PARTICIPANTS' HANDOUTS



Training curriculum for health care providers for management of intimate partner violence and sexual violence in Sierra Leone

THE WORLD BANK
IBRD • IDA

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These materials for participatory exercises form part of the training curriculum for health care providers for management of intimate partner violence and sexual violence in Sierra Leone. The exercises and materials here are based on resources for exercises in the WHO curriculum for caring for women subjected to violence,[1] and have been adapted for a Sierra Leonean context by integrating national legal frameworks and guidelines, and other resources. The Ministry of Health and Sanitation (MOHS) would like to thank the World Bank for its significant support in strengthening the country's health system. The development of this training package would not have been possible without the technical and financial support provided by the World Bank and the government of Japan through the Japan Policy and Human Resource Development (PHRD) grant for Advisory and Analytical Services.

1 World Health Organization (WHO). 2019. Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers.

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Handout 1a: GBV Terminologies

Domestic violence	Any criminal offence arising out of physical, sexual, emotional or psychological, social, economic or financial abuse committed by a person against another person within a domestic relationship.
Gender	The socially constructed characteristics of women and men, such as norms, roles, and relationships of and between groups of women and men. It varies from society to society and can be changed. Gender defines the roles, responsibilities, constraints, opportunities and privileges of men and women in any context.
Gender-based violence	An umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (gender) differences between males and females.
Genital organs	The whole or part of male or female reproductive parts and, for the purposes of the act of sexual violence, includes the anus.
Health care worker	Professionals who provide health services including nurses, doctors, clinical officers, and medical assistants, who have specific training in the field of health care delivery.
Informed consent (medical)	Where the health care provider has disclosed all relevant information with regard to the proposed course of treatment to the patient so that the patient can then arrive at a choice as to whether or not to proceed with the same.
Informed consent (legal)	Where a person has all relevant information regarding a certain course of action prior to agreeing to that action. For this consent to be legally valid the person has to be an adult of sound mind.
Intimate partner violence	Behaviour by an intimate partner that causes physical, sexual, psychological, or economic harm, including acts of physical aggression, verbal abuse, sexual coercion, reproductive coercion, and other controlling behaviours. It covers violence by both current and former spouses and other intimate partners.
Perpetrator	A perpetrator is a person, group, or institution that directly inflicts, supports, or condones violence or other forms of abuse against a person or group of people. A perpetrator could be a partner, ex-partner, boyfriend, father, mother, another family member, another person in the home, a teacher or educator, superior at the workplace, colleague at work or school, another acquaintance, or a stranger. Perpetrators take advantage of being in a position of real or perceived power, decision making, or authority, and thus exert control over others.
Power	The capacity to make decisions that affect oneself or others. Power that is exerted over others is a negative use of power when it is used to dominate, intimidate, abuse, impose obligations on, restrict, prohibit, and make decisions about the lives of others.
Rape	Physically forced or otherwise coerced penetration, even if slight, of the vulva or anus, using the penis, other body parts or an object, without consent.
Sexual penetration	Any act which causes the penetration to any extent of the vagina, anus or mouth of a person by the penis or any other part of the body of another person, or by an object. Note that the terms 'rape' and 'sexual penetration' are often used interchangeably. In Sierra Leone, sexual penetration is used when a minor is involved (a person below the age of 18 years).

Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality, using coercion, by any person regardless of their relationship to the victim, in any setting including but not limited to home and work. Acts of sexual violence include sexual harassment; rape, including forceful anal penetration, attempted rape, and marital rape; exploitation; child sexual abuse and incest; sexual abuse (non-penetrating); forced prostitution; child prostitution, and sexual trafficking.
Survivor (victim)	Any person who has lived through an incident of gender-based violence. A survivor is also known as a 'victim' in the Sexual Offences Act, but survivor is the preferred term.
Violence	Intentional use of force or power, threatened or actual, against oneself, or another person, or against a group or community that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation.
Violence against women	All acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or in private life.

Sources:

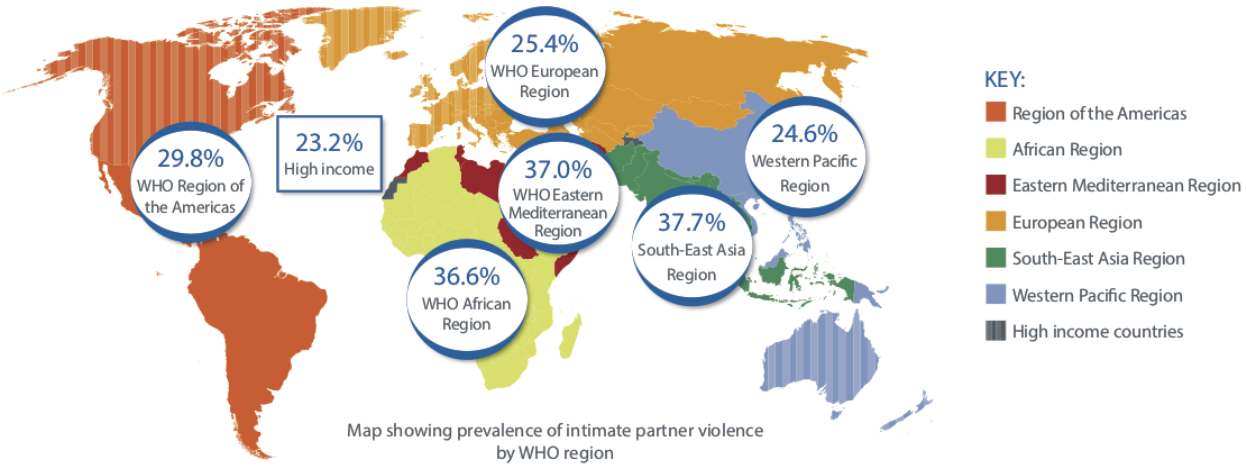
- Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), Forthcoming. *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*
- Sexual Offences Act (2012).

Handout 1b: Violence Against Women – Global Picture/Health Response

VIOLENCE AGAINST WOMEN: GLOBAL PICTURE HEALTH RESPONSE

PREVALENCE ➔

1 in 3 women throughout the world will experience physical and/or sexual violence by a partner or sexual violence by a non-partner



Map showing prevalence of intimate partner violence by WHO region

HEALTH IMPACT: Women exposed to intimate partner violence are ➔

Mental Health

TWICE as likely to experience depression

ALMOST TWICE as likely to have alcohol use disorders

Sexual and Reproductive Health

16% more likely to have a low birth-weight baby

1.5 TIMES more likely to acquire HIV and 1.5 times more likely to contract syphilis infection, chlamydia or gonorrhoea

Death and Injury

42% of women who have experienced physical or sexual violence at the hands of a partner have experienced injuries as a result

38% of all murders of women globally were reported as being committed by their intimate partners

Source: World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 1c: Legal and Policy Frameworks of GBV in Sierra Leone

SIGNED AND RATIFIED INTERNATIONAL HUMAN RIGHTS TREATIES
Convention on the Rights of Persons with Disabilities (CRPD) https://www.un.org/disabilities/documents/convention/convoptprot-e.pdf
Convention for the Protection of All Persons from Enforced Disappearance (CED) https://www.ohchr.org/Documents/ProfessionalInterest/disappearance-convention.pdf
Optional Protocol of the Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT-OP) https://treaties.un.org/doc/source/RecentTexts/iv_9bE.pdf
Optional Protocol to the Convention on the Rights of the Child on the involvement of children in armed conflict (CRC-OP-AC) https://www.ohchr.org/en/professionalinterest/pages/opaccrc.aspx
Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (CRC-OP-SC) https://www.ohchr.org/Documents/ProfessionalInterest/crc-sale.pdf
International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW) https://www.ohchr.org/Documents/ProfessionalInterest/cmw.pdf
Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) https://www.ohchr.org/documents/professionalinterest/cedaw.pdf
Convention against Torture and Other Cruel, Inhuman, or Degrading Treatment or Punishment (CAT) https://www.ohchr.org/Documents/ProfessionalInterest/cat.pdf
International Covenant on Civil and Political Rights (CCPR) https://www.ohchr.org/documents/professionalinterest/ccpr.pdf
International Convention on the Elimination of All Forms of Racial Discrimination (CERD) https://www.ohchr.org/Documents/ProfessionalInterest/cerd.pdf
International Covenant on Economic, Social and Cultural Rights (CESCR) https://www.ohchr.org/Documents/ProfessionalInterest/cescr.pdf

