credentialed health workers are not available or accessible to survivors, and in settings where survivors face barriers to accessing facility-based care.

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19 Inter-Agency Working Group on Reproductive Health in Crises. Inter-agency field manual on reproductive health in humanitarian settings. IAWG; 2018.

20 Okegbe T, Affo J, Djihoun F, et al. *Introduction of Community-Based Provision of Subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC) in Benin: Programmatic Results*. Global Health: Science and Practice 2019, 7:2; and Tilahun Y, Lew C, Belayihun B, Lulu Hagos K, Asnake M. *Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia*. Global Health: Science and Practice 2017, 5:4; and WHO, *Summary Brief: Task sharing to improve access to Family Planning/Contraception*, 2020.

21 WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach* (*Second edition*), 2016.

22 WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.

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, PWDs, survivors with diverse SOGIESCs, including lesbian, gay, bisexual, transgender, queer, intersex (LGBTQI+) and gender non-conforming persons, and older persons (OPs).[23]

- **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.

23 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency field manual on reproductive health in humanitarian settings*. IAWG; 2018.

- **PWDs**: PWDs are at a higher risk of SV and often face extreme discrimination by service providers.
- **People with diverse SOGIESCs**: 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.
- UNICEF, *Caring for Survivors Training Pack*, 2010.
- 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 on Gender Based Violence Interventions in Humanitarian Settings*, 2018)

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.
- **Questioning**: A term often used to describe people who are in the process of exploring their sexual orientation or gender identity.
- **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**: The lack of a sexual attraction or desire for other people.

(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)

Sex: 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 on Gender Based Violence Interventions in Humanitarian Settings*)

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)

Planning a pilot project on community-based care for survivors of sexual violence and intimate partner violence

The following sections detail key preparations to be undertaken as part of planning a pilot project on community-based care for survivors of sexual violence and intimate partner violence, prior to recruiting and training CHWs. The full support of implementing partners is critical for the required preparatory work.

Key components include:

- Selecting the pilot site.
- Identifying implementing partners and finalizing project agreements.
- Identifying staff who have the technical expertise to guide and implement the pilot.
- Meeting with critical stakeholders, including relevant government ministries and health and protection partners.
- Meeting with referral health facilities to garner their support for the project, and to streamline any referrals to the health facility level.
- Supporting partners for systems and community mapping in target sites.
- Providing ongoing support for research, monitoring and evaluation (M&E), and capacity development for community-based provision of essential SRH services.
- Identifying referral points for participants of any focus group discussions and key informant interviews organized as part of M&E efforts.
- Implementing workshops to launch the project at various levels to secure district level leadership and community buy-in.

Selecting sites for piloting community-based care for survivors of sexual violence

The first step in piloting the community-based model is to select appropriate intervention sites. In order to ensure the safety and feasibility of implementing the community-based care approach, the following criteria should be applied during site selection. Appropriate settings for piloting will meet all required criteria; the recommended criteria are not mandatory, but will support successful implementation.

	Criteria	Yes	No
Required	SV survivors face barriers to accessing facility-based medical care due to lack of or limited availability, distance to facilities, stigma, or other barriers		
	No known policy barriers to provision of medical care to survivors by CHWs, or known policy barriers that cannot be overcome.		
	Limited population movement that could impede CHWs' ability to provide care and follow-up services, and the program to implement monitoring activities.		
	Possibility of: • Protection of any documentation by CHWs (e.g., from seizure by authorities or found by perpetrators). • Supply chain management and commodity security. • Community sensitization activities around SV. • Ongoing training and supervision of CHWs. • Robust monitoring of project activities.		
	Village/community leader and other stakeholder understanding of pilot objectives.		
	No known CHW connections with fighting forces.		
	If CHWs will provide medication abortion for pregnancies up to 12 weeks, a referral health facility must be available with the capacity to provide vacuum aspiration services in case of failed or incomplete uterine evacuation.		
Recommended	No requirement to report incidents of SV to traditional or formal judicial systems.		
	Relative accessibility in terms of ensuring a consistent supply chain, maintaining supervision, and quality control.		
	Reasonable CHW to population ratio (2 CHWs per 1,000 population).		
	Community confidence and trust of CHWs, or capacity to build trust exists.		
	Established HIV programs for further referrals for survivors who are found to be HIV positive		

Examining site specific policies

Once the pilot locations are selected, it is essential to gather national and local health protocols, agency protocols, and legal guidelines to understand the context and align pilot implementation.[24] It will also be helpful to know what services CHWs are currently providing, what they have been trained in (such as community case management for childhood illnesses), and how the skills to provide post-rape care build on their existing training and scope of work. This will help CHWs maximize related learning and apply already learned skills.

The implementing organization should identify and assess:

National, local, and agency protocols for clinical care for survivors of sexual violence, including provision of:	Available	Not available	List any restrictions
Emergency contraception			
STI prophylaxis and treatment			
HIV post-exposure prophylaxis			
Hepatitis B vaccine			
Tetanus prevention			
Permitted task-sharing of the above			
Local legal guidelines regarding:	**Available**	**Not available**	
Post-abortion care (available methods, providers who can provide different methods)			
Pregnancy termination (legal indications, available methods, timing of methods depending on gestational age, providers who can provide different methods)			

24 International Rescue Committee, *Clinical Care for Sexual Assault Survivors*, 2020.

National, local, and agency protocols for clinical care for survivors of sexual violence, including provision of:	Available	Not available	List any restrictions
Status of minors (age of majority, age of consent, and laws regarding consent for medical treatment of minors)			
Status of persons with diverse SOGIESCs, including criminalization and disparate treatment under the law: • Gay persons • Lesbians • Bisexual persons • Transgender persons • Queer persons • Intersex persons • Gender non-conforming persons			
Existing legal systems to try perpetrators of sexual violence			
Definitions of sexual crimes			
Mandatory reporting of sexual violence/ abuse (for what type of survivor or perpetrator, and reporting to whom)			
Standards for medical documentation and testimony (what constitutes as valid evidence, and from whom? Can only doctors sign medical certificates?)			

It is essential to follow local treatment protocols to minimize drug resistance. Treatment protocols (job aids) in the participants' packet should be adapted as necessary for this purpose.

Policies governing CHW remits

In some instances, active laws or policies may prohibit CHWs from providing certain services, such as dispensing antibiotics, providing injections, or providing EC to unmarried persons. To inform the development of study protocols in a given setting, the implementing organization should gather and assess national, local, and agency policies governing the services that CHWs are authorized to provide.

It is also essential to understand:

- what services CHWs are currently providing;
- what they have been trained in (such as community case management for childhood illnesses); and
- how the skills to provide post-rape care build on their existing training and scope of work.

This will help CHWs maximize and reinforce related learning, and apply existing skills.

In other settings, there may not yet be protocols or policies available to guide CHW provision of medical care for survivors. In this case, the implementing organization should consider approaching the appropriate ministries to assess if the piloting process can be leveraged to influence the development of supportive policies and protocols. Such advocacy can also offer opportunities to revise any restrictive policies and protocols and create a more enabling environment for survivors to seek care.

Considerations for developing study protocols

Evidentiary medical certificates

When health providers care for survivors, a medical certificate is often issued 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. However, in many settings, records provided by CHWs may not suffice as legitimate evidence of services rendered, although they may still serve as documentation that a CHW-client interaction took place. Accordingly, while a medical certificate can serve as important evidence for future pursuance of legal justice, this is often beyond the scope of services that CHWs can provide. CHWs should be trained to provide information to the survivor about medical certificates, and where they can be referred to obtain a medical certificate if they would like to do so.

This training tool includes an intake form to be completed by providers, including CHWs, to provide a medical track record that serves to remind the provider about the history and care provided. The implementing organization should keep the original records of the medical care provided in a locked cabinet.

