“all survivors need good quality care and support to help them heal and recover”
STRENGTHENING COMMUNITY-BASED CARE
CAPACITY BUILDING

10 DAYS • 8 MODULES

FACILITATOR’S MANUAL

Training for community-based management of survivors of sexual violence

WHAT WILL THEY LEARN?

Through the training, CHWs will be able to:

• Understand sexual violence and what can happen to survivors
• Provide key messages about sexual violence to community members as part of the CHWs’ daily activities
• Communicate with survivors of sexual violence
• Refer survivors to health care and other services, respecting their safety, privacy and dignity
• Directly provide health care to survivors when care at a health facility is too far
Women and girls in conflict and other displaced settings are at heightened risk of sexual violence. This type of violence further increases the risk of unwanted pregnancy, unsafe abortion and sexually transmitted infections, including HIV. These have health and psychosocial consequences that, without appropriate and timely care, could lead to great distress and disruptions in healthy development. Despite this increased vulnerability, care for those who have survived sexual violence is limited in humanitarian settings, as service providers are often ill equipped to treat survivors, and facilities may lack supplies and trained providers at the height of insecurity. The distance to a health facility and the stigma associated with sexual violence are also barriers to accessing care.

The community-based model to providing medical care to survivors of sexual violence adapts the World Health Organization’s (WHO) *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons* (2004) for the use of community health workers (CHWs) to provide post-rape care where facility-based health services are not available or are inaccessible. The piloting of this approach is intended to advance research on alternative models of care and contribute to building an evidence base on whether such a method is safe and feasible in humanitarian settings.

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

- Health education on the benefits of seeking care
- Presumptive treatment for STIs
- Provision of EC to prevent unwanted pregnancies
- Provision of PEP to prevent HIV
- Provision of basic wound care to treat minor injuries
- Provision of basic psychosocial counselling
- Referrals for tetanus and hepatitis B vaccines and other essential services
- Follow-up care

This training package reflects existing evidence, good practice programming and experiences from related pilots,¹ and supports the interagency statement, *Scaling-up the Community-based Health Workforce for Emergencies: Joint Statement by the Global Health Workforce Alliance, WHO, IFRC, UNICEF, UNHCR* that emphasizes the role of the community health workforce.

Community-based approaches to care for survivors of sexual violence is expected to contribute to global commitments to providing medical and psychosocial support to survivors in conflicts, the urgency of which has been recognized in United Nations Security Council Resolutions 1325, 1820, 1888, 1889 and 1960 on Women, Peace and Security. The focus of the global community is on monitoring and reporting of sexual violence perpetrated in conflict; however, the need to ensure services to survivors of this violence is paramount. An alternative approach to facility-based care may offer solutions to settings where traditional methods of health care are not practical for women and girls that need it most.

ACKNOWLEDGEMENTS

This community health worker training tool/facilitator’s guide is a collaborative effort between UNICEF and the Women’s Refugee Commission (WRC). The drafting of this tool was led by Mihoko Tanabe of the WRC with Janel Smith of the International Rescue Committee (IRC) and Jennifer Breads (independent consultant). Sandra Krause provided overall guidance and direction from the WRC. Mendy Marsh, Sarah Karmin, Emmanuelle Compingt, Heather Papowitz, Cecilia Sanchez and Erin Patrick from UNICEF provided much guidance and feedback throughout the process. Wilma Doedens from UNFPA reviewed the clinical guidance. Emma Pearce from the WRC reviewed for disability inclusion. Stacey Patino developed the illustrations for the facilitator and training participants. Erin Stone, Dhabie Brown and Tsufit Daniel assisted in developing and designing many of the participant handouts and job aids.

The staff of WRC and UNICEF would like to thank members of the Inter-agency Working Group on Reproductive Health in Crises (IAWG on RH in Crises) Gender-based Violence (GBV) sub-working group for their input on the content of the tool. Experiences from member organizations, particularly from Médecins Sans Frontiéres Spain, as well as existing guidance on responding to sexual violence and working with community health workers developed by the Hesperian Foundation, IAWG on Reproductive Health in Crises, Inter-agency Standing Committee, International Federation of the Red Cross Red Crescent Societies, IRC, UNICEF, United Nations Population Fund, World Health Organization (WHO) and many others have been critical to shaping this tool.

The tool itself was based on learning from the WRC, Global Health Access Program (GHAP), Burma Medical Association (BMA) and Karen Department of Health and Welfare’s (KDHW) pilot project on community-based care for survivors of sexual assault that has been implemented in Karen State since 2009. As such, the WRC would like to thank the invaluable hard work of GHAP, BMA and KDHW staff, and BMA and KDHW’s community health workers who are on the frontlines in ensuring health care is available to women and girls who have experienced sexual violence in their communities.
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ACRONYMS

ART Anti-retroviral therapy
CHW Community health worker
DV Domestic violence
EC Emergency contraception
GBV Gender-based violence
HO Handout
IASC Inter-Agency Standing Committee
IAWG on RH in Crises Inter-agency Working Group on Reproductive Health in Crises
IEC Information, education and communication
IFRC International Federation of the Red Cross Red Crescent Societies
IRC International Rescue Committee
IUD Intrauterine device
MSF Médecins Sans Frontières
NGO Non-governmental organization
PEP Post-exposure prophylaxis
PTSD Post traumatic stress disorder
RHRC Reproductive Health Response in Crises Consortium
STI Sexually transmitted infection
UNFPA United Nations Population Fund
WHO World Health Organization
OVERVIEW

This training tool has been developed to train the community health workforce to play a role in managing sexual violence in their community.

The objectives of the training tool are to enable community health workers (CHWs) to:

• Understand sexual violence and its consequences in the context of crisis settings
• Provide key messages to community members as part of CHWs’ daily activities to facilitate health-seeking behaviour
• Interact appropriately with survivors of sexual violence
• Refer survivors to health care and other multisectoral services, respecting their safety, confidentiality and dignity
• Directly provide health care in circumstances where facility-based care is not feasible

Scope of gender-based violence and care for survivors of sexual violence

The focus of the training tool is on the health response to sexual violence. This includes any act of forced sex, perpetrated by a stranger or family member, in or outside of a marriage or partner relationship, among any age group or sex, regardless of whether the act constitutes ‘rape’ or other forms of sexual assault as defined in the particular context. 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’. Where ‘sexual assault’ is used, the term means the same as sexual violence in this tool.

A ‘survivor’ in the context of this tool is a person who has experienced sexual violence. Because the vast majority of survivors are women and girls, the tool focuses specifically on this group. It is important to recognize, however, that boys and men are also vulnerable to sexual violence, and tips to understanding the unique needs of male survivors are also included in this tool. Special consideration is additionally given to child and adolescent survivors, persons with disabilities and the elderly.

Health care for survivors of sexual violence is based on existing guidelines and practice, particularly the World Health Organization’s (WHO) 2004 Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons. Comprehensive health care – including CHW initiation of post-exposure prophylaxis – is included for application and piloting in settings where facility-based care is not feasible.

The tool does not include specific steps on how to establish a gender-based violence (GBV) programme, as such guidelines already exist. Instead, the tool focuses on what the facilitator needs to impart for CHWs to play a role within a larger programme or system that responds to the needs of survivors of sexual violence. For more information on how to design, implement and evaluate programmes for survivors of sexual violence, including those that address primary prevention, see:

• Inter-agency Standing Committee (IASC), Guidelines for Gender-based Violence Interventions in Humanitarian Settings: Focusing on Prevention of and Response to Sexual Violence in Emergencies, 2005 (revision in process)
• 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
Understanding the training package

The training package has eight ‘modules’ that will guide the facilitators in training CHWs to provide care and support to survivors of sexual violence in their community. Each module has an overview with an introduction to the topic, list of sessions, their expected length, any required preparation, handouts (HOs) and training aids, and methods to evaluate performance. Modules 1–4 are relevant for CHWs who may only be involved in health education about sexual violence and referring survivors to higher level health care providers and facilities. Modules 1–8 are applicable to CHWs who may be directly treating survivors. Each module is comprised of ‘sessions’. Each session makes use of mini lectures, exercises and activities to guide the facilitator in training the participants, and has the following components:

<table>
<thead>
<tr>
<th>SESSION COMPONENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Session Time</strong></td>
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<tr>
<td><strong>Objectives</strong></td>
</tr>
<tr>
<td><strong>Methods</strong></td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
</tr>
<tr>
<td><strong>Training aids, materials and HOs</strong></td>
</tr>
<tr>
<td><strong>Evaluation and assessment</strong></td>
</tr>
<tr>
<td><strong>Additional resources</strong></td>
</tr>
<tr>
<td><strong>Steps</strong></td>
</tr>
</tbody>
</table>

**FACILITATOR’S NOTES**

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

The training curriculum has been designed for CHWs with varying levels of training and experience. There are three categories of CHWs, detailed below. CHWs should be working in the same communities in which they live.

**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 of sexual violence.

**CHW Category 2:** CHWs are involved in the provision of basic treatment and follow-up care to survivors (Modules 2–6), and should have experience serving as CHWs. Many CHWs will fall into this category (as well as category 1). The eligibility criteria are:

- Enough reading and written literacy to read instructions and complete client records/forms
- Basic numeracy skills to count days and hours and measure dosages
- Basic training in primary health care based on national policies
- Understands the importance and is capable of maintaining confidentiality of survivors and any data collected
- Demonstrates compassion/empathy and willingness to care for survivors of sexual violence
- Capacity to provide minimal documentation if the survivor wants a record for herself/himself

**CHW Category 3:** CHWs involved in higher level care (Module 2–Advanced Module 8). This category is applicable only in settings where CHWs have evolved advanced roles\(^2\) with clinical experience and skills. This category will not be relevant in the pilot settings of Somalia and South Sudan. Eligibility criteria include:

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

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Typically, Category 2 and 3 CHWs will be female, given the nature of the issue addressed; however, male survivors may request a male provider.

Participants that do not read or write will need special attention during and after the training. While the teaching methods for Modules 1–4 and 7 have been tailored for participants with limited literacy, in some cases, materials or HOs may need to be additionally adapted. Facilitators should adapt the schedule to the circumstances of the participants.

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:

  - Facilitator’s Notes
  - CHW manual

  - Trainer’s guide
  - Participant’s handbook
  - Flip chart for CHWs

  - Facilitator’s guide
  - CHW manual


Advanced Module 8 is only applicable to CHWs with extensive clinical experience and roles; rarely would these components be appropriate or relevant.

**Facilitators**

The ideal facilitator is a provider with clinical training in managing survivors of sexual violence and has experience working with CHWs. A facilitator with good facilitation and communication skills is preferred. However, as the modules include step-by-step guidance on how to train participants in each topical area, no additional coursework is expected.

**Methodology**

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

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

Venue

The training should be held in a comfortable venue that can accommodate all participants and facilitators. The room and site should be conducive to learning (well lit, well ventilated, quiet). Electricity is not required.

Evaluation

Pre- and post-test questionnaires and mock situations are included to assess what the participants have learned from this curriculum. 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 50 per cent on the Module 2–4 post-test
- CHW 2:
  - At least 50 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 50 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: 70 per cent
    - CHW 3: 70 per cent

If a participant does not score appropriately, programme staff should decide if the participant can indeed be tasked with managing survivors of sexual violence or she or he should retake the tests or attend a second training.

Ongoing supportive supervision during the project and the first month in particular is critical to ensure good performance of CHWs and to make sure they are able to correctly apply the skills learned during the training. Programme staff and supervisors can assess CHW performance through supervision visits and monthly meetings with the CHWs. Topics that need more attention should be addressed through on-the-job and refresher trainings.

A three-month evaluation tool is further available as part of this training to identify areas that need follow up. The tool is applicable for CHWs 2 and 3, and consists of qualitative questions, a quantitative questionnaire and a clinical assessment (similar to the assessment administered at the end of the training). The same tools can be used at different intervals to make sure CHWs are retaining critical skills.
PART 3

Strengthening Community-Based Care

MODULE 1

INTRODUCTION

Session 1.1: Administration 1 hour 30 minutes
Session 1.2: Training overview 45 minutes
Session 1.3: Pre-test 30 min (CHW 1)
1 hour (CHW 2)
1 hour 15 min (CHW 3)

MODULE 2

WHAT IS SEXUAL VIOLENCE AND WHAT ARE IT’S CONSEQUENCES?

Session 2.1: Unpacking gender, sexual violence and social norms

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

3 hours
Session 2.2: Addressing sexual violence in crisis settings

1. Risks and vulnerabilities to sexual violence in crisis settings
   1.1 What happens during a conflict or natural disaster?
   1.2 Why does sexual violence happen in crisis settings, and what are some additional risks/contributing factors?

2. Consequences of sexual violence for survivors and their community
   2.1 What are the health consequences of sexual violence?
   2.1.1 What are sexually transmitted infections?
   2.1.2 What are HIV and AIDS?
   2.1.2.1 How do we know if someone has HIV?
   2.1.2.2 How can HIV be prevented?
   2.1.2.3 What are treatment options for persons with AIDS?
   2.1.2.4 What are some of the consequences of HIV and AIDS for the individual and the family
   2.1.2.5 Why are HIV positive persons vulnerable in crisis settings?
   2.1.2.6 What are some ways to reduce stigma against persons with HIV and AIDS in the community, and how can CHWs be agents of change?

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

3. Health and other benefits for survivors to seek timely care
   3.1 What are the health benefits of seeking care?
   3.2 What is timely care?
   3.3 What other services can survivors access?

Session 2.3: Health education to facilitate health-seeking behaviour

1. Key messages around sexual violence
   1.1 What are the key messages that the community should know about sexual violence and the importance of seeking care?
### Session 3.1: Principles of working with survivors

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

2. Interacting with survivors
   2.1 How should survivors be treated?
   2.2 How should CHWs communicate with survivors?
   2.3 What are good ways to communicate with a survivor?
   2.4 What are bad ways to communicate with a survivor?
   2.5 How can interpreters be engaged if necessary?

3. Understanding informed consent
   3.1 What is informed consent?

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

1. Understanding mandatory reporting requirements (optional)
   1.1 What is mandatory reporting and when does it apply?

2. Barriers hindering access to care
   2.1 What are the legal or policy barriers that may hinder survivors’ access to services? (optional)
   2.2 How can social norms be applied to address societal barriers for survivors to access services?
### Module 4: Recognizing Survivors and Facilitating Referrals for Sexual Violence

**Session 4.1: Recognizing survivors of sexual violence**

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

**Session 4.2: Referring survivors for health care and other services**

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

   **2 hours 40 minutes**

   (2 hours 30 minutes without optional activity)

2. Putting this all together

   **2.1 How can critical skills for working with survivors be used?**
**MODULE 5 PROVIDING COMMUNITY-BASED CARE FOR SURVIVORS OF SEXUAL VIOLENCE**

**Session 5.1: Refreshing key skills**

<table>
<thead>
<tr>
<th>1. Reviewing treatment options for survivors of sexual violence</th>
<th>2 hours 35 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 What should happen when survivors of sexual violence talk about sexual violence to a CHW?</td>
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<table>
<thead>
<tr>
<th>2. Reviewing key skills for providing health care to survivors</th>
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</tr>
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<tbody>
<tr>
<td>2.1 How are medicines given accurately?</td>
<td></td>
</tr>
<tr>
<td>2.2 How are medicines given safely?</td>
<td></td>
</tr>
<tr>
<td>2.3 How should medicines be stored?</td>
<td></td>
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<tr>
<td>2.4 How can infections be prevented when caring for survivors?</td>
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</table>

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<thead>
<tr>
<th>3. Completing the intake form</th>
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</thead>
<tbody>
<tr>
<td>3.1 What is an intake form?</td>
<td></td>
</tr>
<tr>
<td>3.2 How are the intake forms and monitoring forms completed?</td>
<td></td>
</tr>
<tr>
<td>3.3 How should the intake forms and monitoring forms be stored?</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>1. Preparing the survivor</th>
<th>9 hours 30 minutes</th>
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<tbody>
<tr>
<td>1.1 How should the survivor be prepared to receive treatment?</td>
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</table>

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<thead>
<tr>
<th>2. Taking the survivor’s history</th>
<th>(9 hours 5 minutes without optional activities)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 How should the survivor’s history be taken?</td>
<td></td>
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<tr>
<td>2.2 What questions should be asked to a survivor when taking a health history?</td>
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</tbody>
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<table>
<thead>
<tr>
<th>3. Providing presumptive treatment for STI</th>
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</tr>
</thead>
<tbody>
<tr>
<td>3.1 What are STIs?</td>
<td></td>
</tr>
<tr>
<td>3.2 How can STIs be prevented and what are the medicines provided to survivors?</td>
<td></td>
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</tbody>
</table>

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<thead>
<tr>
<th>4. Providing emergency contraception to reduce the risk of pregnancy</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Who is at risk for pregnancy after sexual violence and what are the consequences of pregnancy?</td>
<td></td>
</tr>
<tr>
<td>4.2 What is EC and how is it provided to female sexual violence survivors?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>5. Providing post-exposure prophylaxis (PEP) to prevent HIV</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1 Who is at risk for HIV?</td>
<td></td>
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<tr>
<td>5.2 What is HIV PEP and how does it work?</td>
<td></td>
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</tbody>
</table>
MODULE 5 (continued)

6. Providing basic first aid to manage wounds
   6.1 What types of wounds can CHWs address?
   6.2 How is minor bleeding controlled with basic first aid?
   6.3 How are wounds cleaned and bandaged with basic first aid?

7. Providing supportive counselling
   7.1 How can survivors be emotionally supported?

8. Referring for tetanus and hepatitis B vaccinations (optional)
   8.1 What is tetanus and who is at risk for tetanus infection?
   8.2 What is the tetanus vaccination and how does it work?
   8.3 What is hepatitis B and who is at risk?
   8.4 What is the hepatitis B vaccination and how does it work?

9. Closing the consultation
   9.1 How should CHWs close the consultation?
   9.2 How can treatment counselling be provided?
   9.3 How can survivors be encouraged to seek HIV counselling and testing?
   9.4 What are ways that survivors can protect themselves and their partners from further health consequences?
   9.5 How can additional referrals be decided?
   9.6 How should the survivor’s safety be evaluated?
   9.7 What should be shared about the follow-up visit?
   9.8 What should CHWs discuss about the intake form?
   9.9 What should CHWs do after the survivor leaves?

10. Putting this all together
    10.1 How can critical skills be demonstrated?

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

1. Providing follow-up care
   1.1 What is follow-up care?
   1.2 How should CHWs follow-up with survivors on their treatment?
   1.2.1 How can partners be encouraged to get treated/tested for STIs and HIV?
   1.2.2 What are the benefits of HIV testing and counselling for couples over individual testing?
   1.3 What should CHWs do if a survivor learns she is pregnant? (optional)
   1.4 What are other ways CHWs can support the survivor during follow-up care?
   1.5 How can CHWs address survivors’ emotional needs?
   1.6 How should CHWs end the follow-up visit?

3 hours
(2 hours 50 minutes without optional activity)
### MODULE 6  SELF-CARE FOR CHWS

#### Session 6.1: Self-care for CHWs

1. Stress related to working with survivors of sexual violence
   1.1 What causes stress?
   1.2 What are different forms of stress?

2. Coping with stress
   2.1 How can I manage and recover from stress?

3. Planning for self-care
   3.1 How is a self-care plan developed?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Duration</th>
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</thead>
<tbody>
<tr>
<td>Stress related to working with survivors of sexual violence</td>
<td>2 hours</td>
</tr>
<tr>
<td>Coping with stress</td>
<td>20 min</td>
</tr>
<tr>
<td>Planning for self-care</td>
<td></td>
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</tbody>
</table>

### MODULE 7  SUMMARY, NEXT STEPS AND CLOSING

#### Session 7.1: Next steps

- 30 min

#### Session 7.2: Post-test and clinical assessment

- 30 min (CHW 1)
- 1 hour (CHW 2)
- 1 hour 15 min (CHW 3)
- 45–60 minutes for clinical assessment

#### Session 7.3: Closing and workshop evaluation

- 1 hour
### Session 8.1: Providing advanced care to survivors of sexual violence

<table>
<thead>
<tr>
<th>Topic</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Providing tetanus toxoid/immunoglobin to prevent tetanus</td>
<td>1.1 What is tetanus and who is at risk for tetanus infection?</td>
</tr>
<tr>
<td></td>
<td>1.2 What is the tetanus vaccination and how does it work?</td>
</tr>
<tr>
<td>2. Providing vaccines to prevent hepatitis B</td>
<td>2.1 What is hepatitis B and who is at risk?</td>
</tr>
<tr>
<td></td>
<td>2.2 What is the hepatitis B vaccination and how does it work?</td>
</tr>
<tr>
<td>3. Managing STIs (syndromic management)</td>
<td>3.1 How can STIs be managed and how is treatment provided?</td>
</tr>
<tr>
<td></td>
<td>3.2 How should partners be managed for STI treatment referral?</td>
</tr>
<tr>
<td>4. Preparing to treat allergic reactions and allergic shock</td>
<td>4.1 What are signs of allergic reactions and allergic shock?</td>
</tr>
<tr>
<td></td>
<td>4.2 How should allergic reactions and allergic shock be treated?</td>
</tr>
</tbody>
</table>
PREPARING FOR THE TRAINING

The facilitator who will train CHWs should know that careful planning is important. This should start several weeks before the training.

1. Initial planning
   • Establish objectives for the training.
   • Establish criteria for participation and identify participants/trainees based on these criteria.
   • Know the training needs of the participants, especially their literacy levels and expected role in managing survivors of sexual violence in the community.
   • Develop a budget for the training.

2. Logistics
   • Decide the training date and venue that will work for participants, facilitators and other stakeholders.
   • Determine the cost per participant with regard to food, lodging, transportation and materials.
   • Reserve the training venue and make it as conducive to learning (i.e. well-lit, good ventilation, limited external noise) as possible. Electricity is not required.

3. Identification of participants and resource persons
   • Contact participants in person or through letters of invitation.
   • Follow-up with participants to confirm their attendance.
   • If resource persons are needed to handle or facilitate topics, make a list of possible persons to invite.
   • Email or send letters to the selected resource persons. Be sure to inform them about the goals and objectives of the training as well as the specifics of what will be expected of them.

4. Preparation and review of the training tool
   • Determine the relevant modules and sessions to use in the training.
   • Review and adapt the methodologies and activities of the sessions as necessary.
   • Select documents to use based on the training needs of the participants.
   • Prepare materials and equipment:
     ▸ Adapt as necessary, photocopy and otherwise obtain any HOs, notebooks, demonstration models or other reference materials for training use and distribution.
     ▸ Prepare flip charts, markers, pencils, pens and anything else you may need.
     Prepare materials that are applicable and most suited to the training venue.
Determining the role of the CHW

The role of the CHW may differ in the programme, depending on national policies and the setting. In circumstances where higher level health care providers such as nurses, midwives and doctors are available, CHWs may only be involved in health education about sexual violence and referring survivors to appropriate services. However, in settings where higher level providers are lacking or health facilities inaccessible, the programme may consider tasking CHWs with a larger role in managing survivors of sexual violence in their community in the context of a well-monitored pilot project.

Modules 2–4 are applicable for settings where CHWs play a role in health education and referral of survivors; Modules 5–6 for situations where CHWs may themselves treat survivors of sexual violence. In some instances, CHWs may be tasked with certain activities listed in Module 5, such as the provision of EC to prevent pregnancy, or antibiotics to prevent STIs but not all components of the package of care. Advance Module 8 is only applicable in settings where CHWs are the providers of last resort and they have the experience, skills and capacity to provide this level of care. A ‘Getting Started’ guidance has been developed to precede this facilitator’s guide on programming considerations for community-based care for survivors of sexual violence.

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

The scope of work as determined by capacity (not by nuances in the setting) is as follows:

✔ = Yes
Blank = No
★ = Only if capacity exists and the intervention warranted

<table>
<thead>
<tr>
<th>Intervention</th>
<th>CHW 1</th>
<th>CHW 2</th>
<th>CHW 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct health education around sexual violence and the benefits of seeking care</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Recognize survivors of sexual violence when they come forward (passive identification)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Actively screen for survivors of sexual violence</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provide some basic first aid to stabilize survivors for referrals</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Refer survivors to higher level health staff or the health facility for health care</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Take a health history</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Collect forensic evidence</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Conduct a minimum medical exam (physical)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Conduct a minimum medical exam (pelvic)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Complete simplified intake form</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Generate a medical certificate (duplicate intake form)</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provide some basic first aid to treat minor injuries</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
<tr>
<td>Provide other wound care as feasible</td>
<td>✔️</td>
<td>✔️</td>
<td>✔️</td>
</tr>
</tbody>
</table>
## Intervention

<table>
<thead>
<tr>
<th>Intervention</th>
<th>CHW 1</th>
<th>CHW 2</th>
<th>CHW 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide presumptive treatment for sexually transmitted infections (STIs), emergency contraception (EC) for pregnancy prevention and supportive counseling (including psychological first aid and basic emotional support)</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Conduct HIV counseling and testing</td>
<td>✔</td>
<td></td>
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<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Provide tetanus toxoid and/or Hepatitis B vaccine</td>
<td>✔</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Provide follow-up care to survivors</td>
<td>✔</td>
<td>✔</td>
<td></td>
</tr>
<tr>
<td>Manage STIs (syndromic management)</td>
<td>✔</td>
<td>✔</td>
<td>★</td>
</tr>
</tbody>
</table>

### General pointers for facilitators

3. Read all sections of the training tool before beginning.
4. Check that all materials needed to complete an exercise are ready. Follow or adapt the ‘steps’ described for each exercise as necessary.
5. Preview key points at the beginning of the training. First impressions and setting expectations are important.
6. Explain the purpose of each exercise included in each session. Give clear instructions, including how much time participants have to complete each activity.
7. Use practical exercises contained in this tool. Give participants plenty of hands-on experience, especially demonstrations. Encourage women to play the role of the CHW during role-plays in trainings with mixed genders.
8. Use examples, discussions, exercises, etc. to reinforce what has been learned.
9. Confirm understanding by asking questions.
11. Remember to close each session with a recap of key points.
12. The more often information is repeated, the more likely it will be remembered, especially when it is repeated in a number of ways.

### Tips on working with CHWs as adult learners

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

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

- Facilitate discussions and activities in such a way that participants feel safe to ask questions and are confident that their contribution will be respected.
- Show respect for the experience of participants by asking them to share their ideas, opinions and knowledge, and recognize that they may be a good resource for reaching your teaching goals.
- Avoid making the participants obey you. Adults are decision makers and self-directed learners. Be the ‘guide on the side’ rather than the ‘sage on the stage’. Listen to what the participants want and need, be flexible in your planning, and change your approach if your agenda or methods are not working.
- Seek feedback from participants and use this feedback to improve your training style as well as the content and flow.
- Keep the content meaningful, relevant and worthwhile to participants. Become aware of what they want (and need) to learn, how much they already know and the priorities and life events that might affect their attention span and participation.
- Make sure everyone is actively participating, and use examples of situations that are familiar to them.
- Be thoughtful and kind, and respectful of participants’ time.
- Engage multiple senses (hearing, seeing, hands-on practice) to enhance learning. Minimize the use of lecture, and show as well as tell. Encourage discussion and provide examples, and allow participants to practise what they are learning.
- Try to reduce the stress associated with learning. Provide participatory learning exercises that are fun and simple.

For more tips on training methods and how to prepare and conduct a training course, consult the first chapter of the WHO’s Rapid containment of pandemic influenza: Facilitator’s Guide – 4 day training course.

**Introductions and ice-breakers**

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

- **Fact or fiction**: Each participant thinks of four facts about herself or himself, one of which is not true. The participants then take turns listing these facts, and the rest of the group guesses the one they think is not true.

- **What made you smile this morning**: Each participant thinks of what made her or him smile on the way to the training. This is a good way to have participants smile, especially on their first day when they may not know each other.

- **Finish the sentence**: Ask each person to complete one of these sentences:
  - The riskiest thing I ever did was...
  - Today on my way to training I was thinking about...
  - When starting a training and you want everyone to introduce themselves, they can complete the sentence, “I am in this training because…”

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

![Ball of yarn exercise](image)

**Energizers°**

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

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

- **Lifeboats:** Have everyone stand up. You will then call out a number and people must quickly move to form groups of that number, linking arms to symbolize the formation of a full lifeboat. People not in a ‘boat’ are out. Repeat the process with different numbers until there is no one left who is not a member of a group. Declare the last boat that can form the winning team.

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

**Tips on grouping participants**

If you are grouping participants for any exercises, one way to do this is to group according to assigned numbers. The facilitator can have the participants count from one (1) to a certain number (i.e., the desired number of groups). For example, count from one (1) to three (3), if you wish to have three groups. Remind the participants to remember the number they call out. Group together all the similar numbers (i.e., group together everyone who called out one, everyone who called out two, and everyone who called out three if you wish to have three groups).

**Tips on using visual materials**

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

- Make sure all participants can clearly see the materials.
- Explain pictures or have participants explain them and point to them as you talk.
- Look mostly at the participants, not at the flip chart or poster.
- Use samples when explaining how to use the drugs, and make sure they are not expired.
- Invite participants to touch and hold sample drugs, instruments, etc.
- If the participants are literate, and safety permits, give the participants a few key instruction sheets to take home. These print materials can remind participants what to do. Be sure to go over the materials with them before they take them home.
MODULE 1

Introduction
## SESSION 1.1
### Administration

<table>
<thead>
<tr>
<th>Session Time</th>
<th>1 hour 30 minutes</th>
</tr>
</thead>
</table>
| Objectives            | By the end of this session, participants will be able to:  
  • Say where to go for administrative information.  
  • Identify at least two ways to make the workshop run smoothly. |
| Methods               | • Discussion  
  • Brainstorming |
| Preparation           | • Develop workshop timetable from the schedule on pages 9–13.  
  • If registration forms will be used, have copies ready for participants to fill in as they enter the training.  
  • Have a sign-in sheet and pen on the table at least 30 minutes before the workshop begins.  
  • Arrange participants’ materials on the registration table so participants can easily be given one of each as they register. |
| Training aids, materials and HOs | • Flip chart, markers, tape, pencil sharpener  
  • Session objectives written on flip chart paper  
  • Workshop registration form if used, sign-in sheet and pen (attached to the end of the facilitator’s guide)  
  • For each participant:  
    ▶ Pen, pencil, eraser, notebook, clipboard if possible  
    ▶ Workshop timetable |
| Evaluation and assessment | None |
| Additional resources  | None |
### PART 3
Strengthening Community-Based Care

#### Steps

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
</table>
| **1. Registration, distribution of materials and logistics**<br>30 minutes | 1. Ensure that all participants sign their names on the sign-in sheet as they enter the training room. Assist any non-literate participants by writing their names for them. Give each person their package as they sign in.  
2. Review logistics related to the training, such as start and end times, how breaks and lunch will be handled, where the restrooms are, whom to ask if they have administrative questions, funds to be provided for anything, and so on.  
3. Briefly review the workshop timetable. |
| **2. Introduction of participants and facilitators**<br>30 minutes | 1. Tell participants they will now introduce themselves. In their introduction, they should say their name, where they live, one thing that is special about the village or district in which they live and one reason they were chosen to be a CHW in their area.  
2. Tell participants to spend no more than one or two minutes talking. Facilitators should start by introducing themselves, setting an example. |
| **3. Training group norms and expectations**<br>30 minutes | 1. Ask participants to come up with simple rules to help the training run smoothly. Add anything important that is missing, such as being on time, turning cell phones off, speaking one at a time, ensuring that what is said in the room remains in the room (confidentiality) and showing everyone respect at all times.  
2. Now, ask participants to say what they expect from the training. It can be what they expect to learn or gain, what they expect to happen during or after the training or what they expect to contribute to the training.  
3. List the main points on flip chart to refer to during the training and at the end to see which expectations were met. If any of the expectations are not realistic, mention that they will not be met during this particular training.  
4. The facilitators can add her or his expectations too.  
5. Summarize by asking participants how they can share in the responsibility of ensuring that norms are followed and expectations are met. |

#### FACILITATOR’S NOTES

**Mention your expectations, such as:**

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

<table>
<thead>
<tr>
<th>Session Time</th>
<th>45 min</th>
</tr>
</thead>
</table>
| **Objectives** | By the end of this session, participants will be able to:  
- State at least two of the training objectives.  
- Understand their overall role in community-based management of survivors of sexual violence. |
| **Methods** | Mini lecture |
| **Preparation** | Know the exact roles that CHWs will play in community-based management of survivors of sexual violence.  
- Write training objectives on flip chart. |
| **Training aids, materials and HOs** | On flip chart paper taped to wall: name of training, training objectives and facilitator’s name. |
| **Evaluation and assessment** | None |
| **Additional resources** | None |
Steps

Workshop goals, objectives, timetable

Mini lecture
30 minutes

1. Explain that the purpose of this training is to prepare CHWs to help survivors of sexual violence.

2. Tell participants the specific objectives of the training. At the end of this training, participants will be able to:
   - Understand sexual violence and its consequences in the context of crisis settings
   - Conduct health education on the benefits of seeking care and where and how to access services
   - Interact with survivors of sexual violence
   - Refer survivors of sexual violence to health care and other support services respecting their safety, confidentiality and dignity
   - Directly provide basic health care if appropriate
   - Understand their roles and responsibilities and how managing survivors of sexual violence fits into their daily responsibilities

3. Give an overview of the expected roles and responsibilities for CHWs in helping survivors of sexual violence. The training tool assumes the checked tasks in the table of interventions that follows will be undertaken by each relevant category of CHWs. Make sure participants know to which category they belong, especially if the training will include a mix of participants.
   - CHW 1s are primarily responsible for conducting health education about the importance of seeking care and where survivors can access services; and for linking survivors they identify to higher level CHWs and health services. They are not expected to provide any direct care.
   - In addition to activities carried out by CHW 1s, CHW 2s can offer basic health care for survivors of sexual violence. While more details of their exact scope will be revisited in Module 5, CHW 2s will be referring patients to the health centre for wound care that they cannot manage, HIV testing and vaccinations for tetanus and hepatitis B. They will also refer for psychosocial care, mental health care, protection, social support and legal justice assistance, among other available support services as appropriate and with the survivor’s approval.
   - In addition to activities carried out by CHWs 1 and 2, CHW 3s will be involved in providing additional health care, especially if they are in settings where referrals to higher level health services are not available.

4. Reassure participants that even if they do not understand exactly what their work will involve now, they will have a better sense as they take part in the training.

5. Review the training schedule as a way to indicate how the objectives will be achieved.

6. Summarize by asking participants to state the main purposes of the training.
The scope of work as determined by capacity (not by nuances in the setting) is as follows:

✔ = Yes
Blank = No
★ = Only if capacity exists and the intervention warranted

<table>
<thead>
<tr>
<th>Intervention</th>
<th>CHW 1</th>
<th>CHW 2</th>
<th>CHW 3</th>
</tr>
</thead>
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<tr>
<td>Conduct health education around sexual violence and the benefits of seeking care</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Recognize survivors of sexual violence when they come forward (passive identification)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Actively screen for survivors of sexual violence</td>
<td></td>
<td></td>
<td>★</td>
</tr>
<tr>
<td>Provide some basic first aid to stabilize survivors for referrals</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
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<td>Refer survivors to higher level health staff or the health facility for health care</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Take a health history</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
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<td></td>
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<td>Conduct a minimum medical exam (physical)</td>
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<td></td>
<td>★</td>
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<td>Conduct a minimum medical exam (pelvic)</td>
<td></td>
<td></td>
<td>★</td>
</tr>
<tr>
<td>Complete simplified intake form</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
<tr>
<td>Generate a medical certificate (duplicate intake form)</td>
<td>✔</td>
<td>✔</td>
<td>✔</td>
</tr>
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<td>✔</td>
<td>✔</td>
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<tr>
<td>Manage STIs (syndromic management)</td>
<td></td>
<td></td>
<td>★</td>
</tr>
</tbody>
</table>
SESSION 1.3

Pre-test

<table>
<thead>
<tr>
<th>Session Time</th>
<th>30 minutes (Modules 2–4)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 hour (Modules 2–6)</td>
</tr>
<tr>
<td></td>
<td>1 hour 15 minutes (Module 2–Advanced Module 8)</td>
</tr>
<tr>
<td>Objectives</td>
<td>By the end of this session:</td>
</tr>
<tr>
<td></td>
<td>• Participants and facilitators will have a baseline</td>
</tr>
<tr>
<td></td>
<td>against which to measure participants’ progress.</td>
</tr>
<tr>
<td>Methods</td>
<td>• Individual work</td>
</tr>
<tr>
<td>Preparation</td>
<td>• Try to find out in advance which participants may</td>
</tr>
<tr>
<td></td>
<td>need a pictorial pre-test.</td>
</tr>
<tr>
<td>Training aids, materials and</td>
<td>• Pre-test for literate CHWs (Modules 2–4; 5–6;</td>
</tr>
<tr>
<td>HOs</td>
<td>Advanced Module 8) (annexed).</td>
</tr>
<tr>
<td></td>
<td>• Pre-test for non-literate CHWs (Modules 2–4)</td>
</tr>
<tr>
<td></td>
<td>(annexed).</td>
</tr>
<tr>
<td>Evaluation and assessment</td>
<td>• Pre-test for literate CHWs (Modules 2–4; 5–6;</td>
</tr>
<tr>
<td></td>
<td>Advanced Module 8) (annexed).</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>(annexed).</td>
</tr>
<tr>
<td>Additional resources</td>
<td>None</td>
</tr>
</tbody>
</table>
1. Explain that in order to know how much participants learn during the training, they will now be given a pre-test to complete. At the end of the training, they will complete the same test. The facilitator will correct both tests and let the participants know how much they improved and what they need to work a little harder on and perhaps seek help for.