NATIONAL LAWS THAT ADDRESS GBV IN SIERRA LEONE		
National legislative frameworks	**Year**	**Description**
Anti-Human Trafficking Act https://sherloc.unodc.org/res/cld/document/sle/2005/the_anti-human_trafficking_act_2005_html/Sierra-Leone_Anti-Human-Trafficking-Law_2005.pdf	2005	Criminalizes trafficking, which includes recruiting, transporting, transferring, harbouring or receipt of persons, using either threats, force, coercion, abduction, fraud, deception, abuse of power or a position of vulnerability. It also criminalizes giving or receiving payments or benefits to achieve the consent of a person who has control over another person for the purpose of exploitation.
Domestic Violence Act http://www.sierra-leone.org/Laws/2007-20p.pdf	2007	Criminalizes domestic violence, and adopts a broad definition of domestic violence that includes sexual, physical, emotional, psychological, and economic abuse perpetrated against an individual in a domestic setting.
Devolution of Estates Act http://www.sierra-leone.org/Laws/2007-21p.pdf	2007	Addresses women's inheritance rights by, for instance, protecting widows from being denied access to the property of their deceased spouse, guaranteeing the right of children born in and out of wedlock to own their deceased father's property, and ensuring proportionate distribution of property between men and women.
Registration of Customary Marriage and Divorce Act http://jafbase.fr/docAfrique/Sierra%20Leone/Customary%20marriage%20and%20divorce%20registration%20act%202009.pdf	2007	Raises the legal age of marriage to 18 years and legalizes all marriages under customary, Muslim, Christian and civil laws.
A Child Rights Act http://www.unesco.org/education/edurights/media/docs/08ca923c5231b0fbc88f532d4f2cc6299909eb8c.pdf	2007	Provides many of the rights found in the Convention on the Rights of the Child and the African Charter of Child Welfare and Rights. It includes information detailing a) the setup of a National Children's Commission b) specific rights provided c) the specific child welfare functions of local committees and District Councils
Sexual Offences Act https://www.warnathgroup.com/wp-content/uploads/2017/11/Sierra-Leone-Sexual-Offenses-Act.pdf	2012	Addresses various types of sexual assault and covers married women, children and people with disabilities. It also prohibits forced sex in marital relationships and protects children from being abused by teachers, as well as traditional and religious leaders.
The Legal Aid Act https://www.refworld.org/pdfid/550a9cab4.pdf	2012	Provides a basic level of free legal support for the defence of anybody accused of a crime but without the financial means for a lawyer.
Sexual Offences (Amendment) Act http://rogee.sl/docs/ROGEE-Sierra-Leone-Act-Sexual-Offences-2019.pdf	2019	Amends the 2012 Sexual Offences Act to: increase the maximum penalty for rape and sexual penetration of a child from 15 years to life imprisonment; introduce an offence of aggravated sexual assault; provide for the prosecution of offences under the Act; and allow for further procedural rules in relation to the original Act.

POLICIES, PLANS, AND STRATEGIES THAT ADDRESS GBV IN SIERRA LEONE		
Policies, Plans and Strategies	**Year**	**Summary of GBV content**
National Policy on the Advancement of Women	2000	■ Provides objectives and strategies to reduce gender gaps in agriculture, education, health, and sanitation sector service delivery, as well as employment and income. ■ Appointment of gender focal points in various government institutions.
National Policy on Gender Mainstreaming http://www.ecreee.org/sites/default/files/documents/news/status_of_gender_mainstreaming_in_sierra_leone_0.pdf	2000	■ Provides a pathway for integration of gender concerns into policies, plans, programs and legislation.
National Gender Strategic Plan https://www.unicef.org/evaldatabase/files/MTE_of_NGSP_Report_-_FINAL.pdf	2010–2013	■ Aimed to operationalize the national policies on advancement of women and gender mainstreaming, to achieve gender equality, particularly in legislation, representation, empowerment and the distribution of resources. ■ Serves as a tool for advocacy and resource mobilization, coordination, monitoring and evaluation. ■ Calls for 30% women's representation in politics and governance as well as increased gender training for legal officers.
Sierra Leone National Action Plan for the Full Implementation of UNSCR 1325 and UNSCR 1820 on Sexual Violence https://www.peacewomen.org/assets/file/NationalActionPlans/sierra_leone_nap.pdf	2009–2010	■ Outlines a national plan for giving effect to UN Security Council Resolutions 1325 and 1820 in Sierra Leone, which aim to address the impact of armed conflict on women and girls, including by strengthening women's participation in conflict prevention. ■ Aimed to contribute to the reduction of conflict, including violence against women and children; the protection and empowerment of women and girls; contribute to increased prosecution of perpetrators as well as rehabilitation of victims; and to contribute to increased participation and representation of women. ■ Sought to ensure effective implementation process and mobilization of resources.
The Code of Conduct (CoC) for teachers and other education personnel in Sierra Leone https://etico.iiep.unesco.org/sites/default/files/sierra_leone_2009_code_of_conduct_for_teachers_and_other_education_personnel.pdf	2009	■ Defines the parameters of unethical conduct of teachers and education personnel, and allows opportunities for changes of attitudes through application of the education sector's Collective Agreement and existing laws.
The National Child Abuse Handbook	2009	■ Aimed at welfare workers in Sierra Leone, and provides a basis for understanding the different categories of child abuse, recognizes the symptoms of abuse, and understands where to report abuse.

The Free Health Care Initiative https://sierraleone.unfpa.org/sites/default/files/pub-pdf/UNFPA_support_Free_Health_Care_Initiative.pdf	2010	■ A government initiative to ensure universal health coverage by providing free preventive and curative health services for pregnant women, lactating mothers and children under five years of age in any public health facility.
The National Referral Protocol on Gender Based Violence https://amnet-online.org/assets/The-National-Referral-Protocol-Launch-19-10-12.pdf	2012	■ Agreement between key government ministries to ensure an effective response to, and coordination of, services for victims/survivors of gender-based violence. ■ Specifies specific roles and responsibilities of government agencies and services in addition to civil society organizations and community mechanisms.
National Child Welfare Policy	2013	■ Recognizes that many situations of child exploitation, violence, neglect and welfare abuse develop as a result of families experiencing chronic poverty. ■ The policy 'represents a significant shift in how child protection is approached in Sierra Leone, and situates child protection within a wider child welfare system through providing support to families and communities.
Third Generation Poverty Reduction Strategy paper III http://extwprlegs1.fao.org/docs/pdf/sie149110.pdf	2013–2018	■ Adopts twin-track approach by not only mainstreaming gender across Pillars 1-7 but also including a separate pillar on Gender Equality and Women's Empowerment.
The National Draft Framework for Child Protection Case Management for Sierra Leone	2015	■ National Case Management Standard Operating Procedures (SOPs) were established to facilitate joint action between the Ministry of Social Welfare, UNICEF, Save the Children, and Partner Organizations, to protect and monitor the wellbeing of children at heightened vulnerability and protection risk during the Ebola response and post-Ebola recovery periods.
FGM/C National Strategy (still in draft)	2015	■ Proposes circumcision should only happen post-18 years of age and with a woman's consent.
National strategy for the reduction of adolescent pregnancy and child marriage https://sierraleone.unfpa.org/sites/default/files/pub-pdf/National%20Strategy%20for%20the%20reduction%20of%20Adolescent%20Pregnancy_final_Oct%202.pdf	2018–2022	■ Aims to address the issues related to adolescent pregnancy and child marriage, and provides a direction for interventions to address these in Sierra Leone. ■ Includes a monitoring and evaluation framework with appropriate milestones and targets for each of the indicators.
Sierra Leone National Reproductive, Maternal, Newborn, Child and Adolescent Health Policy https://www.afro.who.int/sites/default/files/2017-11/Sierra%20Leone%20Reproductive%2C%20Maternal%2C%20Newborn%2C%20Child%20and%20Adolescent%20Health%20Policy.pdf	2017–2021	■ Aligned with other national frameworks, and focuses on priority areas of antenatal care; emergency obstetric and newborn care (EmONC) including the promotion of skilled birth attendance and essential newborn care, integrated management of newborn and childhood illness (IMNCI) and integrated community case management (iCCM), immunization, nutrition; family planning (FP); prevention of teenage pregnancy and water hygiene and sanitation (WASH).

Source: World Bank, 2017, Internal Report, Sierra Leone GBV Risk Assessment Portfolio Review Report; World Bank

Handout 2a: Why Does the Health Care Provider Response Matter?

- Women in many settings identify health care providers as the professionals they trust to disclose abuse and other personal matters to.
- Violence against women is linked to poor health outcomes.
- The health care setting can be a confidential place to provide support and information.
- Addressing violence against women in the health sector reminds patients that violence against women and healthy relationships matter for their health and wellbeing.
- A health care provider asking about intimate partner violence is an opportunity to raise patient awareness of intimate partner violence.
- Asking about violence when health indicators are present can normalize identification questions about violence against women and reduce feelings among women that they are being judged. (*Note: The World Health Organization does not recommend universal screening for violence against women attending health care.*)
- Receiving information about violence against women in the form of posters, brochures, or flyers may allow women to maintain a sense of autonomy in how they discuss violence with their providers. It offers them an opportunity to address their situation according to their stage of readiness.
- When health care providers present assessment of violence against women as necessary for good health and relationships, it can relieve worries about stigma and judgement.
- Health care providers' expressions of concern and support can validate women's experiences, help them recognize abuse, and inspire them to strive for safety.