Myths and misperceptions about policies pertaining to sexual violence and care for survivors

In some settings, health workers, program managers, other stakeholders, and community members may believe myths or have misperceptions about why or when a health provider can or cannot provide care for survivors. For example, health workers may believe that they cannot or should not provide care if a survivor does not have a marriage certificate, or that they need to obtain permission from a

survivor's husband before providing care. In other cases, health workers may believe that a survivor is required to file or present a policy report "verifying" the incident of SV.

It is extremely important to distinguish policy from myth in the pilot setting. When implementing the pilot, training, monitoring, and community sensitization activities must reinforce that CHWs should provide care for all who seek it for any type of SV. **It is not up to the CHW or any health provider to determine or verify "rape."**

Mandatory reporting

Programs should assess mandatory reporting requirements and develop a plan for how to handle cases in settings with mandatory reporting requirements to best meet the needs of survivors and ensure health workers are upholding their legal obligations. While mandatory reporting is often intended to protect survivors—particularly minors—it can undermine survivor-centered approaches to care, in which the survivor is empowered to decide whether or not, when, and to whom they wish to disclose or report the SV.

It may also raise safety concerns, as 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, especially in countries where extramarital sex is illegal, where male husbands and guardians are entitled to access women's medical or personal records, or where marital rape is not recognized under the law. In countries where same-sex relationships are criminalized, men and people with diverse SOGIESCs may be hesitant or less likely to seek health services if mandatory reporting is required.[25]

As a result, in some contexts, implementing organizations may decide to not collect certain types of information, or have CHWs refrain from asking certain types of questions when completing intake forms, because of the potential risks to survivors and/or themselves posed by mandatory reporting requirements or other factors.

Where reporting requirements exist, the WHO *Clinical Management of Rape and Sexual Violence Survivors* guidelines recommend that survivors be fully informed about their choices, and the existing limits to confidentiality. By ensuring survivors are aware of and understand the implications of mandatory reporting requirements, health care workers can help them make informed decisions about what to disclose.[26]

In the pilot settings with mandatory reporting requirements, the implementing organization should determine the best approach for CHWs to use when providing services, and train them accordingly.

Mapping available services to determine the scope of referrals

With CHWs playing a role in a larger health system, it is important to map the services that are available for survivors PRIOR to the training of CHWs. The mapping is part of the groundwork to be completed by implementing organizations' program staff, community advisory boards, and other

25 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings*, 2019.

26 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings*, 2019.

community stakeholders to support CHWs in their work. The table below can help map available referral services for survivors in the pilot setting.[27]

The mapping tool will identify local and international non-governmental organizations (NGOs), locations within the community, and a range of services for women, adolescents, children, PWDs, people with diverse SOGIESCs, people selling sex, and other vulnerable populations. The activity will help implementing organizations obtain the information needed to build on existing capacities within the community, and address context-specific challenges to raising community awareness and providing quality multi-sectoral community-based services to survivors throughout the project.

27 Médecins Sans Frontières - Operational Centre Barcelona, *Sexual & Gender Based Violence: A handbook for implementing a response in health services towards Sexual Violence*, 2011.

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.	◯	◯					
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.	◯	◯					

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 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 PWDs, LGBTQI+ 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.*

If referrals for post-abortion care are not available in the setting, including vacuum aspiration services for first trimester abortions, CHWs should not be providing medication abortions to pregnant people. A back-up system must be available in case of failed or incomplete evacuation of uterine products. The recommended abortion methods in the first trimester are manual or electric vacuum aspiration, or medication methods using a combination of mifepristone followed by misoprostol. Where mifepristone is not available, evidence supports use of misoprostol alone, although it is less effective than when used in combination with mifepristone, and less effective than vacuum aspiration.[28] Terminations in the second trimester are beyond the scope of the CHW, and should be referred to a hospital for dilatation and evacuation and misoprostol-based methods (mifepristone plus misoprostol or misoprostol alone).

28 Inter-Agency Working Group on Reproductive Health in Crises, "Chapter 8: Comprehensive Abortion Care," Inter-agency field manual on reproductive health in humanitarian settings, 2018.

Selecting participating community health workers

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. The below notes three categories of CHWs that can be engaged in the pilot project.

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 (Modules 2-Advance Module 8). This category is applicable only in settings where CHWs have advanced roles[29] 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.

29 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.

- Capacity to provide minimal documentation upon request.

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 that have disabilities, identify as having diverse SOGIEs, or represent other at-risk or minority communities.

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.
  - Facilitator's notes
  - CHW manual
- WHO, *Community case management during an influenza outbreak: A training package for community health workers*, 2011.
  - Trainer's guide
  - Participant's handbook
  - Flip chart for CHWs
- WHO/UNICEF, *Caring for the newborn at home*, 2012.
  - Facilitator's guide
  - CHW manual
- IFRC, *International first aid and resuscitation guidelines*, 2020.

Considerations for piloting community-based care for survivors of sexual violence

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. 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			
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	✓	✓	✓
Provide presumptive treatment for STIs, EC for pregnancy prevention, and supportive counseling (including psychological first aid and basic emotional support)		✓	✓

Intervention	CHW 1	CHW 2	CHW 3
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 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.

To minimize error in providing treatment, implementing organizations should consider prepackaging standard treatment packages. Treatment packages can be color-coded and prepared for adult female survivors that come within three days, five days, and 30 days of the violence. This way, the CHW will not need to dose drugs for each survivor, but can give the appropriate colored packet and simple instructions on patient messaging. A client form is available in the participants' packet where CHWs can note the medicines provided, as well as other information. For children and adolescents, pregnant women, transgender female, or male survivors, CHWs can work from the pre-packaged treatment packets to remove or add medicines as relevant.

Supporting a robust communications strategy to raise community awareness

An important component of the pilot project is to raise awareness of SV, including sexual forms of IPV, and the importance and benefits of seeking care among the different actors in the community.

- *What* is SV, including sexual forms of IPV;
- *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 possible after experiencing SV (preventing pregnancy, preventing STI/HIV; receive basic emotional support);
- *Where* can survivors of SV go for services;
- *What* will survivors of SV expect if they seek health care; and that
- Health services are free, private, voluntary, and safe, and available 24 hours a day, 7 days a week.[30]

Some options to reach different groups are:

- Face-to-face trainings or awareness-raising sessions. These can be conducted by CHWs or peer educators/leaders in schools, youth clubs, religious facilities, support groups for specific communities, and other fora where people congregate.
- Print material, such as brochures, leaflets, posters, etc.
- Theater or drama.
- Radio or television.
- Cell phone messaging.
- Social media.

The following table may be helpful for the program in identifying potential community constituents, and how they can be reached. The table is important given that CHWs will be responsible for health education as part of their day-to-day activities and all members of a community can influence whether or not an enabling environment exists for survivors. The constituents may be survivors, but also shape community norms and roles.

30 WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: Developing protocols for use in humanitarian settings*, 2019.

Constituent	Where are they?	How can messages be communicated to this group? (methods)	How might they hinder or facilitate survivors' access to care?	What are the key messages to convey to these constituents to facilitate survivors' access to care?
Women (Ages 20+)				
Men (Ages 20+)				
Adults with disabilities				
Adults with diverse SOGIESCs • Gay persons • Lesbians • Bisexual persons • Transgender persons • Queer persons • Intersex persons • Gender non-conforming persons				
Elderly				
Adolescent girls (ages 10-19), including married adolescent girls • Early adolescence (10-14) • Mid-adolescence (15-17) • Late adolescence (18-19)				
Adolescent boys (ages 10-19) • Early adolescence (10-14) • Mid-adolescence (15-17) • Late adolescence (18-19)				

Constituent	Where are they?	How can messages be communicated to this group? (methods)	How might they hinder or facilitate survivors' access to care?	What are the key messages to convey to these constituents to facilitate survivors' access to care?
Adolescents with diverse SOGIESCs • Gay persons • Lesbians • Bisexual persons • Transgender persons • Queer persons • Intersex persons • Gender non-conforming persons				
Adolescents with disabilities				
Children (girls aged 5-9)				
Children (boys aged 5-9)				
Children with disabilities				
Persons engaged in sex work				
Community leaders, including leaders of women's groups and other prominent women				
Local community-based organizations				
Support groups for specific populations				
Local Ministry of Health officials				
Traditional health care providers				
Police departments and other law enforcement officers				
Teachers/social workers				
Religious groups				
Other				

Working with facility-based health providers receiving referrals from community health workers

While CHWs 2 and 3 will be trained to provide basic health care for survivors of SV, they will also be trained on when to facilitate referrals to higher level health care as available. Some instances will require immediate referrals from all levels of CHWs (especially CHWs 1 and 2), while others will be conducted primarily by CHWs 2 or 3 as part of their routine work to provide initial care or follow-up care to survivors.