2. Tell participants they have 30 minutes (1 hour for full test; 1 hour 15 min for advanced test) to complete the pre-test. They should answer as many questions as they can, but understand that the pre-test asks things most participants have not yet learned and will be unable to answer. Through participation in the training they will learn the information. By the end of the training, they should be able to answer many more questions correctly.

3. Explain to participants that for some questions they can select multiple answers. If they see a question that says, ‘Circle all that apply’, that means there may be more than one correct answer.

4. Distribute the questionnaire, telling participants not to begin until you say so. If they are non-literate, ask them to follow while you read the questions, and have them circle the appropriate pictorial responses.

5. Let participants know when to start and by what time they must finish. Ask them to use a pencil so they can erase mistakes, and ask them to bring their pre-test to you once they have finished. If they have questions during the test, they can raise their hand. Assist non-literate CHWs individually as necessary.

Find out before starting the training or during the break which participants do not read or read well. Be sure to give them the pictorial version of the test and help them understand the question and what their choices are. They can circle the appropriate picture/image as their response to the questions.
MODULE 2

What is sexual violence and what are its consequences?

Participant handouts
Handout 1: GBV flip book
Handout 2: HIV flip book
### SESSION 2.1

Unpacking gender, sexual violence and social norms

<table>
<thead>
<tr>
<th><strong>Session Time</strong></th>
<th>3 hours</th>
</tr>
</thead>
</table>
| **Objectives**   | By the end of this session, participants will be able to:  
• Understand the meaning of gender, sexual violence and social norms.  
• Learn about the causes, contributing factors and consequences (physical, emotional, and social) of sexual violence.  
• Understand sexual violence in the context of human rights. |
| **Methods**      | • Mini lecture  
• Discussion  
• Scenario  
• Game |
| **Preparation**  | Prepare lecture |
| **Training aids, materials and HOs** | Flip charts, markers and pens |
| **Evaluation and assessment** | None |
### TOPIC 1: UNDERSTANDING GENDER

**1.1 What is gender?**

*Mini lecture*
10 minutes

To introduce the concept of gender, explain the difference between ‘sex’ and ‘gender’. Tell participants that each person is born with either a girl’s body or a boy’s body. These physical differences determine a person’s *sex*.

Explain that a person’s *gender role* refers to the way a community defines what it is to be a woman or a man. Each community expects women and men to look, think, feel and act in certain ways, simply because they are women or men. Gender expectations frequently put women in subservient roles and promote certain behaviors that are harmful to men and women. In many communities, women are expected to prepare food, gather water and fuel and care for their children. Men, however, are often expected to work outside of the home and protect their families from harm. Expecting men to be ‘strong’ and ‘tough’ discourages them from backing down from a fight. Expecting women to serve and obey men suggests that they are of lesser value and puts them at risk for other forms of violence, including sexual violence.

Unlike the physical differences between men and women, gender roles are created by the community. Some activities like washing and ironing clothes are considered women’s work in many communities. Other activities vary from place to place, depending on a community’s traditions, laws and religions. Gender roles can even vary within communities based on people’s level of education, social status or age.⁷

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**FACILITATOR’S NOTES**

‘*Sex*’ is the biological difference between males and females. It does not change and remains the same across cultures and societies.

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

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### TOPIC 2: UNDERSTANDING GENDER-BASED VIOLENCE

#### 2.1 What is GBV?

**Mini lecture**

10 minutes

Summarizing each group’s scenario, discuss when gender roles can sometimes cause harm. In many communities, women are expected to do what men say, and are treated like the property of their fathers or husbands. Every day, women are also slapped, kicked, beaten, humiliated, threatened, abused and even murdered by their partners, and in many contexts this is not considered cause for alarm. Often, women do not speak about this violence because they may feel ashamed, alone or afraid to speak. A man may offer many excuses for hurting a woman – that he was drunk, that he lost control or that she “deserved it.” However, a man chooses to use violence because it is a way he can get what he needs, assert his power or get what he feels is rightfully his as a man. He also chooses to do this because he knows that there are few serious formal or informal consequences for doing so.

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9 Ibid.
2.1 What is GBV?
(continued)

The term **gender-based violence** is used to describe acts of violence that are based on gender roles, particularly a women’s lower status in society.

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**FACILITATOR’S NOTES**

**Gender-based violence (GBV)** is an umbrella term for any harmful act that is perpetrated against a person’s will, and that is based on the gender differences between males and females. The words ‘gender-based’ highlight the gender side of these types of acts; in other words, the relationship between female’s lower status in society and their increased risk to violence. GBV can be sexual, physical, psychological/emotional and economic, and include acts—attempted or threatened—committed with force, coercion or manipulation, and without the agreement or consent of the survivor.

Adapted from: IASC, Guidelines for Gender-based Violence Interventions in Humanitarian Settings, 2005.

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2.2 What are examples of GBV?

**Discussion**

1. Ask participants to come up with examples of GBV. Draw and/or list these on flip chart paper, and encourage ideas and examples.

2. Once you have filled out roughly two flip chart pages, suggest a framework of four general categories: sexual, physical, psychological/emotional and economic violence. Give examples from the flip chart paper if participants are unsure of what the categories mean. For example, say that if someone forces a woman to have sexual intercourse against her will that would be sexual violence. If a husband beats his wife for not making his meal on time, that would be physical violence. If a husband says to his wife that she is worthless every day, that would be psychological or emotional violence. If a husband takes all of the money his wife makes to spend on alcohol, that is economic violence.

3. Divide participants into four groups representing each category, and ask them to:

   - Identify which types of GBV fall within their assigned category, and to add any that they think are missing.
   - Think how the different acts of violence play out among different relationships. Relationships can be between a husband and wife, a mother-in-law and daughter-in-law, parents and children, or other people in the community.
   - Think about any practices that are only expected of a certain sex or age group in their community. Could they be considered GBV?
   - Ask participants to think about violence against children, particularly girls.

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4. Let participants know they have 10 minutes to discuss and three minutes to present. They should select one person to speak on behalf of the group, but others can add as relevant.

5. While participants are discussing, draw a simple tree on flip chart paper. Use only the top two thirds of the page (the bottom one third is for contributing factors/causes). Draw four large branches and label them with the four broad categories.

6. Ask each group to present what was discussed in each group. As the presenters speak, draw smaller branches and write or draw the types of GBV they list.


If participants are not literate, use pictorial images to describe the different types of GBV. Some images are provided as part of the module, but you can ask participants to draw as they discuss, or you can draw on your tree as they present.
2.2 What are examples of GBV? (continued)

7. When all groups have finished presenting, ask if there are any forms of GBV that have not been included in the list. If a suggestion is made by participants that are not gender-based, ask why it is not GBV, and list this on a separate sheet of flip chart paper. The discussion should bring out opinions, biases and cultural issues/beliefs.

8. If any harmful traditional practices that are relevant to the context were not raised, facilitate discussion on how these practices are forms of GBV. Raise this especially if the practice relates to sexual violence.

9. Ask participants which of these particular acts of violence are permitted in their communities. Why are they permitted? Be sure that the issues of dowry, women as property and girls being valued less than boys are considered.
Some definitions:

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

Sexual violence includes:

- **Rape/attempted rape**: Rape is an act of forced sexual intercourse. This can include the invasion of any part of the body with a sexual organ and/or the invasion of the genital or anal opening with any object or body part. Rape and attempted rape involve the use of force, threat of force and/or coercion. Efforts to rape someone that do not result in penetration are considered attempted rape.

- **Sexual abuse**: Actual or threatened physical intrusion of a sexual nature, whether by force or under unequal conditions.

- **Sexual exploitation**: Any actual or attempted abuse of a person in a position of vulnerability (power or trust) for sexual purposes. This can include, but is not limited to, profiting with money, socially or politically from the sexual exploitation of another.

** Trafficking**: The recruitment, transportation, transferring, harbouring or receipt of a person, by threat, use of force or other forms of coercion, abduction, fraud, deception, abuse of power or vulnerability, and giving or receiving of payments or benefits. This is done for the purpose of exploitation, including for prostitution or other forms of sexual exploitation, forced labour or services.

**Sexual harassment**: Any sexual advance, request for sexual favors or other verbal or physical act that is sexual in nature and makes a person feel unsafe or uncomfortable (like sexual jokes, comments, intimidation).

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

10. Wrap up by mentioning that striving towards gender equality and respect for all persons can help reduce GBV. Equality between women and men means that women, girls, boys and men can equally enjoy rights, opportunities, resources and rewards. Equality does not mean that women and men are the same, but that it does not matter whether a person is born female or male to enjoy the same rights, opportunities and life chances. Explain that equality and GBV in the framework of human rights will be discussed more in later sections.

TOPIC 3: SOCIAL NORMS AND SEXUAL VIOLENCE

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

Discussion

1. Explain that social norms are rules about behaviour that members in a group or community expect each other to follow.
   - People follow social norms in order to be accepted and to avoid being punished for not following them.
   - Social norms can tell people what behaviour is expected of them or what behaviour is forbidden.
   - People follow social norms because they see others following them and believe other people think they should follow them too.
   - Social norms enforce gender roles and expectations.
   - Social norms can change over time.

2. Share that social norms are related to groups and how people get along in the different groups they are part of (reference group).

3. Ask CHWs to list some of the groups they belong to (responses can include a religious group, group of friends, greater community groups). Point out that the group can be big or small and what is important is that the members of the group consider the opinions and behaviors of other people in the group to be important and guide the way group members behave.

4. Share that social rewards and punishments also influence norms in the community. People follow social norms because doing so results in rewards like the approval and acceptance of members of the same group. People who do not follow social norms may be punished or shamed by group members.

5. Ask CHWs to brainstorm a few social norms that are generally approved and disapproved in one of the groups they listed above.

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6. Next, share that oftentimes a person may choose to do something based on what she or he thinks other people in the community think and do (conditional preferences). Offer an example, such as behaving “like a man” in one group depends on how a person thinks others believe a man should behave and how they see other men behave. Be sure to discuss that social norms can be contradictory and can be protective or damaging. For example, while most societies consider rape to be bad, it is in fact an accepted part of life in many places.

7. Choose one example of a ‘group’ that CHWs raised, and ask them to describe it.

8. Conclude by telling participants that as health workers they are critical to promoting positive norms by treating survivors with respect and compassion and showing that sexual violence has not impacted their value and worth. Changing social norms involves promoting and expanding the positive aspects of the norms that already exist.

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

(continued)

3.2 How are social norms linked to sexual violence?

Discussion
15 minutes

1. Explain to participants that sometimes social norms continue even when they are harmful or unpopular because people do not know what other group members really think or do. For example, someone might not know that other people in their group also do not approve of a behaviour or practice. Because of this, harmful behaviors like sexual violence may continue even when many people in the group do not believe it is right. Since sex is not usually talked about openly in groups, it can be hard to know what other people really think about sexual violence. It is possible that many people in a group actually dislike sexual violence but remain silent because they think that other group members support it or because they don’t think it matters.

2. Some social norms about gender, sex and violence support sexual violence as something that is normal or not avoidable in a group. For example, groups with norms about masculinity that emphasize dominance, physical strength and male honour may also experience higher numbers of incidents of rape than groups without these norms. This is especially true when women are expected to be compliant and obedient and are traded between men through marriage and dowry exchange.

3. Ask participants to now think of examples of gender-related social norms. Some examples may include:
   - “Sexual activity, including rape, shows a man’s manhood.”
   - “Sexual violence is an acceptable way of putting women in their place or punishing them.”
   - “A woman should obey her husband in all things.”
   - “A girl does not deserve respect if she has sex before marriage.”
   - “Violence and even rape is part of normal life. It is just what happens in this community.”
   - “A person with a disability should feel lucky that someone raped her. She would not have a chance to have sex otherwise.”
   - Explain that they will now play a game to further explore common norms related to gender and sexual violence and explore community attitudes that may be harmful for survivors.
3.2 How are social norms linked to sexual violence? (continued)

**Game**

20 minutes

1. Tell participants to stand up for a game of ‘true or false’. Have participants come to the centre of the room.

2. Read the statements below, and after each one, ask participants whether they think the statement is true or false. If they think the statement is true, they should go to one side of the room. If participants think the statement is false, they should go to the other side of the room. The statements to read are:
   - It is easy for girls to lie about rape.
   - A survivor of sexual violence may have deserved the attack because of the way she dressed or acted.
   - It is a woman’s fault for being raped. She should have been more careful.
   - There are times when it is acceptable for a man to hold a woman down and physically force her to have sex.
   - If a woman’s husband or boyfriend forces her to have sex, it does not count as sexual violence.
   - A woman will always say no to sex. It is therefore up to the man to push for sex.
   - If a man is drunk when he forces sex on a woman, it is not sexual violence.
   - Physical injury is the only health outcome of sexual violence.

3. Keep track of participant responses since this will help you better understand their perceptions towards survivors of sexual violence.

4. After the last statement, let participants know that in fact, all of the statements are false! Inform participants that anyone can be a target of sexual violence, and it is never the person’s fault.

5. If participants are in doubt or do not agree that a statement is false, see what assumptions are behind their thinking, and how that could be stigmatizing for survivors.

6. How can they in their roles address the thinking behind these kinds of statements?
Depending on the setting, participants may not agree that a statement is false. Some pointers or facts to address biases are:

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

- Based on gender equality principles, nothing a woman does gives a man the right to hurt her, even if he thinks she deserves it—even if she herself thinks she deserves it.
- Many incidents of sexual violence are committed by someone a woman knows. Anytime someone is forced to have sex against her or his will, it is sexual violence, whether the attacker is a husband, boyfriend, teacher or a stranger.
- Violence is not just a family matter. Many women are hurt or killed. Sometimes, the violence happens in the family. Violence is a social and community health problem.
- Alcohol does not cause violence, but it often makes it worse. Violence is also common in places where people do not drink alcohol.
- Sexual violence can happen to anyone, including men and boys.
- “Disabled girls are lucky to have someone care for them—even if they have to bear some abuse.” No one is “lucky” to experience abuse, and persons with disabilities have a right to freedom from exploitation, violence and abuse.
- The upheaval caused by conflict can make existing sexual violence worse.


### 3.3 Why does sexual violence happen, and what are some risks/contributing factors?

**Discussion**

| 25 minutes |

1. Draw roots to your tree diagram, and on the side of the flip chart, write, “weather and temperature” as contributing factors. The weather and temperature make the tree grow larger and the roots stronger.

2. Ask participants to suggest why they think sexual violence happens. If any are root causes, add them to the tree. If they are contributing factors, add them under weather/temperature.

3. Review participant feedback from the tree diagram and add any relevant points that have been missed, including increased risks. Clarify any misunderstanding of terms if necessary.

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3.3 Why does sexual violence happen, and what are some risks/contributing factors? (continued)

**Root causes**, including gender roles, can be:
- Male and/or society’s attitudes of disrespect or disregard towards women
- Lack of equality of human rights for all
- Cultural/social norms of gender inequality and discrimination
- Lack of value for women and/or women’s work

**Contributing factors** depend on the situation and can be:
- Alcohol/drug abuse
- Religious beliefs
- Culture and traditional practices
- Crises, including conflict or natural disaster


4. Further explain there are many factors in the individual, family and community that can influence the chances of someone experiencing sexual violence.

Risk factors are characteristics of individuals, relationships, families, schools and other institutions and communities. Types of risk factors include:
- **Individual factors**: The way someone was born or develops, and her or his past history.
- **Relationship factors**: How a person interacts with her or his friends, partners and family. These are the people very close to an individual and can shape a person’s behaviour.
- **Community factors**: This includes schools, workplaces, neighborhoods and other settings where people may experience or commit violence.
- **Social factors**: Larger factors that influence sexual violence in a community, such as gender inequality, religious or cultural belief systems, social norms and policies that create gaps or tension between groups of people.
3.3 Why does sexual violence happen, and what are some risks/contributing factors? (continued)

For example, risk factors associated with experiencing sexual violence include:
- Poverty
- Being young
- Being female
- Conflict settings
- Having previously been raped or sexually abused
- Involvement in sex work
- Becoming more educated and economically empowered (especially if the sexual violence is being committed by an intimate partner, such as a spouse or boy/girlfriend).

5. Summarize that sexual violence exists in most societies and can be fuelled by root causes and contributing factors, including risk factors.

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

Women with disabilities are also more likely to be abused, as:
- Some men may feel angry that they did not get a ‘perfect’ woman.
- Men may think a woman with a disability is easier to control because she may be less able to defend herself.

The prevalence of sexual abuse against persons with disabilities has been found to be higher, especially for institutionalized men and women with intellectual disabilities, intimate partners and adolescents.

If a survivor with disabilities gives information that suggests she or he is being abused by a care giver or family member, the CHW should provide options to ensure the person’s physical safety (e.g., safe houses and other community protection approaches).

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

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

Discussion
10 minutes

Note that it is important to remember that some social norms can also help women and girls that have experienced sexual violence in the community.

1. Ask participants to think of any existing social norms that offer empathy and compassion to survivors.

2. As CHWs prepare to manage survivors of sexual violence in the community, emphasize that they should work to prevent stigmatizing attitudes towards survivors and never fuel them. Reinforce that:
   - The survivor is not to blame
   - Sexual violence can happen to anybody
   - Sexual violence is not about sexual attraction or seduction, but violence
   - Acts of sexual violence violate many human rights principles

TOPIC 4: UNDERSTANDING SEXUAL VIOLENCE IN THE FRAMEWORK OF HUMAN RIGHTS

4.1 What are human rights?

Mini lecture
10 minutes

Explain that human rights are rights that belong to all human beings, whatever the nationality, place where they live, sex, national or ethnic origin, colour, religion, language or other status. Human rights are based on respect for the dignity and worth of each person. Everyone is equally entitled to human rights regardless of who they are.

Acts of sexual violence violate a number of human rights principles protected by international human rights agreements and even national law. Some of the rights that are violated when someone experiences sexual violence include:

- The right to life, liberty and security of the person
- The right to the highest attainable standard of physical and mental health
- The right to freedom from torture or cruel, inhuman, degrading treatment or punishment
- The right to freedom of opinion and expression
- The right to education and personal development
- The right to protection against all forms of neglect, cruelty and exploitation.

Provide examples to illustrate how sexual violence can violate a person’s rights. For example, if a girl is sexually assaulted on her way to collecting firewood, her right to security and protection are violated, as well as her freedom from inhuman or degrading treatment.

Next ask about local frameworks related to rights, including religious texts, proverbs and other familiar guidelines. What do they say about keeping people safe and protecting them from violence?

## SESSION 2.2

### Addressing sexual violence in crisis settings

<table>
<thead>
<tr>
<th>Session Time</th>
<th>4 hours</th>
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<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to understand:</td>
</tr>
<tr>
<td></td>
<td>• Why sexual violence happens in conflict</td>
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<td></td>
<td>• The health, emotional, psychological and social consequences of sexual violence</td>
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<td></td>
<td>• The health and other benefits for survivors seeking timely care</td>
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<tr>
<td><strong>Methods</strong></td>
<td>• Mini lecture</td>
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<tr>
<td></td>
<td>• Discussion</td>
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<td></td>
<td>• Game</td>
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<tr>
<td><strong>Preparation</strong></td>
<td>• Prepare lecture</td>
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<td></td>
<td>• Print and cut HIV cards annexed to the end of the facilitator’s guide for a game on how HIV can and cannot spread. Two sets will be required if you are dividing the participants into two groups.</td>
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<tr>
<td><strong>Training aids, materials and HOs</strong></td>
<td>• Flip chart and markers</td>
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<td></td>
<td>• Sample condoms (male and female)</td>
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<td>• HIV cards (annexed to end of the facilitator’s guide)</td>
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<td></td>
<td>• HIV flipbook (participants’ packet)</td>
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<td></td>
<td>• Sample medicines (EC, antibiotics, etc.) for visual understanding</td>
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<tr>
<td><strong>Evaluation and assessment</strong></td>
<td>Game on how HIV can and cannot spread</td>
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TOPIC 1: RISKS OF AND VULNERABILITIES TO SEXUAL VIOLENCE IN CRISIS SETTINGS

1.1 What happens during a conflict or natural disaster?
Begin this session by exploring what a crisis setting can look like. Conflicts are typically characterized by violence and loss of life; displacement of people and communities; and damage to society’s resources. There is often a need for humanitarian assistance, but there could also be major security risks for the community and even humanitarian staff in some areas.

Natural disasters, like conflicts, also have a serious impact on how communities and societies function. Disasters can result in massive loss of life; separation of families; displacement of people; and the destruction of livelihoods, homes and other infrastructure.

If natural disasters strike conflict settings, they can further impact lives, livelihoods, infrastructure, the local economy and the capacity of service providers to respond.

In crises, many forms of GBV can occur. When communities are first disrupted, community members are moving and systems for protection are not fully in place. Most reported cases of GBV at this time are those of sexual violence involving female survivors and male assaulters. During a crisis, rape can be used as a weapon of war to spread fear, intimidate and humiliate individuals and communities, and force people off their land. Rape may even be approved by a military leader as a ‘reward’ to soldiers. Such an environment can increase the risk of unwanted pregnancies, unsafe abortions and STIs, including HIV.

1.2 Why does sexual violence happen in crisis settings, and what are some additional risks/contributing factors?
1. Revisit the root causes and contributing factors on your tree diagram. Ask participants about crisis-related sexual violence. What are some of the additional risks and vulnerabilities that can contribute to sexual violence in conflicts or disasters? Use a different colour pen to record responses on the tree diagram.

2. Review participant feedback from the tree diagram and add any relevant points that have been missed, regarding crisis-related risks. Clarify any misunderstanding of terms if necessary.

3. Summarize that while GBV exists in most societies, risks and vulnerabilities to sexual violence may increase in crisis settings as the systems and structures that protect them – including their families and communities, law enforcement (police), community norms and rules – are weakened or destroyed.

4. Share that it is important to remember that the consequences of emergencies will differ between men and women, young and elderly, and an individual’s vulnerability to abuse, exploitation and violence. It is also important to remember that sexual violence is under-reported everywhere in the world, and it will be difficult, if not impossible, to know the actual level of the problem.

In cases of displacement, women and girls have limited access to resources, including money, education, skills training, jobs, safe housing, transportation, information, decision making, social networks and influence. At the same time, women most often remain the primary caregivers for their families. This is intensified when men are in hiding or off fighting. This can increase risks of sexual and economic exploitation, trafficking, sexual violence and other types of violence.

**Additional crisis-related factors:**

- Chaos and breakdown of social norms and services, including law enforcement, social services, community norms or religious codes.
- Disruption of families and communities.
- Separation of children from their caregivers; presence of children without adults.
- Separation of persons with disabilities from their primary caregivers.
- High presence of armed actors.
- Sexual violence as a strategy of warfare.*
- Climate of human rights violations, lawlessness and impunity (free from punishment).
- Dependency on aid and resulting vulnerability, including needing to exchange sex for basic needs (sexual exploitation and abuse).
- Possible lack of safety in temporary communities and shelters, overcrowding, location in isolated areas and possible lack of adequate services and facilities.
- Camp leadership often being primarily male; women’s security issues not being considered in decision-making and planning.
- Loss of male power/role in the family and community; seeking to assert power.
- Women taken as war wives, porters or other forms of forced seizure.

*Sexual violence has been used against women in wartime to cause injury; destroy the fabric of the community; extract information; force communities to flee; forcibly impregnate; degrade and intimidate; and punish for actual or alleged actions committed by women or their family members. For example, women may be targeted in order to reach absent male relatives who may have fled or have joined armed forces. Targeting women in this way is symbolic of the fact that men are not able to protect women and that sexually assaulting specific women have brought ‘dishonour’ to an entire family or community.

TOPIC 2: CONSEQUENCES OF SEXUAL VIOLENCE FOR SURVIVORS AND THEIR COMMUNITY

2.1 What are the health consequences of sexual violence?

Discussion
25 minutes

1. Explain that serious and potentially life-threatening health problems can arise from sexual violence. Fatal outcomes include death, if the assaulter or attacker commits murder or if the survivor’s family kills the survivor after the attack in the name of protecting the family’s honour. The survivor can also kill herself (suicide), or if she becomes pregnant as a result of the incident, she could try to end her pregnancy in an unsafe way, possibly leading to death.22

2. Ask participants about other potential health problems a survivor can experience.

3. Draw leaves on the tree, and write each problem on the leaves as participants voice them.

4. Summarize that among the health problems, some of those related to the reproductive system will be explained in more detail.

Other health problems can include:

- **Acute physical**
  - Injury
  - Shock
  - Disease
  - Infection

- **Chronic physical**
  - Disability
  - Somatic complaints
  - Chronic infections
  - Chronic pain
  - Gastrointestinal
  - Eating disorders
  - Sleep disorders
  - Alcohol/drug abuse
  - Fatigue

- **Reproductive**
  - Miscarriage
  - Unwanted pregnancy
  - Unsafe abortion
  - STIs including HIV
  - Menstrual disorders
  - Pregnancy complications
  - Gynaecological disorders
  - Sexual disorders

- **Mental health**
  - Post-traumatic stress
  - Depression
  - Anxiety
  - Substance abuse
  - Self harm/suicide

Point out that more information on the social consequences of sexual violence will be covered in later sections.

Physical consequences for young children can include:

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

Sexual abuse of a child is often different from sexual abuse of an adult in some important ways, such as:

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

2.1.1 What are STIs?

Mini lecture
10 minutes

Before beginning this section, ask participants what they know about STIs. Have they heard of this term before? What types do they know of?

Explain that STIs are infections that are passed from one person to another during sex, including forced sex. Men, women and their children can all be affected. Some common STIs are gonorrhoea, chlamydia, trichomoniasis, syphilis, chancroid, herpes, hepatitis B and HIV.

If a person has any of these signs, she or he may have an STI:
- bad-smelling discharge
- itching genitals
- painful genitals
- sores or blisters on the genitals
- pain in the pelvis or pain during sex

It is also very common to have an STI and have no signs at all. Many women and men have STIs but do not know it. However, untreated STIs can lead to very serious health problems. A woman with an untreated STI can develop a tubal pregnancy (where the baby does not develop in the womb), cancer of the cervix or become infertile. An untreated STI in a pregnant woman can cause a baby to be born too early, too small, blind, sick or dead. A person who has one STI can more easily get another, including HIV.

FACILITATOR’S NOTES

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

23 Hesperian Foundation, A Book for Midwives: Care for pregnancy, birth and women’s health, updated 2010.
2.1.2 What are HIV and AIDS?

Mini lecture

20 minutes

Ask participants what they know about HIV.

Explain that HIV is a tiny germ that causes a disease called AIDS. HIV lives in the body fluids of people who are infected with HIV. This includes blood, semen, wetness in the vagina and breast milk. The virus spreads when the fluids get into the body of another person.

Ask participants if they know how HIV spreads. Answers are:

Sex with someone who has HIV, if the person does not use a condom
- Unsterile needles (reuse of needles) or tools that pierce or cut the skin, such as razor blades
- Infected blood that gets into cuts or an open wound of another person
- An infected mother passing it on to her baby, during pregnancy, childbirth or breastfeeding

In places where blood supplies have not been tested for HIV, people can also become infected from blood transfusions, which is a process where blood is given to someone who has bled heavily.

FACILITATOR’S NOTES

If participants are unfamiliar with what a condom is, explain that it is a narrow bag of thin rubber placed on a man’s penis during sexual intercourse to prevent pregnancy and protect against infection. The bag traps the man’s sperm and other fluids so that they cannot get into the woman’s vagina or womb. Woman’s condoms are also available in some settings, where a woman would place the female condom into her vagina. Show what male and female condoms look like if you have one.

Male condom

Female condom

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

24 Ibid.
2.1.2  What are HIV and AIDS? (continued)

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

AIDS is an illness that develops when a person with HIV cannot fight infections. HIV eventually makes it difficult for the person to fight infections, and when the person becomes very sick and illnesses become more difficult to treat, the person has AIDS.

Draw an image similar to the below on flip chart paper to show what is happening inside the body of a person who has AIDS.

The body has millions of cells called white blood cells that attack germs and fight infection. HIV kills the white blood cells until there are not enough cells left to attack germs. This is when the person has AIDS.

The signs of AIDS are different in each person. Often, they are the typical signs of other common illnesses such as diarrhoea or flu, but they are more severe and will last longer. Medicines and good nutrition can help people fight infections caused by HIV and allow them to live long and productive lives. There is currently no cure for HIV.

Clarify any misconceptions about HIV or AIDS that were raised by participants in the beginning of this session.

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25 Hesperian Foundation, Where there is no doctor, revised 2011.
27 Hesperian Foundation, A Book for Midwives: Care for pregnancy, birth, and women’s health, reprinted 2009.
2.1.2 What are HIV and AIDS? (continued)

**Game**

20 minutes

1. Divide participants into two groups.
2. Handout the HIV cards found at the end of this guide, a blank sheet of flip chart paper (half a page will be enough) and tape to each group.
3. Ask each group to divide their flip chart paper into two, one side for ways that HIV can be spread, and another side for ways that it cannot spread.
4. Ask participants to determine whether each act drawn on the card can spread HIV. If the act can transmit HIV, they should tape the card to the side where HIV can spread.
5. Give participants 5 minutes to discuss and develop their poster. If they feel that any cards are missing, they can write or draw the missing images to the appropriate side of the flip chart paper.
6. Have the groups present their poster, and facilitate a discussion on any misunderstanding.

**Facilitator’s Notes**

Look for:

**HIV can spread by:**
- Sex without using a condom (including sexual violence)
- Unsterile needles or tools that cut the skin
- Infected blood that gets into another person
- Infected mother, during pregnancy, childbirth or breastfeeding
- Blood transfusions where blood has not been tested

**HIV cannot spread by:**
- Touching or hugging
- Kissing
- Sharing food or dishes
- Sharing a bed
- Sharing clothing
- Sharing latrines
- Insect bites

2.1.2.1 How do we know if someone has HIV?

**Mini lecture**

5 minutes

Explain how the HIV test works. When HIV enters the body, the body starts to make something called antibodies to fight the virus. These antibodies usually show in the blood two to four weeks later. The HIV test looks for these antibodies in the blood. An HIV test is the only way to know if a person has been infected with HIV. It is not a test for AIDS.

A positive HIV test means that the person is infected with the virus and the body has made antibodies to fight HIV. Even if the person feels completely well, the person can still spread the virus to others.

A negative HIV test means that a person is not infected with HIV, or the person was recently infected, but the body has not yet made enough antibodies to fight HIV to show on the test.

The HIV test should always be done:

- With the person’s permission.
- With counselling before and after the test, where the counselor explains what to do if the result is positive, and how to remain HIV free if negative.
- With privacy and confidentiality. No one should know the results except the person and those she or he wants to know.

The HIV test can be helpful for survivors of sexual violence, since they can learn how to remain negative or how to live positively.

2.1.2.2 How can HIV be prevented?

**Mini lecture**

10 minutes

Note that to prevent the spread of HIV, men and women can:

- Get tested for HIV.
- Get other STIs treated, making sure partners do too.
- Use condoms with any sex partner whose HIV status is not known or who has HIV. This is especially the case if a person has multiple sexual partners at the same time.
- Avoid piercing or cutting the skin with needles or other tools that are dirty and have not been sterilized. This includes the tools used for piercings, acupuncture, tattoos, scarring or circumcision.
- Avoid sharing razors or a toothbrush.
- Avoid touching someone else’s blood or wound without protection.
- Get treatment.
- If pregnant, enroll in programmes to prevent transmitting the virus during pregnancy, childbirth and breastfeeding.

It is important for everyone to protect themselves from HIV by practicing safer sex, using condoms consistently and correctly, and by sterilizing (cleaning appropriately) tools and equipment and avoiding multiple sexual partners at the same time.

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29 Ibid.
Note that a handout for sterilizing equipment is available in the participant’s packet in Advanced Module 8 (preventing infection handout). This is only relevant for CHWs who will provide direct care.

2.1.2.3 What are treatment options for persons with AIDS?

**Mini lecture**
10 minutes

Explain that there is still no cure for HIV, but medications called antiretrovirals (ARVs) can help people with HIV live longer and have fewer health problems. Anti means against, and the virus that causes HIV is called a retrovirus. If used correctly, ARVs fight against and control the HIV infection. The immune system becomes stronger and the person with HIV is able to fight off infections and become healthy. HIV is not cured, however. Small amounts of the virus will always remain hidden in the body.

A blood test called a CD4 count can show how strong the immune system is by counting CD4 cells. The higher the number is, the better the body can fight infections. Depending on the setting, a CD4 test might be taken.

Antiretroviral therapy (ART) also helps prevent HIV infection for a baby during pregnancy, childbirth and breastfeeding. ART must be taken every day at the same time to keep working well. If a woman stops taking it, her HIV will grow strong enough to make her ill again. Afterwards, if she restarts taking ART, her HIV may be more difficult to treat with the same medicine. There are several possible combinations of medicine to use.

2.1.2.4 What are some of the consequences of HIV and AIDS for the individual and the family?

**Discussion**
25 minutes

1. Next, participants will discuss some of the consequences of HIV and AIDS. Divide them into two groups and ask them to think about how HIV can impact the (a) individual and (b) the family.

2. Tell participants they have 10 minutes to discuss and 3 minutes to present what these consequences can be.

3. Have the groups present their discussion, beginning with the group discussing individual consequences.

4. Once all groups have finished presenting, ask participants to see how they would feel if they just learned that they are HIV positive. What are some of the emotions that an HIV positive person may feel?

5. Sum up the discussion by saying that people react to the news that they are HIV positive in different ways and may experience some or all of the emotions at different times. When people living with HIV or AIDS are able to work through feelings of shock, anger, shame, depression and fear, they have reached an emotional stage of acceptance and can begin focusing on living in a healthy and positive way.

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Examples of consequences for each level are:

**Individual**
- **Physical:** The illness can make the person too weak to do regular activities.
- **Economic:** The person with HIV or AIDS may lose her or his job because of discrimination or illness, which can lead to or worsen poverty.
- **Social:** A person may feel isolated or isolate themselves from others, and may be the target of gossip or teasing. HIV-positive children may be teased by other children at school.
- **Spiritual:** A person with HIV or AIDS may lose faith.

**Family**
- **Social:** The entire family may become isolated from the community if the community thinks the family is shameful or a disgrace.
- **Emotional and psychological:** Heads of households may not be able to provide for family members, increasing the burden and responsibility for others. This could result in children having to drop out of school in order to work, or children becoming heads of households themselves.
- **Economic:** There may be more expenses for medical care and medicines, or to care for orphans and other children; which could worsen poverty.

**Additional social and physical consequences for women:**
- Women are often infected with HIV at a younger age than men. This is because young women and girls are less able to refuse unwanted or unsafe sex and are often married young to older men who have had more chances to be infected.
- Women often live with untreated STIs. Untreated STIs make it easier to become infected with HIV.
- Women get more blood transfusions than men because of problems during childbirth.
- Poor nutrition and weakness from childbearing often make women less able to fight disease.
- Women are blamed unfairly for the spread of AIDS, even though many men are unwilling to wear condoms or limit their number of sex partners.
- Women are usually the caretakers for family members who are sick with AIDS, even if they are sick themselves.

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

- **Shock**: She or he cannot believe that she or he is HIV-positive.
- **Denial**: She or he refuses to accept that she or he is HIV-positive.
- **Fear**: She or he is afraid of the illness; afraid of what will happen to her or him or her or his children; afraid of stigmatization, discrimination, isolation and rejection by others.
- **Loss**: Of control, independence, ability to care for her or his family, respect from family and community, confidence, and self-worth.
- **Grief**: Over loved ones who have died of AIDS, or possibly over her or his own future.
- **Shame or guilt**: For having gotten HIV, for practices that led to getting infected (such as having multiple partners or using intravenous drugs), for the effect it will have on loved ones, especially children.
- **Anger**: With herself or himself or at the people who infected her or him, with a spiritual being (God), at society for the way people living with HIV or AIDS are treated. In some cases, this anger can lead to irresponsible sexual behaviour.
- **Anxiety**: About how the illness will progress and what will happen to them.
- **Low self-esteem**: Rejection by loved ones and the community; inability to work, care for family, or participate in social events.
- **Depression**: Signs include too much or too little sleep, overeating or not eating at all, feelings of hopelessness, irritability, not participating in social events and daily activities.
- **Suicidal thoughts**: Severe depression can lead to wanting to kill oneself.

2.1.2.5 Why are HIV positive persons vulnerable in crisis settings? (additional risk factors)

Crises, such as natural disasters and conflicts, can have a serious impact on how communities function. A crisis can impact lives, infrastructure, local economy and the capacity of service providers to respond. This means that medical and psychosocial support services to people with HIV and AIDS may not be as readily available.