Sources:

- Chang et al., 2005, "Health Care Interventions for Intimate Partner Violence: What Women Want", *Women's Health Issues*; Chang et al., "Understanding Turning Points in Intimate Partner Violence: Factors and Circumstances Leading Women Victims Toward Change", *Journal of Women's Health*.
- World Health Organization (WHO), 2014, *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook*.

Handout 2b: Why Don't Women Leave?

Leaving can be more complicated than it seems.

Women stay in abusive relationships for many reasons; here are a few:

Fear: A woman may be afraid of what will happen if she decides to leave the relationship.

Believing abuse is normal: A woman may not know what a healthy relationship looks like and may be unable to see that her relationship is abusive.

Shame: Women may feel embarrassed to admit that they have been abused, and may think it is their fault for getting into such a situation. They may also worry about judgement from family, friends, and neighbours.

Low self-esteem: Verbal and physical abuse often go hand in hand. When women are repeatedly degraded and blamed for their abuse, especially by someone who is supposed to love them, it is easy for them to start believing the abuse is their fault.

Love/hope for change: Abusers are often charming and manipulative. A woman may hope that her partner will go back to being the person she knew before the violence began.

Children: Some women feel they need to preserve their family for the benefit of their children, no matter what.

Cultural/religious reasons: Cultural or religious norms may make a woman reluctant to leave, out of anxiety over how leaving may reflect on her and her family/community.

Lack of money/resources: A woman may be dependent on an abuser for financial resources, housing, and many other needs. In these situations, it can seem impossible to leave the relationship.

Disability: In some situations, a woman may be physically dependent on her relationship.

Isolation: A woman may feel she has no place to go, or no one to turn to for support.

Source: World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 2c: Barriers to Seeking Care

REASONS FOR NOT SEEKING HELP	REASON FOR SEEKING HELP
✓ She was afraid of bringing shame on her family.	✓ She could not endure any more.
✓ She may fear economic hardship or manipulation.	✓ She was severely injured.
✓ She was embarrassed or afraid of being blamed or not believed.	✓ Her partner had threatened or hit her children.
✓ She was afraid of consequences/threats/more violence.	✓ She had been encouraged by friends or family.

Source: Adapted from World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 3: Guiding Principles for Survivor-Centred Care

Below are the basic principles and approaches that should guide health care providers' behaviour, interventions and assistance when responding to cases of sexual assault:

1. **A rights-based approach:** A rights-based approach includes the right to the highest attainable standard of health and the right to self-determination, which means women being entitled to make their own decisions including sexual and reproductive decisions, and being entitled to refuse medical procedures and/or take legal action.
2. **A survivor-centred approach:** Like a rights-based approach, a survivor-centred approach means that all those who are engaged in programmes related to violence against women prioritize the rights, needs, and wishes of the survivor.
3. **Gender equality:** Assuring gender equality in health means providing care fairly to both women and men, considering their specific health needs and concerns so that they are equally able to realize their rights and potential to be healthy. It requires also being aware of inequalities in power relationships between women and men, and between providers and patients.
4. **Respect:** Actions and response services of all actors will be guided by respect for the wishes, the rights, and the dignity of the survivor.
5. **Belief:** As health care providers, we always believe a woman or girl. It is not our job to judge what happened; it is our job to help the survivor cope with the consequences. It is up to the police to investigate and the courts to decide.
6. **Security and safety:** The security and safety of the survivor are always a priority.
7. **A "do no harm" approach:** A "do no harm" approach involves taking all measures necessary to avoid exposing people to further harm because of the actions of health care providers and humanitarian actors.

Respecting a survivor's universal rights

Universal rights apply to everyone who seeks care at a health care facility, including survivors of any form of violence. At all times, a person seeking care should be treated with dignity and non-discrimination, and be provided with the best health care possible. As a health care provider, respecting these universal rights is not only essential to a survivor's healing, it is your responsibility.

Right to health care

Every survivor has the right to health care. Survivors of violence have the right to high quality health care to help them heal physically and psychologically, regardless of their ability to pay.

Right to non-discrimination

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

Right to information

Every survivor has the right to information in a language she understands. They have the right to know about:

- Their right to privacy, confidentiality, and self-determination.

- The details of the examination.
- Treatment options available.
- Effects and side effects of prescribed medications.
- Available referral services.

Right to privacy

Every survivor has a right to privacy.

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

Right to confidentiality

Every survivor has a right to confidentiality.

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

Right to self-determination

Every survivor has a right to self-determination.

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

Source: Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), Forthcoming, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 4: Active Listening Principles

Listening is an interactive, engaging process whereby the listener focuses attention on the person to whom they are speaking.

- The listener attempts to understand and interpret the non-verbal and verbal messages.
- The listener uses verbal and non-verbal techniques to convey, support, and communicate that they have heard and understood the message.
- Active listening is central to communication.

Types of questions

These types of questions are appropriate for eliciting relevant information:



1

OPEN-ENDED QUESTIONS

These questions are broad in scope and do not limit the area of inquiry.

For example: "What difficulties are you having?" Start interactions with open-ended questions and then move to focused and closed questions.

2

FOCUSED QUESTIONS

The listener defines the area of inquiry but allows considerable latitude in answering.

For example: "Can you tell me about your visit to the doctor?"

3

CLOSED QUESTIONS

These questions require a "yes" or "no", or a numerical answer.

For example: "How long have you been experiencing trouble sleeping?"

The following types of questions should be avoided, as they usually elicit insufficient or inaccurate information:



LEADING QUESTIONS

The listener leads the speaker into an acceptable answer.

For example: "You agree that getting some professional help is the only way you're going to start feeling better, don't you?"

COMPOUND QUESTIONS

Two or more questions are asked without time given for the speaker to respond to the first question in the series.

For example: "Tell me, have you decided on the model of care you want and whether you want to breastfeed?"

Non-verbal communication

Non-verbal communication norms vary across settings and cultures. These guidelines may be helpful to get you to start thinking about what is appropriate in your setting.

Sitting posture

- Sitting at the same level as the speaker can open the conversation.
- Crossed arms and legs can signal less involvement. An open posture shows an openness to the speaker and to what she or he has to say.
- A slight inclination toward a person can convey, "I am with you. I am interested in what you have to say."

Eye contact

- Norms about eye contact vary across contexts. Let your context be your guide on eye contact.
- Frequent and soft eye contact makes the patient feel that the provider is attentive.
- The provider should not make as frequent eye contact during the initial session, but the level of eye contact can be increased and maintained with rapport and the progression of discussion.

Additional support

- Nodding can convey encouragement and compassion, and conveys understanding.
- Conveying confidence and understanding helps patients know that the topic of violence is not new or unusual for the listener.
- An unrushed, relaxed approach waits for the conversation to unfold and does not rush the speaker.

Source: World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 5a: When and How to Identify a Woman or Girl Who May Be Subject to Violence

Many women and girls who have experienced violence present to health facilities to seek care for other ailments, and rarely disclose their exposure to violence to the health care providers. They may be afraid, embarrassed, or ashamed to talk to anyone about it, or may not be aware of the availability and importance of health services for violence. It is therefore important for health care providers to be aware that a survivor's health problems may be caused or made worse by violence.

You should suspect a woman or girl has been subjected to violence if she has any of the following:

- Ongoing emotional health issues, such as stress, anxiety, or depression.
- Harmful behaviours such as misuse of alcohol and drugs.
- Thoughts, plans, or acts of self-harm or (attempted) suicide.
- Injuries that are repeated and not well explained.
- Repeated sexually transmitted infections.
- Unwanted pregnancies.
- Unexplained chronic pain or conditions (pelvic pain or sexual problems, gastrointestinal problems, kidney or bladder infections, or headaches).
- Repeated health consultations with no clear diagnosis.

You may also suspect a problem if a woman or girl's partner or husband is intrusive during consultations, if she often misses her own or her children's health care appointments, or if her children have emotional and behavioural problems.

The World Health Organization (WHO) **does not recommend universal screening** for violence against women or girls attending health care.

Health care providers should raise the topic with women and girls who have injuries or conditions that they suspect may be related to violence.

What to do when you suspect violence

- Ask about violence in an empathic, non-judgmental manner.
- Use language that is appropriate and relevant to the culture and community that you are working in (for example, some women or girls may not like the words "violence" or 'abuse"). Use culturally accepted terms to refer to violence. It is important to use the words that the women themselves use.

Never raise the issue of partner violence unless a woman is alone. Even if she is with another woman, that woman could be the mother or sister of the abuser.