Referrals to facility-based health care made by CHWs

Immediate referral based on observation:*	Referral upon history taking:	Referral upon follow-up care:
• If the survivor is an infant • Swelling and hardness of the abdomen (belly) • Pain in abdomen (belly) • Severe pain in back, chest, arms, legs, or head • Vomiting blood • Heavy bleeding from vagina/anus • Heavy bleeding from other parts of the body • Possible object lodged in vagina/anus • Altered mental state or confusion • Pale, blue, or gray-skin • In a small child, fast or difficulty breathing • If the survivor is unconscious	• If the survivor is an infant • Concerns of possible bleeding inside the body • Infected wounds • Open wounds where skin does not come together by itself • Leaking urine or feces • Object in vagina/anus • Bleeding from vagina/anus • Severe pain • Any abdominal or belly pain • Vaginal bleeding** • Vaginal discharge** • HIV testing** • Tetanus vaccine** • Hepatitis B vaccine**	• Severe side effects of medicines • Signs of STIs that may be a result of treatment failure, or recurrent STI infection • Partner testing for HIV • Pregnancy termination if available** • Other cases that CHWs cannot treat
*CHWs will not complete an intake form if immediate referral is made to a health facility and no treatment is provided.	** CHW 3 may be able to address this level of care.	

The means of referral will differ in each setting and will need to be arranged by the program and the receiving health facility. Depending on the survivor's condition, an ambulance may be necessary if a vehicle is available at the health facility. Program staff should brief health providers from receiving referral facilities in advance of the project about the CHWs' role in providing care to survivors, and what care they are expected to provide at the community level, so that referrals are smooth and streamlined.

More specifically, CHWs will be trained to provide the following treatment for different types of SV:

- While EC is typically not necessary for oral or 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, CHWs will also be trained to provide EC in cases of anal assault in the pilot project.
- For oral assault, the tetanus vaccine will only need 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 will be provided to all survivors of reproductive age who have experienced vaginal or anal assault, even if they were using a method of family planning at the time of the assault.

During pilot start-up, the most important form to review with health providers serving as referral points is the **intake form**. CHWs 2 and 3 will be trained to complete the intake form for every survivor to whom they take a health history, even if the survivor comes after five days of the assault. If the survivor consents to receiving additional services from a health facility, they will be provided with a duplicate intake form to take with them to see the referral staff.

Providers need to trust the information that has been noted on the intake form, so that they do not re-question the survivor for issues that have already been discussed. These include:

- The type of assault that the survivor has sustained (vaginal, anal, and/or oral assault).
- Whether the survivor has been vaccinated against tetanus.
- Whether the survivor has been vaccinated against Hepatitis B.
- What treatment the survivor has received from the CHW (pregnancy testing, voluntary testing and counseling for HIV, EC, PEP, antibiotics for STIs, basic wound care, basic counseling, safe abortion care if less than 12 weeks of pregnancy, etc.).
- What type of health referral the survivor is seeking (HIV, vaccinations, advanced wound care, safe abortion care, etc.).
- What other referrals the survivor has consented to receive.

Health providers receiving referrals should ensure they understand the intake form and know how to contact the CHW for any questions. Further, if appropriate and valid in the setting for legal purposes, the provider can sign the intake form to certify it as reviewed by an accredited health provider. Health facilities should make sure to keep their own records of any care they give to a survivor at the facility level, similar to protocols for all patients that come to the health facility.

Facility based providers may also be able to leverage CHWs' capacity to offer community-based follow-up to survivors, at two weeks after the first visit, although preferably after one week. While health facilities should follow existing protocol on providing their own follow-up to survivors, if a provider judges that the survivor's condition can be best managed by a CHW, the provider can counsel the survivor on issues that they can discuss with the CHW as they begin the healing process. Providers work with CHWs wherever possible to ensure that the survivor receives optimal care as the environment allows, and that they do not fall through the cracks.

Risk mitigation before pilot implementation

In addition to determining the CHWs' scope of work in the setting, it is important for the pilot to troubleshoot any potential negative consequences of community-based care, especially if CHWs are primary providers of care (CHWs 2 and 3).

Sample risk mitigation matrix:

Potential negative consequences	Example solutions to prevent the consequences before they arise	Possible action plans for the project should the consequences occur
The survivor presents with significant trauma that is beyond the CHW's capability to treat.	Agree upon first aid measures and referral protocol via existing and available means within the community.	Follow agreed upon protocol for referral to a higher-level facility. CHWs should document any referrals on their intake forms.
The survivor is at risk of further physical harm/retaliation by the perpetrator(s) due to breach of confidentiality.	Ensure CHWs are aware of the consequences of not maintaining confidentiality. Agree upon and establish communication channels to address protection concerns, including for relocation of survivors if requested and feasible. Ensure CHWs are able to support survivors to make decisions about disclosure to protect confidentiality.	Discuss and take active protection measures. Program staff should discuss the importance of maintaining confidentiality with the CHW.
The survivor is at risk of further physical harm due to discrimination based on disability, sexual orientation, etc.	Recruit and train a diverse cohort of CHWs, including those that have disabilities and have diverse SOGIEs. Conduct values clarification and transformation activities with CHWs as appropriate and feasible. Conduct extensive community outreach to foster social inclusion.	Take active protection measures.
A survivor experiences unrelated physical attacks while seeking care from a CHW they would not have otherwise sought had the pilot not been implemented.	Select a setting with moderate stability to minimize known risks. Proactively identify means of communication, transportation, and locations that can be safely accessed by survivors and CHWs.	Provide care and protection as feasible. Where feasible, budget to support CHW transportation to minimize risks and costs to survivors.

Potential negative consequences	Example solutions to prevent the consequences before they arise	Possible action plans for the project should the consequences occur
CHW refuses to provide post-rape care due to fear of retaliation or personal beliefs (e.g., opposition to providing emergency contraception).	Assess potential challenges posed by CHWs' personal beliefs during CHW identification and training. Raise awareness among and train CHWs on gender issues and the benefits of providing care to survivors, etc., during training. Conduct values clarification and transformation activities with CHWs as appropriate and feasible. Train CHWs to also debrief with a supervisor (program staff) and to let the supervisor know about any concerns they have about providing this care. Proactively identify means of communication, transportation, and locations that can be safely accessed by survivors and CHWs.	Re-evaluate the inclusion of the CHW in this pilot by discussing the reasons for which care was refused. Ensure that care is provided to the survivor in a timely manner, regardless of the CHW's refusal to provide care.
CHW refuses to provide safe abortion care/referral to safe abortion care to the full extent of the law.	Assess potential challenges posed by CHWs' personal beliefs during CHW identification and training. Perform values clarification exercises during CHW trainings.	Re-evaluate the inclusion of the CHW in this pilot by discussing the reasons for which care was refused. Ensure that care is provided to the survivor in a timely manner, regardless of the CHW's refusal to provide care related to safe abortion services.
CHW breaches confidentiality.	Only allow CHWs that demonstrate pre-established competencies to play a role in managing survivors. Emphasize the importance of maintaining confidentiality during CHW trainings. Identify and address any incentives for the CHWs that may lead to breaches in confidentiality.	Re-evaluate the inclusion of the CHW in the project by discussing the circumstances under which confidentiality was breached. Identify and minimize any risks for the survivor resulting from the breach of confidentiality.
A case becomes public and the community tries to seek official or traditional means of redress, against the wishes of the survivor.	Predetermine how best to meet the best interests of the survivor in the context of official and traditional means of redress. Identify and include official and traditional means of redress as part of community mapping. Include information regarding these mechanisms as part of counseling for survivors, including in discussions of disclosure and mandatory reporting. Proactively identify where CHWs can provide care to survivors in confidential and private locations.	Assist the survivor to have their wishes respected as feasible, and ensure their protection. Work with the survivor to determine how they wish to have the situation addressed. Involve respected figures—as relevant and appropriate, and with survivor's consent—to conduct damage control in the community.
A survivor requests a medical certificate, but a family member/third party finds the document.	Review the intake form and predetermine what will be documented for the survivor. Inform the survivor of potential risks to their safety if the document is discovered. Discuss with the survivor options for storing their medical certificate as safely as possible.	Identify and minimize any immediate risks for the survivor and take action within the limits of the setting.