During a crisis, it may be more difficult for a person with HIV or AIDS to take care of her or his health and have access to healthy living. Disruptions in income and security may make it harder to find an HIV care and treatment programme, take care of medical problems early, eat nutritious food, practice safer sex with condoms, get enough rest or prevent infection by washing often.

The stigmatizing social norms and consequences for women that were discussed previously in session 3 continue to exist and impact individuals during a crisis.

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

Discuss with participants that to reduce stigma and discrimination against persons with HIV and AIDS, participants may have to face their own fears of getting HIV, or their own beliefs about who gets HIV, before they can help others stop being afraid of those with HIV and AIDS.

While a husband or the community may blame a woman if she is found to be HIV positive, preventing HIV is not always easy, especially for women.

For example, even if a woman knows to use condoms every time she has sex, her husband may not agree. Other women may be faithful to their husband, but their husbands may be seeing other women or be married to other women.

Ask if the women are to blame in these cases. Direct the discussion so that any prior beliefs that women brought HIV upon themselves are laid to rest. The issue should never be about blame.

Discussion

1. A good way to reduce stigma in the community is to make sure that all health workers and influential persons – such as religious and community leaders, teachers and others – can provide accurate, consistent information to community members. If everyone can do this, it will help prevent the fear caused by wrong ideas about HIV and AIDS. With less fear from neighbours, those with HIV and AIDS, as well as those who care for them, can become more accepted in the community. They can then help others understand every person’s real risk of getting HIV.

2. Ask participants to suggest how they, as CHWs, can be agents of change in their community in the fight against HIV. Write these on flip chart paper.

3. Repeat that a CHW’s empathy and compassion can also help others change their attitudes towards people with HIV and AIDS, condoms, sex and gender. Only through empathy, compassion, acceptance and working together as a community can HIV and AIDS be addressed and social norms about sexual violence be changed.
FACILITATOR’S NOTES

Some examples are:

Give accurate information about how HIV is spread and how it is not spread to every person they see, especially if they treat people with other STIs.

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


4. Note that the key points that have been discussed about HIV and AIDS have been summarized into a flipbook that CHWs can use in their awareness-raising sessions. Go through the flipbook with them, and demonstrate how it can be used. The text on the back of each page supports the pictures on the front of the page. Answer any questions the CHWs may have.

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

Scenario
30 minutes

The next section will have participants return to the topic of sexual violence. This exercise will help participants think through what might happen to a survivor of sexual violence, keeping in mind the discussion they just had about HIV and AIDS. How would the survivor of sexual violence feel? How would her family and community treat her?

1. Divide participants into groups of four. In each group, one person will act as (1) the survivor, (2) a family member, (3) a friend and (4) a neighbour.

2. The survivor should consider what emotions and feelings she would experience. Would this be different if the survivor were married or unmarried?

3. For roles 2-4, how would they treat the survivor when it is known that she has experienced sexual violence? Could anyone have been a witness (seen the assault), and if so, how would that make her or him feel?
2.2 What are the emotional, psychological and social consequences of sexual violence?

(continued)

4. If there are enough groups, assign a different type of survivor to each group, such as a married woman, unmarried young woman, elderly woman, adolescent girl, child, person with a disability, man or adolescent boy.

5. Let participants know they have 10 minutes to plan their skit.

6. As participants present their skits, list feelings or social consequences on flip chart paper, and discuss any that were missed.

<table>
<thead>
<tr>
<th>FACILITATOR’S NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consequences of sexual violence for the survivor can include:</td>
</tr>
<tr>
<td>Emotional and psychological consequences</td>
</tr>
<tr>
<td>• Anxiety</td>
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<tr>
<td>• Fear</td>
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<tr>
<td>• Anger</td>
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<tr>
<td>• Shame, self-hate, self-blame</td>
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<tr>
<td>• Suicidal thoughts, behaviour</td>
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<tr>
<td>• Withdrawal and hopelessness</td>
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<tr>
<td>• Mental disorders such as:</td>
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<tr>
<td>‣ Post-traumatic stress disorder (PTSD)</td>
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<tr>
<td>‣ Depression</td>
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<tr>
<td>Social consequences</td>
</tr>
<tr>
<td>• Blaming the survivor</td>
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<tr>
<td>• Loss of roles in society</td>
</tr>
<tr>
<td>• (e.g., earn income, care for children)</td>
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<tr>
<td>• Rejection from family</td>
</tr>
<tr>
<td>• Social stigma</td>
</tr>
<tr>
<td>• Social rejection and isolation</td>
</tr>
<tr>
<td>• Relationship and family problems</td>
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</tbody>
</table>


TOPIC 3: HEALTH AND OTHER BENEFITS FOR SEEKING TIMELY CARE

3.1 What are the health benefits of seeking care?

Discussion

10 minutes

Up to this point, the training has focused on the negative consequences of sexual violence, why it happens and the problems it can cause for the survivor and her or his family. However, there are ways that the survivor can be helped to reduce further harm.

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

Medicines to prevent pregnancy
• Medicines to prevent or treat STIs
• Medicines to prevent HIV
• Treatment of wounds
• Vaccinations to prevent consequences of infections such as tetanus (‘lockjaw’) and hepatitis B
• Basic support to meet emotional needs
• Links to other support services, such as protection, psychosocial support, legal assistance and higher level medical care

If medicines are available, briefly show participants what they look like.
### MODULE 2: What is sexual violence and what are its consequences?

#### 3.2 What is timely care?

**Mini lecture**

5 minutes

Explain to participants that certain elements of this medical care are time sensitive. Medicines to prevent HIV must be given within three days, or 72 hours. Medicine to prevent pregnancy—EC—must be given within five days, or 120 hours.

Medicines to prevent pregnancy and HIV are most effective when they are given immediately after the incident. The success of these medicines goes down with time. **Timely treatment with medicine is therefore very important** to ensure that survivors receive all health benefits to prevent further trauma, illness and death.

Discuss barriers to timely care in their settings and brainstorm about ways to address them.

#### 3.3 What other services can survivors access?

**Mini lecture**

10 minutes

Note that in general, services that survivors can benefit from include:

- **Psychosocial support** to address survivors’ immediate emotional needs. Psychosocial services offer ongoing psychological assistance through social workers and community services workers. Some survivors may require psychosocial support to deal with their families’ response to sexual violence.

- **Specialized mental health services** for survivors to address their long-term emotional needs, or more specialized care for conditions such as depression or post-traumatic stress disorder.

- **Protection**, such as through safe houses and safe spaces to protect survivors from additional risk. Services to protect children and adults can also be available in the community. Sometimes, community members can come together to develop their own protection strategies and protective circles. These can be in the form of community support groups such as women’s groups, peer groups, drop-in centres or other traditional resources where survivors can feel welcome and protected.

- **Social support services**, such as livelihood support and training for survivors to become less dependent in an abusive relationship and can earn an income. Educational programmes can also teach adults to read and write.

- **Legal help**, to seek justice if possible. Legal/justice services often provide legal counselling, representation and other court support to survivors of sexual violence; and monitoring of court cases and judicial processes where they exist.

Such services are very important for survivors to restore their dignity and rebuild their lives.

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SESSION 2.3

Health education to facilitate health-seeking behaviour

<table>
<thead>
<tr>
<th>Session Time</th>
<th>1 hour 15 minutes</th>
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</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Identify key health education messages for CHWs to convey to individuals and communities about sexual violence</td>
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<tr>
<td></td>
<td>• Gain practice conveying health education messages in health consultations</td>
</tr>
<tr>
<td>Methods</td>
<td>• Mini lecture</td>
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<td></td>
<td>• Role play</td>
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<tr>
<td>Preparation</td>
<td>• Prepare lecture</td>
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<tr>
<td>Training aids, materials and HOs</td>
<td>• Flip chart, markers and pens</td>
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<tr>
<td></td>
<td>• Sexual violence flipbook (participant’s packet)</td>
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<tr>
<td>Evaluation and assessment</td>
<td>• None</td>
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</table>
A flipbook is included in the participants’ packet to help CHWs conduct health education around sexual violence in their daily work. While an activity is devoted to practicing with this tool, you may find it useful as you go through the messages below.

### TOPIC 1: KEY MESSAGES AROUND SEXUAL VIOLENCE

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

**Mini lecture**

45 minutes

Discuss with CHWs that as they see clients in their day-to-day work, they have the opportunity to convey messages about sexual violence as part of health education. Messages include:

- What is sexual violence
- Who can experience sexual violence
- Why does sexual violence happen
- What should survivors do after experiencing sexual violence
- What should others do if they know someone has experienced sexual violence
- What are the benefits of survivors seeking health care immediately (preventing pregnancy, preventing STI/HIV; receiving basic emotional support)
- Where can survivors go for services
- What will survivors of sexual violence expect if they seek health care
- Know that health services are free, private, voluntary and safe, and available 24 hours a day, 7 days a week.

Go through each point and the messages that CHWs can share with community members. These messages have been simplified so that they can be understood by everyone in the community.

What is sexual violence?

- Sexual violence is any sexual act (or 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 can experience sexual violence?

- Anyone can experience sexual violence, including women, men, children and persons with disabilities. Sexual violence can happen to a person at any age, even among married couples.

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Why does sexual violence happen?

- Sexual violence is about violence. It can worsen in conflict situations due to the breakdown of law and order and the community’s norms and codes. Women and girls are also more vulnerable since they have access to fewer resources.
- Nobody deserves to be sexually assaulted no matter how she or he dresses or acts. The way someone dresses or behaves is never a reason for sexual violence.
- Nothing a woman does gives a man the right to hurt her, even if he thinks she deserves it even if she herself thinks she deserves it.
- Many incidents of sexual violence are committed by someone a woman or child knows.
- Anyone can be a target of sexual violence, and it is never the person’s fault.

What should survivors do after experiencing sexual violence?

- See a CHW or go to a health centre immediately for care, preferably within three full days of the assault.
- Even if more than five days have passed since the assault, the health worker can still help survivors with some of the health care needs, care for their feelings and link them to other support services if they would like.

What should others do if they know someone who has experienced sexual violence?

- Support the survivor rather than stigmatize her or him.
- Provide her or him with information on seeking support from a CHW or the health facility for care immediately, preferably within three full days of the assault.
- Do not tell people about the sexual violence without the survivor’s approval. Respect the survivor’s privacy.

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

- Seeking health care as soon as possible can help survivors prevent pregnancy and infections, and receive counselling. Depending on when survivors seek care, the health care worker can help them receive:
  - Medicines to prevent pregnancy
  - Medicines to prevent or treat infections
  - Medicines to prevent HIV
  - Care for wounds
  - Vaccinations to prevent illnesses such as tetanus (lockjaw) and hepatitis B.
  - Basic support to meet emotional needs
  - Link them to additional emotional and social support, protection and legal assistance, if they wish
1.1 What are the key messages that the community should know about sexual violence and the importance of seeking care?

(continued)

- The earlier survivors come for care, the more likely they can prevent HIV (within three full days of the assault) and pregnancy (within five full days of the assault).
- Services are private, free, voluntary and safe. The health care worker will treat survivors with dignity and respect.

Where can survivors seek health care?

- From a CHW or health facility

What will survivors expect if they seek health care?

- The health worker will bring survivors to a private place to talk with and comfort them.
- The health worker will ask for their permission to treat them.
- The health worker will treat their wounds and talk to them about how to take care of themselves.
- Depending on when they seek care, the health worker will give them medicines to prevent pregnancy and infections including HIV, and tell them how to take the medicines.
- If there is anything the health worker cannot treat or care she or he cannot provide, the health worker will ask if survivors would like a referral to a health facility.
- Before the survivors leave, the health worker can help them plan to get emotional support, make sure they have a safe place to stay, and offer other medical care or social support that they may like, including speaking with their families.
- Remember, services from the health worker are private, free and safe.

Role play

39 minutes

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

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

3. Have one person who is especially good and willing demonstrate part of the exercise to the rest of the group. Compliment her or his skills, and provide suggestions that would also be helpful for others.

4. Close this exercise by saying that any messages must be linked to services that are available, so that the community’s expectations can be met, and they will trust what CHWs say. If services are changed or improved, programme staff will let participants know. If the programme develops additional materials (such as posters, brochures, etc.), the resources will be shared with CHWs.

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Health education for persons with disabilities:

Depending on their impairment, persons with disabilities may miss out on health education messages, especially if they are not likely to seek health services.

For example, blind persons may be unable to see any written information. Deaf persons may miss information that is only spoken. Often, persons with intellectual impairments are not directly targeted with information about sexual violence. It is important to talk about sexual violence with women and girls who have intellectual impairments to help them understand they have a right to be safe from abuse. Make sure they know they can talk to someone they trust if they are being touched or abused, and that they will be believed and be safe.

MODULE 3

Principles of working with survivors of sexual violence

Participant handouts

Handout 1: Principles of working with survivors poster

Handout 2: Sample informed consent or assent scripts for referral
Participant handouts

**Handout 1:** Principles of working with survivors poster

**Handout 2:** Sample informed consent or assent scripts for referral
### SESSION 3.1

#### Principles of working with survivors of sexual violence

<table>
<thead>
<tr>
<th>Session Time</th>
<th>2 hours</th>
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<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to understand:</td>
</tr>
<tr>
<td></td>
<td>• Learn key principles of working with sexual violence survivors</td>
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<td></td>
<td>• Learn how to interact and communicate appropriately with survivors</td>
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<td></td>
<td>• Understand informed consent</td>
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<td>• Understand how to work with an interpreter (optional; CHWs 2 and 3 only)</td>
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<tr>
<td><strong>Methods</strong></td>
<td>• Mini lecture</td>
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<td></td>
<td>• Scenario</td>
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</tr>
<tr>
<td></td>
<td>• Poster on key principles (HO)</td>
</tr>
<tr>
<td><strong>Evaluation and assessment</strong></td>
<td>• None</td>
</tr>
</tbody>
</table>
EXPLAIN TO PARTICIPANTS THAT THERE ARE GUIDING PRINCIPLES TO WORKING WITH SURVIVORS OF SEXUAL VIOLENCE. THESE ARE:

• Ensuring the survivor’s physical safety
• Guaranteeing the survivor’s ‘confidentiality’
• Respecting the wishes, the rights and the dignity of the survivor, and if a child, considering what is best for the child
• Treating survivors equally (non-discrimination)

Ensuring the survivor’s physical safety means that if survivors come for care, CHWs should always be aware of the security risks they may be forced to after sexual violence. This means that any conversations that CHWs have with the survivor should be in a private and safe setting, and that the safety of the survivor should be considered. Sharing information about a case without survivors’ approval can put her safety at risk.

Guaranteeing confidentiality means that CHWs do not share the survivor’s story or documents with others. Confidentiality is not about secrecy, but privacy. It is also about restoring control to a survivor so that she or he can make decisions about what she or he needs to do and is important for her or his recovery. If CHWs need to share information with other service providers to organize a referral for other services, they can only do so if the survivor understands what this means and has given her or his approval in advance. This process of giving approval after understanding what the information may be used for is called informed consent (more to follow in section 3). Violating confidentiality can create safety risks for the survivor and her or his family and can cause the survivor to face stigma and discrimination from the community. It can also have negative consequences for the safety and security of service providers, including CHWs. Ensuring confidentiality means that when CHWs go home, they do not share the stories of survivors and what services were provided with anyone, even their spouses or other family members.

Respecting the wishes, rights and dignity of the survivor means that every action CHWs take should be guided by the wishes, needs and capacities of the survivor. CHWs should respect the strength and resilience of the survivor to cope with what happened to her or him, and let her or him make the choices for what support or care she or he would like. Survivors have a right to high quality care to help them heal physically and psychologically, regardless of their ability to pay. CHWs should be good listeners and not make judgments of the survivor. If the survivor is a child, what is in the best interests of the child should be considered (see special considerations below).
1.1 What are the key principles to working with survivors of sexual violence? (continued)

**Treating survivors equally** means that CHWs should treat every survivor equally, and with respect and dignity, regardless of whether the survivor is female or male, where she or he comes from, the circumstances of the incident, the number of times she or he comes for services or the age of the survivor. CHWs should not make assumptions about the survivors’ behaviour or ever blame the survivor. CHWs should be aware of their own prejudices and opinions about sexual violence as examined in Module 2 and not let them influence the way they treat survivors.

Mention that in the participants’ packets there is a poster that lists these guiding principles. They should pin this to a wall or in their notebooks so that they see this every day.

**Best interests of the child** means that the child’s physical and emotional safety are considered. CHWs should assess the positive and negative consequences of any actions with the child and her or his caregivers (as appropriate).

The least harmful course of action is always preferred. All actions should ensure the child’s safety and well-being. Any actions involving a child should therefore:

- Protect the child from potential or further emotional, psychological and/or physical harm
- Reflect the child’s wants and needs
- Empower children and families
- Examine and balance benefits and potentially harmful consequences
- Promote recovery and healing

## TOPIC 2: INTERACTING WITH SURVIVORS

### 2.1 How should survivors be treated?

**Mini lecture**
5 minutes

Explain that when interacting with survivors, CHWs should do so with compassion, competence and confidentiality.

**Competence** means having the required knowledge, skills and qualifications to do the job well and help survivors begin to heal. This is important since CHWs can do more harm for survivors if they are not adequately trained.

**Confidentiality**, again, means that whatever care CHWs provide to a survivor of sexual violence must **never** be discussed with others without the survivor’s approval.

### 2.2 How should CHWs communicate with survivors?

**Mini lecture**
15 minutes

Note several tips that can be helpful for CHWs to interact and communicate with survivors in a survivor-centred manner that will help build trust in the relationship.

It is important to **treat the survivor with dignity**. CHWs must show that they believe the survivor, that they do not question the story or blame her or him, and that they respect her or his privacy.

CHWs should also **be caring and supportive** of the survivor. They should provide emotional support and show sensitivity, understanding and willingness to listen to her or his concerns.

Some helpful statements when interacting with survivors are:

- “I’m glad you have come to me.”
- “I believe you.”
- “I’m sorry this happened to you.”
- “You are safe here.” (If this is true.)
- “What would it take for you to feel safe here?”
- “It’s okay to feel...”
- “You are not to blame.”
- “It’s not your fault.”
- “You are not responsible for what happened.”
- “What you are feeling is very normal for someone who has been through what you have.”
- “You are very brave to talk with me, and I will try to find help.”

---


2.3 What are good ways to communicate with a survivor?

**Mini lecture**
10 minutes

It is important to communicate with a survivor without re-traumatizing her or him (hurting her or him again) and in a way that begins to help her or him heal. If a survivor discusses her or his experience, good listening techniques are:

- Speaking directly to the survivor and not to the parent, caregiver or an interpreter, especially if the survivor is a child or a person with a disability who has agreed to have a trusted person be with her or him.
- Expressing interest and concern with one’s body by facing and looking at the survivor, as well as one’s words.
- Do not interrupt or rush the person when she or he speaks. Allow time to communicate, especially if she or he has an intellectual impairment. Respect silence by waiting with attention and patience, or use supportive statements, such as, “I know this is difficult for you,” or “I am here to listen.”
- Acknowledge her or his emotions with statements including, “I can see you are feeling (upset, sad, scared...).” Never discount the survivor’s feelings by using phrases likes, “It is not that bad,” or “Do not let it bother you.”
- Support any of her or his feelings with statements like, “It is normal to feel (upset, sad, scared, anxious...)” or “People who experience sexual assault often feel...”
- Do not ask ‘why’ questions. They are often judgmental.
- Do not offer your opinions or advice. Give the survivor the information she or he needs to make her or his own decision. More information will be covered in Module 4.

2.4 What are bad ways to communicate with a survivor?

**Mini lecture**
10 minutes

Share that there are bad ways to communicate with a survivor. These include:

- Lack of privacy or inadequate seating, such as a noisy room or interruptions by other people.
- Speaking directly to a parent, caregiver or an interpreter without consent from the survivor.
- Asking leading questions such as, “Are you worried about being pregnant?” Such questions may cause additional anxiety and do not provide space for the survivor to communicate in her or his own words.
- Asking ‘why’ questions, as they often put the survivor on the defensive and might sound like one is blaming her or him. For example, “Why didn’t you tell anyone?” or “Why did you go there?”
- Guessing what the person is saying or jumping to one’s own conclusions after a few sentences.
- Not letting the person finish his/her sentence.
- Using inappropriate body language or not being aware of one’s body language. This includes the tone of voice, looking away from the survivor, crossing one’s arms, ‘hanging’ in one’s chair, being distracted and so on.

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2.4 What are bad ways to communicate with a survivor? (continued)

- Making assumptions about the person. These include views such as, “It was her fault,” “She must be a prostitute, what do you expect?” or “She shouldn’t have gone there.”
- Talking about oneself or one’s views instead of focusing on what the survivor is saying. For example, “This once happened to me as well,” or, “I feel very angry when you tell me this.”
- Touching the person without her or his permission.

**Role play**

15 minutes

1. Divide participants into pairs and have one person play the role of the CHW and another the survivor.

2. Have the survivor come to the CHW for help, and the CHW try to listen to what she or he has to say. Note that this activity is to practise how to interact and communicate with survivors, so CHWs do not need to worry about providing care or referrals just yet.

3. Walk around the room to observe the interactions. Ask participants to switch roles if time permits.

4. When bringing the group back together, ask participants what made them feel comfortable and respected.

2.5 How can interpreters be engaged if necessary?

**Mini lecture**

10 minutes

In most cases, no interpreter will be necessary since CHWs will be caring for survivors from their own communities. However, in the event that they are needed for different dialects, sign language or other communication needs, they may be available from the health centre or another referral organization. It is important that interpreters are not just anybody, but those trained in working with survivors. Programme staff will be identifying interpreters, but they should:

- Be bound to maintain confidentiality (by signing a statement, for example).
- Speak the same language as the survivor, and are of the same ethnic background (or of a similar ethnicity) as the survivor.
- Be the same sex as the survivor.

If CHWs are working with an interpreter, they should ask her or him to:

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

When working with an interpreter the CHW should:

- Introduce herself or himself and the interpreter to the survivor.
- Speak directly to the survivor, not the interpreter.
- Keep eye contact with the survivor, not the interpreter.

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2.5 How can interpreters be engaged if necessary? (continued)

- Review the interpreter’s notes with the interpreter after the interaction.
- Document that an interpreter was used on the intake form (to be discussed later).

As with any service, the survivor’s consent must be sought to use an interpreter. In cases where no interpreter other than a family member is available, CHWs should still ask for the survivor’s consent and speak directly to the survivor.

**Persons with disabilities:**

As with anyone, always communicate need to be through an interpreter, including family members. As with anyone, always communicate directly with survivors with disabilities. In some cases, this may need to be through an interpreter, including family members.

In such cases, CHWs should still ask whether the survivor wishes to be spoken to alone and/or with someone they trust. Ensure interpreters and assistants also understand the importance of maintaining confidentiality.

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**Scenario**

15 minutes

1. Read the scenarios below, and after each one, ask participants what they think was the error made in the CHW’s response to the survivor.

- **Scenario:** It is the end of the day and you would like to go home. A woman comes to you for help, but hesitates in telling the details of what happened to her, so you insist she does since you have very little time.
  - **Do not** pressure: Never insist on the survivor telling the story or revealing details about what happened. A survivor should not be made to repeat her story many times; if you are not in a position to provide care, do not probe for her story, but instead, suggest options for care that she can consider. More details on what this entails will be addressed in Module 4.

- **Scenario:** You have a lot of work to do, including filling out records from your other health duties. A woman comes to you but takes her time to talk. You try to elicit information from her with your facial expressions, and after a while you get impatient. To give her time to talk, you decide to go back to your other work with the survivor in the room.
  - **Do not** make facial expressions or use body language that will lead the survivor to lose trust and faith in you. Give the survivor your undivided attention.

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2.5 How can interpreters be engaged if necessary? (continued)

- **Scenario:** A survivor shares her story, but you brush her off since it was her husband that made her have sex.
  - **Do not** play down or minimize this violence: Not taking a survivor’s story seriously will cause him or her to lose trust in you and can serve as a barrier for her or him to seek help. You could re-victimize the survivor if you do not take her or him seriously.

- **Scenario:** An adolescent girl in a short skirt comes to you for help. You say that it was her fault for dressing this way.
  - **Do not** blame the survivor: Sexual violence is never the survivor’s fault. Tell this to the survivor.

- **Scenario:** A woman who is deaf has come with her sister who can speak. You start talking directly to the sister without checking first with the survivor. It turns out that the survivor can communicate by sign language and her sister knows it well.
  - **Do not** skip the step of checking with the survivor if it is okay for her sister to be present, simply because you do not understand sign language. You must obtain consent from the survivor for anyone – including family – to be present, and if she or he prefers to meet with you alone, see if a trained sign interpreter is available. Make sure you speak directly to the survivor, even if a parent, caregiver or interpreter is present.

2. Foster discussion after each statement is read.

3. Summarize that survivor-centred skills are important because they can provide survivors with the opportunity to talk about their concerns without pressure, and cope with fears. Such skills should be applied by everyone who is in contact with survivors regardless of her or his role in the community.

**FACILITATOR’S NOTES**

Tips on how CHWs can convey information about available services and referral options for the survivor will be covered in Module 4. Make sure to cover this module for CHWs to learn about what (and not just how) to communicate to the survivor.
TOPIC 3: UNDERSTANDING INFORMED CONSENT

3.1 What is informed consent?

Mini lecture

20 minutes

Explain that informed consent means giving the survivor all possible information and options available to her or him so she or he can make choices. It also means informing the survivor that she or he may need to share her or his information with others who can provide services, but only with her or his permission.

Persons with disabilities have the same right to all possible information and options, so they can make their own decisions like everyone else. Most persons with disabilities can understand information and make their own decisions, sometimes through a sign language interpreter. Persons with intellectual impairments may need information conveyed in short, simple messages with time to think and ask questions.

CHWs should ask persons with intellectual impairments to tell them in their own words what they have learned and what they understand are their options. In some cases, persons with disabilities may need additional support from someone they trust to understand the information and make decisions. If a person with disabilities indeed needs someone else to speak for them, CHWs must document this clearly, and continue to include the survivor in all discussions about her or him, respecting her or his safety, confidentiality and dignity at all times.

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

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

SPECIAL
CONSIDERATIONS

Informed consent for child survivors

Informed consent is the voluntary agreement of an individual who has the legal capacity to give consent. To provide informed consent, the individual must have the capacity and maturity to know about and understand the services being offered and be legally able to give consent. Parents are typically responsible for giving consent for their child to receive services until the child reaches 18 years of age. In some settings, older adolescents are legally able to provide consent, especially if they are married or are not under their caregiver’s care.

Informed assent is the expressed willingness to participate in services. For younger children who are by definition too young to give informed consent but old enough to understand and agree to receiving services, the child’s ‘informed assent’ is sought. Informed assent is the expressed willingness of the child to participate in services.


3.1 What is informed consent?
(continued)

There is a difference between informing and advising. Advising means telling someone what they think she or he should do and how she or he should do it. It also means giving personal opinion. Giving advice is not recommended because it is not possible to know whether the advice given is right for that person. Survivors should be helped to let them make their own decisions about their own lives. Telling a survivor what to do does not help a survivor understand and follow her or his own choices. A survivor might feel she or he is not being listened to if being told what to do.

Giving information means giving someone facts so she or he can make an informed decision about what to do. Informing is helpful because it empowers the survivor to think about this information and to have control of her or his choices. It also shows that we respect the survivor’s opinion and judgement. The information should be adapted to the age and capacity of the survivor. More guidance on informed consent will be covered as each skill is introduced.
SESSION 3.2

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

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<thead>
<tr>
<th>Session Time</th>
<th>1 hour 30 min (1 hour without optional activity)</th>
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<tbody>
<tr>
<td>Objectives</td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Understand mandatory reporting requirements</td>
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<tr>
<td></td>
<td>• Address legal and policy barriers that may hinder survivors’ access to services</td>
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<tr>
<td></td>
<td>• Apply the social norms perspective to address societal barriers preventing survivors from accessing care</td>
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<tr>
<td>Methods</td>
<td>• Discussion</td>
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<tr>
<td>Preparation</td>
<td>• Prepare lecture</td>
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<td></td>
<td>• Know the legal, policy and social barriers for survivors to access health care, especially any or believed need for mandatory reporting, a marriage certificate, husband’s permission, a police report</td>
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<td></td>
<td>• Know the programme’s protocols to address or overcome the barriers/challenges</td>
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<tr>
<td>Training aids, materials and HOs</td>
<td>• Flip chart and markers</td>
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<tr>
<td>Evaluation and assessment</td>
<td>• None</td>
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</table>
1.1 What is mandatory reporting and when does it apply? (Optional)

**Mini lecture**

30 minutes

Explain that in many countries, there are laws and policies that require health care providers to report certain (or all) types of rape cases or cases that involve a certain type of survivor or perpetrator. These types of reporting requirements can create a challenge for health care workers. This is because the requirements conflict with principles such as respect for consent, confidentiality and the need to protect the survivor.

To address these challenges, CHWs can:

- Inform survivors about their duty to report certain incidents in line with laws or policies. This must be done as part of the informed consent process.
- Explain the reporting mechanism to the survivor and what she or he can expect after the report is made.

At this time, clarify any confusion regarding reporting policies in the particular setting. If no such policy officially exists, or if there is mixed understanding of what should be reported, make sure to clarify the procedures that CHWs should follow.

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

Continue explaining that mandatory reporting requirements for child survivors can raise even more ethical and safety concerns. Children are more vulnerable and less able to act on their own. There may be instances where reporting the assault is not best for the child. For example, if it might put the child’s safety in danger at home or within her or his community, especially if the assaulter is a family or community member. Other times, services for children may not be available, creating additional risks for the child (separation from family, and so on). The local authorities may themselves be abusive, or there is no system to properly manage the report.

Where children are involved, the best interests of the child should be considered. The appropriate actions will be different depending on the situation, but in general, CHWs should take these three steps:

1. Think through questions such as:
   - Will reporting increase risk of harm for the child?
   - What are the positive and negative impacts of reporting?
   - What are the legal consequences of not reporting?

2. Consult with a supervisor who will decide and develop an action plan.

3. Work with the supervisor who will document the reasons to report or not report the case.

TOPIC 2: BARRIERS HINDERING ACCESS TO CARE

Before this session is introduced, make sure that you and the programme have mapped policy or societal barriers that may hinder survivors’ access to services, particularly health care. Any protocols developed should be conveyed at this time. If there are no policy-related barriers, this session can be skipped.
2.1 What are the legal or policy barriers that may hinder survivors’ access to services? (Optional)

Discussion

30 minutes

1. Share that in some instances, survivors are not permitted to access health care unless she presents a marriage certificate, has her husband’s permission or files a police report that has ‘verified’ the rape. However, every survivor has the right to seek health care.

2. Discuss with participants any legal or policy barriers that exist in the setting for survivors to access timely care. Share any programme-related protocols that have been established to overcome these challenges, including policies around non-discrimination and not asking whether or not the survivor is married.

3. Share other scenarios that CHWs may encounter that can be impacted by laws and policies. A survivor may find herself pregnant since she did not come for care in time to receive EC to prevent pregnancy. What are the survivor’s options in this context? Inform participants that the first priority for any challenge is to think what is best for the survivor, focusing on her safety and health. In this case, they should:
   • Discuss options with the survivor, including where she can access safe abortion care where legal.
   • Explore links and referrals to organizations that might be able to help, such as psychosocial and social support services.
   • Talk further with a supervisor for additional guidance.

4. Foster discussion among participants for other challenging scenarios and possible ways to address them. If any are new, make sure you raise them with programme staff so that protocols can be developed accordingly.

2.2 How can social norms be applied to address any societal barriers for survivors to access services?

Role play

30 minutes

1. Recap what social norms are by asking participants to explain what the term means.

2. Ask participants to remind the group about existing societal norms, attitudes and barriers in the community that can prevent survivors from easily accessing services. Ask participants to think of existing norms that help protect against sexual violence.

3. Divide participants into three groups and have them choose three negative social norms they would like to influence. Have one group represent CHWs, another survivors and the third the community. Ask the CHW group to think of what they can do in their capacity as CHWs to change the negative norms and attitudes. See if the community group thinks the action is a practical and feasible idea. Ask the survivor group if they feel the action is strong enough for them to seek services.

4. Facilitate a discussion on active steps CHWs can take in their daily work to be role models in the community to build trust for themselves as competent and reliable sources of care and as promoters of social norm change.

IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010.
MODULE 4

Recognizing survivors and facilitating referrals for sexual violence

Participant handouts

Handout 1: Offering basic life support
Handout 2: Providing basic first aid for burns
Handout 3: Providing basic first aid for injuries to bones, muscles and joints
Handout 4: Addressing symptoms of shock
Handout 5: Controlling heavy bleeding
Handout 6: Danger signs poster
Handout 7: Providing basic first aid for head, neck or back injury
Handout 8: Providing psychological first aid
Participant handouts

**Handout 1:** Offering basic life support
**Handout 2:** Providing basic first aid for burns
**Handout 3:** Providing basic first aid for injuries to bones, muscles and joints
**Handout 4:** Addressing symptoms of shock
**Handout 5:** Controlling heavy bleeding
**Handout 6:** Danger signs poster
**Handout 7:** Providing basic first aid for head, neck or back injury
**Handout 8:** Providing psychological first aid
## SESSION 4.1

### Recognizing survivors of sexual violence

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<td>Objectives</td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Recognize persons that may need immediate help (passive identification)</td>
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<td></td>
<td>• Create an enabling environment for someone who may have experienced sexual violence</td>
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<tr>
<td>Methods</td>
<td>• Mini lecture</td>
</tr>
<tr>
<td>Preparation</td>
<td>• Prepare lecture</td>
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<td>• Know possible private, quiet locations in the community where CHWs can interact with survivors</td>
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<tr>
<td>Training aids, materials and HOs</td>
<td>• Flip chart and markers</td>
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<td></td>
<td>• Providing psychological first aid (HO)</td>
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<tr>
<td>Evaluation and assessment</td>
<td>• None</td>
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</table>
### TOPIC 1: IDENTIFYING SURVIVORS OF SEXUAL VIOLENCE

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

**Mini lecture**

**51**  15 minutes

Explain that as CHWs, they may come into contact with persons whom they suspect may have experienced sexual violence. Such persons may have torn clothes, physical wounds or show emotional or behavioural symptoms of having suffered severe trauma such as anxiety and fear as discussed in Module 2. CHWs are not expected to routinely screen for sexual violence in their daily work; however, they can still passively identify survivors, especially if the latter tell the CHW that they are in pain or the CHW can see that something is wrong.

Anyone who shows signs of or complains about the problems noted below should be referred immediately to a health care facility.

- Swelling and hardness of the abdominal (belly) area
- Pain in the abdominal (belly) area
- Severe pain anywhere else in the body (back, chest, arms, legs or head)
- Vomiting blood
- Bleeding from the pelvic area (anus/genital area)
- Heavy bleeding from other parts of the body
- Possible object lodged inside vagina/anus
- Altered mental state or confusion
- Pale, blue or gray skin
- Loss of consciousness
- In a small child, fast breathing or difficulty breathing

These conditions, especially if the person is bleeding heavily or becomes unconscious, are dangerous and will require immediate medical attention.

Other possible signs of a person in shock or immediate distress include:

- Skin feeling cold, moist and clammy
  - Fast breathing with small shallow breaths
  - Feeling anxious, panicky or restless, feeling faint or dizzy
  - Thirst or sick feeling and vomiting

The above conditions, especially if the survivor becomes unconscious, are dangerous and will require immediate medical attention. All CHWs should refer people presenting with danger signs immediately to a higher level health facility. More information will be covered in Module 5.

CHWs should be careful not to cause fear or further upset the person. However, if a person is upset, the CHWs can help her or him receive appropriate services.

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1.2 How can CHWs create an enabling environment for someone who may have experienced sexual violence?

Mini lecture
10 minutes

If CHWs suspect that an upset person has experienced trauma, including sexual violence, they should take the survivor to a private, quiet and safe place and ask if she or he needs any help. CHWs should:

1. **Stay close.** A person who has experienced sexual violence may lose her or his basic sense of security and trust in other people. CHWs can help rebuild trust and security by staying close but avoiding touching, and staying calm while the person is upset.

2. **Listen closely:** Following the key principles introduced in Module 3, CHWs can practice good listening and communications skills. If the survivor does not want to talk, she or he does not have to. Simply being a quiet, respectful person by her or his side can be helpful. If the CHWs will be referring for care (CHW 1), they should reduce their questions to a minimum to prevent the survivor from having to share her or his story over and over.

3. **Accept feelings.** CHWs should keep an open mind about what is being said and accept what the survivor is saying about events. They should respect the survivor’s feelings and not correct what the survivor says.

4. **Give practical help.** How to make referrals to available services will be covered in the next section.

5. **Provide help with taking to family if needed.** Some survivors may be afraid to discuss their situation with close family members. If they want to disclose and need help in doing so, offer to help them do so.

As CHWs, **it is NOT their responsibility, nor any health provider’s responsibility, to determine whether or not a survivor has been ‘raped’**. That is a legal determination. If the survivor discloses that she or he has been a victim of sexual violence, CHWs should treat her or him with the same guiding principles, and show compassion, confidentiality and competence.

An HO on providing psychological first aid is available in the participants’ packets.