What to do if you suspect violence and the patient does not disclose it:

- Do not pressure her; give her time to decide what she wants to tell you.
- Tell her about the services that are offered at your facility.
- Tell her about the long- and short-term effects on health outcomes from violence towards her and her children.
- Offer to continue supporting her through follow-up clinic visits.

Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

Handout 5b: Asking About Violence

Here are some statements you can make to raise the subject of violence before you ask direct questions:

- "How is your relationship?", or, "How much tension is there in your relationship?"
- "Sometimes, the people we care about hurt us. Has that happened to you?"
- "What happens when you argue? What happens when he gets angry? Have you felt humiliated or emotionally abused by your partner?"
- "What is the worst thing that has happened in your relationship?"

Here are some simple and direct questions that you can start with that show you want to hear about her problems. Depending on her answers, continue to ask questions and listen to her story. If she answers "yes" to any of these questions, offer her first-line support:

- "Are you afraid of your husband (or partner)?"
- "Has your husband (or partner) or someone else at home ever threatened to hurt you or physically harm or beat you in some way? If so, when has it happened?"
- "Does your husband (or partner) or someone at home bully you or insult you?"
- "Does your husband (or partner) try to control you – for example, by not letting you have money or leave the house?"
- "Has your husband (or partner) forced you into sex or forced you to have any sexual contact you did not want?"
- "Has your husband (or partner) threatened to send you away from the house?"
- "Has your husband (or partner) threatened to kill you?"

Source: World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 6a: First-Line Support

What is first-line support?

First-line support provides practical care and responds to the survivor's emotional, physical, safety and support needs, without re-traumatizing them or intruding on their privacy. Often, first-line support is the most critical care that health care workers can provide. Even if this is all the health care worker can do, it will have significantly helped the client. First-line support has helped people who have been through various upsetting or stressful events, including women and girls subjected to violence.

Remember: This may be your only opportunity to help the survivor of violence.

First-line support cares for emotional needs

First-line support may be the most important care that you can provide to a survivor of violence or abuse, and it may be all that the survivor needs.

First-line support is caring for emotional and practical needs. Its goals include:

- Identifying her needs and concerns.
- Listening to and validating her concerns and experiences.
- Helping her to feel connected to others, calm, and hopeful.
- Empowering her to feel able to help herself and to ask for help.
- Exploring what her options are.
- Respecting her wishes.
- Helping her to find social, physical, and emotional support.
- Enhancing safety.

Remember: When you help a survivor deal with her practical needs, it helps with her emotional needs. When you help with her emotional needs, you strengthen her ability to deal with practical needs.

You do not need to:

- Solve her problems.
- Convince her to leave a violent relationship.
- Convince her to go to any other services, such as police or the courts.
- Ask detailed questions that force her to relive painful events.
- Ask her to analyze what happened or why.
- Pressure her to tell you her feelings and reactions to an event.

Doing these things could do more harm than good.

First-line support involves five simple tasks. It responds to both emotional and practical needs at the same time. The letters in the word "LIVES" can remind you of these five tasks that protect women's lives.



LISTEN	Listen to the woman closely, with empathy and without judging.
INQUIRE ABOUT NEEDS AND CONCERNS	Assess and respond to her various needs and concerns—emotional, physical, social, and practical (for example, childcare).
VALIDATE	Show her that you understand and believe her. Assure her that she is not to blame.
ENHANCE SAFETY	Discuss with her a plan to protect herself from further harm if violence occurs again.
SUPPORT	Support her by helping her connect to information, services, and social support.

Active listening Do's and Don'ts

DO'S

- Allow for silence. Give her time to think.
- Stay focused on her experience and on offering her support.
- Acknowledge what she wants and respect her wishes.

DON'TS

- Do not try to finish her thoughts for her.
- Do not tell her someone else's story or talk about your own troubles.
- Do not think and act as if you must solve her problems for her.

Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook*.

Handout 6b: Communication Skills and Pathway

Raise the subject	Use direct questions	Listen	Inquire	Validate	Enhance safety	Support
Many women experience problems with their husband, or partner, or someone else they live with.	Are you afraid of your husband or partner? Has your husband, or partner, or someone else threatened you or physically harmed you? Has your husband or partner forced you into sex or forced you to have unwanted sexual contact?	Make eye contact. Reflect how she is feeling. Respect her rights and dignity. Be gentle. Don't rush her.	Ask open-ended questions. Ask for clarification or detail. Reflect back her feelings. Help her identify needs or concerns. Summarize what she said.	It's not your fault. You are not to blame. You are not alone. Everybody deserves to feel safe at home. I am concerned this may be affecting your health.	Has physical violence increased in the past six months? Is he violently and constantly jealous of you? Has he ever beaten you when you were pregnant? Has he ever threatened you with a weapon? Do you believe he could kill you?	Ask her, "What would help the most if we could do it right away?" Help her to identify and consider her options. Discuss her social support.

Source: Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), Forthcoming, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 6c: Enhance Safety

Many women and girls who have been subjected to violence fear for their safety. Even in situations where the survivor is not worried and believes that the violence will not happen again, explain to her that the violence is not likely to stop on its own. Even women and girls who are not facing immediate serious risk could benefit from having a safety plan. The plan helps them to deal better with a situation where violence occurs suddenly. Assessing and planning for safety is an ongoing process. Have this conversation with the survivor each time you meet her.

Questions to assess the immediate risk of violence*

Survivors who answer "yes" to at least three of the following questions may be at especially high immediate risk of violence:

1. Has physical violence happened more often or got worse over the past six months?
2. Has he ever used a weapon or threatened you with a weapon?
3. Has he ever tried to strangle you?
4. Do you believe he could kill you?
5. Has he ever beaten you when you were pregnant?
6. Is he violently and constantly jealous of you?

*Adapted from Snider, et al., 2009, "Intimate Partner Violence: Development of a Brief Risk Assessment for the Emergency Department." *Academic Emergency Medicine: Official Journal of the Society for Academic Emergency Medicine.*

For women who are at high immediate risk of violence, it may be unsafe to return home. In this case, make an appropriate referral to a shelter or safe housing, or work with her to identify a safe place that she can go to (for example, a friend's home or church).

SAFETY PLANNING	
Safe place to go	If you needed to leave your home in a hurry, where would you go?
Planning for the children	Would you go alone or take your children with you?
Items to take with you	Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?
	Can you put together items in a safe place, or leave them with someone, just in case?
Financial	Do you have access to money if you need to leave? Where is it kept? Can you get it in an emergency?
Support of someone close by	Is there a neighbour you can tell about the violence who can call the police or come with assistance for you if they hear the sounds of violence coming from your home?

Avoid putting the survivor at risk

Always talk about violence and safety planning when the survivor is alone. Never discuss it if she is with her husband or other family member, or anyone else who has accompanied her—even a friend.

Remember to keep all her health records safe and confidential!

Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook*.

Handout 6d: Health Care Providers' Common Questions

Here are answers to some questions that health care providers often ask about working with survivors of violence.

"Why not offer advice?"

What is important is that the survivor is listened to and offered an opportunity to tell their story to an empathic person. Most survivors do not want to be told what to do. Listening well and responding with empathy is far more helpful than you may realize. It may be the most important thing you can do. The survivor needs to find their own path and come to their own decisions, and talking about it can help them do this.

"Why doesn't she just leave him?"

There are many reasons that women and girls stay in violent relationships. It is important not to judge them and not to urge them to leave. A survivor must make that decision for herself in her own time.

Reasons for not leaving include:

- She depends on her partner's income. Many women can find it difficult to be financially independent.
- She believes that children should be raised with a father and thinks that her welfare is less important than this ideal.
- She thinks that violence is normal in relationships and that all men will be violent and controlling.
- She fears an extreme and violent reaction to her leaving.
- Her self-esteem is low, and she believes that she cannot manage on her own.
- She feels she has no place to go or no one to turn to for support.
- She still loves him and thinks he will change.
- She thinks that he needs her.
- She does not want to be alone.
- She is afraid of being abandoned by the community for having left her partner.

"How did she get herself into this situation?"

It is important to avoid blaming the survivor for what happened. Blaming the survivor will get in the way of giving her good care. Violence is never appropriate in any situation. There is no excuse or justification for violence or abuse. Just because a survivor did something that made her partner angry does not mean that she deserved to be hurt.

"What can I do when I have so few resources and so little time?"

First-line support (LIVES) is the most helpful care you can give. It does not necessarily take long, and it does not require additional resources. Also, you can learn about resources in the health care system and in the community that can help the survivor. You might even consider whether you could help a confidential community support group get started.

"That wasn't the way we were taught."

Health care providers are generally taught that their main role is to diagnose the problem and treat it. However, in this situation, limiting the focus to medical concerns is not helpful. Instead, you need to add a human focus by listening, identifying the survivor's needs and concerns, strengthening her social support, and enhancing her safety. Also, you can help the survivor see and consider her options, and help her feel she has the strength to make and carry out important decisions.