Potential negative consequences	Example solutions to prevent the consequences before they arise	Possible action plans for the project should the consequences occur
Documentation kept hidden by the CHW is found/looted.	Keep documentation/records minimal with no identifying information of the name, age, sex, and village of the survivor. Identify where and how documents will be safely and securely stored before beginning service delivery. Establish a contingency plan for safe evacuation or destruction of documentation in the event of an emergency (e.g., setting has to be evacuated due to insecurity).	Identify and minimize any immediate risks for survivors. Re-evaluate storage of records to prevent reoccurrence.
Perpetrators discover the role of the CHW in providing post-rape care, and the physical safety of the CHW becomes a concern.	Agree upon and establish communication channels to address protection concerns. Reinforce the overall role of CHWs in the community.	Assist CHWs to address this situation by possibly relocating the CHW.
The community becomes suspicious of the CHW suddenly coming into close contact with a survivor that may not have had any reason for an encounter.	Predetermine means of follow-up care to monitor and address unintended consequences. Identify safe, private, neutral locations where CHWs can provide care to survivors, if they are not able to receive care in their homes.	Increase community understanding of the role of CHWs in providing services for primary health care issues. For a particular situation, ensure the safety of the CHW while the issue is resolved.
A CHW refuses to continue providing care, having discovered potential risks to their family's safety. Demand for post-rape care has been created, however, and a survivor has come forward.	Discuss potential risks and establish safety and protection protocols with CHWs before enabling them to assume responsibilities and identify responsible ways to relinquish duties. Address any incentive issues for the CHW to maintain motivation. Train multiple CHWs in each site.	Ensure that remaining CHWs continue providing care through addressing motivation, etc.

Resources for Values Clarification and Attitudes Transformation

CHWs play an essential role in delivering and referring for life saving services, including emergency contraception, post-abortion care, and safe abortion care, and in ensuring that care is available to survivors in all their diversity. Implementing organizations can refer to the following resources to support values clarification and attitudes transformation (VCAT) activities among CHWs and program staff.

- Ipas, Abortion Attitude Transformation: A values clarification toolkit for humanitarian audiences, 2018.
- Ipas, Disability inclusion in reproductive health programs: An orientation and values clarification toolkit, 2021.

Monitoring community-based care

Because of the nature of the project as a pilot project, the following questions can be monitored and evaluated at key intervals over the course of project implementation:

- Was the provision of services by CHWs **safe** (per medical protocol, etc.) and **feasible** (in terms of CHWs' ability to connect with survivors to provide services, maintain confidentiality, garner trust among the community, etc.)?
- To what extent did disclosure and uptake of multi-sectoral services for GBV increase in intervention areas?
- What are the levels of survivors/participants' satisfaction with the interventions?
- What changes have occurred in related knowledge, attitudes, and behaviors among service providers, including CHWs, as a result of the training and intervention?

Both qualitative and quantitative tools can be used to assess changes in reporting SV and other forms of GBV and identify bottlenecks in accessibility of services and barriers to "breaking the silence" around SV and IPV.

Monitoring data collected over the course of the project should monitor access to services and quality and utilization of services. Suggested indicators include:

Indicator	Numerator	Denominator	Sources	Indicator Type	Target
% of sexual violence survivors seeking care at a pilot project site who receive package of care for sexual violence per pilot protocol	# of sexual violence survivors who receive treatment and care in a timely* manner (1)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (A) **	CHW monitoring form	Outcome	100%
Change in % of community members (disaggregated by gender, age, and marital status) who report more gender equitable attitudes towards addressing GBV in their community	--	--	KAP baseline and endline surveys	Outcome	60%
Change in % of community members (disaggregated by age, gender) who report having access to medical care for sexual violence if needed	--	--	KAP baseline and endline surveys	Outcome	40%
Change in % of community members (disaggregated by age, gender) who report having access to psychosocial care for sexual violence if needed	--	--	KAP baseline and endline surveys	Outcome	40%
# of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (A)	--	--	CHW monitoring form	Process	--
# of sexual violence survivors who seek health care for sexual violence from CHWs at the sites in < 72 hours (to receive PEP) (B)	--	--	CHW monitoring form	Process	--
# of sexual violence survivors who seek health care for sexual violence from CHWs at the sites in < 120 hours (to receive EC) (C)	--	--	CHW monitoring form	Process	--
% of sexual violence survivors from whom informed consent is sought from CHWs	# of sexual violence survivors from whom informed consent is sought from CHWs (**2**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	100%

Indicator	Numerator	Denominator	Sources	Indicator Type	Target
% of sexual violence survivors who receive STI presumptive treatment from CHWs per local protocol	# of sexual violence survivors who receive STI presumptive treatment from CHWs per local protocol (**3**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	100%
% of sexual violence survivors who receive EC < 120 hours from CHWs	# of sexual violence survivors who receive EC <120 hours from CHWs (**4**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites in < 120 hours (**C**)	CHW monitoring form	Process	100%
% of sexual violence survivors who receive PEP < 72 hours from CHWs	# of sexual violence survivors who receive PEP <72 hours from CHWs (**5**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites in < 72 hours (**B**)	CHW monitoring form	Process	100%
% of sexual violence survivors who receive basic wound care (first aid) from CHWs	# of sexual violence survivors who receive basic wound care from CHWs (**6**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	--
% of sexual violence survivors who receive basic emotional support from CHWs	# of sexual violence survivors who receive basic emotional support from CHWs (**7**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	100%
% of sexual violence survivors referred by CHWs for tetanus toxoid, Hepatitis B, or other vaccines (where available)	# of sexual violence survivors for whom a referral was made by CHWs (**8**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	--
% of sexual violence survivors referred by CHWs for other medical , psychosocial, protection, etc. services (where available)	# of sexual violence survivors for whom a referral was made by CHWs (**9**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	--

Indicator	Numerator	Denominator	Sources	Indicator Type	Target
% of sexual violence survivors seen by a CHW with whom issues of their personal safety and security are discussed	# of sexual violence survivors seen by a CHW who receive counseling on personal safety and security (**10**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	100%
% of sexual violence survivors who request a copy of their medical records using a standardized, minimal form	# of sexual violence survivors who request medical records (**11**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	--
% of sexual violence survivors seeking care who receive two week follow-up visit from CHWs	# of sexual violence survivors who receive two week follow-up visit from CHWs (**12**)	Total # of sexual violence survivors who seek health care for sexual violence from CHWs at the sites (**A**)	CHW monitoring form	Process	100%
Change in % of community members (disaggregated by gender, age, and marital status) who demonstrate knowledge about GBV, its consequences, the benefits of seeking timely care, and where survivors can report for support or services	--	--	KAP baseline and endline surveys	Outcome	85%
# of CHWs per 1,000 women ages 15-49 in program target population trained specifically for this pilot project	# of CHWs	# of women ages 15-49 in target population	Training roster, local organization population information	Process	2 per 1,000 population
% of CHWs who attend training that pass the post-test to start the pilot project	# CHWs who pass	Total # CHWs who attend training	Training roster, Post-test scores	Process	100%

*Timely care refers to medical treatment appropriate at the time the survivor has sought care. If the survivor reports too late for (3) per local STI presumptive treatment protocol (if restrictions apply); (4) for EC, or (5) for PEP, then "timely" care (1) does not include (3), (4) or (5).