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### SESSION 4.2

**Referring survivors for health care and other services**

<table>
<thead>
<tr>
<th><strong>Session Time</strong></th>
<th>2 hours 40 minutes (including 10-minute optional activity)</th>
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<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to:</td>
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<tr>
<td></td>
<td>• Learn what role CHWs can play in making confidential referrals</td>
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<td></td>
<td>• Learn when and how to make confidential referrals</td>
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<td></td>
<td>• Know what to share about health and support services for which referrals are available</td>
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<td></td>
<td>• Know what to do when referrals are not available</td>
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<tr>
<td><strong>Methods</strong></td>
<td>• Mini lecture</td>
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<tr>
<td></td>
<td>• Discussion</td>
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<td></td>
<td>• Scenario</td>
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<td>• Role play</td>
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<tr>
<td><strong>Preparation</strong></td>
<td>• Prepare lecture</td>
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<td></td>
<td>• Map who is doing what where to respond to sexual violence, including referral mechanisms</td>
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<td></td>
<td>• Identify private and safe locations for client interactions</td>
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<tr>
<td></td>
<td>• Know how much basic first aid participants have learned to stabilize persons in life-threatening conditions for referrals</td>
</tr>
<tr>
<td><strong>Training aids, materials and HOs</strong></td>
<td>• Flip chart and markers</td>
</tr>
<tr>
<td></td>
<td>• Addressing symptoms of shock (optional)</td>
</tr>
<tr>
<td></td>
<td>• Controlling excessive bleeding (optional)</td>
</tr>
<tr>
<td></td>
<td>• Providing basic first aid for burns (optional)</td>
</tr>
<tr>
<td></td>
<td>• Providing basic first aid to survivors with a head, neck or back injury (optional)</td>
</tr>
<tr>
<td></td>
<td>• Providing basic first aid to survivors with injuries to bones, muscles or joints (optional)</td>
</tr>
<tr>
<td></td>
<td>• Offering basic life support (optional)</td>
</tr>
<tr>
<td><strong>Evaluation and assessment</strong></td>
<td>• Role play to demonstrate learned skills to identify and refer survivors</td>
</tr>
</tbody>
</table>
### TOPIC 1: REFERRING SURVIVORS FOR CARE

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

*Mini lecture* 53

10 minutes

Remind participants that CHWs play a very important role in enabling survivors of sexual violence to receive life-saving health care and other support services. Even if as in the case of CHWs 1, they are only responsible for health education, they still serve as bridges for survivors.

Review again the basic expectations for CHWs in each category.

- **CHW 1s** are primarily responsible for health education about the importance of seeking care and where survivors can receive services, and linking any survivor they identify to higher level CHWs and health services. They are not expected to provide any direct health care.

- In addition to activities carried out by CHW 1s, **CHW 2s** can offer basic health care to survivors of sexual violence. While more details of their exact scope will be revisited in Module 5, CHW 2s will be referring survivors to the health facility for wound care that they cannot manage, HIV testing and tetanus or hepatitis B vaccines. They will also refer for psychosocial care, mental health care, protection, social support and legal justice assistance, among other available support services.

- In addition to activities carried out by CHWs 1 and 2, **CHW 3s** will be involved in providing additional health care, especially if they are in settings where referrals to higher level health services are not possible. However, they will also refer for other support services as noted under CHW 2.

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

*Discussion*

30 minutes

1. Present the completed table on the next page on flip chart paper or another medium (HOs, for example).

2. Go through each row to discuss who is responsible for the activity, what specific services the organization or facility provides and where it is located. Note whether or not the referral services are available 24 hours a day, seven days a week.

3. Discuss the quality of these services since rumours, true or not, and bad experiences can easily damage the reputation of these services and raise doubt among survivors to the benefits of seeking care.

4. Discuss how survivors would access each service. Are they too far to walk to? If the programme has plans to provide for safe transportation, mention this to participants.

5. Are there referrals that CHWs will not be facilitating? If so, mention these, and how survivors can still access the services (through case workers if they exist, for example).

6. If any traditional resources are mentioned, make a note of these and inform programme staff after the training to follow up and explore whether the resource can serve as a possible site for referral, if this has not already been done.

---

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

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

<table>
<thead>
<tr>
<th>Linkages to services</th>
<th>Organizations responsible and what they provide</th>
<th>Where is this referral located?</th>
<th>When are they open? (24/7)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral to CHWs 2 and 3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to a mid/low level facility that can treat shock, open wounds, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to a mid- or high-level facility that has surgical capacity for abdominal or pelvic problems, broken bones, etc.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for HIV prevention services (HIV testing, antenatal care, and prevention of mother-to-child transmission of HIV)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for HIV treatment services (ART)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for abortion services where legal</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for psychosocial support</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for specialized mental health services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for shelter and protection, including community protection for survivors</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral to police</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for legal assistance</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral for social support (rehabilitation, reintegration, income generation, education, support groups, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1.3 How should CHWs refer survivors of sexual violence?

Discussion

15 minutes

1. If survivors present with any of the danger signs, inform CHWs that they should refer them to a higher level health facility immediately. If a survivor is bleeding heavily, CHWs should cover the wound with a clean cloth, press down and apply pressure on the wound or instruct the person to do so as she or he is able, until the person can be referred. If there is an object sticking out of the wound, it should not be removed. It should be left there and CHWs should try to stop the object from moving with clean pads and bandage until the person can be referred.

2. If survivors are in stable condition, CHWs should still take timely action and not make the survivor wait. Referrals for health care are time sensitive.

3. Ask participants to recall and explain the basic principles of working with survivors as discussed in Module 3. These are:
   - Ensure the physical safety of the survivor.
   - Guarantee confidentiality.
   - Respect the wishes, rights and dignity of the survivor.
   - Treat survivors equally (non-discrimination).

4. Ask CHWs to recall good communications skills when interacting with survivors. CHWs should always let the survivor share what she wishes in the way she or he would like.
1.3 How should CHWs refer survivors of sexual violence? (continued)

5. Explain to participants that when preparing to make referrals to services, it is important to provide information to survivors and manage expectations. Below are some key points for providing such information:

6. Provide the survivor with information about all available services and their quality. This will help the survivor choose the care and support she or he wants.
   - Share the information in a way that the survivor understands, and check whether the survivor has understood the information.
   - Be aware that when a survivor tells her or his story, this might be an indication that she or he trusts the CHW and might have high expectations about what the CHW can do to help. Do not force the survivor to tell her or his story by asking too many questions.
   - Always be clear about the type of support and assistance CHWs can offer.
   - Never make promises that cannot be kept.
   - Respect the limitations of what they can do as CHWs.
   - Share that at the survivor’s request, CHWs can go with the survivor to services that she or he selects. In some settings where case managers or social workers are responsible for coordinating survivors’ care, such persons can also go with survivors. Once the survivor decides the services that she or he would like to receive, CHWs should tell the referral services (or case manager) in advance that the survivor is interested in seeking services, so that they can prepare for the survivor.

1.4 What can be shared with survivors to refer them for health services?

Mini lecture55 (15 minutes)

1. Begin by noting that as CHWs, participants should be primarily interested in seeing that survivors receive health care, no matter how late they disclose their need for it. While survivors should not be pressured into seeking services or agreeing to receive care, there are benefits for survivors to seeking timely care. Ask participants to recall what these are, if a survivor reports within three full days, five full days and after five days:
   - If the survivor comes for care within full three days (less than 72 hours) of the assault, she or he can receive the following services in a confidential manner:
     - Antibiotics to prevent or treat STIs
     - EC to prevent unwanted pregnancy (only females)
     - Care of wounds
     - PEP to prevent HIV
     - Emotional care/basic psychosocial support
     - Tetanus toxoid vaccination
     - Hepatitis B vaccination

1.4 What can be shared with survivors to refer them for health services? (continued)

- If a survivor presents herself after three full days but within five full days (72–120 hours), she or he can receive:
  - All of the above except PEP to prevent HIV
- If a survivor presents her or himself after full five days (more than 120 hours), she or he can still receive:
  - Antibiotics to prevent or treat STIs
  - Care of any remaining wounds
  - Emotional care/basic psychosocial support
  - Tetanus toxoid vaccination
  - Hepatitis B vaccination within 14 days

2. Depending on what is available in the setting and what CHWs can provide versus the health facility, draw and adapt the following table on flip chart paper.

<table>
<thead>
<tr>
<th>Service</th>
<th>Up to when can a survivor receive the care after the assault?</th>
<th>From where is this available?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics to prevent or treat STIs</td>
<td>Anytime</td>
<td>CHW 2 and 3s; health facility</td>
</tr>
<tr>
<td>EC (pills) to prevent unwanted pregnancy</td>
<td>5 full days</td>
<td>CHW 2 and 3s; health facility</td>
</tr>
<tr>
<td>PEP to prevent HIV</td>
<td>3 full days</td>
<td>CHW 2 and 3s; health facility</td>
</tr>
<tr>
<td>Wound care (basic)</td>
<td>Anytime</td>
<td>CHW 2 and 3s; health facility</td>
</tr>
<tr>
<td>Emotional care (basic)</td>
<td>Anytime</td>
<td>CHW 2 and 3s; health facility</td>
</tr>
<tr>
<td>Tetanus vaccine</td>
<td>Anytime</td>
<td>Health facility (or CHW 3)</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>14 days</td>
<td>Health facility (or CHW 3)</td>
</tr>
</tbody>
</table>

3. Explain that for CHWs providing health care to which survivors have agreed to receive (CHWs 2 and 3), steps to providing direct care will be discussed in Module 5. For CHW 1s, if a survivor agrees to receiving health care and is not presenting with immediate danger signs, they should inform higher level CHWs in their setting that the survivor is willing to seek care, and have them come to the survivor. Alternatively, CHW 1s can accompany the survivor until the survivor is safely with an appropriate caregiver in a private, safe location.

As a reminder, if a survivor presents with any danger signs as discussed earlier, all CHWs (including CHW 1s) should refer her or him immediately to a higher level health facility.
In some instances, a survivor may hesitate to seek health care given beliefs that any act to seek care is associated with seeking justice (including traditional forms of justice), which they do not wish to do. It can be helpful to reinforce that health care and legal/justice action can be considered separately; as CHWs, the most important health message to share is the benefits to seeking health care and where services can be accessed.

1.5 What should be shared with survivors to refer them to other support services?

Scenario

20 minutes

1. CHWs can also organize referrals to other support services, including psychosocial, mental health, protection and legal services, only if the survivor agrees, and especially if there are no case workers in the setting to manage the survivor’s care. Any service that CHWs suggest to survivors should be good quality, confidential and safe. (CHWs should keep to the services listed in the table just discussed, as they would have assessed for quality and appropriateness).

2. To practice thinking through possible scenarios of facilitating referrals, read the statements below and facilitate discussion. Remind participants that their responses should reflect the tips they have learned in earlier sessions.

- **Scenario 1:** A survivor comes to you for help, saying that her uncle came over when no one was home and forced her to have sex with him. The nearest safe house is a day’s walk, and it is already getting late, so you send her home for the night. Why is this a problem?
  - Remind CHWs that the survivor’s need for safety should not be ignored. Do not instruct the survivor to return to a home or a village that she or he knows to be unsafe, or where the assaulter continues to threaten her or him. Instead, help the survivor to plan for safety. Whenever possible, ensure the survivor is not in immediate danger of further sexual violence. If the offender is in the survivor’s home, help find the survivor an alternative place to stay or a way to keep her or him safe in the home (e.g., having someone else stay). If it is not your role to develop a safety plan for the survivor, inform appropriate persons/actors with the survivor’s consent to have them follow up.

- **Scenario 2:** A survivor is interested in receiving mental health care, to learn how to cope with her feelings after the assault. Assuming this service exists, how would you facilitate the referral?
  - Provide information to survivors about available services, who offers them, and when they are open. Provide practical assistance if needed and available (e.g., transport, calling the service, going with or identifying someone to go with the survivor).

- **Scenario 3:** You think a survivor would benefit from referral services; however, you know that the service is not private or confidential. Should you refer?
  - Do not refer survivors to services that will not provide confidential, respectful care.

3. Divide participants into pairs and tell them to find in their packets the sample scripts to receive consent to refer for adults, children and persons with intellectual impairments. Give participants a few minutes to read the scripts. If participants are non-literate, read one sample aloud to them, or role play with a participant to demonstrate the process.

4. Ask one person in the group to play the CHW and the other a survivor (adult, child or person with an intellectual impairment). Have the CHW go through the process of obtaining informed consent to refer, noting all of the points covered in this session.

5. Walk around listening to how the CHWs ask for consent. While they may not be comfortable with the script, encourage participants to speak in their own words with a caring attitude. Help any groups with non-literate participants.

6. Switch roles when the first role play is complete, but have the second CHW practice the script for a different type of survivor.

7. If time permits, ask for volunteers to demonstrate in front of the group for each survivor category. Try to do this if many participants are non-literate so that you can provide additional guidance as necessary.

**FACILITATOR’S NOTES**

The scripts call for CHWs to:

- Introduce themselves.
- Offer comfort and understanding.
- Explain what services are available, how they can help her or him, and any risks.
- Ask the survivor if she or he has any questions.
- See if the survivor would like to be referred to any of the services.
- Agree upon how the survivor can access these services.
- When obtaining consent, CHWs should be mindful that they:

  - Provide the survivor with information about all available services and their quality.
  - Explain the information in a way that the survivor understands, and check whether the survivor has understood the information.
  - Be clear about roles and the type of support and assistance they can offer.
  - Do not make promises they cannot keep.
  - Take the survivor to a private place.
  - Introduce yourself.
  - Offer comfort and understanding.
  - Explain what services are available for services, and how they can help her or him, and any risks.
  - Ask the survivor if s/he has any questions.
  - See if the survivor would like to be referred to any of the services.
1.6 What if no referral services are available? (Optional)

Discussion

10 minutes

1. Mention to participants that in some settings, a wide range of support services may not be available due to limited programs or the means to access them. In such cases, CHWs will only be expected to do what they can, and mention the services that do exist. For example, if professional mental health services are not available, then they should not offer this as a possible service that the survivor can access since they will only be creating disappointment for the survivor.

2. Ask participants about any limits to services in the setting, and what suggestions they may have to address this gap. Additionally, if the programme has developed troubleshooting plans, mention these as appropriate.

3. Summarize the discussion that despite any limits to available services, the survivor’s safety is always very important. CHWs should make every effort to ensure the survivor is safe through contacting existing protective services or their own supervisors to have them think of ways to help the survivor. Further, as CHWs (especially CHWs 2 and 3), participants do have control over the health services they can provide. Module 5 will go over how these services can be provided safely and in a confidential manner.

TOPIC 2: PUTTING IT ALL TOGETHER

2.1 How can critical skills be demonstrated?

Role play

40 minutes

1. Inform participants that this exercise pulls together all of the key skills they have learned in this training.

2. Divide participants into three groups. Give each member of the group one role and ask the group to develop a single play with a series of scenes. The purpose is to consider how CHWs should act and present themselves, taking into consideration their role in the community.

   • Scenario 1: One member of the group works as a CHW. ‘Fatima’ comes to the CHW with a minor health complaint, but she is distraught and dishevelled. You think something more is bothering Fatima but you are not sure what.

   ‣ Suggestions: The group needs to decide what the CHW should do, what questions to ask and what information to give. Is the CHW gentle with the survivor and does she or he find privacy? Sometimes, simply telling the person what the CHW sees (such as, “you appear upset,” or, “it seems something has happened to your clothes”) can be helpful prompts for the survivor. Does the CHW competently provide information about what Fatima could do? Does the CHW communicate appropriately with Fatima and let her make decisions? If Fatima wants services, does the CHW make timely referrals?


2.1 How can critical skills be demonstrated? (continued)

- **Scenario 2:** One member of the group is a CHW who helped when Fatima came for care after being sexually assaulted. A friend or relative comes to the CHW to ask about Fatima: “Why did she come to you? What is wrong with her?” What can the CHW say to this person?
  - **Suggestions:** The group should decide who the questioner is and how hard she or he pushes for information and how the CHW should answer. Other members of the group could be witnesses to the questioning and perhaps make it more difficult for the CHW by asking why she or he does not simply provide the information. What happens if the questioner becomes angry? How does the CHW protect confidentiality?

- **Scenario 3:** Another CHW overhears some people talking about Fatima. There is a rumour going around that she is a ‘loose woman’. What should the CHW say?
  - **Suggestions:** How does the CHW respond to the community by promoting compassion and notions such as respect and non-discrimination?

3. Give each group 15 minutes to develop the scenario and three minutes to act it out for the larger group.

4. Allow five minutes for the larger group to provide feedback after each role play.

**Facilitator’s Notes**

The role plays should emphasize that all CHWs should:

- Encourage survivors to seek health care from CHWs or the health facility as soon as possible and within three full days.
- Help survivors get care, including from support services as relevant, available and with the survivor’s consent.
- Protect the confidentiality of survivors.
- Avoid asking questions beyond the minimum necessary to perform their duties and get the survivor the care she needs.
- Not discriminate as survivors are never to blame for the violence; they have done nothing wrong and deserve the best possible care.

Adapted from: IRC, Clinical Care for Survivors of Sexual Assault: A Multi-Media Training Tool, 2008.

**Stop here if you are working with CHW 1s. Skip to Module 6 to close the training.**
MODULE 5

Providing community-based care for survivors of sexual violence

Participant handouts
- HO 1: Bandaging a wound
- HO 2: Caring for survivors flowchart
- HO 3: Cleaning a wound
- HO 4: Controlling minor bleeding
- HO 5: Form for survivors
- HO 6: Health history questions
- HO 7: How to give medicines accurately
- HO 8: How to use medicines safely
- HO 9: Intake and monitoring forms
- HO 10: Medicines for types of sexual violence
- HO 11: Pain scale
- HO 12: Pictorial presumptive treatment protocol STIs
- HO 13: Pictorial treatment protocol emergency contraception
- HO 14: Pictorial treatment protocol PEP regimens
- HO 15: Preventing infection (basic)
- HO 16: Sample informed consent or assent script to provide care
- HO 17: Table of medicines
- HO 18: Table of weight-based treatment for antibiotics
Participant handouts

Handout 1: Bandaging a wound
Handout 2: Caring for survivors flowchart
Handout 3: Cleaning a wound
Handout 4: Controlling minor bleeding
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Handout 15: Preventing infection (basic)
Handout 16: Sample informed consent or assent script to provide care
Handout 17: Table of medicines
Handout 18: Table of weight-based treatment for antibiotics
# SESSION 5.1

## Refreshing key skills

<table>
<thead>
<tr>
<th>Session Time</th>
<th>2 hours 35 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td>-</td>
<td>• Understand the different treatments to be provided depending on the time the survivor reports</td>
</tr>
<tr>
<td>-</td>
<td>• Learn how to provide medicines accurately and safely</td>
</tr>
<tr>
<td>-</td>
<td>• Learn how to store medicines</td>
</tr>
<tr>
<td>-</td>
<td>• Review infection prevention measures</td>
</tr>
<tr>
<td>-</td>
<td>• Know how to complete forms and store them safely</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td>• Mini lecture</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td>• Prepare lecture</td>
</tr>
<tr>
<td>-</td>
<td>• Know the level of participants’ skills in giving medicines accurately and safely</td>
</tr>
<tr>
<td>-</td>
<td>• Learn about standard precaution/infection prevention measures used in the programme, and adapt the participant HO as necessary</td>
</tr>
<tr>
<td>-</td>
<td>• Understand information storage and handling procedures</td>
</tr>
<tr>
<td><strong>Training aids, materials and HOs</strong></td>
<td>• Flip chart and markers</td>
</tr>
<tr>
<td>-</td>
<td>• Flow chart/algorithm on care for survivors of sexual violence (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• Table of medicines (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• How to give medicines accurately (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• How to give medicines safely (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• Preventing infection (basic) (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• Intake form (HO)</td>
</tr>
<tr>
<td>-</td>
<td>• Monitoring form (HO)</td>
</tr>
<tr>
<td><strong>Evaluation and assessment</strong></td>
<td>• None</td>
</tr>
</tbody>
</table>
### TOPIC 1: REVIEWING TREATMENT OPTIONS FOR SURVIVORS OF SEXUAL VIOLENCE

#### 1.1 What should happen when survivors of sexual violence talk about sexual violence to a CHW?

**Discussion**

30 minutes

1. Ask participants to refer to the **flow chart** in the participants’ packets for care for survivors of sexual assault. The flowchart is a decision tree for what type of health care CHWs should provide, depending on how soon after the assault the survivors seek care about what type of assault she or he sustained. If the survivor complains about the below symptoms or presents with signs of a life-threatening emergency, she or he must be referred immediately to a higher level health facility. Ask participants if they can remember the danger signs covered earlier:

- Swelling and hardness of the stomach (belly)
- Pain in the abdominal (belly) area
- Severe pain anywhere else in the body (back, chest, arms, legs or head)
- Vomiting blood
- Bleeding from the pelvic area (vagina or anus)
- Heavy bleeding from other parts of the body
- Possible object lodged inside pelvic area (vagina/anus)
- Altered mental state or confusion
- Pale, blue or gray skin
- Loss of consciousness
- In a small child, fast breathing or difficulty breathing

If she or he does not have any danger signs, CHWs can follow steps in the rest of the flow chart for survivors of sexual violence.

2. Go through the steps required that depend on when the survivor comes for care. The different scenarios are:

- Less than three full days since the assault
- Less than five full days since the assault
- More than five full days since the assault
FACILITATOR’S NOTES

As a reminder, if a survivor presents her or himself within three days, or 72 hours, she or he can receive the following care if indicated:

- EC to prevent pregnancy
- Antibiotics to prevent or treat STIs
- Care of wounds
- Basic psychosocial support
- Post-exposure prophylaxis to prevent HIV
- Tetanus vaccination
- Hepatitis B vaccination
- Follow-up care

If a survivor presents herself within five days, or 120 hours, she can receive:

- All of the above except PEP to prevent HIV

If a survivor presents herself after five days, she can still receive:

- Antibiotics to prevent or treat STIs
- Care of remaining wounds
- Basic psychosocial support
- Tetanus vaccination
- Hepatitis B vaccination within 14 days
- Follow-up care


1.1 What should happen when survivors of sexual violence talk about sexual violence to a CHW? (continued)

3. Summarize up to when survivors can receive a particular type of medicine or vaccination, using the table below. The participant HOIs also contain a pictorial version of this table that they can use to follow along.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Up to when should a survivor receive medicines after the assault?</th>
<th>Does the medicine need to stay cold?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics to prevent or treat STIs</td>
<td>Anytime</td>
<td>No</td>
</tr>
<tr>
<td>EC (pills) to prevent unwanted pregnancies</td>
<td>5 days</td>
<td>No</td>
</tr>
<tr>
<td>PEP to prevent HIV</td>
<td>3 days</td>
<td>No</td>
</tr>
<tr>
<td>Tetanus vaccine</td>
<td>Anytime (through referral)</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>14 days (through referral)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

4. Let participants know that each step in the flow chart will be discussed at length in the next several hours (or days) of the training.
The following sections on giving medicines accurately and safely are particularly useful for CHWs who may not be comfortable dosing medicines by age, weight, pregnancy status or allergies. This knowledge will be helpful in interpreting the pictorial version of the protocols that will be discussed in detail for each treatment. However, these sections can be shortened if CHWs have much experience, or if pre-packaged treatment packets will be used in the pilot where CHWs will have little or no opportunity to determine dosage. You should still review storage of medicines and infection control with all participants. Handouts are available in the participant packets.

TOPIC 2: REVIEWING KEY SKILLS TO PROVIDING HEALTH CARE TO SURVIVORS

2.1 How can medicines be given accurately?

Mini lecture
40 minutes

To be able to give the medicines to survivors, CHWs must know:

- What the medicine is called
- In what forms the medicine comes
- How to take the medicine correctly (dose and frequency)
- Whether the medicine is safe to give
- If the medicine causes side effects
- What happens if a survivor takes too much or not enough of the medicine
- What to do if the survivor is already pregnant, is breastfeeding or has an allergy
- Medicines come in different forms. Tablets, capsules and liquids are usually taken by mouth. Injections are given with a needle directly into a person’s muscle, tissue or under the skin. Creams or ointments that contain medicine are applied directly to the skin.

Many medicines, especially antibiotics, come in different weights and sizes. To be sure CHWs give the survivor the right amount, they should check how many grams, milligrams or micrograms each pill or capsule contains.

Draw the below amounts on flip chart paper, including what that means when cutting a tablet.

1 tablet = one whole tablet
½ tablet = half of a tablet
1 ½ tablet = one and one-half tablets
¼ tablet = one quarter or one-fourth of a tablet

There are also different types of measurements. Medicine is usually weighed in grams (g) and milligrams (mg). Write the following on flip chart paper:

1,000 mg = 1 g (one thousand milligrams makes one gram)
1 mg = 0.001 g (one milligram is one-thousandth part of a gram)
2.1 How can medicines be given accurately? (continued)

Some medicines, particularly for children, are weighed in milligrams or even smaller amounts called micrograms (mcg or µcg). 1 µcg = 0.001 mg. This means there are 1,000 micrograms in a milligram.

Other medicines are measured in units (U) or international units (IU).

For liquid medicine given to children, amounts are in milliliters or cubic centimeters. A cubic centimeter is the same as a milliliter. If the medicine does not come with a special spoon or dropper to measure liquid, household measures can be used.

1 tablespoon = 1 Tb = 15 ml
1 teaspoon = 1 tsp = 5 ml

Some medicines are also based on a person’s weight, so that a survivor receives a certain amount of medicine for every kilogram she or he weighs. If a scale is not available, CHWs should estimate how much the person weighs. The treatment protocols for adults and children provide instructions on how to decide how much medicines CHWs should give.

It is important for the survivor to take medicines at the right time. Some medicines should be taken only once a day, but others must be taken more often. A clock is not needed. If the directions say “1 pill every eight hours” or “three times a day,” CHWs should advise the survivor to take one pill at sunrise, one in the afternoon, and one at night. If the instructions are “one pill every six hours,” or “four times a day,” the survivor should take one in the morning, one at midday, one in the late afternoon, and one at night.

Draw the picture (the columns with the sun and moon) on flip chart paper and show how CHWs can use this to help survivors know what time to take what medicine.

The above information is useful for CHWs to understand the treatment protocols. They can have plenty of practice as they work through the protocols.
2.1 How can medicines be given accurately?

Demonstration
15 minutes

1. Review the following examples with participants. One medicine comes in two sizes. Draw on flip chart paper:

![Diagram of 200 mg and 400 mg tablets]

If the survivor needs to take: “400 mg, by mouth as a single dose,” but CHWs only have 200 mg tablets, the survivor needs to take 2 tablets.

![Diagram showing 200 mg tablets added to get 400 mg]

If CHWs have 400 mg tablets, the survivor only needs to take 1 tablet.

![Diagram of a single 400 mg tablet]

2. In the next example, tell participants that the survivor needs to take 200 mg of medicine two times daily. What should participants draw if they have 200 mg tablets? What about for 400 mg tablets?
2.2 How can medicines be given safely?

**Mini lecture**

15 minutes

Any time CHWs give medicines to survivors, they should also give the survivor good instructions:

- How to take it, including how much to take (dose), and how often to take it each day and for how many days.
- The need to take all the tablets for as long as advised. If she or he stops taking the medicine too soon, the problem may not have been cured and could become worse. It is very important for CHWs to inform survivors to finish all of the medicine.
- The side effects the medicine can cause, and how to address them.
- Whether the medicines should be taken on a full or empty stomach.
- The need to avoid taking many medicines at the same time since some medicines can stop other medicines from working or will cause problems when taken together. However, medicines that CHWs will provide for treatment after sexual violence can all be taken together.
- The need to keep medicines in a cool, dry place and out of reach of children.

When giving medicines, CHWs should make sure the medicines are not near their expiration date. This date is typically written in small print on the package or bottle.

Doxycycline or tetracycline (antibiotics) especially should not be used after the expiration date has passed since they may be harmful. CHWs should not give pills that are starting to fall apart or change colour, or capsules that are stuck together or have changed shape.

CHWs should also tell survivors not to take more medicines than the amount they are told to take, thinking that this will make the medicines work faster. This is not true and can be dangerous. If the survivor takes too much medicine at one time or too often, or if she or he takes some medicines for too long, the medicine may harm her or him.

More information on **how to give medicines accurately** and **use medicines safely** are available in the participants’ packets.

2.3 How should medicines be stored?

**Mini lecture**

5 minutes

Mention to participants that none of the medicines that CHW 2s will provide need to be refrigerated. However, CHWs should keep medicines in a cool, dry place and out of reach from children. They should also be sheltered from dust and dirt. If they are given a medicine pouch or bag, they can store the medicines inside and keep the bag in a cool, dry place. CHWs should refill their supply before they have given out the last treatment through the health facility or programme staff (as appropriate).

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Learn about standard precaution measures and infection control procedures for the programme, and modify the mini lecture below and participants’ handouts as necessary.

**FACILITATOR’S NOTES**

### 2.4 How can infections be controlled when caring for survivors?

**Mini lecture**\(^{62, 63}\)

20 minutes

Note to CHWs that there are several precautions they must take for **basic infection control** when treating survivors. Infections are caused by germs that are too small to see. Every person carries germs, and any equipment and tools used to care for survivors will also need to be cleaned of any germs. The four ways to prevent infection are:

- Washing hands with soap and running water, before and after giving care, especially after touching blood and other fluids from the survivor. If blood or body fluids splash into their eyes or mouth, rinse immediately with plenty of clean water.

- Covering any cuts or open wounds on their hands with bandages, using gloves or a clean plastic bag as a substitute for gloves if they are not available.

- Avoiding any direct contact with blood, by, for example, asking the survivor to put pressure on the wound herself or himself, and using plenty of cloth or dressing.

- Cleaning blood spills on tables and floors and appropriately disposing of dirty bandages and used cloth.

If CHWs prick or wound themselves when handling blood or body fluids, they should wash the area well with soap and clean water and notify their supervisor or health facility staff. CHWs should make sure they are protected against tetanus too.

A HO is available for participants on **basic infection prevention**. An additional HO is also available for more advanced infection prevention if CHWs will be using tools that will need to be disinfected.

### TOPIC 3: COMPLETING THE INTAKE FORM

**3.1 What is an intake form?**

**Mini lecture**\(^{64}\)

10 minutes

The **intake form** is a document in which CHWs note the care they provide to survivors. It is an important form to track the survivor’s progress as she or he begins to heal. For security reasons, the form does not include any space to note the survivor’s name or the perpetrator’s name.

If the survivor wishes to eventually seek legal justice, a copy of the intake form may serve as documentation that the survivor sought health care for sexual violence. The original intake form should therefore be safely stored in the event that the survivor needs it. The survivor may also wish to keep a copy for her or his records, although the safety of this should be discussed with the survivor. The survivor has the sole right to decide whether and when to use this document.\(^{65}\)

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\(^{63}\) Hesperian Foundation, A Book for Midwives: Care for pregnancy, birth and women’s health, updated 2010.

\(^{64}\) WHO, Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons, 2004.

\(^{65}\) Ibid.
When health providers care for survivors, a medical certificate is often provided that summarizes the survivor’s history and findings with the specific purpose to use in court if the survivor chooses this option and legal justice is available. The intake form, which CHWs complete, is a medical record that serves to remind her or him about the history and care provided. While a medical certificate can serve as important evidence for future pursuance of legal justice, the form is beyond the scope of services that CHWs can provide. Protocol can instead be established in the pilot sites for CHWs to develop a duplicate copy of the intake form should the survivor request written information and the survivor understands any potential security risks to possess such documentation.

Documentation of the survivor’s medical history, in particular of pre-existing symptoms or previous treatment for STIs, should be handled very carefully to avoid stigma and discrimination. All survivors, whether or not they report STI-like symptoms, will receive the same supportive treatment and counselling services. If medical documents are ever presented in court, the fact that a survivor was treated for a possible pre-existing infection or STI exposure may be used against her.

3.2 How are the intake forms and monitoring forms completed?

Demonstration

10 minutes

Note to CHWs that they also need to complete a monitoring form since the intake form is particularly confidential. This form will help the programme see when survivors are reporting, what kind of care she or he is receiving and what types of referral she or he is requesting. Once CHWs complete an intake form, they are responsible for copying the information into the monitoring form so that the information from all survivors is on one form that can be submitted to programme staff on a routine basis.

1. Briefly review the intake form with participants so that they know what it looks like. Let them know that they will go through each section as the treatment is discussed.

2. Briefly review the monitoring form so that they can see where each section of the intake form corresponds to the columns of the monitoring form. Point out also that the monitoring form does not note any identifying information (names of the survivor).

3. Request participants to write as neatly as possible so that they can read their own writing, as well as programme staff.
Before introducing the next section, confirm with programme staff that they have determined correct steps for data handling and storage. They should have decided issues such as:

- Where any intake forms, as well as other documentation, will be stored
- Who will have access to the confidential information
- If programme monitoring is conducted in a central office, how information about provided services will be sent safely and confidentially to the centralized location for monitoring purposes

3.3 How should the intake forms and monitoring forms be stored?

**Mini lecture**

10 minutes

Remind participants that they need to make sure that any information collected from survivors is managed and stored safely. All medical and health information related to the survivor should be kept confidential at all times, even from family members (unless the survivor is a child). Any information that is written about the survivor and what care has been provided—including the intake and monitoring forms—cannot be shared with anyone without the survivor’s consent.

Review with participants where they should keep completed intake and monitoring forms, and how often they need to send their data to programme staff.

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

<table>
<thead>
<tr>
<th>Session Time</th>
<th>9 hours 30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Prepare the survivor to receive treatment</td>
</tr>
<tr>
<td></td>
<td>• Take a health history</td>
</tr>
<tr>
<td></td>
<td>• Provide presumptive treatment for STIs</td>
</tr>
<tr>
<td></td>
<td>• Provide EC to prevent pregnancy</td>
</tr>
<tr>
<td></td>
<td>• Provide PEP to prevent HIV</td>
</tr>
<tr>
<td></td>
<td>• Provide wound care with basic first aid</td>
</tr>
<tr>
<td></td>
<td>• Provide supportive counselling</td>
</tr>
<tr>
<td></td>
<td>• Refer for tetanus and hepatitis B vaccines</td>
</tr>
<tr>
<td></td>
<td>• Close the consultation</td>
</tr>
</tbody>
</table>

| **Methods**        | • Mini lecture |
|                    | • Role play |
|                    | • Discussion |
|                    | • Case study |

| **Preparation**    | • Prepare training session and gather necessary materials |
|                    | • Know and adapt to the local context the treatment protocol HOs for STI prevention, EC and PEP, and the table of weight-based treatment for antibiotics. |
|                    | • Know if/where referrals are available for tetanus and hepatitis B vaccines |

| **Training aids, materials and HOs** | • Informed consent scripts (HO) |
|                                      | • Flow chart/algorithm on care for survivors of sexual violence (HO) |
|                                      | • Questions on taking a health history (HO) |
|                                      | • Intake form (HO) |
|                                      | • Medicines for types of sexual violence (HO) |
|                                      | • Monitoring form (HO) |
|                                      | • STI presumptive treatment protocol (HO) |
|                                      | • Table of weight-based treatment for antibiotics (HO) |
### SESSION 5.2
Training aids, materials and HOs (continued)

- EC treatment protocol (HO)
- PEP protocol (HO)
- Controlling minor bleeding (HO)
- Cleaning a wound (HO)
- Bandaging a wound (HO)
- Providing basic first aid for burns (HO) (optional)
- Providing basic first aid to survivors with injuries to bones, muscles or joints (HO) (optional)
- Offering basic life support (HO) (optional)
- Infection prevention (Basic) (HO)

### Evaluation and assessment

- Scenario/role play to bring learning altogether.

### Additional resources

TOPIC 1: PREPARING THE SURVIVOR

1. Ask participants about the steps to take to prepare a survivor. Have them discuss for a few minutes among themselves, and then see what they raise. Then, walk through with participants the correct steps, given below:

- Take the survivor to a private place where she or he will not be overheard and where all care can be provided. She or he should not be required to move from room to room.
- Introduce yourself.
- Offer comfort and understanding.
- Explain what is going to happen during each step, why it is important, what it will tell you and how it will influence the care you will give.
- Reassure the survivor that she or he is in control of the timing and what happens during the interaction.
- Reassure the survivor that everything that is discussed will be kept confidential. Only if she or he agrees will you share the survivor’s information with others who can provide additional services. Note any mandatory reporting requirements if applicable.
- Ask the survivor if she or he has any questions.
- Ask the survivor if she or he wants to have a specific person present for support. Try to ask this when she or he is alone. The number of people allowed in the room should be limited to the minimum necessary. Police officers should not be present in the room.
- Do not force or pressure the survivor to do anything against her or his will. Explain that she or he can decline or refuse any part of the services, and at any time.
- Ask whether the survivor consents/agrees to receive help. Make sure the survivor has been informed of all possible information and options available, and any benefits and risks of what she or he will receive. If she or he consents to receive treatment, you should note this on the intake form.

If the survivor is a person with an intellectual impairment, CHWs should specially make it a point to explain the process slowly and clearly and in a language she or he can understand.