"What if she decides not to report violence to the police?"

Respect her decision. Let her know that she can change her mind. However, evidence of sexual assault must be collected within five days. Let her know if there is someone she can talk to further about her options and help her make a report if she chooses to.

"What if she starts to cry?"

Give her time to do so. You can say, "I know this is difficult to talk about. You can take your time".

"What if you suspect violence, but she doesn't acknowledge it?"

Do not try to force her to disclose. (Your suspicions could be wrong.) You can still provide care and offer further help.

"What if she wants me to talk to her husband."

It is not a good idea for you to take on this responsibility. However, if the survivor feels it is safe to do so and it will not make the violence worse, it may be helpful for someone he respects to talk to him—perhaps a family member, friend, or religious leader. Warn her that if this is not done carefully it could lead to more violence.

"What if the partner is one of my clients, too?"

It is extremely hard to keep seeing both partners when violence and abuse are happening in a relationship. The best practice is to try to get a colleague to see one of them while ensuring that the confidentiality of the woman's disclosure is protected. Do not offer couple counselling.

"What if I think her partner is likely to kill her?"

Share your concerns honestly with the survivor, explaining why you think she might be at grave risk and explain that you want to discuss with her the possible options for making her safe. In this situation, identifying and offering secure alternatives for where she can go is particularly important. Ask if there is a trusted person you can include in the discussion and whom you can alert to the risk.

Source: World Health Organization (WHO), 2019, *Caring for Women Subjected to Violence: A WHO Curriculum for Training Health-care Providers*.

Handout 7a: Roles and Responsibilities of Health Care Providers in IPV and SV Services

Activity/Function	Doctor	Community Health Officer	Nurse	Midwife	Counsellor	Other* (specify)
Identifying survivor of intimate partner violence or sexual violence	X	X	X	X	X	
Offering first-line support	X	X	X	X	X	
Documenting history including emotional state	X	X	X	X	X	
Preparing survivor of sexual assault for clinical examination	X	X	X	X	X	
Performing head to toe examination	X	X	X	X		
Collecting forensic evidence	X	X	X	X		
Conducting relevant laboratory tests	X	X	X	X		
Caring for injuries needing urgent or immediate attention	X					
HIV post-exposure prophylaxis if sexual assault survivor presents within 72 hours	X	X	X	X		
Emergency contraception if sexual assault survivor presents withing five days	X	X	X	X		
STI treatment /prophylaxis for sexual assault survivor	X	X	X	X		
Vaccinations for hepatitis B and tetanus	X	X	X	X		
Planning follow up visits	X	X	X	X	X	
Offering basic psychosocial support	X	X	X	X	X	
Helping with more severe mental health problems	X				X	
Preparing and signing the medico-legal certificate	X					
Reporting to legal authorities	X					
Providing/facilitating referrals to other services	X		X	X	X	

*Other: Community Health Officers, Laboratory officers, monitoring and evaluation officers, specialists (trauma surgeon, ob-gyn, psychologist, psychiatrist, orthopaedic surgeon) and other non-medical staff in health care facilities, such as administrative staff, data clerks, and security.

Source: World Health Organization (WHO), 2017, *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers.*

Handout 7b: Referral and Linkage

Terminology used in referrals for GBV services

Referral: A procedure by which a service provider sends a survivor of violence to the most appropriate service point where the survivor can receive the required service, because they cannot, at their level (of expertise, experience or responsibility) respond to the survivor's needs.

Follow-up: Contacting the survivor at a later, specified date to check on their progress since the last appointment.

Referral system: A system that facilitates good coordination (organization, preparation, adequate and timely support) and good collaboration between actors and service providers.

Referral pathway: A flexible mechanism that links survivors to supportive and competent services.

Counter-referral: The response, return action, or feedback that the referral service delivery point gives the referring facility about services that are provided to the survivor. It is initiated by the structure receiving the referred client.

Types of referrals for GBV services

1

Referrals within the health facility

Survivor is referred from one service delivery point to the next for provision of the appropriate prevention or response services within the same health facility (see health facility flow chart below).

2

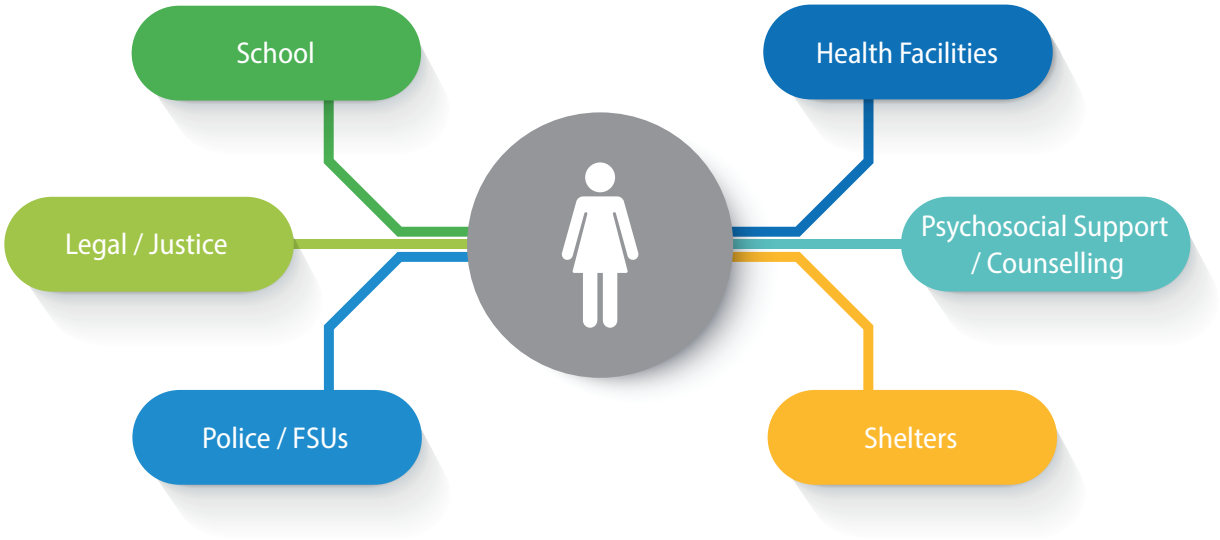
Referrals outside the health facility

Survivor is referred outside the health facility for additional services that she may require from other service providers, for example, police (Family Support Unit), shelters, or psychological or legal services (see referral network flowchart).

Referrals outside the health facility

Role of referring unit (health facility)	Role of receiving unit
■ Maintains an updated referral directory with contact details of referral services. ■ Identifies client and provides necessary services. ■ Provides ongoing treatment. ■ Refers client for services not provided onsite. ■ Follows up with client and receiving organization. ■ Documents referral activity. ■ Conducts quality assurance.	■ Receives client. ■ Provides service. ■ Documents service. ■ Refers clients to other needed services.

Referrals outside the health facility



Source: Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), Forthcoming, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 8a: History-Taking Checklist

History-taking

A detailed history of the incident guides the health care provider during the physical examination to identify and record injuries. Explain this to the survivor, and reassure her of confidentiality, if she is reluctant to give detailed information.

General tips for history-taking

- Before taking the history, review any documents or paperwork brought by the survivor to the health facility. Do not ask questions that have already been asked and documented by other people involved in the case.
- Try to create a climate of trust, keep a respectful attitude and calm voice, and maintain eye contact as culturally appropriate.
- Questioning should be done gently and at the survivor's own pace. Do not rush the survivor.
- Let the survivor tell her story the way she wants to.
- Respect the survivor's dignity. Do not express negative judgements about her or others.
- Avoid any distraction or interruption during history-taking.
- Ask one question at a time. Speak simply and clearly. Ask for clarification or detail if needed.
- Document the history in the survivor's own words (verbatim).
- Consider special circumstances, such as disabilities or experience of conflict, as you take the history.

Taking a good history involves getting information about the overall medical history, incident history, gynaecological and mental health assessment, and forensic history.

- Start by documenting the necessary demographic and administrative information as per the standard medical form (see the Sample History and Examination Form, which will be distributed for Exercise 8.1: Role-Play on History-Taking).
- Document additional notes in the client's clinical file.

Medical history

General medical information should cover any past health problems, allergies, and any medications that the woman is taking. Examples of questions you can ask include:

- Do you have any ongoing health problems? If yes, please list them.
- Do you have any allergies? If so, to what?
- Are you taking any medicines, herbs, or potions?
- Have you been vaccinated for tetanus? If yes, when?
- Have you been vaccinated for hepatitis B? if yes, when?
- Have you had an HIV test? If yes, when? May I ask for the result?

Incident history

The reason for obtaining an account of the violence is to guide the examination, so that all injuries can be found and treated; to assess the risk of pregnancy, STIs and HIV, and guide specimen collection and documentation. In the incident history, the description of the incident must be detailed, including WHEN it happened, WHAT happened, WHO did it, and WHERE it happened.