**(A) is the total number of survivors that seek any type of health care from a health care worker for SV.

Nuts and Bolts: Getting Ready for the CHW 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 (PWDs, 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 PWDs, 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[31]

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 providers/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.

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

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

- 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.

Additional resources:

- Community Health Workers Training - Facilitator's Manual
- Community Health Workers Training – Participant Packet

Determining available medications in the pilot setting

(All tables from 2018 Inter-agency *Field Manual on Reproductive Health in Humanitarian Settings* or 2019 WHO *Clinical Management of Rape and IPV Survivors*)

Review the protocols below for STI presumptive treatment, EC, HIV PEP, and medication abortion. Compare with local protocol and available drugs/regimens by circling any drugs that will be used in the pilot setting, and then complete the last column. Always follow local treatment protocols for STIs and use drugs and dosages that are appropriate for children, adolescents, and pregnant women.

STI presumptive treatment in ADULTS	WHO Protocol[32] 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	*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.*	
	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		

32 Inter-Agency Working Group on Reproductive Health in Crises. *Inter-agency field manual on reproductive health in humanitarian settings*. IAWG; 2010.

Determining available medications in the pilot setting (continued)

STI presumptive treatment in ADULTS	WHO Protocol[32] Circle drug used in pilot setting	Notes	Local drugs and dosaging if different from WHO to be used in pilot setting
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.*	
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*		
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		
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** or **spectinomycin** or **cefixime**	125 mg intramuscularly, single dose 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose 8mg/kg of body weight orally, 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.*	
	>45 kg	Treat according to adult protocol			
Chlamydial infection	<45 kg	**azithromycin** or **erythromycin**	20 mg/kg orally, single dose 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** or **azithromycin**	500 mg orally, 4 times daily for 7 days 1 g orally, single dose		
Syphilis		**benzathine penicillin***	50,000 IU/kg IM (up to a maximum of 2.4 million IU), single dose		
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[33]** ***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	

33 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.

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.

Annex I

Decision-making tool on care and tasks to be undertaken by CHWs

INTERVENTIONS AND CONSIDERATIONS	YES	NO
Conduct health education around sexual violence, including sexual forms of IPV, and the benefits of seeking care		
A. Is health care for survivors of sexual violence available in the setting (through the pilot or otherwise)?	○	○
If "yes," intervention can be offered by CHWs 1, 2 and 3. (See Module 2, Session 2.3)		
Recognize survivors of sexual violence when they come forward (passive identification)		
A. Is health care for survivors of sexual violence available in the setting?	○	○
If "yes," intervention can be offered by CHWs 1, 2 and 3. CHW 1 should refer for health services. (See Module 4)		
Actively screen for survivors of sexual violence or sexual forms of IPV		
A. Is there a system to respond to survivors of sexual violence?	○	○
B. Do CHWs have prior experience and skills in working with survivors?	○	○
If the answers are "no" to even one, this intervention should not be implemented, and CHWs should rely on self-reporting by survivors in the provision of care. WHO guidance further discourages from universal screening of IPV.		
Provide some basic first aid to stabilize survivors for referrals		
A. Do CHWs have the capacity to be taught basic first aid?	○	○
If "yes," basic first aid can be taught to stabilize survivors until they can reach higher level services. For CHW 1, this should be at a minimum. (See optional handouts in Module 4, Session 4.2, section 1.3)		
Refer survivors to higher level health staff or the health facility for health care		
A. Is there a referral system available?	○	○
If "yes," this intervention can be undertaken by CHWs 1, 2 and 3. (See Module 4, session 4.2)		
Obtain informed consent and prepare the survivor		
A. Will CHWs provide clinical care to survivors if they consent?	○	○
If "yes," CHWs 2 and 3 can obtain informed consent. CHW 1 should not be involved in obtaining informed consent since they will not be treating survivors for sexual violence.		

INTERVENTIONS AND CONSIDERATIONS	YES	NO
Take a health history		
A. Will CHWs provide care after taking a history?	○	○
If "yes," CHWs 2 and 3 can take a survivor's history. CHW 1 should not be involved in providing any part of the care below. (See Module 5, session 5.2, section 2)		
Collect forensic evidence		
A. Does capacity exist in the setting for forensic evidence collection (laboratory capacity or chain of evidence capacity)?	○	○
B. Does capacity exist to use the information collected (ability to use evidence in court)?	○	○
CHWs 1, 2 and 3 should NOT be collecting forensic evidence even if "yes" to A and B, given the scope of their work and priorities of ensuring health care. However, CHWs 2 and 3 can briefly document general observations on the intake form. (See Module 5, session 5.1, section 3 and session 5.2 session 2)		
Conduct a minimum physical and pelvic exam		
A. Are the CHWs providers of last resort in the setting (i.e., no referral to higher level health care is available).	○	○
If "no," CHWs should NOT be conducting the physical or genital exams. CHWs 2 and 3 should be limiting any exam to basic observation and presumptive treatment. Any condition requiring further examination or care should be referred to a higher level facility. If "yes," CHW 3 (with advanced skills) should only be conducting a physical examination if they cannot provide the particular care otherwise, and only with the survivor's consent. Any invasive activity should be avoided to the extent possible.		
Complete simplified intake form		
A. Are CHWs literate?	○	○
B. Can the intake forms be stored securely?	○	○
If "no" to both, then CHWs should not complete intake forms. If "yes" to both, CHWs 2 and 3 can complete intake forms. However, if "yes" to A but not B, the pilot can possibly have CHWs 2 and 3 complete one monitoring form where all collected information is aggregated. (See Module 5, session 5.1, section 3) Note that the intake form does not collect perpetrator information or identifying information about the survivor. This is to minimize security risks for the survivor and CHW; however, it also limits the ability for survivors to pursue legal justice at a later date.		

INTERVENTIONS AND CONSIDERATIONS	YES	NO
Generate a medical certificate (duplicate intake form)		
A. Can safety of the documentation be ensured?	○	○
B. Is there use for this information in the setting?	○	○
If "yes" to both, CHWs 2 and 3 can provide a copy of the intake form (if used), but only upon request and after discussing any possible security risks with the survivor. (See Module 5, session 5.2, section 11.6)		
Treat minor injuries		
A. Can the observed wound or condition be treated with basic first aid?	○	○
If "yes" to A, CHWs 2 and 3 can provide basic first aid. (See Module 5, session 5.2, section 8)		
Provide other wound care as feasible		
A. Does the wound require suturing and is higher level care available in the setting (referral)?	○	○
B. Does the wound require suturing and is higher level care not available in the setting?	○	○
If "yes" to A, CHWs 2 and 3 should refer to higher level care. If "yes" to B, only CHW 3 should attend to this if they are the provider of last resort, and only if capacity exists for this type of care.		
Obtain a pregnancy test		
A. Is pregnancy testing available in the setting?	○	○
If "yes," CHWs 2 and 3 can be engaged in this effort.		
Provide pregnancy options information and safe abortion care referral		
A. Is safe abortion care legal in the setting?	○	○
If "yes," CHWs 1, 2, and 3 can be engaged in options counseling and providing information for referrals for safe abortion care.		
Provide presumptive treatment for STIs, EC for pregnancy prevention, and supportive counseling (including psychological first aid and basic emotional support)		
A. Will supportive supervision for CHWs be available?	○	○
B. Can the setting adequately procure commodities for treatment?	○	○
If "yes," CHWs 2 and 3 can be engaged in this effort. (See Module 5, session 5.2)		