CHWs should not skip the process of obtaining consent or assent even if they assume that it is not necessary or that the survivor may have difficulty understanding. CHWs should document clearly the steps they took to obtain consent in the notes section of the intake form, and any support from other people that the survivor may have had in the decision-making process.


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1.1 How should the survivor be prepared to receive treatment? (continued)

Role play 70  
30 minutes

This exercise is an opportunity for participants to practice obtaining informed consent to provide direct care. Obtaining informed consent is more than just reading a script to a survivor. It involves helping the survivor understand what to expect when receiving health care and to answer any questions that she or he might have. This is an important and difficult skill to master and requires practice.

1. For this exercise, divide participants into groups of two and distribute the informed consent scripts (HO). One participant will act as the CHW (provider) and the other will play the role of a survivor (adult, child or person with an intellectual impairment). Tell participants they will role play the consent process. Where appropriate, the person portraying the survivor should ask for more explanation.

2. Move between groups throughout the room and offer suggestions or constructive comments.

3. Make note of problems that many groups are having and the areas in which they do well. Have participants change roles.

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

5. End the exercise by pointing out some of the positive points that you noticed during the exercise, as well as some of the problems.

Make your comments general and do not identify specific groups or individuals as you share your observations. For example, if you noticed that in several groups the ‘provider’ was speaking very fast and did not stop to ask the survivor to see if she had questions, you might say, “Remember how important it is during this process to engage the survivor. Some survivors will be too scared to ask questions. CHWs should go slowly and ask them several times throughout the consent process if they have any questions. This will help them feel more open about sharing their concerns.”

Among survivors with disabilities, stress that it is important to talk directly to them (and not to their caregivers), explain the process in language they understand and give them choices as with everyone else.

TOPIC 2: TAKING THE SURVIVOR’S HISTORY

2.1 How should the survivor’s history be taken?

To give good care to a survivor, CHWS should explain to participants that they will first take a health history. This is where they find out about the survivor’s general health, what happened during the incident of sexual violence, current symptoms she or he is experiencing, and her or his past medical issues. Based on what they learn, they can then follow the flow chart on what care to provide.

Before taking the history, CHWs should review any documents or paperwork brought by the survivor, especially if she or he has been referred from another service. This will help CHWs not ask questions that have already been asked and documented by other people involved in the case. Having to tell the whole story over and over again to many people is re-traumatizing.

CHWs should follow the key principles of working with survivors, and show good communications skills as covered in Module 3. A CHW should:

- Be a good listener.
- Use a calm tone of voice and maintain eye contact if culturally appropriate.
- Respect the survivor and do not tell the person what is best for her or him to do.
- Be patient and do not press for more information if the survivor is not ready to speak about her or his experience.
- Ask survivors only relevant questions.
- Do not discuss the prior sexual history or survivor’s status of virginity since these are not relevant.
- Avoid any distraction or interruption.
- Write these on flip chart paper if they have not already been noted.

CHWs should NOT be asking the survivor to undress, especially their private areas, since this is not necessary for taking a history and knowing whether or not a referral is needed.

Before each step of the care process, CHWs should first explain to the survivor what they are going to do.

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Working with child survivors: When communicating with a child survivor, begin by building trust and creating a safe environment.

Make the child feel comfortable by allowing a parent or caregiver to accompany her, unless there is reason to believe that the accompanying adult is the perpetrator. Talk to the child in words she or he understands. Allow her or him to use dolls or other playthings or draw pictures to communicate.

The age and developmental stage of children should be considered when talking with children:

**Infants and toddlers (0–5 years old):** Children in this age range should not be asked directly about their abuse. The non-offending parents/caregivers should be the primary sources of information about the child and suspected abuse.

**Young children (6–9 years old):** Children in this age range can be directly interviewed by the service provider, although if possible, additional information should be gathered from trusted people in the child’s life. The children may have a difficult time answering general questions, resulting in them saying, “I don’t remember” or “I don’t know” often, or they may give vague responses such as “The man did a bad thing,” but fail to share more. Caregivers/parents or someone the child trusts can be involved as long as the child requests that adult to be present (and the adult is not a suspected abuser). Children benefit greatly from a mixture of both verbal and art-based communication techniques.

**Young and older adolescents (10–18 year olds):** Children in this age range can be directly interviewed by the service provider. Open-ended questions can produce important information about sexual violence. Caregivers/parents or someone the child trusts can be involved as long as the child requests that adult to be present (and that adult is not a suspected abuser). Adolescents have more capacity to communicate but service providers should remember they are also still developing.

2.1 How should the survivor’s history be taken? (continued)

**Role play**

15 minutes

1. Divide participants into groups of three, with a speaker, a listener and an observer.

2. Let the speaker know that he or she should talk about something that is of real concern to the person. He or she does not need to share anything that is private or embarrassing. Sharing a real part of his or her life, however, will make this exercise more interesting and useful. Be sure to pause often to encourage the listener to respond, even though this may seem a little unnatural.

3. To the listener: Practice active listening techniques. Acknowledge and confirm what the speaker says by repeating, “I heard you say…” Summarize to see if you understand correctly. Try to ask open-ended, non-judgemental questions, such as “Would you tell me more about that?” to obtain more information.

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

5. Let participants know that each interview should last about five minutes. At the end, the speaker should describe her or his experience (did she or he feel listened to?) and the observer should comment on what she or he saw.

6. If time permits, repeat the exercise and change roles. The exercise can also be done with only the speaker and listener exchanging their impressions of the interview.

2.2 What questions should be asked to a survivor when taking a health history?

**Mini lecture**

60 minutes

Learning a survivor’s basic health history will guide CHWs to provide the appropriate care. Share that an HO of questions on taking a health history is available for CHWs to follow in the participants’ packet. Note that this HO is not a flowchart, but should serve as a guide to make sure CHWs do not skip a step. As they take the survivor’s health history, they should make sure to record the relevant information on the intake form to avoid asking the same questions repeatedly.

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The questions below are the minimum questions to ask a survivor to ensure she receives the care she needs. A flow chart has been developed for this purpose, which accompanies the intake form. The intake form where the care provided is documented has been simplified to list only critical information. Note that neither the name of the survivor nor perpetrator information is collected for security reasons.

If capacity exists for more detailed examination, the WHO history and examination form may be best to use. See Annex 5 of WHO, *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons*, 2004.

### 2.2 What questions should be asked to a survivor when taking a health history?

(continued)

**The health history includes:**

- **Age:** Ask the survivor her or his age. Note this on the intake form. Take note of the pubertal stage of the survivor and ask an adolescent girl if she has begun menstruating. If the survivor is a woman or adolescent girl who has reached puberty (including development of breast buds), she may be eligible to receive EC to prevent pregnancy.

- **Vaccination status:** Ask the survivor if she or he is vaccinated for tetanus and hepatitis B. Note this on the intake form. A survivor who is fully vaccinated will not need to receive these vaccines. A survivor who is not vaccinated or does not know her or his vaccination status can receive these vaccines if they are available.

- **Medications and allergies:** Ask the survivor if she or he is currently taking any medications. Also ask if she or he has any known allergies to medicines. Note these on the intake form. If she or he does not know, ask if she or he has ever developed hives, itching, swelling or trouble breathing after taking a medicine.

**Incident history**

- **Date of incident:** Ask the survivor what day and time she experienced sexual violence. Note this on the intake form. If the incident was less than three days ago, she or he may be eligible to receive PEP to prevent HIV. If it was less than five days, she may be eligible to receive EC to prevent pregnancy.

- **Physical violence:** Ask the survivor if she or he experienced any physical violence or injury. Ask her where on her body she experienced the physical violence. She or he may require wound care or tetanus vaccine if the violence resulted in broken skin.

- **Penetration:** Ask the survivor if she or he was penetrated vaginally, anally or orally (through her vagina, anus or mouth). Note this on the intake form. She or he may require PEP to prevent HIV, antibiotics to prevent STIs, hepatitis B vaccine and EC to prevent pregnancy (for women and adolescent girls).
2.2 What questions should be asked to a survivor when taking a health history? (continued)

### Current signs and symptoms

- **Pain:** Ask the survivor if she or he is experiencing any pain. Ask her or him where the pain is located. Ask her or him how severe the pain is on a scale of 0 (no hurt) to 10 (hurts worst) using the FACES Pain Rating Scale (below). A survivor who is experiencing some pain may receive anti-pain medication (paracetemol). A survivor who is experiencing severe pain or any abdominal (belly) pain should be referred quickly to higher level health care.

![Wong-Baker FACES Pain Rating Scale](image)

- **Bleeding:** Ask the survivor if she is experiencing any vaginal bleeding or discharge. A survivor who reports vaginal bleeding or discharge will need to be referred to a higher level health facility.

### FACILITATOR’S NOTES

**Pain or discomfort in the lower part of a woman’s abdomen (belly)**

(if asked by participants):

Possible causes of pain in the lower abdomen (belly) related to sexual violence are:

- **Bladder infection:** Is urination very frequent or painful?
- **Pelvic inflammatory disease:** This can be a late stage of gonorrhoea or chlamydia, with pain in the lower abdomen (belly) and fever.
- **Complications from an abortion:** There may be fever, bleeding from the vagina with clots, abdominal (belly) pain, difficulty urinating and shock. The survivor should be given antibiotics and referred to a higher level facility at once. Her life is in danger.

Some of the above problems are less serious. Others are dangerous. They are not always easy to tell apart. Special tests or examinations may be needed. **CHWs should refer survivors with any abdominal (belly) pain to a higher level health facility.**

2.2 What questions should be asked to a survivor when taking a health history? (continued)

Other medical history

- **Pregnancy:** Ask the survivor if she is currently pregnant. Note this on the intake form. A survivor who is pregnant will not need to receive EC and must receive antibiotics that are safe to take during pregnancy to prevent STIs. A survivor who is not pregnant or is unsure whether or not she is pregnant can receive EC.

- **HIV status:** Ask the survivor if she or he is HIV-positive. Note this on the intake form. A survivor who is HIV-positive will not need to receive PEP. If she or he is HIV-negative or does not know her HIV status, she or he can receive PEP.

**SPECIAL CONSIDERATIONS**

Adapting the history for a child survivor: When taking the history of a child survivor, take a few minutes to talk to the child in private, separate from her or his parent or caregiver.

Questions for the child survivor include:

Has this sexual violence happened before?

- Is the person who did this someone you know?
- Did she or he say something bad would happen if you told anyone?
- Is there anything else you would like to talk about?

If the child gives information that suggests she or he is being abused by a family member or parent, the CHW will need to ensure the child has a safe place to go (not home with the suspected abuser).


As you go through the next section, draw the table below on flip chart paper. A similar **HO on medicines for types of sexual violence** is available in the participants’ packets.

<table>
<thead>
<tr>
<th>Activity</th>
<th>Sexual assault</th>
<th>Anal assault</th>
<th>Oral assault</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics to prevent or treat STIs</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes for gonorrhoea, chlamydia and syphilis</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No for trichomoniasis</td>
</tr>
<tr>
<td>EC (pills) to prevent unwanted pregnancy</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>PEP to prevent HIV</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tetanus vaccine</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Hepatitis B vaccine</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>
While EC is typically not necessary for anal assault, given that CHWs will not be asking detailed questions about the assault to determine the risk of sperm leaking into the vagina, the position of the assault or location of ejaculation; and survivors may not be familiar with their reproductive anatomy, EC can be provided in cases of anal assault in the pilot project.

For oral assault, presumptive treatment for trichomoniasis is not necessary. Further, as the risk of HIV transmission is low, PEP does not need to be provided. The tetanus vaccine only needs to be provided if there are wounds in or around the mouth, or if the survivor has not been vaccinated in 10 years.

While typically, survivors are asked whether or not they are using a method of family planning, CHWs will not be asking this question, due to added challenges to determine if EC is warranted, or if any risk of pregnancy exists. As such, in this pilot, EC can 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.


TOPIC 3: PROVIDING PRESUMPTIVE TREATMENT FOR SEXUALLY TRANSMITTED INFECTIONS

3.1 What are STIs?

Mini lecture
5 minutes

As a reminder, STIs are infections passed from one person to another during unprotected sex. Common STIs include gonorrhoea, chlamydia, syphilis, HIV and trichomoniasis. A survivor of sexual violence is at risk for STIs if she or he experienced vaginal, anal or oral penetration. The signs of STIs are:

- Unusual discharge from the vagina or anus
- Unusual smell from the vagina or anus
- Pain or discomfort in the lower abdomen, especially when having sex or while urinating
- Itchiness, rash or sores on the genitals or in the throat

Many STIs do not leave any signs or symptoms. HIV will be discussed in more detail later.

3.2 How can STIs be prevented and what are the medicines to provide survivors?

Discussion
30 minutes

If a survivor has had unprotected sex (penetration of the penis without the use of a condom, in the mouth, anus or vaginal) she or he is at risk for having an STI and should be offered medication, whether or not she or he has any signs or symptoms of an STI. The antibiotics will prevent any STIs the survivor might have been exposed to, or treat any STIs the survivor might already have.
The antibiotics given to a survivor depend on the amount of time that passed since the assault. Doses should be based on protocol and will differ depending on whether the survivor is an adult woman, pregnant woman or a child. The medicine that is given to prevent STIs after an assault is a combination of the same medicines given to treat some STIs such as gonorrhea, chlamydia and syphilis.

Some antibiotics are not safe for pregnant women. If a woman is pregnant she should be treated according to appropriate guidelines. Children will require very specific antibiotic dosages based on weight and age.

IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010, pp. 28–33.

1. Review the pictorial STI presumptive treatment protocols for adults and children, as well as the table of weight-based treatment for antibiotics. These should be in the participants’ packets. Give participants time to review the protocol and ask questions, especially regarding doses for pregnant women or those with allergies to certain medicines. Make sure they understand how to read the protocols and tables.

2. Emphasize to participants that they should refer to the protocol to ensure the survivor receives the right antibiotics in the correct amount. Survivors should always be given the shortest course of treatment. For example, if the survivor presents within 30 days of the incident, 400 mg of cefixime and 1 g (1,000 mg) of axithromycin by mouth can prevent gonorrhoea, chlamydia and syphilis without symptoms.

3. Review one example together. For example, the protocol states that a child less than 45 kg or younger than 12 years of age should take ‘8 mg/kg by mouth, single dose’ of cefixime to prevent gonorrhoea. According to the table of weight-based treatment for antibiotics, a 34 kg child would need 272 mg of the medicine. The child can be given either one 200 mg tablet, or half of a 400 mg tablet.
Refer to the local prevention protocols. If there is no local protocol, refer to the WHO protocol. All protocols and the table of weight-based treatment should be adapted for the training session in advance. If pre-packaged packets will be used, only review scenarios where CHWs may need to adapt the treatment, such as for children, men or in cases of oral assault.

Since many people with STIs do not have symptoms, every survivor should receive the entire range of preventive antibiotics if she or he has had unprotected sex, regardless of whether or not she or he has symptoms.

For oral assault only, the survivor should be given antibiotics to prevent gonorrhoea, chlamydia and syphilis. Antibiotics for trichomoniasis are not needed.

There is no presumptive treatment protocol for yeast infection, as this is considered a reproductive tract infection and not necessarily an STI. Treatment is given if symptoms (itching and white curd-like discharge) appear. Presumptive treatment for herpes is also not recommended. Genital herpes is treated as soon as possible after lesions appear.

From: IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010; Additional communications with UNFPA, October, 2013.

Role play
30 minutes

1. Divide participants into small groups to practice giving antibiotics to prevent STIs. Provide participants with drugs for demonstration.

2. Provide scenarios of a child, adult woman and pregnant woman, arriving within 30 days and after 30 days, with and without signs of STIs.

3. Observe the role plays to ensure participants demonstrate skills in providing correct antibiotics and doses according to the protocol.

TOPIC 4: PROVIDING EMERGENCY CONTRACEPTION TO REDUCE THE RISK OF PREGNANCY

4.1 Who is at risk for pregnancy after sexual violence and what are the consequences of pregnancy?

A survivor of sexual violence is at risk for unintended pregnancy if she:

- Is a female who is menstruating, or adolescent girls who have developed breast buds
- Has experienced vaginal penetration with a penis
- Is not already pregnant

Unwanted pregnancy after sexual violence can result in problems for the survivor, such as the spouse or family disowning the survivor, or the survivor being considered unsuitable for marriage. Social stigma may drive the survivor to seek an unsafe abortion, which has the risk of illness and possibly death.
4.2 What is EC and how is it provided to female survivors of sexual violence?

Mini lecture

15 minutes

EC is a medicine that can prevent a woman or girl from becoming pregnant after having unprotected sexual intercourse. The medicine works by stopping the woman’s egg from being released for fertilization and may prevent the sperm and egg from meeting. A female survivor of sexual violence who is of reproductive age (menstruating girls and women, or adolescents who have developed breast buds) and presents for care within five days (120 hours) after vaginal penetration should receive EC to prevent unintended pregnancy.

EC is not needed for survivors who experience only oral assault. For anal assault, since CHWs will not be asking detailed questions about the assault, EC can still be provided.

SPECIAL CONSIDERATIONS

Adolescent girl survivors are eligible for emergency contraception as soon as they have developed breast buds or other secondary sexual characteristics, even if they have not yet started menstruation. There are cases where first ovulation results in pregnancy.

A pregnancy test is not required to provide EC pills. If a woman is pregnant but does not know that she is pregnant, she can still take the EC pill and it will not harm the pregnancy. EC is not a method of abortion. If the woman knows she is pregnant, the CHW does not need to give EC pills because they will have no effect.

There are two EC regimens that can be used:

- The levonorgestrel-only regimen: 1.5 mg of levonorgestrel in a single dose (this is recommended because it is more effective and has fewer side effects).
- The combined estrogen-progestogen regimen: one dose of 0.1 mg ethinylestradiol plus 0.5 mg of levonorgestrel taken 12 hours apart.
- There are pills that have been made to serve as EC, but they are not always available. If designated EC pills are not available, EC can be provided using regular oral contraceptive pills. The number of pills to take depends on the amount of estrogen or progestogen each pill contains. See protocol HOs on how many pills are needed.

77 IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010; and WHO, Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons, 2004.

78 ICEC, “Mechanism of Action: How do levonorgestrel-only emergency contraceptive pills (LNG ECPs) prevent pregnancy?” March 2012.
4.2 What is EC and how is it provided to female survivors of sexual violence?

Case study
5 minutes

1. Provide participants with this case study: A 25-year-old woman comes to you four days after vaginal assault. She tells you that she is not currently pregnant or taking contraceptives. What would you do?
   A. Offer her EC pills.
   B. Tell her it is too late to take EC pills.
   C. Require her to take a pregnancy test before taking EC pills.

2. Ask participants to raise their hands if they think the answer is A. Repeat for B and C.

3. Discuss why A is the answer, including that this woman of reproductive age (15–49 years) reported within five days of the assault. A pregnancy test is not required for a woman to take EC.

Discussion
10 minutes

1. Distribute the EC treatment protocol.79

2. Give participants time to review the protocol and ask questions.

3. Emphasize that participants should refer to the protocol to ensure the survivor receives the appropriate EC regimen.

FACILITATOR’S NOTES

You should know what EC regimens are available in the setting and what will be used in the project before this section is introduced. If pre-packaged EC pills are not available locally, EC can be provided using regular oral contraceptive pills. Make sure this information is conveyed so that CHWs can provide EC.

For anal assault, it is not typically possible for a survivor to become pregnant, given the low risk of sperm leaking into the vagina, the position of the assault, location of ejaculation or knowledge of the survivor regarding her reproductive anatomy. EC can still be provided in cases of anal assault. CHWs are not expected to ask detailed questions about the assault, which would warrant their providing EC for anal assault.

Role play
15 minutes

1. Divide participants into small groups to practice giving EC. Ask participants to find the treatment protocols in their package. Hand out EC pills for demonstration.

2. Provide scenarios of an adolescent, adult woman and pregnant woman arriving within 120 hours and after 120 hours of sexual violence.

3. Observe the role plays to ensure participants demonstrate skills in providing correct treatment according to protocol.

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If intrauterine devices (IUDs) are available through referral health facilities, you can mention what they are and how they work. In theory, if survivors live close enough to a health facility, they should be seeking care from the facility rather than a CHW.

**IUDs and sexual violence:** Survivors that seek care within five days after sexual violence may be able to receive an IUD if she has not had additional unprotected sex during her current menstrual cycle. An IUD is a small object that is inserted into the womb by a specially trained health worker. It can stay in the womb for 12 years or more before it must be removed and replaced. It is more effective at preventing pregnancy than EC pills. The IUDs used for EC are made of copper.

IUDs do not protect against STIs, including HIV. If an IUD is used as EC, the survivor must take antibiotics to prevent STIs.

IUDs should not be recommended to survivors who are already pregnant, or those unable to get to a health facility where it can be inserted or removed by a trained health worker. IUDs can be used safely by women who are breastfeeding.

Side effects of IUDs can include light bleeding during the first week after getting an IUD. Some women have longer, heavier and more painful periods, but this usually stops after the first three months.

When a woman wants to stop using an IUD, it must be removed by a trained health worker. A woman can become pregnant as soon as the IUD has been removed.

TOPIC 5: PROVIDING POST-EXPOSURE PROPHYLAXIS (PEP) TO PREVENT HIV

FACILITATOR’S NOTES

This section should only be covered if the provision of PEP is warranted in the context and CHWs will be initiating PEP. The current WHO guidance is that only nurses and above can initiate PEP, although CHWs can play a role in encouraging patients to continue taking the entire 28-day dose and helping to manage any side effects. However, this tool is piloting the safety and effectiveness of CHWs providing PEP in conflict settings where access to such cadres is very limited. See WHO, Task Shifting: Global Recommendations and Guidelines, 2008, for more information.

If HIV testing will be made available for survivors (not required for PEP provision), the programme should have determined where survivors can access ARVs.

5.1 Who is at risk for HIV?

Mini lecture
5 minutes

Remind participants that a survivor of sexual violence may be at risk for HIV if she experienced vaginal or anal penetration. HIV infection is spread through blood and body fluids. Survivors often have tissue injuries (breaks in the lining of the vagina or anus) due to the violent nature of the act and are at increased risk for HIV infection. CHWs should assess the risk for HIV when learning whether the survivor experienced vaginal or anal penetration, so that the survivor is not asked the same questions again and again.

5.2 What is HIV PEP and how does it work?

Mini lecture
10 minutes

HIV PEP is a medication that can reduce the risk of HIV transmission after sexual violence if given promptly.

PEP must be started within 72 hours or three days after a survivor experiences vaginal or anal assault. PEP should be started as soon as possible. PEP is more effective the sooner it is started.

PEP is not needed if the survivor only experiences oral assault.

All survivors should be asked if they would like voluntary counselling and testing (VCT) for HIV to learn her or his HIV status. However, HIV testing is not required to provide PEP. Survivors who cannot or do not wish to undergo HIV testing and who are not already known to be HIV-positive should be offered PEP if indicated. A short PEP treatment is not expected to do harm in someone who does not know her or his HIV status and who is actually HIV-positive.

PEP consists of two ARV drugs given twice a day for 28 days. The drugs are zidovudine (ZDV or AZT) and lamivudine (3TC). These drugs are also available in one combined tablet called Combivir (ZDV/AZT + 3TC). Refer to your protocol and note that the amount of medicine or dosage is adjusted for children based on their age and weight.

To ensure survivors have access to the full course, they may be given the full 28-day course at the initial visit, with instructions to complete the entire course.

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80 IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010.

Pregnant women and children may be eligible to receive PEP. The dose is adjusted for children based on age and weight (see treatment protocols).

Refer to the local treatment protocol, including for children based on age and weight. If there is no local protocol, consult the WHO protocol. This includes, WHO, Antiretroviral Therapy for HIV Infection in Infants and Children: Towards Universal Access: Recommendations for a public health approach, 2010 revision; and WHO/ILO, Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, 2007.

From: IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010, p. 29.

5.2 What is HIV PEP and how does it work? (continued)

Case study 15 minutes

Read the following case study and the questions below:

1. A 41-year-old survivor comes to you two days after being attacked by multiple assailants who assaulted her vaginally and anally.

   **Question:** What would you do?
   A. Offer her PEP.
   B. Tell her it is too late to take PEP.
   C. Require her to take an HIV test before offering PEP.

   **Answer:** A. Due to the nature of the assault (vaginal and anal penetration, broken skin, multiple assailants), the survivor is at risk for HIV infection. She has come to you within 72 hours so is eligible to receive PEP. HIV testing is not required to give PEP.

2. A 25-year-old survivor with an intellectual impairment is brought to you by her caregiver. She was assaulted vaginally by her neighbour three days ago.

   **Question:** What would you do?
   A. Offer her PEP.
   B. Skip discussing whether the survivor would like to get tested for HIV before taking PEP since you doubt she is sexually active.
   C. Require her to take an HIV test since otherwise you don’t think she will get tested at all.

   **Answer:** A. Due to the nature of the assault (vaginal and anal penetration, broken skin, multiple assailants), the survivor is at risk for HIV infection. She has come to you within 72 hours so is eligible to receive PEP. Persons with disabilities should be treated in exactly the same manner as those without visible disabilities.
5.2 What is HIV PEP and how does it work? (continued)

3. A 16-year-old survivor comes to you five days after being assaulted vaginally by her uncle.

**Question:** What would you do?

A. Offer her PEP.

B. Encourage her to take an HIV test now and/or in three months’ time and let her know where support, care and treatment services are available if needed.

C. Do not mention the possibility that the survivor could have HIV since it will be too much for her or him to cope with.

**Answer:** B. Since it has already been more than three days since the incident, PEP will not be effective. However, knowing her or his status can help the survivor access support, care and treatment services, and enable her to stay healthy.

**Discussion**

1. Ask participants to find the PEP treatment protocols in their packets. Give them time to review the protocol and ask questions.

2. Ask participants whether there are any barriers to providing PEP. What is the dose for an adult survivor? What is the dose for a child survivor?

3. Emphasize to participants that they should refer to the protocol to ensure the survivor receives the appropriate PEP regimen.

**Role play**

1. Divide participants into small groups to practice giving PEP.

2. The scenarios to practice are:
   - Child survivor arriving within three days of sexual assault.
   - Child survivor arriving after three days of sexual assault.
   - Adult survivor arriving within three days of sexual assault.
   - Adult survivor arriving after three days of sexual assault.

3. Observe the role plays to ensure participants demonstrate skills in providing correct treatment according to the patient’s history and treatment protocol.

**TOPIC 6: PROVIDING BASIC FIRST AID TO MANAGE WOUNDS**

6.1 What types of wounds can CHWs address?

**Mini lecture**

Emphasize to participants that survivors with bleeding from the genital areas or a possible object lodged inside them should be referred to higher level care immediately.

Sometimes, survivors can present with wounds and injuries on other parts of their bodies due to violent physical assault. CHWs can provide basic first aid for minor wounds and bleeding.

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### 6.1 What types of wounds can CHWs address? (continued)

A wound will not require stitches if the edges of the skin come together by themselves. If survivors have clean wounds where the edges of the skin do not come together by themselves, they need to be referred within 24 hours (one day) to a higher level health facility. Dirty wounds that require stitches will also need to be referred as soon as possible.

### 6.2 How can minor bleeding be controlled with basic first aid?

**Role play**

15 minutes

1. To control minor bleeding, the following steps should be followed. These are listed in the *Controlling Bleeding HO*:
   - Cover the wound with a clean cloth. Avoid direct contact with the person’s blood. Wear gloves if they are available. If there are no gloves, use a plastic bag as a barrier.
   - Press down and apply pressure on the wound. Apply the bandage firmly enough to stop the bleeding but not so tight as to cut off circulation.
   - Instruct the survivor to apply pressure to the wound.
   - Give emotional support by explaining what is happening and giving reassurance.
   - If the bleeding does not stop, press on the wound more firmly and apply more bandages. Do not remove the first dressings.
   - Wash hands with soap and water after giving care.

2. Group survivors in pairs and have them demonstrate bleeding control. Distribute cloth and bandages to practice. If a model is available, they can practice on the model instead.

3. Remind participants that any severe bleeding should be referred, and if an object is sticking out of the wound, they should not remove it. They should leave it there and try to stop the object from moving with clean pads and bandages before the survivor is referred to a higher level health facility.

### 6.3 How can wounds be cleaned and bandaged with basic first aid?

**Mini lecture**

10 minutes

Explain that for any wounds that do not require a referral to a higher level health facility, CHWs should clean any tears, cuts and abrasions from the wound and remove dirt and dead or damaged tissue.

When cleaning the wound, CHWs should be careful to clean out all the dirt. They should lift up and clean under any flaps of skin, but do not rub the wound to get out the dirt. They can use clean tweezers, a clean cloth or gauze to remove bits of dirt, but they should always be boiled first to be sure they are sterile.

Any dirt that is left in a wound can cause an infection. If possible, the wound should be squirted with cool, boiled water in a syringe or suction bulb.

After the wound has been cleaned, CHWs can dry the area around the wound and apply a thin layer of antibiotic cream if available. CHWs can then place a piece of **clean** gauze or cloth to cover the top. It should be light enough so that the air can get to the wound and help it heal.

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Also see Hesperian Foundation, *Where There is No Doctor: A village healthcare handbook*, revised 2011, pp. 84-87.
### MODULE 5: Providing community-based care for survivors of sexual violence

#### 6.3 How can wounds be cleaned and bandaged with basic first aid? (continued)

If the survivor has a dirty wound and has never had a tetanus injection, CHWs should refer her or him to the health facility to receive a tetanus injection and provide antibiotics to prevent infection. They can also consider giving antibiotics to prevent infection, or paracetamol for pain relief.

CHWs should remember to wash their hands with soap and water after giving care.

<table>
<thead>
<tr>
<th>Role play</th>
<th>15 minutes</th>
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<tbody>
<tr>
<td>1. Using the instructions in the participants’ HOs, group participants in twos and have them practise cleaning and bandaging a wound.</td>
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<table>
<thead>
<tr>
<th>FACILITATOR’S NOTES</th>
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<tbody>
<tr>
<td>Additional HOs (optional) are available in the participants’ packets on:</td>
</tr>
<tr>
<td>• Providing basic first aid for burns</td>
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<tr>
<td>• Providing basic first aid to survivors with injuries to bones, muscles or joints</td>
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<tr>
<td>• Offering basic life support</td>
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<tr>
<td>These skills are beyond the scope of this training; however, they may be useful if CHWs need to organize referrals.</td>
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<tr>
<th>FACILITATOR’S NOTES</th>
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<tbody>
<tr>
<td>Health care for survivors includes referral for psychological and social problems, such as common mental disorders, stigma and isolation, use of drugs, risk-taking behaviour and family rejection. Even through trauma-related symptoms may not occur, or may disappear over time, all survivors should be offered a referral to psychosocial or mental health services in the community if they exist.</td>
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### TOPIC 7: PROVIDING SUPPORTIVE COUNSELLING

#### 7.1 How can survivors be emotionally supported?

**Mini lecture**

15 minutes

Share with CHWs that as most survivors of sexual violence never tell anyone about the incident, if the survivor has confided in CHWs, it is a sign that she or he trusts them. Their compassionate response to her or his disclosure can have a positive impact on her or his recovery.

CHWs should provide non-intrusive, practical care. They should listen, but not force the survivor to talk about the incident, and ensure that her or his basic needs are met. As it may cause more psychological problems, CHWs should not push the survivor to share her or his personal experiences beyond what she or he would naturally share.

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86 Hesperian Foundation, Where There is No Doctor, 2012, pp. 84-87.

7.1 How can survivors be emotionally supported? (continued)

Survivors are at increased risk of symptoms, including:
- Feelings of guilt and shame
- Uncontrollable emotions, such as fear, anger and anxiety
- Nightmares
- Suicidal thoughts or attempts
- Numbness
- Abuse of drugs or alcohol
- Sexual dysfunction
- Unexplained physical problems
- Social withdrawal

CHWs should tell the survivor that she or he has experienced a serious physical and emotional event. Advise her or him about the emotional, social and physical problems that she or he may experience. They should explain that it is common to experience strong negative emotions or numbness after sexual violence.

CHWs should further advise the survivor that emotional support may be helpful. Encourage her or him, but do not force her or him, to confide in someone she or he trusts, and to ask for this emotional support, perhaps from a trusted family member or friend. Survivors can be encouraged to participate actively in family and community activities.

Sometimes, the survivor may have experienced involuntary orgasm during the assault, which often leaves the survivor feeling guilty. CHWs should reassure her or him that if this occurred, it was the body’s reaction and was beyond her or his control.

Explain gently that sexual violence is always the assaulter’s fault and never the survivor’s fault. The survivor should be assured that she or he did not deserve to be assaulted, the incident was not her or his fault, and it was not caused by her or his behaviour or manner of dressing. CHWs should never make moral judgements of the survivor.

Special considerations for men: Male survivors are even less likely than women to report the incident because of the extreme embarrassment that they typically experience.

While the physical effects differ, the psychological trauma and emotional effects for men are similar to those experienced by women. Further, when a man is anally assaulted, pressure on the prostate can cause an erection and even orgasm. Reassure the survivor that if this occurred, it was the body’s reaction and was beyond his control.

TOPIC 8: REFERRING FOR TETANUS AND HEPATITIS B VACCINATIONS (OPTIONAL)

FACILITATOR’S NOTES

Only cover this section if the tetanus toxoid vaccination or the hepatitis B vaccines are available from a higher level health facility.

8.1 What is tetanus and who is at risk for tetanus infection?

Mini lecture
2 minutes

Tetanus is a serious disease caused by germs entering a wound. The disease can be prevented through immunization. A survivor of sexual violence who presents with breaks in the skin or mucous membranes may be at risk for tetanus infection.

Tetanus vaccine is not needed for survivors who experienced oral assault only, unless there are wounds in or around the mouth, or she has not been vaccinated in the last 10 years.

8.2 What is the tetanus vaccination and how does it work?

Mini lecture
5 minutes

The tetanus vaccine is given as an injection in the upper arm for adults or buttocks for children. There are three doses. The second dose is typically given four weeks after the first dose, and the third dose is given six months to one year after the first dose.

CHWs should ask the survivor if she or he has received the full three doses of the tetanus vaccine. If she or he has not or does not know, note this on the intake form to refer the survivor to the health facility for the injection with her or his consent, no matter how long it has been since the incident.

SPECIAL CONSIDERATIONS

Tetanus vaccination is safe for pregnant women and children.

From: WHO, Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons, 2004

8.3 What is hepatitis B and who is at risk?

Mini lecture
2 minutes

Hepatitis B is a common and serious infection that may cause problems such as liver failure, liver disease and liver cancer.

Survivors of sexual violence that have been exposed to the assaulter’s blood or body fluids through vaginal, anal or oral penetration may be at risk for hepatitis B infection.
8.4 What is the hepatitis B vaccination and how does it work?

Mini lecture
5 minutes

The hepatitis B vaccine is given by an injection in the thigh for children under 2 years of age or in the upper arm for adults and older children. There are three doses. The second dose should be given one month after the first dose and the third dose six months after the first dose. However, doses will vary on the product.

Unvaccinated or inadequately vaccinated survivors should be offered the hepatitis B vaccine within 14 days of the incident. Ask the survivor if she or he has received the full three doses of the hepatitis B vaccine. If the survivor has not or does not know, note this on the intake form to refer the survivor to the health facility for the injection with her or his consent.

SPECIAL CONSIDERATIONS

Hepatitis B vaccine is safe for pregnant women and children.


TOPIC 9. CLOSING THE CONSULTATION

9.1 How should CHWs close the consultation?

Mini lecture
10 minutes

At the end of the visit, CHWs should:

- Reassure the survivor again that the assault was not her or his fault and that confusing emotional reactions are normal.

- Provide treatment counselling, including clear and simple instructions for medications and wound care (see section 9.2).

- Encourage the survivor to get tested for HIV from the health facility if the survivor does not know her or his status (see section 9.3).

- Discuss ways that the survivor can protect herself or himself and her or his partner(s) from further health consequences (see section 9.4).

- Decide together what referrals the survivor would like or need (more health services, psychosocial, protection, legal, social, etc.) (see section 9.5).

- Discuss personal safety concerns and make sure the survivor has a safe place to go (see section 9.6).

- Encourage a follow-up visit in two weeks, preferably one week if the survivor is taking PEP (sooner if the survivor is a person with an intellectual or psychosocial impairment to provide ongoing opportunities for her or him to ask questions or clarify health matters) (see section 9.7).

- Review the intake form to see that it is complete. If an interpreter or caregiver was present, CHWs should make a note of this on the form. (see section 9.8)

- See if the survivor wants a record of this visit, discussing any security concerns (see section 9.9).

- Answer any questions the survivor may have.

9.2 How can treatment counselling be provided?

Discussion

30 minutes

1. Ask participants to recall what they need to discuss with survivors when providing any medicines or treatment. These are:
   - What and how to take medicines, including how much to take (dose), how many times each day to take it and for how many days.
   - The importance of taking the full dose i.e., all of the tablets for as long as advised. If she or he stops taking the medicine too soon, the problem may not have been cured and could become worse.
   - Side effects the medicine can cause and how to address them.
   - Whether the medicines should be taken on a full or empty stomach.
   - The need to avoid taking other medicines at the same time since some medicines can stop other medicines from working or will cause problems when taken together.
   - The need to keep medicines in a cool, dry place and out of reach from children.