WHEN

- Could you tell me when (day) the incident happened? What time did happen?

WHAT

- Could you tell me what happened, please? Has something like this happened before? Do you mind telling me what the person did?
- If the survivor reports physical violence, ask:
  - Were you punched, kicked, slapped, grabbed, beaten, dragged, or tied? Was there any struggle, or any other related injuries?
  - Was a weapon used? What weapon was used?
- If the survivor reports sexual violence, ask:
  - Did they penetrate using any of the following: penis, finger, or other object? Do you mind describing this more?
  - Did the perpetrator ejaculate inside you?
  - Did the perpetrator use a condom and lubricants?
  - After this happened to you, did you vomit, urinate, defecate, or brush your teeth? Rinse your mouth? Change your clothes? Wash or bathe? Use a tampon or pad?

WHO

- Do you know who did it? was it a stranger or someone they know? How many people did it?
- NB: Most sexual assault is caused by people the survivor knows, or who are in a position of trust—close relatives, teachers, religious leaders, employers, landlords, neighbours, etc.

WHERE it happened is the exact location where the incident took place.

Gynaecological history (for female survivors)

The purpose of a gynaecological history is to check for risks of pregnancy and STIs, and check whether findings in the examination could have resulted from previous traumatic events, pregnancy, or delivery.

- Are you using any contraceptive methods? If yes, which one?
- Were you using this method when the incident happened?
- **Menstruation and pregnancy**
  - When did your last menstrual bleeding start?
  - Were you menstruating at the time of the event?
  - Do you think that you might be pregnant? If yes, how many weeks pregnant?
  - Have you ever been pregnant? If yes, how many times?

- **History of consenting intercourse** (only if samples are taken for DNA analysis in assault case)
  - When was the last time you had sex willingly? With whom? (For example, husband, boyfriend, stranger?)

Mental health assessment

Ask general questions about how the survivor is feeling and what her emotions are while taking her history, for example:

- How do you feel?
- How have things changed for you?
- Are you having any problems?
- Are you having any difficulties coping with daily life?

Note: If your general assessment identifies problems with mood, thoughts or behaviour, and she is unable to function in her daily life, she may have more severe mental health problems. You need to note this and refer her for professional care.

Forensic history

- Ask if the survivor changed her clothes and how the clothes were transported—in a paper or plastic bag, for example—and if they were handed over to the police.
- Ask if the survivor went to the toilet (urinated or defecated) or took a bath, brushed her teeth, or cleaned herself.
- Find out and document if the survivor may have left any marks on the perpetrator.

Head to toe physical examination

The primary objective of the examination is to evaluate the nature, extent, and severity of the injuries sustained, and to determine what medical care should be provided to the survivor. A systematic, head to toe physical examination of the survivor should be conducted according to the medical examination form.

General tips for examination

- Ask the survivor's permission to do the physical exam.
- Obtain consent for each step (see the consent procedures below).
- Ask if she/he wants a specific person to be present for support, such as a family member or friend.
- If you are a male provider and the survivor is female, ask is she is comfortable with you examining her (and vice versa). If not, find the same-sex provider to do the exam.
- See that another person is present during the exam—preferably a specially trained support person or the same-sex health care provider.
- Introduce this person, and explain that she is there to give the woman help and support.
- Otherwise, keep the number of people in the room to a minimum.
- Make sure the equipment and supplies are prepared.

General exam

- Always look at the survivor first, before you touch her, and note her appearance and mental state.
- Take the patient's vital signs (pulse, blood pressure, respiratory rate, and temperature).
- Work systematically using the physical exam checklist (see below).
- Evaluate general appearance, hygiene, and nutritional status.
- Document the state of the clothes: (if the survivor is wearing the same clothes that were worn during an assault) stains, tears, colour; collect and put all items in separate paper bags and label them.
- The initial assessment may reveal severe medical complications that need to be treated urgently, and for which the patient will have to be admitted to hospital. Such complications might be:
  - Extensive trauma (to the genital region, head, chest, or abdomen).
  - Asymmetric swelling of joints (septic arthritis).
  - Neurological deficits, respiratory distress.

Describe systematically and draw on the attached pictograms the exact location of the wounds, bruises, petechiae (bleeding under the skin), marks, etc. Document type, size, colour, form, and others. Describe as completely and accurately as possible. DO NOT interpret the findings.

Genito-anal examination—women and girls

In cases of sexual assault, a genito-anal examination is necessary. This is a sensitive examination, particularly the speculum exam.

- Help the survivor feel as comfortable as possible.
- Let her know when and where you will touch her.
- Help her lie on her back with her legs bent, knees comfortably apart.
- Place a sheet over her body. It should be drawn up at the time of examination.
- Work systematically. Have a good light source to view injuries (refer to Handout 8c for the exam checklist).
- Record all your findings and observations clearly and fully on a standard exam form.

Positioning boys and men for genito-anal examination

- Try not to put the survivor in the position they were violated in to conduct the genito-anal examination.
- The examination of external genitalia may be performed with the patient in the sitting, supine or standing position.
- Evaluation of the anus may be performed with the patient in the supine, lateral recumbent, or prone position with gentle retraction of the gluteal folds.

Handout 8b: Obtaining Consent

Before a full medical examination of the survivor can be conducted, informed consent must be obtained by ensuring that the survivor fills out the consent form. Survivors must understand the options open to them and be given sufficient information to enable them to make informed decisions about their care.

Ensure that a safe and respectful environment is created for the survivor, allowing her to control the course of the evaluation.

The following items should be discussed to obtain a survivor's consent to an examination.

1. Request permission to examine the survivor.
2. For a survivor aged below 18 years, ask if she wants a parent, guardian, and/or the police to be present.
3. Explain to the survivor that she will be examined and treated only if she wants. Explain that she can refuse any or all aspects of the examination.
4. Describe the four aspects of the exam:
   - Medical exam.
   - Pelvic exam.
   - Evidence collection.
   - Turnover of medical information and evidence to the police if she wants legal redress.
5. For each aspect of the exam, let the survivor ask questions and answer them fully. Make sure that she understands.
6. Once you are sure that she has understood the exam and the form completely, ask her to sign.
7. Ask another person to sign the form as a witness if required.
8. Request the survivor's permission to submit the medical report to the police if appropriate.

Informed consent/assent guidelines*

Age group (Years)	Child	Caregiver	If no caregiver or not in child's best interest	Means
0-5	-	Informed consent.	Other trusted adult's or case worker's informed consent.	Written consent.
6-11	Informed assent.	Informed consent.	Other trusted adult's or case worker's informed consent.	Oral assent, written consent.
12-14	Informed assent.	Informed consent.	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child).	Written assent, written consent.
15-18	Informed consent.	Obtain informed consent with the child's permission.	Child's informed consent and a sufficient level of maturity.	Written consent.

*Adapted from Kenya Ministry of Public Health & Sanitation, Ministry of Medical Services, 2014, *National Guidelines on Management of Sexual Violence in Kenya.*

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CONSENT FOR EXAMINATION

Note to centre staff:

This form should be read to the survivor or guardian in her/his first language. Clearly explain to the survivor what the procedure for the medical examination involves, and allow to choose any or none of the options listed. The survivor can change mind at any time, and a new form can be completed.

(Print name of survivor) (Medical provider's name and title)

I, _____ , give my permission for _____

to perform the following (select one option for each, do not leave blank):

A medical examination:	☐ Yes ☐ No
A pelvic examination:	☐ Yes ☐ No
A speculum exam (if medically necessary):	☐ Yes ☐ No
Collection of evidence, such as body fluid samples, collection of clothing, hair combings, scrapings, or cuttings of fingernails:	☐ Yes ☐ No
Blood draw:	☐ Yes ☐ No

I understand that I can refuse any aspect of the examination that I do not wish to undergo.

Patient: Signature:

_____ _____

Guardian: Signature (if the patient is a minor):

_____ _____

Staff ID/Code: Date:

_____ _____

Sources: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), 2020, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 8c: Physical Exam Checklist

Physical exam checklist	
Look at all the following:	**Look for and record:**
General appearance. Hands and wrists, forearms, inner surfaces of upper arms, armpits. Face, including the inside of the mouth. Ears, including inside and behind ears. Head. Neck. Chest, including breasts. Abdomen. Buttocks, thighs, including inner thighs, legs, and feet.	Active bleeding. Bruising. Redness or swelling. Cuts or abrasions. Evidence that hair has been pulled out, and recent evidence of missing teeth. Injuries such as bite marks or gunshot wounds. Evidence of internal traumatic injuries in the abdomen. Ruptured eardrum.
Genito-anal examination for girls and women	
Genitals (external). Genitals (internal examination, using a speculum). Anal region (external).	Active bleeding. Bruising. Redness or swelling. Cuts or abrasions. Foreign body presence.
Genito-anal examination for boys and men	
Genitals (external: penis, testicles and perineum). Anal region (external).	Active bleeding. Bruising and lacerations. Redness or swelling. Cuts or abrasions. Bite marks. Foreign body presence. Anal sphincter laxity, swelling, and mucosal tears; bleeding; sphincter spasm, discharge. Check for skin tags that can form when tears heal.