INTERVENTIONS AND CONSIDERATIONS	YES	NO
Conduct HIV counseling and testing		
A. Does the setting have the capacity for HIV testing?	○	○
If "no," then this intervention should not be implemented. If "yes," CHWs 2 and 3 can be engaged in this effort.		
Initiate PEP		
A. Will there be higher level health care workers or staff that can monitor CHW initiation of PEP?	○	○
B. Can the pilot be specifically designed to assess the safety and feasibility of CHW initiation of PEP, where current WHO guidance does not endorse this level of activity?	○	○
C. Is HIV prevalence relatively high or are there other reasons to warrant provision of PEP? (A good indicator is to see whether any health facilities in the area routinely provide PEP, or only on a case-by-case basis.)	○	○
D. Can PEP be pre-packaged for easy distribution by CHWs?	○	○
E. Can survivors be followed-up within one week of PEP initiation?	○	○
If "no" to any of the five, then PEP should be initiated by a nurse or above. If "yes" to all five, CHW 3 (with advanced skills) can be considered for this effort. (See Advanced Module 8)		
Provide PEP once initiated		
A. Can the setting procure PEP adequately (i.e., will there be problematic supply chain gaps)?	○	○
B. Can PEP be pre-packaged for easy distribution by CHWs?	○	○
If "no" to any of the two, then this intervention should not be implemented. If "yes" to both, CHW 2 and 3 can be engaged in this effort. (See Module 5, session 5.2, section 7)		
Provide tetanus toxoid and/or Hepatitis B vaccine		
A. Is a cold chain available?	○	○
B. Can infection prevention standards be met?	○	○
C. Can CHWs provide injections in the setting (policy or existing experience)?	○	○
If "no" to any of the three, then this intervention should not be implemented, and CHWs 2 and 3 should refer survivors to a health facility. (See Module 5, session 5.2, section 10) If "yes" to all of the three, then CHW 3 (with advanced skills) can be engaged in this effort. (See Advanced Module 8, session 1 and 2)		

INTERVENTIONS AND CONSIDERATIONS	YES	NO
Provide HPV vaccine		
A. Is the vaccine readily available?	○	○
B. Can infection prevention standards be met?	○	○
C. Can CHWs provide injections in the setting (policy or existing experience)?	○	○
If "no" to any of the three, then this intervention should not be implemented, and CHWs 2 and 3 should refer survivors to a health facility. (See Module 5, session 5.2, section 8) If "yes" to all of the three, then CHW 3 (with advanced skills) can be engaged in this effort. (See Advanced Module 8, session 1 and 2)		
Assess for safety and refer for additional support		
A. Safe locations are available in the setting for safety planning.	○	○
B. Referrals to higher level health services and other support services (protection, social support, psychosocial care, etc.) are available to address survivor needs.	○	○
If "yes" to both, CHWs 2 and 3 can be engaged in this effort.		
Provide follow-up care to survivors (2 weeks, 1 week preferable if taking PEP)		
A. Setting provides enough stability for CHWs to be able to follow-up.	○	○
B. Referrals to higher level health services and other support services (protection, social support, psychosocial care, etc.) are available to address survivor needs.	○	○
If "yes" to both, CHWs 2 and 3 can be engaged in this effort. (See Module 5, session 5.3)		
Provide safe abortion care (medication management) to the full extent of the law		
A. Medication abortion is legal in the setting.	○	○
B. Follow-up is possible with survivors who opt to terminate a pregnancy.	○	○
If "yes" to both, can consider engaging CHW 3 for (with advanced skills) this effort.		
Treat recurring STIs		
A. Are the CHWs providers of last resort in the setting (i.e., no referral to higher level health care is available).	○	○
B. Can the setting adequately procure commodities for treatment?	○	○
If "yes" to both, CHW 3 (with advanced skills) can be engaged in this effort. (See Advanced Module 8, session 3)		

Annex II

Reviewing the evidence

The following table presents the evidence base for task-shifting/-sharing guidance on the interventions that comprise medical care for sexual violence survivors.

Sexual Violence Intervention Table Key[34] [35] [36]

Level of care where intervention can be provided	**Level**	**Explanation**
	Referral	This level of delivery of interventions refers to hospitals in general. These can be either district hospitals or referral hospitals.
	Primary	Primary care facilities equipped to provide clinical care.
	Community	Community services, through CHWs and outreach workers.
Type of health workers who can implement intervention	**Type of health worker**	**Additional job titles**
	Physician clinicians	Specialist medical doctors Non-specialist medical doctors
	Non-physician clinicians	Advanced level associate clinicians Associate clinicians Medical assistants Nurse practitioners
	Midwives	
	Nurses	
	Auxiliary nurse midwives	
	Auxiliary nurses	
	Lay health workers	Community health workers Village health worker
	Pharmacy workers	

34 WHO, *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A global review of the key interventions related to reproductive, maternal, newborn and child health*, 2011.

35 WHO, *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions through Task Shifting*, 2012.

36 IPPF, *IPPF Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013.

Sexual Violence Interventions

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Conduct health education on sexual violence, including IPV, and benefits of seeking care	All levels	All	IEC materials	Gatuguta A, Katusiime B, Seeley J, Colombini M, Mwanzo I, Devries K. *Should community health workers offer support healthcare services to survivors of sexual violence? a systematic review*. BMC Int Health Hum Rights. 2017;17(1):28. Published 2017 Oct 12. IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery*, 2015. WHO, *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting*, 2012.	CHWs are encouraged to provide health education and promotion for sexual violence and IPV.
Recognition of SV survivors (passive identification), including sexual forms of IPV	All levels	All	None	WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, 2013 IPPF, *IPPF Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013.	Health providers should ask about exposure to IPV when assessing conditions that may be caused or complicated by IPV, in order to improve diagnosis/identification and subsequent care. --Strong However, they should only ask if systems are available to respond to identified survivors.
Actively screen for survivors of sexual violence or sexual forms of IPV	Not specified in guidance.	Not specified in guidance.	None	WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019. WHO. *Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines*, 2013. Wirtz AL, Glass N, Pham K, et al. *Comprehensive development and testing of the ASIST-GBV, a screening tool for responding to gender-based violence among women in humanitarian settings*. Confl Health. 2016;10:7. Published 2016 Apr 20. Vu A, Wirtz A, Pham K, et al. *Psychometric properties and reliability of the Assessment Screen to Identify Survivors Toolkit for Gender Based Violence (ASIST-GBV): results from humanitarian settings in Ethiopia and Colombia*. Confl Health. 2016;10:1. Published 2016 Feb 9.	Guidance is not specific to CHWs. "Universal screening" or "routine enquiry" (i.e. asking women in all health-care encounters) **should not** be implemented. The ASIST-GBV screening tool has demonstrated utility and validity for use in confidential identification and referral of refugees and IDPs who experience GBV (threats of violence, physical violence, forced sex, sexual exploitation, forced pregnancy, forced abortion, and early or forced marriage).