2. Remind participants that with every medicine or treatment CHWs provide, they need to make sure to ask for the survivor’s consent.

Review messages for each treatment that CHWs will provide.

When offering antibiotics to a survivor to prevent STIs, the following messages should be provided. The points about condom use are especially important for adult survivors who are in a relationship where sex is still expected from them, despite the incident (such as between a married couple, if one of the partners does not know that the other had been assaulted).

- **Treatment:** Antibiotics are medicines that can prevent STIs that she or he might have been exposed to, or treat any infections she or he might already have, even if she or he has no symptoms. Go over how the medicines should be taken and note that the antibiotics must be taken for the full course to be effective.

- **Side effects:** Some antibiotics can cause nausea or an upset stomach. To reduce side effects, the medicines may be taken with food.

- **Caution:**
  - If no PEP is given to the survivor, CHWs should explain that condoms must be used during sex until the antibiotic regimen is completed in order to prevent transmitting STIs to any partner.
  - If PEP is given, condoms must be used for three months after PEP is started, or until an HIV test taken three months after the assault is negative.

- **Follow-up:** Pelvic inflammatory disease may develop if an STI is not cured. This may lead to infertility if it is not treated. A survivor who develops signs of pelvic inflammatory disease (severe stomach pain, fever, green or yellow, bad smelling discharge or bleeding from the vagina) should go to a higher level health facility for treatment.

89 IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010, p.29.
9.2 How can treatment counselling be provided? (continued)

Messages to give a survivor taking EC to prevent pregnancy are:

- **Treatment:** EC is a medicine that can prevent pregnancy if taken within five full days of unprotected sexual intercourse; the sooner it is taken the better. Go over how the medicine should be taken.

- **Side effects:** EC may cause mild nausea. The survivor may take the pills with food to prevent nausea. EC may also cause vomiting. If the survivor vomits within two hours after taking EC, she should take another dose. If vomiting occurs more than two hours after taking EC, she does not need to repeat the dose.

- **Caution:** EC does not prevent pregnancy from sexual intercourse that takes place after the pills are taken.

- **Follow-up:** EC is not always effective at preventing pregnancy. If the survivor does not get her menstrual period within a week after it is expected, she should return for a pregnancy test. Spotting or slight bleeding is common with the levonogestrel regimen, and this should not be confused with normal menstruation.

Messages to give a survivor taking PEP to prevent HIV are:

- **Treatment:** Medicines can reduce the risk of HIV infection if they are taken within three full days of the assault, and are taken twice a day for a full 28 days.

- **Side effects:** About half of the people taking PEP may experience some type of side effect. PEP may cause tiredness, weakness, loss of appetite, nausea and flu-like symptoms. These side effects are temporary and can be relieved with ordinary pain reliever such as paracetamol. These symptoms will also go away once the survivor stops taking the medication. The symptoms are not dangerous. PEP should also be taken with food to reduce nausea and vomiting. If the side effects are too hard to manage, the survivor should go to a higher level health centre.

- **Caution:** Survivors should use condoms every time she or he has sex for the next three months or until the follow-up HIV test is negative.

- **Follow-up:** Even with side effects, it is very important to take the medicines every day for 28 days since otherwise she or he could still become infected with HIV if the assaulter was HIV positive.

For survivors who have had minor wounds treated, messages are:

- **Treatment:** Minor wounds can be treated with basic first aid. The survivor can take paracetamol for pain relief as necessary.

- **Follow-up:** Change the gauze or cloth every day and look for signs of infection. Go to the health centre if the wounds look red, hot and painful to touch after some days.

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9.2 How can treatment counselling be provided? (continued)

For survivors that have experienced minor tears and cuts to their genitals, CHWs can advise basic care. This includes informing survivors to:  
- Soak the genital area three times each day in warm water that has been boiled and cooled.
- Pour water over the genitals while passing urine so that it will not burn. Drinking a lot of liquid makes the urine weaker so it will burn less.
- Watch for signs of infection, such as heat, yellow liquid (pus) from the torn area, a bad smell and pain that gets worse. If any of these signs are present, they should go to a health facility.
- Wait to have sex until the genitals no longer hurt and any tears have healed. For many women, having sex makes them think about the assault. They should not be pressured into having sex.

3. To survivors that receive medicines, CHWs should fill out a pictorial form for survivors that notes how often and for how long to take the medicines. The form is available in the participants’ packets.

Role play
25 minutes

1. Group participants into pairs and have them practise treatment counselling and completing the pictorial medicine form. The pairs should switch roles (CHW and survivor) once they are finished. Participants should refer to their treatment protocol HOs for dosaging by age and weight.

2. Walk around the room to provide any guidance as necessary. Pay close attention to whether participants are asking for the survivor’s agreement/approval for each treatment and medicine offered.

9.3 How can survivors be encouraged to seek HIV counselling and testing?

Mini lecture
10 minutes

While it is not required that survivors are tested for HIV to be offered PEP, explain to participants that they should encourage survivors to go to the health centre for an HIV test since they will no longer need to take PEP and will need to access further health care if they test positive for HIV. If the survivor tests negative for HIV, she or he should continue taking PEP and can be tested again after 2-4 months to make sure that PEP has worked. There are advantages and disadvantages to knowing one’s HIV status. The advantages are:

If the survivor is negative, she or he can learn how to protect her or himself to stay negative and prevent HIV infection.

If the survivor tests positive, she or he can:
- Prevent transmission of HIV to her baby or to her or his partner
- Learn how to protect her or himself from future STIs and other infections
- Have her or his partner get tested and receive treatment
- Get care and treatment early to prevent health problems
- Make changes in how she or he lives so that she or he can stay healthy
- Get support from other HIV-infected people in the community
- Plan for her or himself and her or his family’s future

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92 Ibid.
93 Ibid.
9.3 How can survivors be encouraged to seek HIV counselling and testing? (continued)

The disadvantages of knowing the test results are that she or he may have many different feelings if she or he finds out she or he is infected with HIV. It is normal at first to be shocked and deny the test result. The survivor may also feel anger and despair, and blame her or himself or others.

Tell participants that the survivor does not need to tell the result to anyone, not even to the CHW. If she or he is interested in getting tested, refer her or him to the health facility, and let her or him know where she or he can access HIV support, care and treatment services. She or he should not delay starting PEP while waiting for a test result.

9.4 What are ways that survivors can protect themselves and their partners from further health consequences?

Discussion
10 minutes

1. A survivor must never be forced to tell a partner of her treatment. She may worry that her partner will leave her, act out violently or accuse her of being unfaithful if he finds out. CHWs can advise survivors to:

   • Use a male or female condom each time she has sexual intercourse.
   • Avoid sex for three months. If the survivor does not have sex, she will not be able to transmit or be exposed to STIs. Some women may find this the best option; however, for most women, this choice is not possible or desirable.
   • Have sex in ways that avoid getting the partner’s body fluids in the vagina or anus, such as seeking mutual pleasure with the hands. Oral sex is not recommended as there is still a small risk of transmitting STIs and HIV.

2. Ask participants to suggest strategies that survivors can use to talk about condom negotiation with partner(s). These can include:

   • Focus on safety. When a survivor talks about wanting to use a condom, her partner may say that she does not trust him. Yet, the issue is safety, not trust. Since a person may have an STI without knowing it, or may get HIV from something other than sex, it is difficult for a person to be sure she or he is not infected. Using condoms is a good idea for every couple, even if both partners have sex only with each other.
   • Practise talking with the CHW or a trusted friend first. Ask a friend to be the survivor’s partner and then practice what she wants to say.
   • Do not wait until the survivor is about to have sex to talk about it. Choose a time when the survivor and partner are feeling good about each other.
   • Use other people as examples. Sometimes learning that others in the community are using condoms can help influence the partner to do so as well.

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94 Ibid.

9.4 What are ways that survivors can protect themselves and their partners from further health consequences? (continued)

- **Try to respond to the partner’s concerns.** Using condoms is one of the easiest ways to prevent infections and unwanted pregnancy. However, many people do not use them at first. Here are some responses to common complaints about condoms:
  - “I tried them before and didn’t like them.” Sometimes condoms just take time to get used to. Try to agree that you will use them for a couple of weeks. Usually, both partners will realize that sex can be just as enjoyable when using condoms.
  - “We never used condoms before. Why should we start now?” Explain that now that you know more about the risks of unprotected sex, it seems like a good idea to protect each other.

9.5 How can additional referrals be decided?

**Discussion**

1. Bring back the flip chart used to discuss available services in Module 4. Review as needed with participants to refresh their memories on what services are available where, from whom, when, and how survivors can access them (transport, accompanying arrangements, etc.)

2. Be sure that CHWs ask whether survivors (and any dependents) have a safe place to go, and if not, to contact available protection services or their own supervisors, with the survivor’s consent.

CHWs can mention other services in the community that may be helpful for the survivor, such as health services for **hepatitis B and tetanus vaccines**; psychosocial support; and mental health services. If the survivor requests or agrees to these referrals, CHWs should make arrangements through contacting a case worker if appropriate or the relevant services directly. CHWs should develop a plan with the survivor on how she or he will access the services safely. They should further discuss with persons with disabilities about what kind of support may help them to access the services (e.g., transportation, interpreters) and make appropriate arrangements considering strategies to also ensure confidentiality.

CHWs should note referrals on the intake form.

9.6 How should the survivor’s safety be evaluated?

**Mini lecture**

The role of CHWs is to link survivors to protective services if she or he has safety and security concerns. They should therefore ask how the survivor sees the situation, and whether or not she or he feels safe going home. If she or he feels unsafe, or is unable to find the means to go home safely, with the survivor’s permission, call relevant protection services (safe spaces, women’s groups, etc.) to arrange for the survivor’s safety.

9.7 What should be shared about the follow-up visit?

**Mini lecture**

All survivors of sexual violence will benefit from follow-up care. Survivors should return for follow-up care in two weeks (preferably one week if taking PEP).

CHWs should convey to survivors that during the follow-up visit, the CHW will ask the survivor how she is feeling, and how she or he is faring with the medicines. CHWs can also help secure additional referrals to support services, should the survivor like them.

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### 9.7 What should be shared about the follow-up visit? (continued)

If the survivor agrees to a follow-up visit, decide on a time and a safe place to meet. Note this information on the intake form. If the survivor is taking PEP and/or prefers to meet earlier, accommodate her or his wishes. She or he should feel welcome to see a CHW at any time.

### 9.8 What should CHWs discuss about the intake form?

**Discussion**

If the survivor plans to visit the health facility for a health referral, make a copy of the intake form for her or him to give to the health provider. This will help the provider know what care has been provided so that she or he does not ask unnecessary questions. If it will be a risk for the survivor to have this record, propose alternative ways that the health provider can receive the form. This may be through the programme, or through case workers if available. Any decision must be made with the survivor’s consent.

Mention that the survivor’s original intake form will be stored safely in a locked cabinet, and that she or he can request a copy any time she or he likes. When she or he comes back for a follow-up visit, the same form will be used. If she or he would still like to take home a record of the visit at this time, she or he can be given a copy of the intake form.

Discuss the benefits and possible negative consequences for the survivor having her or his own records at home. The benefits could be that even if she or he were to move homes, she or he would still have a record of the visit. A possible risk is that if someone finds the document, the survivor may be exposed to more safety and security problems. For example, if a family member is the abuser, what would she or he do if she or he finds out the survivor sought care? What if the assaulter, who is not a family member, breaks into the survivor’s home and finds the document? While no one’s name is noted, these are concerns that should be discussed with the survivor for her or him to weigh the options.

If the survivor still requests documentation for her or himself, make a copy of the intake form. Make sure to keep the original, and note at the bottom of the intake form that a copy of the record has been given.

### 9.9 What should CHWs do after the survivor leaves?

**Mini lecture**

CHWs should transfer the information from the intake form to the monitoring form as soon as possible. It is better for CHWs to transfer the information soon after the consultation, so that the interaction is still fresh in their mind. It is important that the monitoring form has no mistakes, since the information recorded on the form is what programme staff will use to monitor what is happening in the pilot overall.

Review again each column of the monitoring form with participants so that they understand how to transfer the information from the intake form, and keep their notation consistent. Remind participants to triple check what they have transferred since the data form is what programme staff will review.

Once CHWs have transferred the information, they should file the original intake form and any other relevant documents in a locked cabinet and follow the programme’s data handling processes.
TOPIC 10: PUTTING THIS ALL TOGETHER

FACILITATOR’S NOTES

For this exercise, it may be helpful for you to draw the intake form on flip chart paper so that you can fill it out as you go. Alternatively, you can make copies to give to participants so that they can practise using the form as they review the scenarios. There are several different ways to complete this exercise. Depending on the participants and amount of time available, you can choose to review all scenarios as a group, or divide participants into smaller groups and have them go through one scenario each to present to the larger group. This exercise can also be done as a role play in pairs, where one person plays the CHW and the other the survivor. If a role play, participants can practise all stages, from obtaining consent through taking a history, providing care, and planning next steps. Treatment should follow local protocol.

10.1 How can critical skills be demonstrated?

Scenario 97
(1 hour)

1. For each scenario, CHWs will need to think through what can be prevented given the timing of the survivor coming for care, and what doses to give. This should be written down.

2. They should then consider (a) points to include in the counselling and care plan, and (b) other services they would offer or refer the survivor to.

10.1 How can critical skills be demonstrated? (continued)

Scenario 1: A 36-year-old female survivor comes to the CHW three days after being sexually assaulted. She states she wants all available treatment. She says she has no allergies that she knows of, and does not have abdominal pain or bleeding. She does not know her HIV status. You have no dedicated EC; however, you do have a combined oral contraceptive with 0.05 mg of estrogen estrodiol (EE) and 0.25 mg of levonorgestrel (LNG).

Response

<table>
<thead>
<tr>
<th>Care</th>
<th>Dose (follow local protocol)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics to prevent STIs</strong></td>
<td>• Give 400 mg of cefixime and 1,000 mg of azithromycin by mouth as single doses to prevent gonorrhoea, chlamydia and syphilis.</td>
</tr>
<tr>
<td><strong>EC (pills) to prevent unwanted pregnancy</strong></td>
<td>• Give two tablets of EE and LNG for the first dose.</td>
</tr>
<tr>
<td></td>
<td>• Advise survivor to take two tablets of EE and LNG after 12 hours.</td>
</tr>
<tr>
<td><strong>PEP to prevent HIV</strong></td>
<td>• Give 28-day supply of combined tablet containing Zidovudine (300 mg) and Lamuvidine (150 mg). One tablet should be taken twice a day for 28 days.</td>
</tr>
<tr>
<td></td>
<td>• Encourage survivor to go to the health facility for HIV testing and counselling.</td>
</tr>
<tr>
<td><strong>Wound care (basic)</strong></td>
<td>None.</td>
</tr>
<tr>
<td><strong>Emotional care (basic)</strong></td>
<td>Basic counselling.</td>
</tr>
<tr>
<td><strong>Tetanus vaccine</strong></td>
<td>Refer to health facility.</td>
</tr>
<tr>
<td><strong>Hepatitis B vaccine</strong></td>
<td>Refer to health facility.</td>
</tr>
<tr>
<td><strong>Follow-up care</strong></td>
<td>Advise her to come back in one week, and if not, in two weeks</td>
</tr>
</tbody>
</table>

- If the survivor asks about sexual relations after the assault, CHWs should advise that they should wait until their genitals no longer hurt and any tears have healed. For many women, having sex makes them think about the assault. They should not be pressured into having sex.98
- Survivors can be reminded to use condoms to protect against infections, especially if they are not sure if their partner(s) have an STI.
- As discussed, survivors who are taking PEP should be encouraged to use condoms every time the survivor has sex until the follow-up HIV test is negative.
- Referral services that may be beneficial are psychosocial support, mental health services, and any other support she may like. These should be discussed and planned with the survivor’s consent.
**Scenario 2:** A 5-year-old boy is brought for care six days after being sexually assaulted. He weighs 15 kg. The assault included anal penetration by an uncle. He is crying and is in pain. His mother states she wants all available treatment. She states he has no allergies that she knows of.

**Response**

<table>
<thead>
<tr>
<th>Care</th>
<th>Dose (follow local protocol)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics</strong> to prevent STIs</td>
<td>• Give 120 mg of cefixime and 300 mg of azithromycin by mouth as single doses to prevent gonorrhoea, chlamydia and syphilis.</td>
</tr>
<tr>
<td><strong>EC (pills) to prevent unwanted pregnancy</strong></td>
<td>None. Not applicable.</td>
</tr>
</tbody>
</table>
| **PEP to prevent HIV**        | • Give 28 day supply of Zidovudine 100 mg capsule and Lamivudine 150 mg tablet. Advise that one capsule of Zidovudine should be taken three times a day. Half a tablet of Lamivudine should be taken twice a day.  
• Encourage mother to take the child to the health facility for HIV testing and counselling. |
| **Wound care** (basic)        | Refer to the health facility since the boy is reporting pain. He can be given paracetomol to manage the pain. |
| **Emotional care** (basic)    | Provide basic counselling and referral to psychosocial support/mental health services.       |
| **Tetanus vaccine**           | Refer to health facility.                                                                    |
| **Hepatitis B vaccine**       | Refer to health facility.                                                                    |
| **Follow-up care**            | Advise the mother to bring the boy back in one week, and if not, in two weeks.                |

- **How can critical skills be demonstrated?** (continued)

- A 5-year-old child should not be asked directly about the assault. Instead, CHWs should ask the mother what happened.

- Never restrain or force a frightened child to do anything against her or his wishes. Restraint and force are often part of sexual abuse, and if used by those attempting to help, will increase the child’s fear and anxiety, and worsen the psychological impact of the violence.

- What is best for the child should be considered at all times, especially the child’s physical safety. Any referral and follow-up plans must be made with this in mind.

- CHWs should know how to address mandatory reporting requirements (inform those who will report) and discuss this issue with the caregiver.
**Scenario 3:** An 11-year-old girl is brought to the clinic by her aunt who is her guardian. She reports multiple sexual assaults by a group of five soldiers four days ago. Her aunt is very concerned about HIV. She wants all possible treatment given to the girl. The girl’s weight is 35 kg. She shows signs of breast development. The girl reports bleeding from her anus.

### Response

<table>
<thead>
<tr>
<th>Care</th>
<th>Dose (follow local protocol)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antibiotics</strong> to prevent STIs</td>
<td>• Give 280 mg of cefixime and 700 mg of azithromycin by mouth as single doses to prevent gonorrhoea, chlamydia and syphilis.</td>
</tr>
<tr>
<td><strong>EC (pills) to prevent unwanted pregnancy</strong></td>
<td>• Give 2 tablets of 0.75 mg levonorgestrel only tablets by mouth as a single dose. EC can be given to an adolescent that has developed breast buds, even if she has not begun menstruating.</td>
</tr>
<tr>
<td><strong>PEP to prevent HIV</strong></td>
<td>• Encourage the aunt to take the child to the health facility for HIV testing and counselling.</td>
</tr>
<tr>
<td><strong>Wound care</strong> (basic)</td>
<td>Refer to the health facility for bleeding from her genitals. Give pain relief, such as paracetomol.</td>
</tr>
<tr>
<td><strong>Emotional care</strong> (basic)</td>
<td>Provide basic counselling and referral to psychosocial support/mental health services.</td>
</tr>
<tr>
<td><strong>Tetanus vaccine</strong></td>
<td>Refer to health facility.</td>
</tr>
<tr>
<td><strong>Hepatitis B vaccine</strong></td>
<td>Refer to health facility.</td>
</tr>
<tr>
<td><strong>Follow-up care</strong></td>
<td>Advise her to come back in one week, and if not, in two weeks.</td>
</tr>
</tbody>
</table>

- CHWs should be careful working with younger adolescents. The best interests of the child need to be the priority at all times.

3. Have participants practise transferring information they just noted on the intake form to the monitoring form. See if they have any questions.
## Providing follow-up care to survivors of sexual violence

### Session Time
3 hours (2 hours 30 minutes without optional activity)

### Objectives
By the end of this session, participants will be able to:
- Understand what follow-up care is offered to survivors.
- Learn ways that CHWs can help survivors in the healing process.

### Methods
- Mini lecture
- Scenario
- Case study
- Discussion

### Preparation
- Prepare lecture
- Know if pregnancy tests are available and how soon they can detect pregnancies
- Know the legal indications for safe abortion care

### Training aids, materials and HOs
- Flip chart and markers
- Intake form (HO)
- Monitoring form (HO)

### Evaluation and assessment
None

### Additional resources
**TOPIC 1: PROVIDING FOLLOW-UP CARE**

1.1 What is follow-up care?

*Mini lecture*
10 minutes

Explain to CHWs that during the follow-up visit, CHWs will:

- Ask the survivor how she is doing with the medicines, and any side effects she or he is experiencing (see section 1.2).
- If the survivor has additional health problems, assess per skills taught in Module 5 on whether she or he will need to be seen by a higher level health provider.
- If she or he has not already been tested, ask if the survivor wants to take an HIV test. If she or he agrees, refer her or him to the health centre. This is always optional.
- Encourage partner referral for STI and HIV testing and treatment as necessary (see sections 1.2.1 and 1.2.2).
- See whether or not the survivor may be pregnant and provide counselling as necessary (see section 1.3).
- Assess the survivor’s emotional state and ensure she has appropriate psychosocial and mental health support (see section 1.5).
- Ask the survivor if any support services have been helpful (if referrals were made and completed).
- Decide together what additional referrals the survivor would like, including additional health services, psychosocial, mental health, protection, social and legal support. Referrals should follow the same processes as previously discussed.
- Discuss new or existing safety concerns.
- CHWs should document the care they provided and any issues of concern on the intake form. If the survivor requests a copy for her or his records, give her or him a copy, weighing the security risks.

1.2 How should CHWs follow-up with survivors on their treatment?

*Mini lecture*
15 minutes

When CHWs ask the survivor how she or he is doing with the medicines and any side effects she or he is experiencing, they should also:

- Remind survivors to finish the full course of antibiotics to prevent or treat STIs.
- If the survivor is taking PEP, remind her or him to complete the 28-day treatment regimen.
- If the survivor has been tested for HIV, ensure she or he is following the instructions received at the health facility. If HIV positive, the survivor should no longer be taking PEP. (See section 1.2.1-1.2.2 on how to discuss HIV testing with their partner.)

If the survivor did not take an HIV test, she or he should be encouraged to get tested at the health facility.

CHWs can ask a survivor if she or he has noticed any of the following common symptoms and signs of an STI:

- Unusual vaginal discharge (liquid) in terms of amount, smell or colour
- Itching of the vagina
1.2 How should CHWs follow-up with survivors on their treatment? (continued)

- Pain while passing urine
- Pain during sex
- Lower abdominal (belly) pain
- Rash, sores or ulcers in the genital areas

If the survivor has symptoms of an STI, it could be because the medicine did not work, or she or he has a new infection from a partner or partners who also have an STI. CHWs should refer cases of treatment failure or recurrent STI infection to a higher level health facility. Messages to provide survivors for relief from the discomfort of some STIs are:

- Wear underclothes made of cotton
- Wash underclothes once a day and dry them in the sun
- Sit in a pan of clean, warm water for 15 minutes, two times a day
- If it is painful to pass urine, pour clean water over the genital area while passing urine

FACILITATOR’S NOTES

Advanced Module 8 has information on syndromic management of STIs as well as partner notification and management strategies for STIs.

1.2.1 How can partners be encouraged to get treated/ tested for STIs and HIV?

Mini lecture
10 minutes

Further explain that anyone who is treated for an STI may develop another infection if sexual partners are not treated. The sexual partner may or may not have symptoms and, if left untreated, could continue to reinfect his or her partners. It is also possible that her or his partner already has an STI and that she or he could pass it to the survivor if the partner does not also get treatment. Partners include current partner(s) and all partners within the last two to three months.

Many people with HIV do not have signs and symptoms of the infection. Even if a survivor takes medicine to prevent HIV transmission after an assault, it is possible that this medicine will not work. Therefore, she or he should use condoms for three months with all partners for every act of sexual intercourse until an HIV test result is obtained.

Alternatively, if the survivor tests positive for HIV, she or he may want to make sure her or his partner is not also positive. This can be a difficult issue for partners to talk about and survivors should never be forced to share information about their health or treatments with anyone else (including partners), especially if they feel that doing so will make them unsafe.

If appropriate, and risks for violence or rejection are weighed, CHWs may suggest that a survivor go to the health centre with her or his partner so they can both get any STIs treated and learn about their HIV status together to understand how to make healthy decisions for their future.
1.2.2 What are the benefits of HIV testing and counselling for couples over individual testing?

Discussion

10 minutes

1. Draw two columns on flip chart paper and ask participants to think through the benefits of HIV couples counselling and testing as appropriate.

2. Once the columns are completed, compare with the table below and add if any have been missed.

<table>
<thead>
<tr>
<th>Individual HIV counselling and testing</th>
<th>Couples HIV counselling and testing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Survivor learns only her own HIV status</td>
<td>Partners learn each other’s HIV status</td>
</tr>
<tr>
<td>Survivor is faced with the burden of disclosing to her or his partner</td>
<td>Counsellor can help ease the tension and diffuse blame</td>
</tr>
<tr>
<td>Only one person hears the information</td>
<td>Partners hear information together, enhancing likelihood of shared understanding</td>
</tr>
<tr>
<td>Counselling messages take into account only one person’s status</td>
<td>Counselling messages are based on the results of the couple, and can be tailored to positive concordant (both partners HIV positive), negative concordant (neither partner HIV positive), and discordant (one partner HIV positive, one partner HIV negative)</td>
</tr>
<tr>
<td>There is no moderated opportunity for couples to talk through difficult issues</td>
<td>The counsellor creates a safe environment and can help couples talk through issues they may not have disclosed before</td>
</tr>
<tr>
<td>Treatment and care decisions are more likely to be made in isolation</td>
<td>Treatment and care decisions can be made together</td>
</tr>
</tbody>
</table>

Game

10 minutes

Tell participants they will now play a game to dispel any myths and misperceptions about disclosing HIV status. Have participants stand up and gather in the centre of the room.

Read each statement below and ask participants if they think it is true or false. Those who think it is ‘true’ should go to the right side of the room; those who think it is ‘false’ should go to the left. Once participants have moved, read the fact and see if participants have questions or thoughts.

Statement 1: If one partner is HIV positive, the other partner automatically is, too.

Answer: False

Fact: A couple can have different HIV statuses. One partner’s HIV status does not determine the other partner’s HIV status, and just because one partner is infected does not necessarily mean the other partner is, too. The only way to find out is through an HIV test.

1.2.2
What are the benefits of HIV testing and counselling for couples over individual testing? (continued)

**Statement 2:** If one partner is HIV negative, the other partner automatically is, too.

**Answer:** False

**Fact:** As stated above, a couple can have different HIV statuses. One partner’s HIV status does not determine the other partner’s HIV status.

**Statement 3:** HIV-negative status is a protection from God.

**Answer:** False

**Fact:** The HIV-negative partner can become infected at any time if he or she does not take measures to lessen risk.

**Statement 4:** If you have unprotected sex once, and are HIV negative, you might as well continue.

**Answer:** False

**Fact:** Although HIV may not have transmitted in previous exposures, every new exposure poses a risk of HIV transmission. It is never too late to take measures to lessen risk.

**FACILITATOR’S NOTES**

Know in advance if pregnancy tests are available, and how soon they can detect pregnancies.

Also know the legal indications for safe abortion care, which may include rape and the mental and physical health of the woman.

1.3
What should CHWs do if a survivor learns she is pregnant? (Optional)

**Mini lecture**
10 minutes

CHWs can administer a pregnancy test if survivors report that menstruation is late and they agree to be tested. If the test is positive, CHWs should counsel survivors on possible options in the community, including support groups.

If safe abortion care for sexual violence is legal, CHWs should share where such resources are available in the event the survivor wishes to terminate her pregnancy. CHWs should not have their own belief systems influence whether or not a survivor can access safe abortion services.
1.4 What are other ways CHWs can support the survivor during follow-up care?

Scenario 35 minutes

Read the following scenarios and brainstorm with CHWs on how they can address some of the potential challenges raised by survivors.

Scenario 1: A survivor returns to you one week later complaining of vomiting after taking PEP. What advice would you give her?
   A. Tell her to stop taking PEP.
   B. Tell her to continue taking PEP with food and anti-nausea medication.
   C. Tell her she is infected with HIV.

Answer: B. Nausea and vomiting are common side effects of the medications used for HIV PEP. Survivors should be encouraged to complete the regimen. CHWs should encourage the survivor to take PEP with food to reduce nausea and vomiting. If nausea and vomiting still occur, CHWs can provide anti-nausea medication if it is available. It is important that the person complete the full 28-day treatment regimen in order for PEP to be effective at preventing HIV.

Scenario 2: A survivor finds out she is HIV positive after undergoing HIV testing and counselling. She shares her status with you and does not know what to do. What advice will you give her?
   A. Counsel her to let her know she can stop taking PEP and can access support, care and treatment services as available.
   B. Tell her to continue taking PEP.
   C. Tell her that if she tested positive now, she must have gotten HIV before the assault, so this is not your problem.

Answer: A. Ways in which CHWs can help HIV-positive survivors is by helping her or him:

- Decide who to tell about being HIV-infected, and how.
- Find the support of others who are also HIV-infected.
- Get the care and treatment she needs early from the health centre, including preparing for and taking ART.
- Get the support she needs from her family.
- Understand how to stay healthy for as long as possible, by eating nutritious foods and getting enough rest.
- Plan for her or him future.
- Learn how to be sexual in a safe way, by using condoms.

If the survivor is found to be HIV positive, she or he should stop taking PEP.

Scenario 3: A 21-year-old female survivor came for care two weeks after the assault. You did not give her EC since it was after five days. During the follow-up care, she tells you that she has missed her period, and that she is likely pregnant. What advice will you give her?

A. Tell her that it was her fault for coming for care so late. She should have come earlier.

B. Share your personal belief about abortion and what the survivor should or should not do.

C. Give emotional support and practical options for the survivor to consider.

Answer: C. Emotional support and clear information are needed to ensure that survivors understand the choices that are available if they become pregnant:\footnote{WHO, *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons*, 2004, p.28.}

- In many countries, the law allows for termination of a pregnancy due to rape. Where safe abortion services are available, let the survivor know where and how she can access this if she so chooses.
- There may be adoption or foster care services in the area.
- Advise survivors to seek support from someone they trust, such as a religious leader, family member or a friend.
1.5 How can CHWs address survivors’ emotional needs?

Case Study

(1 hour)

Emotional and psychosocial needs will often last much longer than any physical consequences of the assault. Provide a series of statements that a CHW may hear from a survivor of sexual violence. Ask participants to identify which common emotional reactions the survivor is expressing as a consequence of the sexual violence (i.e., fear, denial, depression, anxiety).

Ask participants to discuss the key messages that may help the survivor, and how CHWs can support the survivor through the coping process.

**Statement #1:** “I’m constantly scared. A sudden noise, an angry voice, moving bushes and I am afraid. I am also afraid that my husband will divorce me if he finds out, and my family will take my children.”

**Consequence:** FEAR. During an assault, many survivors fear for their lives. Often, this fear is a direct result of the offender’s threats. After the violence, a survivor may be fearful of the dark, of being alone or going out by herself. She may experience fear caused by the possibility of pregnancy or STIs, or live in fear of running into her assailant again. She can also be fearful of the possible consequences of the sexual violence, including rejection from the family.

**Coping mechanisms:** All of these fears are very real concerns and CHWs should try to ensure that practical steps are taken for the survivor to feel as secure as possible. In all instances, CHWs should see the survivor’s fears as normal and expected, and support her or him to develop ways that will contribute to the rebuilding of her or his security and confidence in day-to-day living. If the survivor has come for care within three days, reassuring her or him that the health services she or he has received to prevent pregnancy and HIV may help reduce fears about the health consequences of sexual violence.

If the survivor reports after five days, talk through the support services in the community that she or he can access, if/when she or he would like to do so. Ensuring confidentiality will minimize the risk of others finding out what happened.

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**Statement #2:** “I feel so tense and jumpy.”

**Consequence:** ANXIETY. Survivors of sexual violence often experience severe anxiety that may show as physical symptoms, such as difficulty breathing, muscle tension, nausea, stomach cramps or headaches. They are often easily startled.

**Coping mechanisms:** These reactions can be eased as survivors gradually heal and find ways to cope with their stress. Offering relaxation exercises or rituals, and/or physical exercise may also help them deal with anxiety.
Examples of relaxation techniques that can be taught to both adults and children include controlled abdominal breathing or relaxation.

- **Belly breathing:** This technique of controlled breathing has the person focus on his or her breathing so that she or he breathes deeply and slowly. Breathing in this manner tends to relax the body. Controlled breathing helps to eliminate or reduce feelings of tension or anxiety, and by concentrating on breathing patterns, the survivor can distract her or himself from unpleasant thoughts or images. The technique is taught by having the person concentrate on breathing in and out through the nose. One hand should be on the stomach and one hand on the chest. When breathing in, the hand on the stomach should move up, and when breathing out, it should move down. The hand on the chest should stay still and not move the whole time.

- **Relaxation:** This technique helps relax the body and decrease muscle tension. This is helpful for children and adults who have trouble falling asleep or who have physical symptoms of anxiety. Body relaxation is usually taught by having the person move between tensing and relaxing her or his muscles. Focusing on this difference teaches survivors how to recognize tense feelings and how to relax them.

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**Statement #3:** “I want to kill him; I hate him, everything, everyone.”

**Consequence:** ANGER/HOSTILITY. Anger is a difficult emotion for most people. Culturally, women and children are often discouraged from expressing anger, and it is most frequently directed at a different target. She or he may also be angry at the response she or he received from others to whom she or he shared her or his experience.

**Coping mechanisms:** Given her or his experience, the survivor’s reactions of anger are acceptable and natural. However, if CHWs work with a survivor, they too could be a target of this anger. CHWs should not take this personally, but help the survivor find positive and safe ways to vent anger and hostility, and use her or his energy in a positive way.
1.5 How can CHWs address survivors’ emotional needs? (continued)

Statement #4: “I feel like I don’t have anyone to talk to who understands and supports me. I can’t tell anyone around me about this.”

Consequence: LONELINESS/ISOLATION. Sexual violence survivors often experience feelings of loneliness, isolation and despair if they are unable to share their experiences with others. They avoid talking about their experiences since remembering the violence is painful; they fear that others cannot understand them; or they fear being stigmatized or isolated by friends or family. However, many survivors never forget their experiences and these are relived in nightmares and flashbacks. Not speaking about the violence, but reliving it in nightmares and flashbacks results in a state of fear that prevents survivors from healing.

Coping mechanisms: CHWs can serve as a ‘safe person’ in whom survivors can confide. Assure survivors their confidentiality, and refer them to support groups and other safe places where they can share their concerns and begin to recover. It is very important that survivors are listened to in a compassionate, non-judgmental way, and they understand that they are not alone and can receive help. Ensuring that survivors have the opportunity to share their concerns with persons that are understanding and respectful will help restore their dignity and help them heal. As CHWs, it is important to sensitize the community about the causes and consequences of sexual violence to reduce rejection of survivors by the community.

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Statement #5: “I feel so helpless. Will I ever be in control again?”

Consequence: POWERLESSNESS/LOSS OF CONTROL. Because all forms of sexual violence involve a survivor losing power over her or his body during the assault, one of the CHW’s primary roles can be to help the survivor regain a sense of control.

Coping mechanisms: By explaining procedures and options, and by respecting and supporting his or her choices, a CHW can assist the survivor to regain a sense of control. Supporting the survivor’s choices, rather than advising the survivor, is one of the most important and difficult skills of caring for survivors. By helping them find solutions to problems they face, CHWs can help survivors regain a sense of control.
Statement #6: “I feel I am going crazy – one minute I feel nothing, then suddenly I feel really angry.”

Consequence: MOOD CHANGES. After the assault, survivors’ emotions may swing from intense emotional pain to complete lack of feeling (numbness). They may feel depressed, restless or deflated, confused or angry. Having uncontrollable emotions may make them believe they are psychologically unstable. Among the most commonly misunderstood reactions is emotional numbness, which is a common response to a terrifying event. Those around survivors often misunderstand this response as an indication that the survivor is calm and relatively unharmed. However, in reality, this is a way of coping with the overwhelming experience.

Coping mechanisms: CHWs can support survivors by explaining that intense mood changes are common and normal responses to extremely stressful events. The survivor should also be reassured that as they understand and cope with the effects of the assault, these reactions will get better. It is important to recognize that a lack of feeling is a normal reaction and not a sign that the person was never assaulted. Explaining such a reaction to a survivor may help her or him recognize and acknowledge the incident. Severe and persistent lack of feeling is an indicator for referral to mental health services.

Statement #7: “I’m okay. I’ll be alright. I don’t need any help.”

Consequence: DENIAL. Following the initial shock of the assault or even months later, survivors may deny that they were ever assaulted. They try to ignore what happened in an attempt to regain stability. Some survivors may feel that if the offender did not penetrate, they were not sexually assaulted, or alternatively, “If the offender did not put fluid inside, then it was not as bad.”