Source: Adapted from World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook*.

Handout 9a: Collecting Forensic Evidence and Maintaining a Credible Chain of Evidence

Forensic examination is a medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future that require medical opinion. Forensic management is essential in helping survivors of sexual violence access justice through judicial processes. Proper management of evidence helps in presenting credible evidence to the courts to prove whether sexual violence indeed occurred, and to link the perpetrator to the crime.

Guiding Principles

- Ensure essential supplies and commodities for forensic evidence collection are available.
- **Collect evidence as soon as possible after the incident.** Ideally, the specimen should be collected within 24 hours of the assault. After 72 hours, yields are reduced considerably. The specimen should be collected before the survivor takes a bath.
- Whenever possible, **forensic evidence should be collected during the medical examination** so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic.
- **Avoid contaminating the specimen.** Always wear non-powdered gloves and protective gear. Store each exhibit separately in a place that guarantees safety and confidentiality.
- **Ensure that the specimen is packed, stored and transported safely and securely.** Exhibits should not be exposed to direct light and sunshine. If wet, exhibits should be dried under shade or in a dark room. Biological evidence material (for example, body fluids or soiled clothes) should be packaged in paper envelopes or bags after drying. **Avoid plastic bags.** For specimens that require transportation, ensure that this is done within stipulated timeframes as recommended by the laboratory.
- **Ensure that the specimen is accurately labelled.** Label all specimens clearly with the survivor's name and date of birth, the health care provider's name, the type of specimen, and the date and time of collection.
- **Ensure that the specimen is appropriately packaged to ensure that it is secure and tamper-proof.** Only authorized people should be entrusted with specimens
- **Ensure that documentation of all collection and handling procedures is accurate, as opportunities for follow-up examinations may not arise.** It is thus vital to make full use of this single patient contact. The information recorded may be used in criminal proceedings.
- **Maintain continuity.** Once a specimen has been collected its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should be recorded. An exhibit register should be maintained.
- Call on an expert if you lack adequate training to handle a particular type of exhibit.

See table below for the types of specimen that can be collected for forensic evidence.

Procedure for collecting and storing forensic samples and exhibits

- Take oral, external genital/labial swabs, and high vaginal and/or anal swabs for microscopy, culture, and sensitivity testing.
- Ensure that at least three (3) high vaginal swab (HVS) specimens are collected. These should be air-dried before packing.
- Collect urine specimen for microscopy and to observe for: spermatozoa, culture and sensitivity, drugs and alcohol, and to conduct pregnancy testing.
- Collect blood to determine the haemoglobin level, HIV serology for child survivors older than 18 months (for child survivors below 18 months, a dried blood spot (DBS) sample for DNA PCR test should be collected), and syphilis and hepatitis B infection.
- Collect pubic hair, nail swabs, nail clippings, and foreign bodies as forensic specimens that can be used as evidence.
- Certain areas of the body (for example. the axilla, behind the ears, in the mouth, the soles of feet) that are not usually examined as part of a routine medical examination are of forensic interest and must be inspected.
- Unusual specimens, such as clothing, should be collected as part of a forensic examination. Refer to Annex 6 for examples of forensic specimens and how to handle them.

Chain of Custody

- Ensure all specimens are clearly labelled and packed appropriately away from environmental harm, for example, excessive heat.
- Make a record of all specimens collected and results in the laboratory register that should be kept locked away.
- Sign and date the medical certificate.
- Contact the receiving police officer.
- The receiving police officer should sign and date confirming that the forensic specimens have been received.

Types of specimen that can be collected as forensic evidence*

Specimen	Source of specimen
Injury evidence	Physical and/or genital trauma can be proof of force and should be adequately documented and recorded on pictograms in the post rape care (PRC) forms.
Clothing	Torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (for example, if replacement clothing is not available) then describe its condition.
Foreign materials	Foreign materials (for example, soil, leaves, or grass) on the survivor's clothes or body, or in hair, may corroborate the survivor's story.
Sperm and seminal fluid	Swabs may be taken from the vagina, anus, or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis.
Blood or urine	May be collected for toxicology testing (as evidence, for example, whether the survivor was drugged).
DNA analysis	Where available, can be done on material found on the survivor's body or at the location of the incident, which might be soiled with blood, sperm, saliva or other biological material from the perpetrator (on clothing, condoms, etc), as well as on swab samples from semen stains, and involved orifices, and on fingernail cuttings and scrapings. In this case, blood from the survivor must be drawn to allow her DNA to be distinguished from any foreign DNA found.

**Source:* Kenya Ministry of Public Health & Sanitation, Ministry of Medical Services, 2014, *National Guidelines on Management of Sexual Violence in Kenya.*

Handout 9b: Sierra Leone Medical Certificate

MEDICAL CERTIFICATE FOR ADULT

STATEMENT OF DR: _____

Address: _____

Date: _____ Tel: _____

I certify that I have examined on this day of: (hour, day, month, year) _____

at the request of: (name, surname) _____

born: (day, month, year) _____

Referred by: _____

She declares to have been sexually assaulted at: (hour, day, month, year) _____

at: (place) _____ by _____

GENERAL OBSERVATION: _____

_____

PHYSICAL INJURIES: _____

_____

GENITAL FINDINGS: _____

_____

ANAL FINDINGS: _____

_____

FORENSIC EVIDENCE TAKEN: _____

_____

EVALUATION OF PREGNANCY RISK: _____

_____

The absence of injuries does not mean that a sexual assault did not occur.

SIGNATURE: _____ DATE: _____

MEDICAL CERTIFICATE FOR CHILD

I, the undersigned: (NAME, first and last names) _____

title: (indicate the function)_____

on this date and time: (day-month-year, time) _____

at the request of: (name, the surname of father, mother, legal representative) _____