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Provide some basic first aid to stabilize survivors for referral	All levels	All	First aid kit.	IFRC, *International Federation of Red Cross and Red Crescent Societies. International first aid and resuscitation guidelines 2020*, 2020. Hesperian Foundation, *Where There is No Doctor*, 2020.	IFRC and Hesperian Foundation guidance are for lay persons.
Refer survivors to higher level health staff or the health facility for health care	All levels	All	Transport.	IFRC, *International Federation of Red Cross and Red Crescent Societies. International first aid and resuscitation guidelines 2020*, 2020.	IFRC guidance is for lay persons and volunteers.
Obtaining informed consent and preparing the survivor	All levels	All (presumed)	Consent scripts	IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery*, 2015.	Guidance is not specific to CHWs, although presumed to be a feasible and safe task, if trained.
Taking the history	All levels	All (presumed)	Intake form, clipboard	WHO, UNFPA, UNHCR, *Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings*, 2019.	Guidance is not specific to CHWs, although presumed to be a feasible and safe task, if trained.
Collection of minimum forensic evidence	Not specified in guidance	Non-specific, although existing guidelines note "clinicians and nurses" (presumably physician clinicians, non-physician clinicians and nurses)	Comb, glass slides, paper sheet/bag Speculum Set of replacement clothes Tape measure for measuring bruises, lacerations, etc.	WHO, UNODC. *Strengthening the medico-legal response to sexual violence*, 2015. . WHO, *Guidelines for medico-legal care of victims of sexual violence*, 2003.	No guidance exists on CHW collection of minimum forensic evidence. Utility of this intervention is questionable for CHWs, given priorities, CHW capacity. and use of information. Health workers must be specifically trained and have supervised experience in order to conduct forensic medical examinations. While it may be the role of health workers to document injuries and to collect other forms of medico-legal evidence, it is not their role to determine whether sexual assault has occurred.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Performing the physical and genital exam	Not specified in guidance	Non-specific, although existing guidelines note "clinicians and nurses" (presumably physician clinicians, non-physician clinicians and nurses)	Speculum Gown, cloth or sheet to cover survivor during examination	WHO, *Guidelines for medico-legal care of victims of sexual violence*, 2003.	No guidance exists on CHWs conducting a minimum medical exam.
Treating minor injuries (Burns, bleeding, head and spinal injury, chest and abdomen injuries, injured extremities, wounds and abrasions, dental injuries, eye injuries.)	All levels	All	First aid kit or equivalent Paracetamol, etc. for pain relief	IFRC, *International Federation of Red Cross and Red Crescent Societies. International first aid and resuscitation guidelines 2020*, 2020. Hesperian Foundation, *Where There is No Doctor*, 2020.	IFRC and Hesperian Foundation guidance are for lay persons.
Provision of wound care requiring suturing (Suturing of minor perineal/ genital lacerations)	Primary Referral	Non-specialist medical doctors, advanced level associate clinicians, midwives, nurses, auxiliary nurse midwives, auxiliary nurse	Sterile medical instruments for repair of tears and suture material Local anesthesia Antibiotics for wound care	WHO, *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting*, 2012.	WHO 2012 recommendations conclude that this task is outside the competency of lay health workers.
Obtaining a pregnancy test	All levels	All	Urine pregnancy test	IPPF, *IPPF Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013. *WHO Recommendations: Optimizing Health Worker Roles to Improve Access to Key Maternal and Newborn Health Interventions Through Task Shifting*, 2012.	Confirmation of pregnancy permitted by all cadres. Urine pregnancy tests are available over the counter in most settings.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Providing pregnancy options information and safe abortion care referral to the full extent of the law	All levels	All	None	WHO, *Health worker roles in providing safe abortion care and post-abortion contraception*, 2015.	**Lay health workers**: Information on safe providers/laws--Recommended.
Provision of supportive counseling (including basic psychological first aid)	All levels	All	None	IFRC, *International Federation of Red Cross and Red Crescent Societies. International first aid and resuscitation guidelines 2020*, 2020. IASC, *IASC Guidelines on Mental health and Psychosocial support in emergency settings*, 2007.	CHWs serve as important providers of psychosocial care.
Provision of emergency contraception	All levels	All	Emergency contraceptive pills Oral contraceptives (progestin only and combined)	WHO, *Summary Brief. Task sharing to improve access to Family Planning/ Contraception*, 2020.	CHWs can safely and effectively provide the following contraceptive services: education and counselling, information on SDM, E36 Method, and LAM; oral contraceptives and condoms; and hormonal injectables, under targeted monitoring and evaluation. Provision of EC is not yet specified in these recommendations. Although EC pills are very safe and have few restrictions, evidence on their provision by lay health workers is lacking or has not been reviewed. Despite this, WHO permits Initiation and distribution of COCs, POPs, and EC by lay health workers.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Presumptive treatment for and management of sexually transmitted infections (STIs)	All levels	All	Materials for counseling Condoms (male and female) Antibiotics in line with essential medicine guidelines	WHO, *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A global review of the key interventions related to reproductive, maternal, newborn and child Health*, 2011. WHO, *Guidelines for the treatment of Chlamydia trachomatis*. 2016. WHO, *Guidelines for the treatment of Neisseria gonorrhoeae*, 2016. WHO, *Guidelines for the treatment of Treponema pallidum (syphilis)*, 2016. WHO, *Sexually transmitted and other reproductive tract infections: a guide to essential practice*, 2005.	WHO permits provision of antibiotics in line with essential medicine guidelines by all health worker cadres.
HIV pre-/post-test counseling	All levels	All	Materials for counseling	WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. IPPF, *Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013. WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	CHWs are encouraged to conduct intensified post-test counselling.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
HIV testing	All levels	All	HIV rapid diagnostic tests	Kennedy CE, Yeh PT, Johnson C, Baggaley R. *Should trained lay providers perform HIV testing? A systematic review to inform World Health Organization guidelines*. AIDS Care. 2017;29(12):1473-1479. WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. IPPF *Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013. WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	Based on evidence supporting using trained lay providers, a WHO expert panel recommended lay providers be allowed to conduct HIV testing using HIV rapid diagnostic tests. Lay providers who are trained and supervised can independently conduct safe and effective HIV testing using rapid diagnostic tests (RDTs) (strong recommendation, moderate-quality evidence). Trained and supervised non-laboratory staff including lay persons can undertake blood finger prick for sample collection. CHWs are not advised to request CD4 testing or to take and prepare blood for a CD4 test.
Recommendation of two or more ARV drug PEP regimens	Primary Referral	Physician clinicians, non-physician clinicians, midwives, nurses	None	WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	WHO guidance does not permit CHWs to recommend drug regimens for PEP, especially since it involves testing for co-infection with Hepatitis B