Coping mechanisms: As CHWs, it is important to help the survivor realize what happened, so that she or he can accept help if needed and begin the recovery process. Denial is a strong action to protect oneself. Therefore, a survivor should never be pressured to explain what happened or share any details. By listening and showing the CHWs care, they can create a safe environment in which the survivor can begin to build trust and share as much as she or he feels is appropriate.
1.5 How can CHWs address survivors’ emotional needs? (continued)

Statement #8: “I feel as if I did something to make this happen. If only I hadn’t...”

Consequence: GUILT/BLAME. Survivors of sexual violence may feel that they could have avoided the assault by acting differently. These types of reactions are often strongly linked to the myths about sexual violence that exist in the community that frequently blame the survivor rather than the offender. The behaviour and reactions of friends, family, neighbors and police may reinforce the survivor’s own feeling that she or he, “asked for it,” or should have done something to avoid it. The survivor may also feel guilty that she or he has brought shame to her or his family and her or himself if she or he talks about it or reports it to others. Similarly, if the survivor believes she or he could have resisted more forcefully, she or he may also feel at fault.

Coping mechanisms: The role of CHWs is to provide information that demonstrates that anyone can experience sexual violence. The offender is always at fault, never the survivor. Nothing a survivor does is, “asking for it.” Under all circumstances, CHWs must reinforce that the survivor is not to blame and that it is the offender who is at fault. However, it may take time for the survivor to accept this, and the survivor’s feelings of guilt need to be accepted while being reassured that she or he was not responsible.

Statement #9: “I feel so dirty, like there is something wrong with me now. Can you tell that I’ve been raped? What will people think?”

Consequence: EMBARRASSMENT/SHAME. Many people who have experienced sexual violence feel very ashamed and embarrassed. They often feel dirty and in some way, marked for life. This reaction may prevent survivors from speaking out about the violence. Cultural norms can strengthen such feelings. Underlying these feelings is that survivors often have to live with day-to-day discrimination and stigma.

Coping mechanisms: Providing opportunities for survivors to talk about and question these beliefs will help them place the responsibility for the assault with the offender. Confidentiality and privacy are particularly important in order to help the survivor feel comfortable and safe. Stressing that embarrassment is a normal reaction can help the survivor to accept and address these feelings. Helping the survivor recognize the situations in which she or he faces stigma and discrimination is also helpful.
1.5 How can CHWs address survivors’ emotional needs?

(continued)

**Statement #10:** “I feel I can’t do anything anymore...I’m disgusted by myself. I’m just worthless.”

**Consequence:** LOSS OF SELF-CONFIDENCE. The experience of violence exposes the survivor to the reality that she cannot always protect herself or himself no matter how hard she or he tries. The assault is not only an invasion of the survivor’s physical self, but it also affects emotions, thoughts and social interactions. The experience of assault raises many issues that can destroy self-confidence and beliefs about the world. Therefore, it is not surprising that survivors often experience low self-esteem.

**Coping mechanisms:** To facilitate the healing process, CHWs can help survivors build a new sense of confidence. This confidence can begin with the realization that surviving the violence took incredible strength and hard work. Every action the survivor takes (e.g., seeking help, sharing his or her story, etc.) should be recognized as a step towards regaining confidence. It is essential to focus on the positive aspects of the ways the survivor tries to help herself or himself.

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**Statement #11:** “Suddenly people in my community won’t talk to me – my neighbors stopped helping me, and the kids at the school tease my children.”

**Consequence:** STIGMA AND DISCRIMINATION. A common problem for survivors is the stigma and discrimination they experience after sexual violence. This can take many forms, including neighbors and other community members excluding the survivor from activities; verbal or physical abuse of the survivor and/or her or his family and children; and discrimination in access to services such as social services and education. This can deepen the survivor’s emotional distress (shame, isolation, depression, etc.), as well as make it more difficult for her or him to access services.

**Coping mechanisms:** It is important to support the survivor to learn her or his own ways to deal with the stigma and discrimination, as well as receive social support (e.g., identifying neighbors who are supportive or social support networks). CHWs can provide information on services that are sensitive to survivors, and if these do not exist, to provide them with accurate information about existing services and the benefits and risks involved.
1.5 How can CHWs address survivors’ emotional needs? (continued)

Statement #12: “Since the rape, things have been tense in my family.”

Consequence: RELATIONSHIP DIFFICULTIES. Many survivors experience difficulties in relationships as a result of sexual violence. This can come from many factors, including stigma among family members; changes in the survivor’s behaviour and emotions; difficulties for family members to understand and support the survivor; and additional problems such as health problems. Family members may disagree about how to respond to sexual violence (e.g., a husband may be supportive of his wife but his side of the family blames her).

Coping mechanisms: It is important to understand the source of the problem in the family. Discuss with the survivor and try to help her or him find strategies to address them. If the CHW is known and trusted by other family members, and the survivor agrees, CHWs could discuss with them how they could better support the survivor.

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Statement #13: “How am I going to go on? I feel so tired and hopeless and nothing seems to interest me anymore.”

Consequence: DEPRESSION. Many survivors of sexual violence suffer times of depression, such as losing the will to live and interest in daily activities, and experiencing numbness, loss of appetite, difficulty sleeping and constant tiredness.

Coping mechanisms: CHWs can try to help the survivor show their grief, sadness and anger. The release of grief and the appropriate refocusing of anger will empower the survivor. Survivors showing signs of severe depression (e.g., thoughts about wanting to kill themselves and behaviour) should be referred to mental health services.

***

Statement #14: “I can’t stop thinking about the attack. I have nightmares when I sleep and sometimes during the day I feel as if it is happening over again.”

Consequence: FLASHBACKS AND NIGHTMARES. Memories of the violence often return without warning. Nightmares are common among survivors. Sometimes, flashbacks occur during the day and will be so real that the survivor feels as if she or he is reliving the assault.

Coping mechanisms: CHWs can explain to a survivor that she or he is having a flashback. Reassure the survivor that flashbacks are a normal response to the violence and will health with time. They represent a response that, like nightmares, will decrease as the recovery process continues. If a survivor experiences a flashback while talking, encourage her or him to take slow, gentle breaths. Tell the survivor that she or he is remembering but not experiencing the violence. Help the survivor look around the room and realize where she or he is, that she or he is in a safe place and no one will hurt her or him. This reaction is normal.
Reactions in children across age and developmental stages:

Infants and toddlers (ages 0–5): It is common for young children to show behaviours from when they were younger. This means that children may lose certain skills they previously had (for example, bladder control), or they may go back to behaviours they had outgrown (e.g., thumb-sucking). Similarly, young children often want to cling to familiar adults, including caregivers to whom they feel close. They may also resist leaving places where they feel safe, or be afraid to go to places that may bring back memories of a frightening experience. Major changes in eating and/or sleeping habits are common and young children may complain of physical aches and pains that have no medical reason.

Young children (ages 6–9): Young children may also show regressive behaviours, such as asking adults to feed or dress them, or they may report unexplained physical problems just as the younger age group (0 to 5 years) does. They may show emotions such as sadness, fear, anxiety and anger, and feelings of shame and guilt. However, children of this age group have a better understanding of the meaning of sexual abuse and they have more advanced thoughts and beliefs about what they experience and what they think are negative consequences. As a result, they may begin to avoid their friends and refuse to go to school, or they may begin to behave aggressively. They may also be unable to concentrate, resulting in a drop in how they perform in school.

Adolescents (ages 10–19): In general, adolescents tend to place more importance on their friends and ‘fitting in’. This can complicate their efforts to understand sexual abuse. Adolescents may be reluctant to discuss their feelings or may even deny any emotional reactions to the sexual abuse, partly because of their desire to fit in and avoid the shame and stigma associated with sexual abuse. Adolescents, especially older adolescents, are more likely to show traumatic responses similar to adults.


Discussion
15 minutes

1. Discuss what barriers exist for CHWs to provide follow-up to survivors in their setting, or limitations to the care they can provide.

2. As participants what they think can be helpful strategies to improving follow-up and addressing limitations. List these on flip chart paper.

1.6 How should CHWs end the follow-up visit?

Mini lecture
5 minutes

As with the initial consultation, CHWs should ensure the survivor is safe and decide together with the survivors what additional referrals the survivor may like. CHWs should inform the survivor that she or he is welcome to come back anytime she or he would like, especially at six weeks and three months, although sooner is always fine.

CHWs should document the care they provided and any issues of concern on the follow-up section of intake form. If the survivor requests a copy for her or his records, give her or him a copy, weighing the security risks.

Once the survivor leaves, CHWs should note on the monitoring form that the follow-up visit was undertaken, and safely store both the original intake and monitoring forms according to protocol.
MODULE 6

Self-care for community health workers
### SESSION 6.1

**Self-care for community health workers**

<table>
<thead>
<tr>
<th><strong>Session Time</strong></th>
<th>2 hours 20 minutes</th>
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<tbody>
<tr>
<td><strong>Objectives</strong></td>
<td>By the end of this session, participants will be able to:</td>
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<tr>
<td></td>
<td>• Recognize different forms of stress</td>
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<tr>
<td></td>
<td>• Identify ways to deal with stress and understand how social and organizational support can help reduce stress related to working with survivors</td>
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<tr>
<td></td>
<td>• Apply strategies for self-care</td>
</tr>
<tr>
<td><strong>Methods</strong></td>
<td>• Mini lecture</td>
</tr>
<tr>
<td></td>
<td>• Discussion</td>
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<tr>
<td></td>
<td>• Exercise</td>
</tr>
<tr>
<td><strong>Preparation</strong></td>
<td>• Prepare lecture</td>
</tr>
<tr>
<td><strong>Training aids, materials and HOs</strong></td>
<td>• Flip chart and markers</td>
</tr>
<tr>
<td></td>
<td>• Blank sheets of paper</td>
</tr>
<tr>
<td><strong>Evaluation and assessment</strong></td>
<td>• None</td>
</tr>
</tbody>
</table>
1.1 What causes stress?

Discussion
30 minutes

1. Inform participants that working with survivors of sexual violence and being regularly exposed to stories of sexual violence can be very difficult. It is therefore very important for CHWs to learn how to care for themselves and each other. Before discussing self-care, explain that it is helpful to first think about things in life that cause stress (stressors) and things that feel good and/or give strength (resources).

2. Draw a matrix similar to the example below on flip chart paper. Ask participants to take a blank sheet of paper and copy the matrix. Ask them to think about things that cause stress in their daily life and work, and activities or resources that make them feel good. They will need to distinguish between what they can control and what they cannot control. Below the matrix, ask them to write their ‘personal signs of stress’ and give examples.

<table>
<thead>
<tr>
<th>What gives me stress?</th>
<th>What gives me strength?</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Major stressors)</td>
<td>(Resources)</td>
</tr>
<tr>
<td><strong>Examples: What I can control</strong></td>
<td><strong>Examples: What I cannot control</strong></td>
</tr>
<tr>
<td>Thinking about work at home.</td>
<td>The ongoing conflict in my home area.</td>
</tr>
<tr>
<td>Wanting everything to be perfect, wanting to help everybody.</td>
<td>The high number of cases of sexual violence in my community.</td>
</tr>
<tr>
<td>Worrying over my children.</td>
<td></td>
</tr>
<tr>
<td>Meeting with friends and neighbors.</td>
<td>Seeing a positive change in the way community members engage with survivors.</td>
</tr>
<tr>
<td>Taking a long walk.</td>
<td></td>
</tr>
<tr>
<td>Playing with my children.</td>
<td></td>
</tr>
<tr>
<td>Being able to help survivors of sexual violence.</td>
<td></td>
</tr>
</tbody>
</table>

My ‘personal signs of stress’: e.g., *sleeping badly, having a headache/stomach ache, being easily irritated*.104

3. Give participants 5–10 minutes to fill in their matrix.

4. Bring the group back together and invite a few participants to talk about how they completed their matrix and what they see as their signs of stress. List examples on the flip chart and let participants discuss. Highlight that for some people, a ‘stressor/resource you can control’ might for others be ‘a stressor/resource you cannot control’.

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### 1.1 What causes stress? (continued)

5. Ask participants why they think the difference between control/no control as well as individual differences are so important. Note that very often, stressors they cannot control have a bigger impact than those they can control.

6. When the matrix on the flip chart is completed, circle/underline stressors (and resources, if any) that are related to working with survivors of sexual violence. Conclude by saying that it is important to be aware of the stressors to which CHWs are exposed and to recognize possible signs of stress.

### 1.2 What are the different forms of stress?

**Mini lecture**

- **10 minutes**

Explain to participants that there are different forms of stress. Stress is a normal and natural response designed to protect, maintain and make life better. It encourages people to get up in the morning, accomplish tasks and seek out new work and enjoyable relationships. If the ways of managing stress are healthy, stress can be positive. However, long-lasting stress or frequent high levels of stress reduces people’s ability to control and deal with it effectively, and people can begin to feel helpless.

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**FACILITATOR’S NOTES**

**Stress** is an immediate, physical, social and psychological response to a change in the situation around people. It is an ‘alarm reaction’ when people are faced with something that might be a threat. This threat might be a change in the internal or external environment to which people have to adapt and with which people have to cope. Every person reacts differently to stress. People have different limits. Not everyone feels stress in the same situation.


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A main source of stress is **day-to-day stress**. Much of this stress is positive. As long as people feel that they can control the stressors, they are okay.

A high level of stress can have a very negative impact on people’s work and life. Long-lasting stress (cumulative stress) is the most common for workers in conflict settings. It occurs when a person suffers from exposure to a number of different stressors for long periods of time. The causes are usually a combination of personal, work and event-related and can cause frustration.

When this type of stress is not well managed, there is risk for overload, which is the point at which stress overcomes people’s ability to manage. Overload can lead to burnout. Burnout can be caused by:

- Working long hours without any support or recognition
- Working with and for survivors but not having the resources to provide the care needed
- Working in areas that are not secure

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**Discussion**

- **15 minutes**

1. Ask participants what burnout could look like, and list these on flip chart paper.
**FACILITATOR’S NOTES**

**SIGNS OF BURNOUT CAN INCLUDE.**

**Body reactions:**
- Chronic fatigue
- Sleeping problems
- Frequent headaches
- Ulcers/stomach problems
- Loss of appetite

**Emotional reactions:**
- Depression
- Anger
- Irritability
- Feeling frustrated or trapped

**Thoughts:**
- Having very negative thoughts about one's own performance or in general
- Becoming very cynical
- Starting to focus on failures and/or the failures of others

**Behaviour:**
- Not showing up at work
- Working very hard and long hours
- Risk of alcohol, cigarettes, etc.
- Being in constant fights with colleagues or family/friends


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1.2 What are the different forms of stress? (continued)

**Mini lecture**
10 minutes

Inform participants that there are two types of stress that can impact people greatly and lead to extreme distress. One is stress that comes after experiencing an event that overwhelms people’s ability to cope. Such events are usually sudden, violent and unexpected.

Examples of incidents that can bring about this type of stress (critical incident stress) are:
- Becoming a victim of or witnessing security incidents, such as attacks, robbery, threats, etc.
- Accidents
- Being faced with survivors of an incident
- Being victim to a natural disaster
- Being faced with the sudden loss of a peer

The second type of stress can occur after extremely stressful events (secondary trauma or vicarious trauma). For example, when CHWs listen regularly and with empathy to stories of sexual violence, they can become affected and begin to suffer from signs of stress that are somewhat similar to those of survivors. The stories people hear are often very ‘alive’; people create images of what they hear. This can have a similar result as being faced with the terrifying event ourselves.

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1.2 What are the different forms of stress? (continued)

Signs of these two types of stress can be:

Taking work home. This means that even when people are not at work, when they are home or with their families, they are unable to stop thinking about work.

- Not being able to sleep well.
- Feeling strong emotions during or after working with a survivor.
- Being generally anxious.
- Feelings of being overwhelmed, like there is no way to cope with what is happening around them.
- Feelings of incompetence, such that people can no longer accomplish what they once did well.
- Listlessness, depression, never feeling happy or sad, just muted or without feeling.
- Disturbing thoughts of survivors, their families and extremely stressful events through dreams, nightmares, daydreaming, repeating images or real mental replaying of survivors’ experiences.
- Anger at survivors, their families, the system, themselves and/or at staff/society.
- Overreacting to small events, especially at home.
- Having fantasies about paying back someone for the harm caused.
- Haunting memories of people’s own terrifying events.
- Emotional detachment (no feeling, no emotion, loss of humour) from people who are close.

Summarize by explaining that it is important to recognize the signs of different forms of stress so that participants know how to prevent or address them.

FACILITATOR’S NOTES

Different cultures express distress in different ways. This does not imply that particular groups of people do not experience stress. Some cultures teach that showing emotion is negative and somehow shows a weakness of character. In such cultures, persons under stress may not cry or cry very little, or do not show very much feeling. It should never be assumed to mean that they are not experiencing stress, but rather, that they have a very high threshold for showing emotion because of how they were raised or how their culture judges the display of emotion.

Every person is also different and experiences stress in her or his own way. What is stressful for one person might not have the same impact on someone else. People can react differently when faced with the same situation of stress or the same incident. Therefore, never make assumptions about a person’s reactions or behaviour.

### TOPIC 2: COPING WITH STRESS

#### 2.1 How can I manage and recover from stress?

**Mini lecture**

15 minutes

Provide suggestions on how CHWs can best manage stress, support and be supported by each other. Some suggestions include:

- Thinking about what has helped them cope in the past and what we can do to stay strong.
- Trying to take time to eat, rest and relax, even for short periods of time.
- Trying to keep reasonable working hours so that they do not become too tired.
- Considering, for example, dividing the workload among others, working in shifts and taking regular rest periods.
- Remembering that they are not responsible for solving all problems. They can only do what they can to help people help themselves.
- Minimizing intake of alcohol, caffeine or nicotine (smoking) and avoiding nonprescription medicines.
- Checking in with fellow peers to see how they are doing and having them check in on them. Find ways to support themselves.
- Getting support by talking with friends, loved ones or other people they trust.

Taking time for rest and reflection is also an important part of helping with recovery. Some possible ways include:

- Talking about their experiences with a supervisor, colleague or someone else they trust.
- Accepting what they are able to do to help others, even in small ways.
- Learning to think about and accept what they did well, what did not go very well, and the limits of what they could do in the situations.
- Taking some time, if possible, to rest and relax before beginning work again.
- If they find themselves with upsetting thoughts or memories about the event, feel very nervous or extremely sad, have trouble sleeping, drink a lot of alcohol or take drugs, it is important to seek support from someone they trust. CHWs should speak to a supervisor, health professional or mental health specialist if these difficulties continue for more than one month.

#### Discussion

30 minutes

1. Divide participants into small groups to discuss personal strategies for how to manage stress and how to recover from stress. They can also think about ways of coping that are specific to their culture, such as relaxation techniques, cultural and recreational activities, religious activities, and so on.

2. Let participants know they have 15 minutes to discuss before they report back to the group.
2.1 How can I manage and recover from stress? (continued)

3. Once each group has presented, emphasize that individual strategies to balance stressors are very helpful, but social support or organizations can also be helpful in coping with stress. These can include support from other CHWs, self-care groups, staff meetings, support from leaders and so on.

4. Have participants raise what kind of support would be helpful from the programme and their supervisor in carrying out their work to care for survivors of sexual violence.

5. Note this information on flip chart paper and let participants know that you will present their ideas about the kind of support that would be helpful to programme staff at the end of the training.

6. Share any supervision or support plans of the programme to participants as relevant.

TOPIC 3: PLANNING FOR SELF-CARE

3.1 How is a self-care plan developed?

Exercise 30 minutes

1. Ask participants to look again at the stressor matrix they filled earlier.

2. Ask them to develop a self-care plan by noting the possible strategies to cope with the stressors they listed. Suggest that they think about individual strategies, culture-specific coping mechanisms and social and organizational support.

3. Read the guiding questions to help them develop their self-care plan:106

   - What activities would help you relax, find distance from your work and not take work home?
   - What can you change so that uncontrollable stressors in your life become controllable?
   - How can you deal with the uncontrollable stressors?
   - Where can you seek social support? Whom would you go to share experiences related to caring for survivors of sexual violence?
   - What organizational or changes in your surroundings would help you deal with stress? How can our organization best support you? What can you do to begin making changes?

4. Remind participants of the possibility of talking with a resource person appointed by the programme about their experiences or questions that arise around their self-care.

5. Invite participants to store their self-care plan at home or in the office. Encourage them to occasionally review it as a way of monitoring whether they are taking care of their own needs.

MODULE 7

Summary, next steps and closing
### SESSION 7.1

## Next steps

<table>
<thead>
<tr>
<th>Session Time</th>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Objectives</td>
<td>By the end of this session, participants will be able to:</td>
</tr>
<tr>
<td></td>
<td>• Plan next steps</td>
</tr>
<tr>
<td>Methods</td>
<td>• Discussion</td>
</tr>
<tr>
<td></td>
<td>• Exercise</td>
</tr>
<tr>
<td>Preparation</td>
<td>• Prepare lecture</td>
</tr>
<tr>
<td>Training aids, materials and HOs</td>
<td>• Flip chart and markers</td>
</tr>
<tr>
<td></td>
<td>• Blank sheets of paper</td>
</tr>
<tr>
<td>Evaluation and assessment</td>
<td>• None</td>
</tr>
<tr>
<td>Additional resources</td>
<td>• None</td>
</tr>
</tbody>
</table>
1. Congratulate participants on what they have learned in the training. This should include their role in the programme; raising awareness in the community around gender, GBV and the importance and benefits of seeking care after sexual violence; and referring survivors for care with their consent. If Modules 5-6 (and the Advanced Module) were covered, this can also include directly providing medical care to survivors of sexual violence. Now, participants should think about how they will put it into practice.

2. Ask participants to work in three groups and discuss how they will implement what they learned during the week. Who needs to know about what they have been trained to do and are expected to do? What is the first step they will take? Then what? What help will they need? Let them spend about 10 minutes.

3. Give each group three minutes to present their ideas. As they speak, take notes on the flip chart.

4. After all groups have presented, ask each group what they can learn from the plans and ideas presented by the other two groups.

5. Briefly discuss key things on the list that CHWs did not mention in their planning that pertain to programme implementation.

FACILITATOR’S NOTES

Mention programme-related logistics, such as when CHWs will receive any supplies, how supervision will be conducted, when monthly meetings will be held (if relevant), and so on.
## SESSION 7.2

### Post-test and clinical assessment

| Session Time | 30 hours (Modules 2-4)  
1 hour (Module 2-4; 5-6)  
1 hour 15 min (2-Advanced)  
45-60 minutes/person for clinical assessment |
|---|---|
| Objectives | By the end of this session, participants will be able to:  
• Have an indication of how much they learned during the training |
| Methods | • Individual work  
• Clinical assessment (CHWs 2 and 3) |
| Preparation | • Determine a clinical assessment schedule for CHWs 2 and 3 so that they are not all waiting to have their turn. |
| Training aids, materials and HOs | • Post-test for literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed)  
• Post-test for non-literate CHWs (Modules 2-4) (annexed) |
| Evaluation and assessment | • Post-test for literate CHWs (Modules 2-4; 5-6; Advanced Module 8) (annexed)  
• Post-test for non-literate CHWs (Modules 2-4) (annexed)  
• Clinical assessment for CHWs 2 and 3 |
| Additional resources | • None |
POST-TEST

1. Point out to participants that they have learned a lot in a very short time. Ask them if they feel satisfied with what they learned. Tell them they will now have the opportunity to take the same test they took at the beginning of the training. Encourage them to answer the questions as best they can, using what they have learned.

2. Distribute the written test. Ask participants to write their names at the top of each page.

3. Tell participants they have 30 minutes to complete the post-test (1 hour for full test; 1 hour 15 minutes for advanced test). Let them know when that hour begins. Collect the tests after 30 minutes (1 hour if full test; or 1 hour 15 minutes for advanced).

4. Assist non-literate participants to complete the pictorial post-test.

CLINICAL ASSESSMENT (CHWs 2 AND 3 ONLY)

FACILITATOR’S NOTES

The clinical assessment is only relevant for CHWs 2 and 3. The test should be administered individually where you will read the case study on the CHW clinical assessment tool. Follow the prompts and have the CHW take you through what she or he would do for the survivor. A detailed checklist is available for you to mark whether the CHW has applied a key skill. Each ‘yes’ receives one point, and more than 40 total points in total (70%) is a passing score.

If the CHW does not pass the clinical assessment, the programme can decide whether she or he can retake the test. The same scenario can be applied in that case to ensure she or he understands her or his original mistakes.

45-60 minutes each

1. Take participants one by one to a private room and administer the clinical assessment tool. Instructions are noted on the tool itself. CHWs can bring their treatment protocols and job aids with them, but not the module summaries.

2. Mark on the checklist whether or not the CHW has applied a key skill. Make sure that all rows are marked with a ‘Yes’, ‘No,’ or ‘Not applicable’.

3. Note comments as you go, and when the CHW has finished, give feedback on the scenario. Correct any mistakes or misunderstandings.

4. Tally the ‘Yes’ points, and let the CHW know if she or he has passed the test.
## SESSION 7.3

### Closing and workshop evaluation

<table>
<thead>
<tr>
<th>Session Time</th>
<th>1 hour 30 minutes</th>
</tr>
</thead>
</table>
| **Objectives**        | By the end of this session, the facilitator/programme staff will have:  
|                       | • A sense of how participants found the training |
| **Methods**           | Discussion        |
| **Preparation**       | Marked post-test  |
| **Training aids, materials and HOs** |  
|                       | • Return participants’ marked tests to them  
|                       | • Final training evaluation form |
| **Evaluation and assessment** | None |
| **Additional resources** | None |
## REVIEW OF POST-TEST AND CLINICAL ASSESSMENT

**Discussion**  
1 hour

1. Congratulate and comment on the written/pictorial post-tests as appropriate.
2. Explain that the scores are one indication of what participants learned and that how they perform their duties is another.
3. Comment on your perceptions of the progress made, what might need more attention and how that attention will be given.
4. Return pre- and post-tests to participants so they can see how they did. Encourage and challenge them.
5. If CHWs 2 and 3 are present, provide overall feedback on their performance to the clinical assessment test. Review key skills as necessary.
6. Since the same test will be used over and over, collect the tests from participants after giving them a chance to look at them and ask questions. Only CHWs that achieve the below scores will be allowed to perform their duties pertaining to managing survivors of sexual violence:
   - **CHW 1:**
     - At least 50 per cent on the Module 2-4 post-test
   - **CHW 2:**
     - At least 50 per cent on the Module 2-4 post-test
     - At least 80 per cent on the Module 2-6 post-test
     - At least 70 per cent on the clinical assessment
   - **CHW 3:**
     - At least 50 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
     - At least 70 per cent on the clinical assessment

## CLOSING AND WORKSHOP EVALUATION

30 minutes

1. The workshop organizer should give a brief summary of what participants learned during the week, thanking them for their active participation and congratulating them on their progress. If certificates of completion will be issued, present them at this time.
2. Depending on the local context, give participants a chance to speak.
3. When all participants have expressed their feedback, ask them to complete a workshop evaluation form. Tell them what they write will help improve the training in the future. Assist non-literate and semi-literate participants to complete theirs, or convert this exercise into a group discussion.
4. Collect the evaluation forms before participants leave.
MODULE 8: ADVANCED
(CHW 3 only)

Providing advanced community-based care for survivors of sexual violence

**Participant handouts**

- **Handout 1**: Knowing where to give an injection
- **Handout 2**: Partner management of STIs
- **Handout 3**: Pictorial treatment protocol for STIs
- **Handout 4**: Pictorial treatment protocol tetanus and hep B
- **Handout 5**: Preparing a syringe for injection
- **Handout 6**: Preventing infection (advanced)
- **Handout 7**: Reproductive health anatomy
- **Handout 8**: STI identification and management flowchart
- **Handout 9**: Treating allergic reactions and allergic shock

**Facilitator’s notes**

The advanced module is only relevant in settings where CHWs have additional skills and experience to form a CHW 3 category and/or they are providers of last resort given lack of possible referrals to higher level health facilities.
Part 3: Strengthening Community-Based Care

Participant handouts

Handout 1: Knowing where to give an injection
Handout 2: Partner management of STIs
Handout 3: Pictorial treatment protocol for STIs
Handout 4: Pictorial treatment protocol tetanus and hep B
Handout 5: Preparing a syringe for injection
Handout 6: Preventing infection (advanced)
Handout 7: Reproductive health anatomy
Handout 8: STI identification and management flowchart
Handout 9: Treating allergic reactions and allergic shock
### SESSION 8.1

**Providing advanced care to survivors of sexual violence**

<table>
<thead>
<tr>
<th>Session Time</th>
<th>6 hours, 15 minutes</th>
</tr>
</thead>
</table>
| **Objectives**     | By the end of this session, participants will be able to:  
  • Provide tetanus toxoid/immunoglobulin to prevent tetanus  
  • Provide vaccines to prevent hepatitis B  
  • Manage STIs, including among partners  
  • Treat allergic reactions and allergic shock |
| **Methods**        |  
  • Mini lecture  
  • Discussion  
  • Case study  
  • Role play |
| **Preparation**    |  
  • Prepare materials for demonstration and lectures in advance  
  • Learn whether a cold chain, tetanus and hepatitis B injections are available, and whether CHWs can administer injections  
  • Adapt intake, health history and monitoring forms to note the provision of additional services  
  • Adapt protocols for STI treatment to local context  
  • Adapt the infection prevention HO according to the programme’s protocol |
| **Training aids, materials and HOs** |  
  • Flip chart and markers  
  • Reproductive anatomy (HO)  
  • Hepatitis B and tetanus vaccination protocols (HO)  
  • Preparing a syringe for injection (HO)  
  • Knowing where to give an injection (HO)  
  • Managing STIs (HO)  
  • STI treatment protocol (HO)  
  • Treating partners for STIs (HO)  
  • Being prepared to treat allergic reactions and allergic shock (HO)  
  • Preventing infection (advanced) (HO)  
  • Medications, syringes, needles, model for demonstration |
| **Evaluation and assessment** |  
  • None |
| **Additional resources** |  
Only cover the following section if the tetanus toxoid vaccination is available in the setting and CHW 3 have been trained in providing injections. This vaccination requires a cold chain and adherence to infection prevention standards.

If tetanus toxoid will be provided, but CHWs have inadequate training in providing injections, consult training resources for additional information.

**TOPIC 1: PROVIDING TETANUS TOXOID/IMMUNOGLOBIN TO PREVENT TETANUS**

1.1 What is tetanus and who is at risk for tetanus infection?

-Mini lecture [107]

5 minutes

As discussed in Module 5, tetanus is a serious disease caused by bacterial entering a wound. The disease can be prevented through immunization. A survivor of sexual violence who presents with open wounds or cuts may be at risk for tetanus infection.

**FACILITATOR’S NOTES**

Make sure the intake and monitoring forms have been adapted to include the provision of tetanus and/or hepatitis B injections so that CHWs can see where they need to indicate the care provided.

1.2 What is the tetanus vaccination and how does it work?

-Mini lecture [108]

10 minutes

A survivor of sexual violence who presents with breaks in the skin or mucous membrane and has not been fully vaccinated against tetanus, or her or his vaccination status is uncertain, is at risk of tetanus.

If the survivor has not been fully vaccinated, vaccinate immediately, no matter how long it has been since the incident.

Tetanus toxoid is available in several different preparations. Antitetanus immunoglobin (anti-toxin) is expensive and needs to be refrigerated. It is not available in many low-resource settings. CHWs should refer to the local protocol to determine preparation and dose.

**FACILITATOR’S NOTES**

Refer to the local treatment protocol. If there is no local protocol, refer to the WHO protocol.


[108] Ibid.
SPECIAL CONSIDERATIONS

1.2 What is the tetanus vaccination and how does it work? (continued)

Tetanus vaccination is safe for pregnant women and children. For children less than seven years old, DTP (diphtheria, tetanus toxoid, and pertussis vaccine) or DT (diphtheria and tetanus toxoid) is preferred to tetanus toxoid alone.


The tetanus vaccine is given intramuscularly, using a syringe and needle, in the upper arm for adults or the buttocks for children. If tetanus toxoid and immunoglobulin are administered at the same time, different syringes, needles and injection sites must be used.109

Message to give survivors are:

- Survivors that receive the tetanus vaccination should complete the vaccination schedule
- The second dose should be given four weeks after the first dose
- The third dose should be given six months to one year after the first dose

Discussion
10 minutes

1. Ask participants to take out the tetanus vaccination protocol (HO or local protocol) from their packets.110 Give them time to review the protocol and ask questions.

2. Emphasize to participants that they should refer to the protocol to ensure the survivor receives the correct vaccination.

Demonstration
30 minutes

1. Demonstrate how to prepare a syringe for injection and where to give an injection using step-by-step instructions with images in the participant HOs.111

2. Review infection prevention procedures, as detailed in the advanced infection prevention HO. Be sure to cover safe storage of needles and syringes, and safe disposal.

---

109 Images and guidance from Hesperian Foundation, Where There is No Doctor, 2012, pp. 72-73.
111 Hesperian Foundation, Where There is No Doctor, 2012, pp. 72-73.
### TOPIC 2: PROVIDING VACCINES TO PREVENT HEPATITIS B

#### FACILITATOR’S NOTES

Only cover this section if the Hepatitis B vaccination is available in the setting and CHWs have been trained in providing injections. This vaccination requires a cold chain and adherence to infection prevention standards.

If the hepatitis B vaccine will be provided, but CHWs have inadequate training in providing injections, consult additional training resources on providing injections.

#### 2.1 What is hepatitis B and who is at risk?

**Mini lecture**

5 minutes

As discussed in Module 5, hepatitis B is a common and serious infection that may cause liver failure, liver disease and liver cancer in up to 40 per cent of patients.

Survivors of sexual violence who have experienced vaginal, anal or oral penetration and were exposed to the assaulter’s blood or body fluids may be at risk for hepatitis B infection.

#### 2.2 What is the hepatitis B vaccination and how does it work?

**Mini lecture**

15 minutes

Inform participants that unvaccinated or inadequately vaccinated survivors should be offered the hepatitis B vaccine.

Survivors should be given the hepatitis B vaccine within 14 days of the incident.

The recommended dose varies by product. The hepatitis B vaccine is commonly available in the form of the pentavalent vaccine (DTP-Hib-HepB). Refer to local protocol for preparation and dose.

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113  Ibid.
SPECIAL CONSIDERATIONS

Hepatitis B vaccine is safe for pregnant women and children. The dose and administration site should be adjusted for children.


FACILITATOR’S NOTES

Refer to the local treatment protocol. If there is no local protocol, refer to the WHO protocol.

2.2 What is the hepatitis B vaccination and how does it work? (continued)

The hepatitis B vaccine is given by intramuscular injection in the thigh (children under 2 years) or in the upper arm (adults and older children). Injection in the buttocks is not recommended, as it is not as effective.

Messages to give a survivor who receives hepatitis B vaccination are:

- A survivor who receives the hepatitis B vaccination should complete the vaccination schedule. Depending on the product, the second dose should be given 1-2 months after the first dose. The third dose should be given 4-12 months (most often 6 months) after the first dose.
- The survivor may experience redness and tenderness at the vaccination site.

Discussion

10 minutes

1. Ask participants to take out the hepatitis B vaccination protocol from the participant’s packets. Give participants time to review the protocol and ask questions.

2. Emphasize to participants that they should refer to the protocol to ensure the survivor receives the right vaccination.

---

114 Images and guidance from Hesperian Foundation, Where There is No Doctor, 2012, pp. 72-73.

115 MSF Spain, Sexual & Gender Based Violence: A handbook for implementing a response in health services towards sexual violence, May 2011.

2.2 What is the hepatitis B vaccination and how does it work? (continued)

Demonstration
15 minutes

1. Demonstrate **how to prepare a syringe for injection and where to give an injection** using step-by-step instructions on the HOs.\(^\text{117}\)

2. If not already covered for the tetanus vaccination, review infection prevention procedures as detailed in the **advanced infection prevention** HO. Be sure to cover safe storage of needles and syringes, and safe disposal.

Role play
45 minutes

1. Divide participants into small groups to practise giving the hepatitis B vaccine. Provide them with the hepatitis B vaccine suspension, syringes, needles and a model for demonstration.

2. Observe the role plays to ensure participants demonstrate skills in providing vaccinations according to protocol and provide appropriate messages.

**TOPIC 3: MANAGING STIs (SYNDROMIC MANAGEMENT)**

The following describes basic syndromic management approaches to treating STIs. While instructions have been tailored so no observation is required (treatment based on self-reports), if you feel participants need to better understand the reproductive anatomy, refer to the relevant **anatomy HO** in the participant packet.

For any treatment, refer to the local treatment protocol. If there is no local protocol, refer to the WHO protocol.

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\(^{117}\) Hesperian Foundation, *New Where There is No Doctor*, 2012, pp. 72-73.
### 3.1 How can STIs be managed and how is treatment provided?

**Mini lecture**

45 minutes

Sometimes a survivor may have certain signs or symptoms of an STI. Many STIs, including gonorrhoea, chlamydia, syphilis and trichomoniasis can be treated with antibiotics. The antibiotics used will depend on local guidelines and the drugs that are available. If left untreated, STIs can lead to chronic pain, pregnancy complications and infertility.