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Initiation of two or more ARV drug PEP regimens	Primary Referral	Physician clinicians, non-physician clinicians, midwives, nurses	PEP	WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. WHO, ILO. *Post-Exposure Prophylaxis to Prevent HIV Infection: Joint WHO/ILO Guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection*, 2007. WHO, *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A global review of the key interventions related to reproductive, maternal, newborn and child Health*, 2011. WHO, *Rapid advice: use of antiretroviral drugs for treating pregnant women and preventing HIV infection in infants*, 2010. WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	While CHWs can provide ARVs, they are not permitted to *initiate* PEP under current WHO guidance. Trained non-physician clinicians, midwives and nurses can initiate first-line ART (strong recommendation, moderate-quality evidence). Local protocols could allow for post-exposure prophylaxis initiation at the district level (that is, supply of a starter pack), followed, if needed, by referral to a tertiary level institution for complete risk assessment and clinical management. Follow-up care and support could be provided in appropriate clinical settings, preferably as close as possible to the local community, so long as the person does not need to be evacuated or protected for security reasons.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Provision of PEP once initiated	All levels	All	PEP	WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. Interagency Task Team HIV in Humanitarian Emergencies, *Prevention of Mother-to-Child Transmission (PMTCT) in Humanitarian Settings: Part II Implementation Guide*, 2015.	Trained and supervised lay providers can distribute ART to adults, adolescents and children living with HIV (strong recommendation, low quality evidence). Trained non-physician clinicians, midwives and nurses can **maintain** ART (strong recommendation, moderate-quality evidence). Trained and supervised **community health workers** can **dispense** ART between regular clinical visits (strong recommendation, moderate-quality evidence). These recommendations apply to all adults, adolescents and children living with HIV. Task shifting to lower-level qualified health workers and from qualified health workers to lay staff is a viable solution.
Provision of counseling and support for PEP	All levels	All	None	WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	CHWs are encouraged to conduct counselling on ART with individual patient or caregiver if the patient is a child.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Co-trimoxazole prophylaxis	All levels	All (presumed)	Co-trimoxazole	WHO, *Consolidated guidelines on the use of antiretroviral drugs for treating and preventing HIV infection: recommendations for a public health approach*, second edition. 2016. WHO, *Guidelines on post-exposure prophylaxis for HIV and the use of co-trimoxazole prophylaxis for HIV-related infections among adults, adolescents and children*. 2014.	Co-trimoxazole prevents and treats a variety of bacterial, fungal and protozoan infections. Recently, new evidence has emerged that, with effective scaling up of ART, co-trimoxazole prophylaxis has a broader benefit beyond preventing Pneumocystis jirovecii pneumonia and reducing HIV-associated mortality among people with low CD4 counts. Specifically, the value of using co-trimoxazole prophylaxis to prevent malaria and severe bacterial infections in adults and children with HIV was reviewed when developing the systematic evidence to inform this new guidance. Existing guidance does not detail which cadre can provide this care.
Provision of Hepatitis B vaccine	All levels	All	Vaccine	Otto, B. F., Made Suarnawa, I., Stewart, T., Nelson, C., Ruff, T.A., Widjaya, A., & Maynard, J.E.: At-birth immunization against hepatitis B using a novel pre-filled immunization device stored outside the cold chain. *Vaccine* 1999(18):498-502.	Research is available from development contexts on Hepatitis B vaccines through the safe and proper use of the Uniject device, which has received WHO prequalification.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Provision of Tetanus Toxoid	All levels	All	Vaccine (TT vaccine)	WHO, *Essential Interventions, Commodities and Guidelines for Reproductive, Maternal, Newborn and Child Health: A global review of the key interventions related to reproductive, maternal, newborn and child Health*, 2011. WHO, *Pregnancy, Childbirth, Postpartum and Newborn Care: a guide to essential practice*, 2005. Quiroga, R., Halkyer,P., Gil, F., Nelson, C., & Kristensen, D. A prefilled injection device for outreach tetanus immunization by Bolivian traditional birth attendants. *Pan Am J Public Health*, 1998;4(1):20-25. Sutanto, A., Suarnawa, I.M., Nelson, C.M., Stewart, T., & Indijati Soewarso, T. "Home delivery of heat-stable vaccines in Indonesia: outreach immunization with a prefilled, single-use injection device." *Bulletin of the World Health Organization*,1999;77 (2):119-126.	Research is available from development contexts on the delivery of tetanus toxoid through the safe and proper use of the Uniject device, which has received WHO prequalification.
Prevention of HPV	All levels	All	HPV Vaccine	No specific guidance available.	Given that CHWs can safely provide immunizations in prefilled syringes with adequate monitoring and supervision, HPV vaccines can likely be given by CHWs.
Management of self-limiting side-effects of ARV drugs in PEP regimens (follow-up care)	All levels	All	None	WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	
Management of severe toxicities of ARV drugs in PEP regimens (follow-up care)	Not specified in guidance, although presumably referral.	Physician clinicians, non-physician clinicians	None	WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	
Execution and interpretation of post-exposure HIV test (follow-up care)	All levels	All	HIV test	WHO, *Task Shifting: Global Recommendations and Guidelines*, 2008.	

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Provision of safe abortion care (medication) to the full extent of the law	All levels	All	Misoprostol Mifepristone	WHO, *Health worker roles in providing safe abortion care and post-abortion contraception*, 2015. WHO, *Safe abortion: technical and policy guidance for health systems*, second edition, 2012.	**Lay health workers**: Pre- and post-abortion counselling--Recommended in specific circumstances. Management of uncomplicated incomplete abortion/miscarriage with misoprostol--Recommended in the context of rigorous research. **Subtasks for medical abortion in the first trimester**: No recommendation is made on the independent provision of medical abortion in the first trimester for lay health workers, but recommendations are made for subtasks as follows: Assessing eligibility for medical abortion--Recommended in the context of rigorous research. Administering the medications and managing the process and common side-effects independently--Recommended in the context of rigorous research. Assessing completion of the procedure and the need for further clinic-based follow-up--Recommended in the context of rigorous research. **Role of self-management approaches** **Medical abortion in the first trimester**: No recommendation for overall task Self-assessing eligibility--Recommended in the context of rigorous research. Managing the mifepristone and misoprostol medication without direct supervision of a healthcare provider--Recommended in specific circumstances. Self-assessing completeness of the abortion process--Recommended in specific circumstances. Self-administering injectable contraception--Recommended in specific circumstances. Home use of misoprostol is a safe option for women. Increasingly, after receiving the mifepristone in the clinic, women receive misoprostol for self-administration at home within 24–48 hours following the mifepristone. Women using misoprostol at home may leave the facility shortly after taking the mifepristone. They must be told what to expect with regard to vaginal bleeding and expulsion of products of conception following use of misoprostol, and how to recognize complications and whom to contact if they should occur. Explaining that the misoprostol dose should be taken as planned regardless of whether bleeding occurs following mifepristone is important for the few women who experience such bleeding.

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Post-abortion contraception (follow-up care)	All levels	All	Condoms Oral contra-ceptives Hormonal injectables	WHO, *Summary Brief. Task sharing to improve access to Family Planning/ Contraception*, 2020. WHO, *Health worker roles in providing safe abortion care and post-abortion contraception*, 2015. World Health Organization (WHO) Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health/ Center for Communication Programs (CCP) Knowledge for Health Project., *Family planning: a global handbook for providers* (2018 update), 2018. Okegbe T, Affo J, Djihoun F, et al. Introduction of Community-Based Provision of Subcutaneous Depot Medroxyprogesterone Acetate (DMPA-SC) in Benin: Programmatic Results. *Glob Health Sci Pract.* 2019;7(2):228-239. Published 2019 Jun 27. Tilahun Y, Lew C, Belayihun B, Lulu Hagos K, Asnake M. Improving Contraceptive Access, Use, and Method Mix by Task Sharing Implanon Insertion to Frontline Health Workers: The Experience of the Integrated Family Health Program in Ethiopia. *Glob Health Sci Pract.* 2017;5(4):592-602. Published 2017 Dec 28.	CHWs can safely and effectively provide the following contraceptive services: education and counselling, information on SDM, E36 Method, and LAM; oral contraceptives and condoms; and hormonal injectables, under targeted monitoring and evaluation. Provision of post-abortion contraception: Insertion/removal of implants--Recommended in the context of rigorous research. Initiation/continuation of injectable contraceptives--Recommended in specific circumstances. For self-injection, the following are important considerations when making the self-injection option available: Adequate arrangements for storage and for keeping sharps safely at home. Training in and the provision of mechanisms for the safe and secure disposal of used injectable contraceptives (especially in settings with high HIV prevalence). Ensuring a way to procure injectable contraceptives on a regular basis without needing to repeatedly visit a health-care facility. Since 2016, the Advancing Partners & Communities (APC) project has been helping the Benin Ministry of Health provide subcutaneous DMPA-SC; brand name Sayana Press. through facility-based health care providers and community health workers known as relais communautaires (RCs).

Intervention	Level of care where intervention can be provided	Type of health workers who can implement intervention	Key commodities	Updated practice guidelines, training manuals and evidence	Notes pertaining to CHWs
Referrals to protection, legal support, shelters, psychosocial, mental health and other services	All levels	All	None	IFRC, *International Federation of Red Cross and Red Crescent Societies. International first aid and resuscitation guidelines 2020*, 2020. IASC, *Guidelines for integrating gender-based violence interventions in humanitarian action: reducing risk, promoting resilience and aiding recovery*, 2015. WHO, UNHCR, *mhGAP humanitarian intervention guide (mhGAP-HIG): clinical management of mental, neurological and substance use conditions in humanitarian emergencies*, 2015. *IPPF Medical Bulletin: IMAP Statement on Task Sharing in Sexual and Reproductive Health*, 2013.	CHWs serve as important providers of psychosocial care, and referrals to other services.

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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 and the United States Department of State. The views expressed do not necessarily reflect the UK government's official policies, UNICEF, or those of all Consortium partners.

Communities Care: Transforming Lives and Preventing Violence

United Nations Children's Fund
Programme Division, Child Protection in Emergencies
3 United Nations Plaza
New York, NY 10017
Email: mmarsh@unicef.org
Website: www.unicef.org

Women's Refugee Commission
122 East 42nd Street
New York, NY 10168-1289
+1.212.551.3115
Email: info@wrcommission.org
Website: womensrefugeecommission.org