Many STIs can be identified and treated based on typical symptoms and signs. A syndrome is a group of symptoms reported by a survivor. As discussed earlier, CHWs can ask a survivor if she or he has noticed any of the following common symptoms and signs of an STI, such as:

- Unusual vaginal discharge (liquid) in terms of amount, smell or colour
- Itching in the vagina
- Pain while passing urine
- Pain during sex
- Lower abdominal (belly) pain
- Rash, sores or ulcers in the genital areas

If someone does not have signs or symptoms of an STI, that does not mean that there is no infection. STIs are often present without symptoms, especially in women.

The following table explains the signs and symptoms for the main STI syndromes and their most common causes. It also presents guidelines for how a CHW may support anyone with these symptoms. This table is also available in the participant packets as an HO on managing STIs.

---

## Signs and symptoms for main STI syndromes

<table>
<thead>
<tr>
<th>Syndrome</th>
<th>Symptoms (survivor reports)</th>
<th>Signs</th>
<th>Common causes</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaginal discharge</strong></td>
<td>• Unusual vaginal discharge (in terms of amount, smell, or colour)</td>
<td>• Abnormal vaginal discharge (in terms of amount, smell, or colour)</td>
<td>• Trichomoniasis</td>
<td>• Treat with antibiotics for trichomoniasis, gonorrhoea, and chlamydia per <a href="H0s">STI treatment protocol</a>.</td>
</tr>
<tr>
<td></td>
<td>• Vaginal itching</td>
<td></td>
<td>• Gonorrhoea</td>
<td>• Conduct a syphilis test if available. If the result is positive or if a syphilis test is not available, also treat with antibiotics for syphilis.</td>
</tr>
<tr>
<td></td>
<td>• Pain while urinating</td>
<td></td>
<td>• Chlamydia</td>
<td>• If discharge is white with reported curd-like appearance, and presence of itching, also treat for possible yeast infection.</td>
</tr>
<tr>
<td></td>
<td>• Pain during sex</td>
<td></td>
<td>• Yeast infection</td>
<td>• Refer to higher level health facility when possible if discharge is reported as yellow, green or smells very bad (may be a sign of pelvic inflammatory disease).</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Consider referral to higher level facility if fever, pregnancy or abnormal vaginal discharge (bleeding between periods or heavy bleeding) is also present.</td>
</tr>
<tr>
<td><strong>Lower abdominal pain</strong></td>
<td>• Lower abdominal (belly) pain</td>
<td>• Vaginal discharge</td>
<td>• Gonorrhoea</td>
<td>• Treat with antibiotics for trichomoniasis, gonorrhoea, chlamydia per <a href="H0s">STI treatment protocol</a>.</td>
</tr>
<tr>
<td></td>
<td>• Pain during sex</td>
<td>• Tenderness when lower abdomen (belly) is touched</td>
<td>• Chlamydia</td>
<td>• Conduct a syphilis test if available. If the result is positive or if a syphilis test is not available, also treat with antibiotics for syphilis.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fever</td>
<td>• Other anaerobic bacteria</td>
<td>• Refer to higher level health facility when possible especially if fever, pregnancy, abnormal vaginal discharge or bleeding (bleeding between periods or heavy bleeding) is present.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Also refer to higher level facility for severe reports of pain in lower abdomen.</td>
</tr>
<tr>
<td><strong>Genital ulcer</strong></td>
<td>• Genital sore</td>
<td>• Genital ulcer</td>
<td>• Syphilis</td>
<td>• Treat with medications per <a href="H0s">STI treatment protocol</a>.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Chancroid</td>
<td>• Also treat with antibiotics for trichomoniasis, gonorrhoea, chlamydia per <a href="H0s">STI pictorial treatment guideline</a>.</td>
</tr>
</tbody>
</table>
3.1 How can STIs be managed and how is treatment provided? (continued)

Anyone who is experiencing signs and symptoms of STIs and their related syndromes should be treated immediately, according to the guidelines outlined on the STI treatment protocol for adults and children.

**SPECIAL CONSIDERATIONS**

**Pregnant women, children and males:** Some antibiotics are not safe for pregnant women. If a woman is pregnant she should be treated according to appropriate guidelines.

**Children will also require very specific antibiotic dosages based on weight and age.**

Men who report discharge from their penis, pain during urination and/or urinating more frequently than usual may have an STI. Gonorrhoea and chlamydia are the most common causes of these symptoms and should be treated according to protocols. Men may follow the same medication dosing guidelines for treatment of STIs as non-pregnant adult women.


When offering antibiotics to a survivor for managing STIs, messages to provide are:119

Condoms must be used during sex until the antibiotic treatment regimen is complete in order to prevent transmitting an STI to the partner.

- Antibiotics must be taken for the full course to be effective.
- Pelvic inflammatory disease—inflammation of the pelvis—may develop if an STI is not cured. This may lead to infertility if it is not treated. A survivor who develops signs of Pelvic inflammatory disease (severe abdominal pain, fever, green or yellow bad smelling discharge or bleeding from the vagina) should go to a higher level health facility for treatment.
- Survivors should also go to a higher level health facility if symptoms get worse or no improvement is seen after a week of treatment.
- To get relief from the discomfort of some STIs, survivors can try the following:
  - Wear underclothes made of cotton.
  - Wash underclothes once a day and dry them in the sun.
  - Sit in a pan of clean, warm water for 15 minutes, two times a day.

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120 IAWG on Reproductive Health in Crises, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010., p.29.

### 3.1 How can STIs be managed and how is treatment provided? (continued)

- If it is painful to pass urine, pour clean water over the genital area while passing urine.
- Anyone who is treated for an STI may develop another infection if sexual partners are not treated. The sexual partner may or may not have symptoms and, if left untreated, could continue to spread infection. Partners include current partner(s) and all partners within the last two to three months.

### Role play

<table>
<thead>
<tr>
<th>30 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1.</strong> Review the <strong>STI treatment protocol</strong> HO for adults and children. This should be in the participant packets. Give participants time to review the protocol and ask questions, especially regarding doses for pregnant women or those with allergies to certain medicines.</td>
</tr>
<tr>
<td><strong>2.</strong> Emphasize to participants that they should refer to the protocol to ensure the survivor receives the right treatment. Survivors should always be given the shortest course of treatment. Remind participants that just because the survivor is being treated for STI-like symptoms does not mean that she or he definitely has an STI. Emphasize that it is safest to treat a survivor just in case these medications can help her or him feel better.</td>
</tr>
</tbody>
</table>

### FACILITATOR’S NOTES

Refer to the local treatment protocol and disease prevalence data. If there is no local protocol, refer to the WHO protocol. All **treatment protocol** HOs should be ready before the training.

Patterns of genital ulcer disease vary in different parts of the world but genital herpes, chancroid and syphilis are most common. If a genital ulcer is noted or reported, treatment appropriate to local causes should be given. For example, in areas where both chancroid and syphilis are prevalent, survivors with genital ulcers should be treated for both conditions.

Generally, if a survivor reports a genital ulcer or sore, treatment for syphilis and chancroid should be given. Treatment for herpes simplex virus (HSV2) may be considered in areas where the prevalence of HSV2 is 30 per cent or higher.

If a survivor reports only small, numerous, blister-like lesions, then treatment for HSV2 should be given. Note that treatment for herpes is expensive and may not be available in low-resource settings.

An HO is available on how to respond to survivors who develop an **allergic reaction or allergic shock** to medicines. While not mandatory, this information may be helpful, especially if CHWs are providers of last resort.

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3.2 How should sexual partners be managed for STI treatment referral?

Mini lecture 122
20 minutes

A survivor who is successfully treated for an STI will begin to feel better but may return later with another infection. The following questions will help determine whether this is due to a problem with the treatment or a new infection:

- Treatment failure: Did the survivor take all of the medicine? Did the survivor stop taking her or his medicine as soon as she or he began to feel better?
- Reinfection: Did the partner receive treatment? Did the survivor and partner(s) use condoms or abstain from sex after starting treatment?

The survivor’s sexual partner may or may not have symptoms and, if left untreated, could spread infection to others in the community. Partners may include current partner(s) and all partners within the last three months.

The following table shows partner notification management strategies based on the major signs and symptoms a survivor may report. This table is also available in the participants’ packets as an HO for treating partners for STIs.

<table>
<thead>
<tr>
<th>Signs and symptoms</th>
<th>Possible explanations</th>
<th>Partner management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genital sore or ulcer</td>
<td>STI very likely</td>
<td>Treat partners for syphilis and chancroid</td>
</tr>
<tr>
<td>Urethral discharge (men)</td>
<td>STI very likely</td>
<td>Treat partners for gonorrhoea and chlamydia</td>
</tr>
<tr>
<td>Pain and burning during urination</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower abdominal (belly) pain</td>
<td>Pelvic inflammatory disease, often STI but other causes possible</td>
<td>Treat partners for urethral discharge (gonorrhoea and chlamydia)</td>
</tr>
<tr>
<td>Pain during sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginal discharge (in terms of amount, smell, or colour)</td>
<td>Non-STI infection most likely</td>
<td>No partner treatment unless relapse (then give treatment for trichomoniasis)</td>
</tr>
</tbody>
</table>

Facilitator’s notes

Not all reproductive tract infections are sexually transmitted. Therefore, CHWs must be careful not to mislabel or stigmatize someone as having an STI when the diagnosis is not clear. For instance, the symptom of vaginal discharge may be the result of an infection that was not contracted through sex. Attempting to notify and treat partners in this situation would be unnecessary as partners do not need treatment, and notifying them may be damaging to their relationship. Violence, distrust and divorce are possible consequences of partner notification if not managed correctly.

From IAWG on Reproductive Health in Crises, Sexually Transmitted Infections, Inter-agency Field Manual on Reproductive Health in Humanitarian Settings, 2010, chapter 9, pp. 178-180.

122 WHO, Sexually Transmitted and Other Reproductive Tract Infections, 2005, p. 12.
3.2 How should sexual partners be managed for STI treatment referral? (continued)

A survivor may feel afraid to talk about her symptoms or treatment with her partner. She may worry that her partner will leave her, act out violently or accuse her of being unfaithful. The survivor should never be forced to notify a partner of her symptoms or her treatment. A CHW can support a survivor during this time by:

- Listening to the survivor’s fears or concerns.
- Reminding the survivor that she does not have to tell a partner of her recent treatment for STI-related symptoms if she does not feel comfortable doing so.
- Reminding the survivor that receiving treatment to treat the symptoms of an STI does not mean that she definitively has an STI.
- Educating the survivor about ways to practise sex and negotiate for condom use if she chooses not to tell her partner(s) and is concerned she may get the infection again.

**Role play**

1. Divide participants into pairs to practise discussing how a CHW may support a survivor who is concerned about telling a partner of her treatment for a possible STI. One participant will act as the survivor and the other participant will be the CHW.

2. Survivor situation: You have been noticing an unusual vaginal discharge and strong odour in your underclothes and were offered antibiotic treatment for what may have been an STI. You and your partner do not usually use a condom during sex. You are afraid that if you tell your partner you may have an STI, he will leave you or hurt you.

   CHW: The survivor appears nervous, on top of the recent sexual assault, and asks for your advice about what to do.

3. Ask pairs to report back to the larger group about what advice the CHW offered and whether the survivor felt it was helpful or not helpful. Review content from previous lectures to ensure key messages are captured, including:

   - Reminding the survivor that she does not have to talk to her partner if she is worried about her safety.
   - Helping the survivor understand that if her partner has an STI, she can become re-infected.
   - Encouraging the survivor to use condoms with her partner(s), especially if she does not know if they have an STI.
   - Practice role play with the survivor and discuss ways she can try to talk to her partner about using a condom.
### TOPIC 4: PREPARING TO TREAT ALLERGIC REACTIONS AND ALLERGIC SHOCK

<table>
<thead>
<tr>
<th>4.1 What are signs of allergic reactions and allergic shock?</th>
<th>Inform participants that some medicines, especially antibiotics like penicillin and ampicillin, can produce an allergic reaction, usually within 30 minutes after an injection. An allergic reaction can turn into allergic shock, which is an emergency. To prevent allergic reaction and allergic shock, before giving an injection, CHWs should ask: “Have you ever had a reaction to this medicine, like hives (red blotches on the skin), itching, swelling or trouble breathing?” If the answer is yes, they should not use that medicine in any form, or any medicine from the same family of medicines. Whenever CHWs inject medicines, they should watch for signs and have medicines for treating them nearby. Signs of mild allergic reactions are itching, sneezing, hives or rash. Signs of moderate to severe allergic reactions are itching, hives, swollen mouth and tongue or difficulty breathing. Signs of allergic shock are itching or hives; swollen mouth and tongue; weak, rapid pulse or heartbeat (more than 100 beats per minute for an adult); sudden paleness or cool, moist skin (cold sweats); difficulty breathing; or loss of consciousness. All of this information is available in the participant HOs, which should be distributed before the next section is covered.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mini lecture&lt;sup&gt;123&lt;/sup&gt; 10 minutes</td>
<td>Inform participants that some medicines, especially antibiotics like penicillin and ampicillin, can produce an allergic reaction, usually within 30 minutes after an injection. An allergic reaction can turn into allergic shock, which is an emergency. To prevent allergic reaction and allergic shock, before giving an injection, CHWs should ask: “Have you ever had a reaction to this medicine, like hives (red blotches on the skin), itching, swelling or trouble breathing?” If the answer is yes, they should not use that medicine in any form, or any medicine from the same family of medicines. Whenever CHWs inject medicines, they should watch for signs and have medicines for treating them nearby. Signs of mild allergic reactions are itching, sneezing, hives or rash. Signs of moderate to severe allergic reactions are itching, hives, swollen mouth and tongue or difficulty breathing. Signs of allergic shock are itching or hives; swollen mouth and tongue; weak, rapid pulse or heartbeat (more than 100 beats per minute for an adult); sudden paleness or cool, moist skin (cold sweats); difficulty breathing; or loss of consciousness. All of this information is available in the participant HOs, which should be distributed before the next section is covered.</td>
</tr>
<tr>
<td>4.2 How should allergic reactions and allergic shock be treated?</td>
<td>Treatment for mild allergic reaction is to give survivors diphenhydramine by mouth three times a day until the signs disappear. Pregnant or breastfeeding women may find the discomfort of a mild allergic reaction better than the risks of taking an antihistamine. Treatment for moderate to severe allergic reactions involves injecting epinephrine immediately under the skin. Diphenhydramine or promethazine should also be given by mouth or by injection into a muscle. Treatment for allergic shock requires injection of epinephrine immediately under the skin. Diphenhydramine or promethazine should also be injected into the muscle. Hydrocortisone (cortisol) is further injected into muscle and repeated as necessary. The person should be watched to make sure the signs do not come back, and given steroid medicines to take by mouth if the signs return.</td>
</tr>
<tr>
<td>Mini lecture&lt;sup&gt;124&lt;/sup&gt; 20 minutes</td>
<td>Treatment for mild allergic reaction is to give survivors diphenhydramine by mouth three times a day until the signs disappear. Pregnant or breastfeeding women may find the discomfort of a mild allergic reaction better than the risks of taking an antihistamine. Treatment for moderate to severe allergic reactions involves injecting epinephrine immediately under the skin. Diphenhydramine or promethazine should also be given by mouth or by injection into a muscle. Treatment for allergic shock requires injection of epinephrine immediately under the skin. Diphenhydramine or promethazine should also be injected into the muscle. Hydrocortisone (cortisol) is further injected into muscle and repeated as necessary. The person should be watched to make sure the signs do not come back, and given steroid medicines to take by mouth if the signs return.</td>
</tr>
<tr>
<td>Discussion 10 minutes</td>
<td>1. Review the hand out on treating allergic reactions and shock in detail. Give participants time to ask questions. 2. Emphasize to participants that they should refer to the HO to ensure the survivor receives the right treatment.</td>
</tr>
</tbody>
</table>

---

### 4.2 How should allergic reactions and allergic shock be treated?

**Demonstration**
10 minutes

1. Show participants how to give an injection under the skin through following the brief instructions in the HO. If participants have not covered intramuscular injections, also review the relevant information in the tetanus and hepatitis B vaccination sections.

2. If not already covered when discussing how to administer the tetanus or hepatitis B vaccinations, review infection prevention procedures as detailed in the *advanced infection prevention* HO. Be sure to cover safe storage of needles and syringes, and safe disposal.

**Role play**
20 minutes

1. Divide participants into small groups to practise responding to allergic reactions and allergic shock. Provide them with the relevant drugs, syringes, needles and a model for demonstration.

2. Observe the role plays to ensure participants demonstrate skills in treating allergic reactions and shock according to protocol and provide appropriate messages.
ANNEXES

Participant handouts

Annex 1: Registration form & attendance sheet
Annex 2: Participant daily evaluation form
Annex 3: HIV cards
Annex 4: Steps to providing healthcare for survivors of sexual violence
Annex 5: Sample intake form and monitoring form
Annex 6: Treatment protocols
Annex 7: Final training evaluation
### ANNEX 1 Registration form and attendance sheet

Location: ____________________________________________

<table>
<thead>
<tr>
<th>Name</th>
<th>Signature</th>
<th>Sex</th>
<th>Village</th>
<th>Pre-test score</th>
<th>Post-test score</th>
<th>Difference pre/post</th>
<th>% Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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<td>3.</td>
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<td>4.</td>
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<tr>
<td>11.</td>
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<tr>
<td>12.</td>
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</tr>
<tr>
<td>13.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

Prepared by: ____________________________________________
Verified by Programme Manager: ____________________________
ANNEX 2

Participant daily evaluation form

Date: _______________________________________

1. What did you enjoy most about today?
   __________________________________________
   __________________________________________
   __________________________________________

2. What did you learn today that you will use when you go back home?
   __________________________________________
   __________________________________________
   __________________________________________

3. What is the most valuable thing you learned today (any knowledge or skill)?
   __________________________________________
   __________________________________________
   __________________________________________

4. Was there anything you did not understand during today's sessions?
   Please give an example of what you did not understand.
   __________________________________________
   __________________________________________
   __________________________________________

5. What other specific comments or questions do you have?
   __________________________________________
   __________________________________________
   __________________________________________

Thank you!
PART 3
Strengthening Community-Based Care

ANNEX 3
HIV cards

- sex without a condom
- blood transfusion
- pregnancy, childbirth or breastfeeding
- unsterile needle or tools
- infected blood that gets into a cut
- hugging
ANNEX 3  HIV CARDS (continued)

- kissing
- sharing a meal
- sharing clothes
- insect bites
- sharing a bed
- sharing a latrine
ANNEX 4

Steps to providing health care for survivors of sexual violence

Are there any danger signs?
Observing or complaining by person:
- Swelling and hardness of the abdomen (belly)
- Pain in the abdomen (belly)
- Severe pain anywhere else in the body (back, chest, arms, legs or head)
- Vomiting blood
- Bleeding from the genital area (vagina or anus)
- Heavy bleeding from other parts of the body
- Possible object lodged inside vagina/anus
- Altered mental state or confusion
- Pale, blue or gray skin
- Loss of consciousness
- In a small child, fast breathing or difficulty breathing

NO

- Take to a private place
- Offer comfort and understanding
- Explain steps and procedures
- Obtain consent to provide care
- Take brief medical history
- Ask how many days it has been since assault

3 full days or less

- Provide medicines to prevent STIs, Pregnancy and HIV

5 full days or less

- Provide medicines to prevent STIs and Pregnancy

More than 5 full days

- Provide medicines to prevent STIs

YES

- Decide on referrals to support services
- Discuss safety and place to go
- Make a follow-up after two weeks, or one week if the survivor takes PEP
Sample intake form

Survivor ID: ________________________ CHW ID: ________________________
Date of incident: __________________ Date of treatment: __________________

☐ Female  ☐ Male  Age: ______  Child is <13 years  ☐ Yes  ☐ No  ☐ Don’t know

Puberty?

Vaccinated against tetanus

Vaccinated against hepatitis B

Treatment information provided and consent obtained to provide treatment  ☐ Yes  ☐ No  ☐ Don’t know

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Yes</th>
<th>No</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antibiotics to prevent STIs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency contraception</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PEP to prevent HIV</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Care of minor wounds</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal security concerns discussed</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Treatment counseling (Type: STI, HIV, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Referral (Type: HIV testing, vaccines, other health, protection, psychosocial, etc.)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

General observations (note any wounds treated or conditions requiring referral)

<table>
<thead>
<tr>
<th>Two-week follow-up visit scheduled:  ☐ Yes  ☐ No</th>
<th>Date: _______  Time: ________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Follow-up visit:  ☐ Clinic  ☐ House  ☐ Other</td>
<td>If ‘no’, why?</td>
</tr>
<tr>
<td>Treatment</td>
<td>Yes</td>
</tr>
<tr>
<td>Counseling (Type: STI, HIV, etc.)</td>
<td></td>
</tr>
<tr>
<td>Referral (Type: HIV testing, psychosocial, etc.)</td>
<td></td>
</tr>
<tr>
<td>Follow-up notes</td>
<td></td>
</tr>
</tbody>
</table>

☐ Patient requests copy of record  ☐ Copy of record given to patient
### Monitoring form

*NEVER* record any personal or confidential information (such as a survivor’s name).

| Date of incident (Day/Month/Year) | Date care provided (Day/Month/Year) | Sex (M or F) | Adult/Child | Consent to provide care (Yes or No) | STI antibiotics (Yes or No) | EC (Yes or No) | HIV PEP (Yes or No) | Care of minor wounds (Yes or No) | Treatment counseling (Yes or No) | Referrals made (where, and for what) | Personal security concerns discussed (Yes or No) | Follow-up visit completed (Yes or No; date) | Record provided to patient (Yes or No) | Other |
|-----------------------------------|------------------------------------|--------------|-------------|-------------------------------------|-----------------------------|---------------|-------------------|-------------------------|-----------------------------|-------------------------------------|----------------------------------------|-----------------------------|---------|
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
|                                   |                                    |              |             |                                     |                             |               |                   |                         |                             |                                     |                                         |                             |          |
### WHO-recommended STI treatment protocols for adults

**Note:** These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow local treatment protocols for sexually transmitted infections.

<table>
<thead>
<tr>
<th>STI</th>
<th>WHO Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhea</strong></td>
<td></td>
</tr>
<tr>
<td>cefixime</td>
<td>400 mg orally, single dose</td>
</tr>
<tr>
<td>or</td>
<td>125 mg intramuscularly, single dose</td>
</tr>
<tr>
<td>ceftriaxone</td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydial infection</strong></td>
<td></td>
</tr>
<tr>
<td>azithromycin</td>
<td>1 g orally, in a single dose</td>
</tr>
<tr>
<td><em>(This antibiotic is also active against incubating syphilis (within 30 days of exposure) or)</em></td>
<td></td>
</tr>
<tr>
<td>doxycycline</td>
<td>100 mg orally, twice daily for 7 days</td>
</tr>
<tr>
<td><em>(contraindicated in pregnancy)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Chlamydia infection in pregnant women</strong></td>
<td></td>
</tr>
<tr>
<td>azithromycin</td>
<td>1 g orally, in a single dose</td>
</tr>
<tr>
<td><em>(This antibiotic is also active against incubating syphilis (within 30 days of exposure) or)</em></td>
<td></td>
</tr>
<tr>
<td>erythromycin</td>
<td>500 mg orally, 4 times daily for 7 days</td>
</tr>
<tr>
<td>or</td>
<td>500 mg orally, 3 times daily for 7 days</td>
</tr>
<tr>
<td>amoxicillin</td>
<td></td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td></td>
</tr>
<tr>
<td>benzathine benzylpenicillin*</td>
<td>2.4 million IU, intramuscularly, once only <em>(give as two injections in separate sites)</em></td>
</tr>
<tr>
<td>or</td>
<td>2 g orally as a single dose</td>
</tr>
<tr>
<td>azithromycin</td>
<td><em>(for treatment of primary, secondary and early latent syphilis of &lt; 2 years duration)</em></td>
</tr>
<tr>
<td><em>(This antibiotic is also active against chlamydial infections)</em></td>
<td></td>
</tr>
<tr>
<td><strong>Syphilis, patient allergic to penicillin</strong></td>
<td></td>
</tr>
<tr>
<td>azithromycin</td>
<td>2 g orally as a single dose</td>
</tr>
<tr>
<td><em>(for treatment of primary, secondary and early latent syphilis of &lt; 2 years duration)</em></td>
<td></td>
</tr>
<tr>
<td>doxycycline</td>
<td>100 mg orally, twice daily for 7 days</td>
</tr>
<tr>
<td><em>(contraindicated in pregnancy)</em></td>
<td></td>
</tr>
<tr>
<td>Both azithromycin and doxycycline are active against chlamydial infections</td>
<td></td>
</tr>
<tr>
<td><strong>Syphilis in pregnant women allergic to penicillin</strong></td>
<td></td>
</tr>
<tr>
<td>azithromycin</td>
<td>2 g orally as a single dose</td>
</tr>
<tr>
<td><em>(for treatment of primary, secondary and early latent syphilis of &lt; 2 years duration)</em></td>
<td></td>
</tr>
<tr>
<td>erythromycin</td>
<td>500 mg orally, 4 times daily for 14 days</td>
</tr>
<tr>
<td>Both azithromycin and erythromycin are also active against chlamydial infections</td>
<td></td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong></td>
<td></td>
</tr>
<tr>
<td>(vaginal/anal assault)</td>
<td></td>
</tr>
<tr>
<td>metronidazole</td>
<td>2 g orally as a single dose</td>
</tr>
<tr>
<td>or</td>
<td>400 or 500 mg orally, 2 times daily for 7 days</td>
</tr>
<tr>
<td>tinidazole</td>
<td>2 g orally as a single dose</td>
</tr>
<tr>
<td>or</td>
<td></td>
</tr>
<tr>
<td>metronidazole</td>
<td>Avoid metronidazole and tinidazole in the first trimester of pregnancy</td>
</tr>
</tbody>
</table>

*Note: If the survivor presents within 30 days of the incident, benzathine benzylpenicillin can be omitted if the treatment regimen includes azithromycin 1 g as a single dose, which is effective against incubating syphilis as well as chlamydial infection. If the survivor presents more than 30 days after the incident, azithromycin 2 g as a single dose is sufficient presumptive treatment for primary, secondary and early latent syphilis of < 2 years duration and also covers chlamydial infections.*
### WHO-recommended STI treatment protocols for children and adolescents

**Note:** These are examples of treatments for sexually transmitted infections. There may be other treatment options. Always follow local treatment protocols for sexually transmitted infections.

<table>
<thead>
<tr>
<th>STI</th>
<th>Weight or age</th>
<th>WHO Protocol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gonorrhoea</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;45 kg</td>
<td>ceftriaxone</td>
<td>125 mg intramuscularly, single dose or spectinomycin 40 mg/kg of body weight, intramuscularly (up to a maximum of 2 g), single dose or (if &gt; 6 months) cefixime 8 mg/kg of body weight orally, single dose</td>
</tr>
<tr>
<td>&gt;45 kg</td>
<td></td>
<td>Treat according to adult protocol</td>
</tr>
<tr>
<td><strong>Chlamydial infection</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;45 kg</td>
<td>azithromycin</td>
<td>20 mg/kg orally, single dose or erythromycin 50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 7 days</td>
</tr>
<tr>
<td>&gt;12 years</td>
<td></td>
<td>Treat according to adult protocol</td>
</tr>
<tr>
<td>&gt;45 kg but &lt;12 years</td>
<td>erythromycin</td>
<td>500 mg orally, 4 times daily for 7 days or azithromycin 1 g orally, single dose</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>benzathine penicillin*</td>
<td>50,000 IU/kg IM (up to a maximum of 2.4 million IU), single dose</td>
</tr>
<tr>
<td><strong>Syphilis, patient allergic to penicillin</strong></td>
<td>erythromycin</td>
<td>50 mg/kg of body weight daily, orally (up to a maximum of 2 g), divided into 4 doses, for 14 days</td>
</tr>
<tr>
<td><strong>Trichomoniasis</strong> (vaginal/anal assault)</td>
<td>&lt;12 years</td>
<td>metronidazole 5 mg/kg of body weight, orally, 3 times daily for 7 days</td>
</tr>
<tr>
<td>&gt;12 years</td>
<td></td>
<td>Treat according to adult protocol</td>
</tr>
</tbody>
</table>

*Note: If the survivor presents within 30 days of the incident, benzathine penicillin presumptive treatment for syphilis can be omitted if the treatment regimen includes azithromycin, which is effective against incubating syphilis as well as chlamydial infection.*
EC Protocol

<table>
<thead>
<tr>
<th>Regimen</th>
<th>Amount per dose</th>
<th>Common brand name</th>
<th>First dose (number of tablets)</th>
<th>Second dose 12 hours later (number of tablets)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Levonorgestrel only</td>
<td>750 mg</td>
<td>Levonelle, NorLevo, Plan B, Postinor-2, Vikela</td>
<td>Take 2 tables</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>30 mg</td>
<td>Microlut, Microval, Norgeston</td>
<td>Take 50 tablets</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>37.5 mg</td>
<td>Ovrette</td>
<td>Take 40 tablets</td>
<td>0</td>
</tr>
<tr>
<td>Combined</td>
<td>EE 50 mg</td>
<td>Eugynon 50, Fertilan, Neogynon, Noral, Nordiol, Ovion, Ovral, Ovran, Tetrygonon/PC-4, Prenon, E-Gen-C, Neo-Primovlar 4</td>
<td>Take 2 tablets</td>
<td>Take 2 tablets</td>
</tr>
<tr>
<td></td>
<td>plus LNG 250 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or EE 50 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>plus NG 500 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>EE 30 mg</td>
<td>Lo-Femenal, Microgynon, Nordete, Ovral L, Rigevion</td>
<td>Take 4 tablets</td>
<td>Take 4 tablets</td>
</tr>
<tr>
<td></td>
<td>plus LNG 150 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>or EE 30 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>plus NG 300 mg</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*EE* = ethinylestradiol; *LNG* = levonorgestrel; *NG* = norgestrel.


Recommended two-drug combination therapies for HIV-PEP in adults

<table>
<thead>
<tr>
<th>Weight or age</th>
<th>Treatment</th>
<th>Prescribe</th>
<th>28-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult</td>
<td>Combines tablet containing Zidovudine (300 mg) and Lamivudine (150 mg)</td>
<td>1 tablet twice/day</td>
<td>60 tablets</td>
</tr>
<tr>
<td></td>
<td>or Zidovudine (ZDV/AZT) 300 mg tablet plus Lamivudine (3TC) 150 mg tablet</td>
<td>or</td>
<td>or</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 tablet twice/day</td>
<td>60 tablets</td>
</tr>
</tbody>
</table>
Recommended two-drug combination therapies for HIV-PEP in children

<table>
<thead>
<tr>
<th>Weight or age</th>
<th>Treatment</th>
<th>Prescribe</th>
<th>28-day supply</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;2 years or 5-9 kg</td>
<td>Zidovudine (ZDV/AZT) syrup* 10 mg/ml plus Lamuvidine (3 TC) syrup 10 mg/ml</td>
<td>7.5 ml twice/day plus 2.5 ml twice/day =420 ml (i.e. 5 bottles of 100 ml or 3 bottles of 200 ml) plus = 140 ml (i.e. 2 bottles of 100 ml or 1 bottle of 200 ml)</td>
<td></td>
</tr>
<tr>
<td>10-19 kg</td>
<td>Zidovudine (ZDV/AZT) 100 mg capsule plus Lamuvidine (3 TC) 150 mg tablet</td>
<td>1 capsule three times/day plus ½ tablet twice/day 90 capsules plus 30 tablets</td>
<td></td>
</tr>
<tr>
<td>20-39 kg</td>
<td>Zidovudine (ZDV/AZT) 100 mg capsule plus Lamuvidine (3 TC) 150 mg tablet</td>
<td>2 capsule three times/day plus 1 tablet twice/day 120 capsules plus 60 tablets</td>
<td></td>
</tr>
</tbody>
</table>

*Discard a bottle of syrup 15 days after opening

Guide for administration of tetanus toxoid and tetanus immunoglobulin to people with wounds

<table>
<thead>
<tr>
<th>History of tetanus immunization (number of doses)</th>
<th>If wounds are clean and &lt;6 hours old or minor wounds</th>
<th>All other wounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Uncertain or &lt;3</td>
<td>TT*</td>
<td>TT*</td>
</tr>
<tr>
<td>Yes</td>
<td>TIG</td>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>3 or more</td>
<td>No, unless last dose &gt;10 years ago</td>
<td>No, unless last dose &gt;5 years ago</td>
</tr>
<tr>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

* For children less than 7 years old, DTP or DT is preferred to tetanus toxoid alone. For persons 7 years and older, Td is preferred to tetanus toxoid alone.

** The second dose should be completed at four weeks, the third dose at 6 months to 1 year.

Guide for administration of hepatitis B vaccine

This vaccine provides life-long immunity to hepatitis B. It is given in 3 separate doses: the 2nd dose is given 1 to 2 months after the first dose; and the 3rd dose is given 4 to 12 months after the 2nd dose. **Must be stored at 2 to 3° C or it loses its strength. Doses for these two brands of the vaccine are different:**

<table>
<thead>
<tr>
<th>Engerix-B</th>
<th>Children 0 to 11 years, 10 ucg; children 12 to 19 years and adults, 20 ucg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recombivax HB</td>
<td>Children 0 to 11 years old, 2.5 ucg; children 12 to 19 years, 5 ucg; adults 10 ucg</td>
</tr>
</tbody>
</table>

127 Hesperian Foundation, A Book for Midwives: Care for pregnancy, birth and women’s health, updated 2010.
Final training evaluation

Date: __________________________________________________ Location of training: ______________________________________

Please circle the response that best meets how you feel about each question.

1. How well were you able to understand the content of the training?
   - Very well
   - Well
   - Poorly
   - Not at all

2. How well did the training meet your need for technical information about providing care to survivors of sexual violence?
   - Very well
   - Well
   - Poorly
   - Not at all

3. How well did the training meet your need to understand how to communicate with survivors of sexual violence?
   - Very well
   - Well
   - Poorly
   - Not at all

4. How well did the training help you overcome any concerns you had about caring for survivors of sexual violence?
   - Very well
   - Well
   - Poorly
   - Not at all

5. How much will the training change how you care for survivors of sexual violence in the future?
   - Very much
   - Somewhat
   - Very little
   - Not at all

6. Did the training change your attitude toward survivors of sexual violence?
   - Very much
   - Somewhat
   - Very little
   - Not at all

7. How would you rate the exercises used in the training?
   - Very good
   - Good
   - Poor
   - Not at all

8. How would you rate how the training was facilitated?
   - Very good
   - Good
   - Poor
   - Not at all

9. Please note any comments or suggestions.

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

_____________________________________________________________________________________________________________________________________________________

Thank you.
EVALUATION TOOLS

The following tools are enclosed:

1. Pre-/post-test for Literate CHWs (Modules 2-4; 5-6; Advanced Module 8)
2. Pre-/post-test for Non-literate CHWs (Modules 2-4)
3. Answer key to pre-/post-test
4. Clinical assessment tool for CHWs 2 and 3 (adult survivor)
5. Three month assessment tool for CHWs 2 and 3
6. Answer key to three month assessment tool for CHWs 2 and 3
7. Three month clinical assessment tool for CHWs 2 and 3 (child survivor)

CHWs should be administered different sections of the test per their level:
CHW 1

Pre-test
1 Pre-test for Literate CHWs (Modules 2-4)
2 Pre-test for Non-literate CHWs (Modules 2-4)

Post-test
1 Pre-test for Literate CHWs (Modules 2-4)
2 Pre-test for Non-literate CHWs (Modules 2-4)

CHW 2

Pre-test
1 Pre-test for Literate CHWs (Modules 2-4, 5-6)

Post-test
1 Post-test for Literate CHWs (Modules 2-4, 5-6)
4 Clinical assessment tool (adult survivor)

Three month evaluation
5 Three month evaluation tools
6 Three month clinical evaluation tool (adult or child survivor)

CHW 3

Pre-test
1 Pre-test for Literate CHWs (Modules 2-4, 5-6, Advanced Module 8)

Post-test
1 Post-test for Literate CHWs (Modules 2-4, 5-6, Advanced Module 8)
4 Clinical assessment tool (adult survivor)

Three month evaluation
5 Three month evaluation tools
6 Three month clinical evaluation tool (adult or child survivor)

Passing scores at post-test and three months are as follows:

CHW 1:
- At least 50% on the Module 2-4 post-test (1)

CHW 2:
- At least 50% on the Module 2-4 post-test (1)
- At least 80% on the Module 2-6 post-test (1)
- At least 70% on the clinical evaluation (end of training and three months) (4)
- At least 70% on three month evaluation tool (separately for clinical assessment) (4, 5, 6)

CHW 3:
- At least 50% on the Module 2-4 post-test (1)
- Average of 80% on the Module 2-6 and Advanced Module 8 post-tests (1)
- At least 70% on the clinical assessment (end of training and three months) (4)
- At least 70% on three month evaluation tool (separately for clinical assessment) (4, 5, 6)

Note that the evaluation questions can be simplified significantly if pre-packaged treatment packets will be made available for CHWs in the pilot.