the child called: (name, surname) _____

born: (day, month, year) _____

living at: (precise address) _____

Referred by: _____

In the interview, the child told me that: _____

_____

GENERAL OBSERVATION: _____

_____

PHYSICAL INJURIES: _____

_____

GENITAL FINDINGS:_____

_____

ANAL FINDINGS:_____

_____

FORENSIC EVIDENCE TAKEN:_____

_____

In the interview (name of the person accompanying the child) has declared:_____

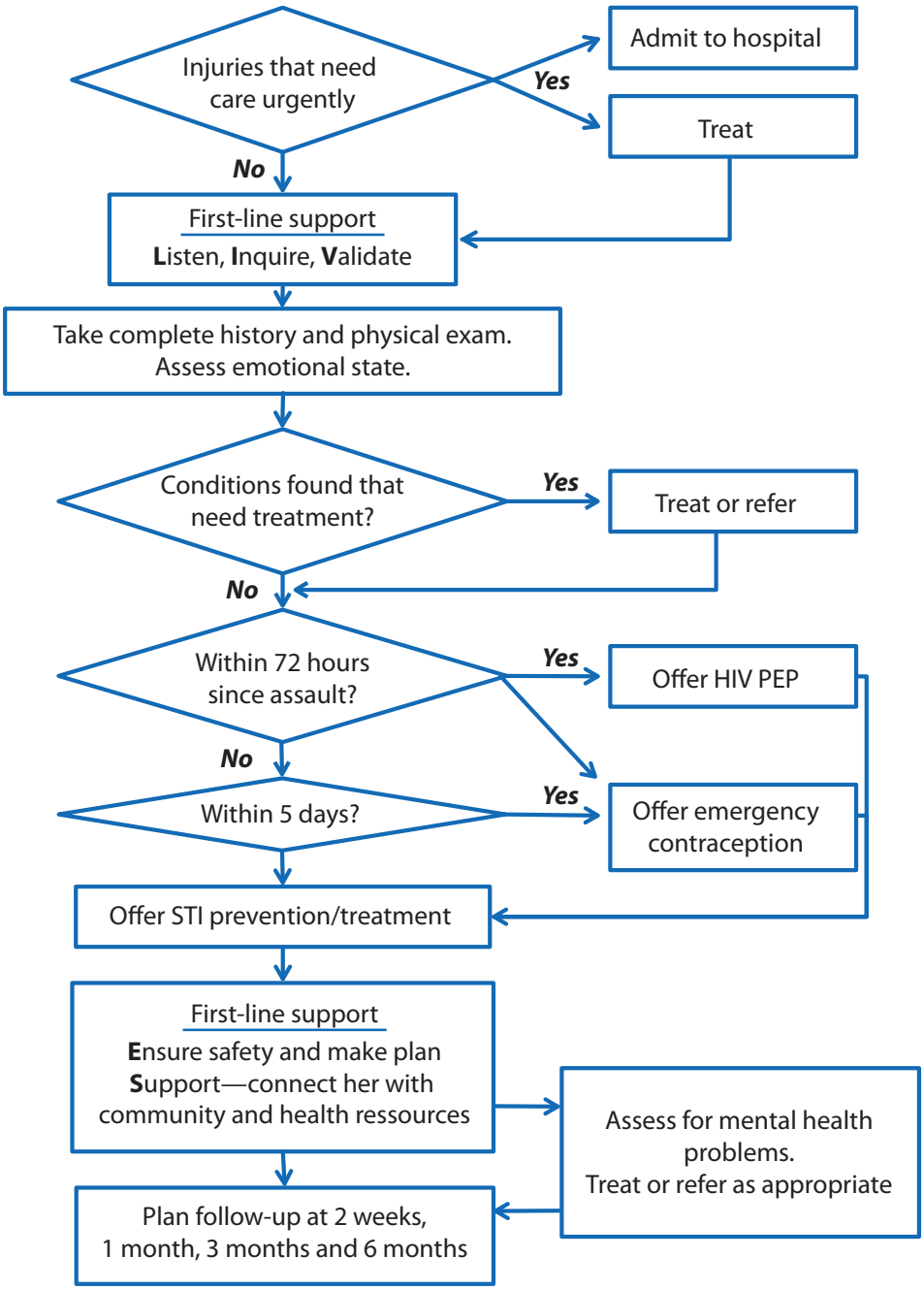
_____

The absence of injuries does not mean that a sexual assault did not occur.

SIGNATURE: _____ DATE: _____

Source: Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), 2020, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 10a: Pathway for Initial Care After Sexual Assault or Abuse



Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

Handout 10b: Follow-up After Sexual Assault or Abuse

Follow-up visits should take place at 2 weeks, 1 month, 3 months and 6 months after the assault. The table below gives a summary of the health checks and laboratory tests that service providers should conduct during the follow-up sessions.

2-week follow-up visit	
Injury	Check that any injuries are healing properly.
	Check that the survivor has completed the course of any medications given for STIs.
STIs	Check adherence to PEP if she is taking it.
	Discuss any test results.
Pregnancy	Test for pregnancy if she was at risk. If she is pregnant, tell her about the available options.
Mental health	Continue first-line support and care.
	Assess the patient's emotional state and mental status. If any problems, plan for psychosocial support and stress management, such as progressive relaxation or slow breathing.
Planning	Remind her to return for further hepatitis B vaccination in one month and in six months, and HIV testing at three months and at six months, or else to follow up with her usual health care provider.
	Ask her to return for follow-up if emotional and physical symptoms of stress have emerged or become more severe, or if there is no improvement at all by one month after the event.
	Make next routine follow-up appointment for one month after the assault/abuse.
1-month follow-up visit	
STIs	Give a second hepatitis B vaccination, if needed. Remind the survivor about the six-month dose of the vaccine.
Mental health	Continue first-line support and care.
	Assess her emotional state and mental status. Ask if she is feeling better. If there are new or continuing problems, plan for psychosocial support and stress management.
	If you suspect depression, alcohol or substance abuse, or post-traumatic stress disorder, refer for specialized care to a specifically trained health care provider with a good understanding of sexual violence.
Planning	Make next routine follow-up appointment for three months after the event.

3-month follow-up visit	
STIs	Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment and care.
Mental health	Continue first-line support and care.
	Assess her emotional state and mental status. Ask if she is feeling better. If there are new or continuing problems, plan for psychosocial support and stress management.
	If you suspect depression, alcohol or substance abuse or post-traumatic stress disorder, refer for specialized care to a specifically trained health care provider with a good understanding of sexual violence.
Planning	Make next routine follow-up appointment for six months after the event. Also remind her of the six-month dose of hepatitis B vaccine, if needed.
6-month follow-up visit	
STIs	Offer HIV testing and counselling. Make sure that pre- and post-test counselling is available and refer for HIV prevention, treatment, and care. Give a third dose of hepatitis B vaccine, if needed.
Mental health	Continue first-line support and care.
	Assess her emotional state and mental status. Ask if she is feeling better. If there are new or continuing problems, plan for psychosocial support and stress management.
	If you suspect depression, alcohol or substance abuse, or post-traumatic stress disorder, refer for specialized care to a specifically trained health care provider with a good understanding of sexual violence.

Source: World Health Organiza.tion (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook*.

Handout 10c: Testing Schedule

Schedule		
Test for:	**Initial Test**	**Retest**
Pregnancy	At 2 weeks.	None.
Chlamydia, gonorrhea, trichomonas	At 2 weeks.	None.
Syphilis	At 2 weeks.	At 3 months.
HIV	On the first visit if the patient is willing.*	At 3 months and at 6 months.
Hepatitis B	At first visit.**	None.

*If the woman tests positive for HIV at the first visit, do not give PEP. If she is unwilling to test and her HIV status is unknown, offer PEP.

**Test if the woman is uncertain whether she has received all three hepatitis B vaccinations. If testing at first visit shows that she is already immune, no further vaccination is required.

Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

Handout 10d: Emergency Contraceptive Methods in the Context of Violence

If emergency contraception (EC) is used soon after sexual assault, it can help a woman avoid pregnancy. Offer EC to any woman who has been sexually assaulted, along with counselling so that she can make an informed decision on the method to use.

Emergency contraception counselling points

To reassure her, give her details about each method (see table below). Also, you can ask her if she has been using an effective contraceptive method, such as pills, injectable, implants or female sterilization. If so, it is unlikely that she will get pregnant. Also, if her last menstrual period began within 7 days before the attack, she is not likely to get pregnant.

In any case, she can take EC if she wishes.

- Use of EC is a personal choice that only the woman herself can make.
- EC can help her to avoid pregnancy, but it is not 100% effective.
- EC pills work mainly by stopping the release of the egg.
- **EC pills will not cause abortion.**
- EC pills will not prevent pregnancy the next time she has sex.
- EC pills are not meant for regular use in place of a more effective, continuing contraceptive method.
- **She does not need to have a pregnancy test before taking EC pills.** If she is already pregnant, the EC will not harm the pregnancy. However, a pregnancy test may help identify whether she is already pregnant, and she can have one if she wishes.

Types of EC

Type of EC	Drug regime	Mechanism of action	Counselling points
Pills	Levonorgestrel only	Works better and causes less nausea and vomiting than combined regime. Preferred dose: 1.5 mg levonorgestrel in a single dose.	**She should take the EC pills as soon as possible.** She can take them up to 5 days after the sexual assault, but they become less effective with each day that passes. EC pills may cause nausea and vomiting. If she vomits within 2 hours after taking EC pills, she should return for another dose as soon as possible. She may have spotting or bleeding a few days after taking EC pills. If she had other acts of unprotected sex since her last menstrual period, she might already be pregnant. EC pills will not work, but they will not harm the pregnancy.
	Combined estrogen-progesterone	Use if levonorgestrel-only pills are not available. Dosage: 2 doses of 100µg ethinyl estradiol plus 0.5 mg levonorgestrel, taken 12 hours apart.	

Emergency IUD	Copper IUD	Good choice for very long-lasting contraception if the woman is interested in the IUD and could be referred for it immediately.	Can be used for EC up to 5 days after unprotected intercourse. More effective than EC pills. The higher risk of STI following rape should be considered if using a copper IUD.

Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

Handout 11: Helping Survivors with More Severe Mental Health Problems

Many women who are subjected to intimate partner violence or sexual violence will have emotional or mental health problems. Once the violent assault or situation passes, these emotional problems will likely get better. Most people recover. There are specific ways you can offer help, and techniques you can teach women to reduce stress and help them heal. These methods have been mentioned to you in your session today, and you can find the details in your slides for this module.

Some women, however, will suffer more severely than others. It is important to be able to recognize these women and to help them obtain care. If such help is not available, there are things that first-line health care providers can do to reduce their suffering.

Assessment of mental status

You assess mental status while you do the general health examination. Assessing mental status begins with observing and listening closely. Take note of the following:

Appearance and behaviour	■ Does she take care of her appearance? ■ Are her clothing and hair cared for, or in disarray? ■ Is she distracted or agitated? ■ Is she restless, or is she calm? ■ Are there signs of intoxication or misuse of drugs?
Mood, both what you observe and what she reports	■ Is she calm, crying, angry, anxious, very sad, without expression?
Speech	■ Is she silent? ■ How does she speak (clearly or with difficulty)? ■ Is she speaking too fast or too slow? ■ Is she confused?
Thoughts	■ Does she have thoughts about hurting herself? ■ Are there bad thoughts or memories that keep coming back? ■ Does she see the event over and over in her mind?

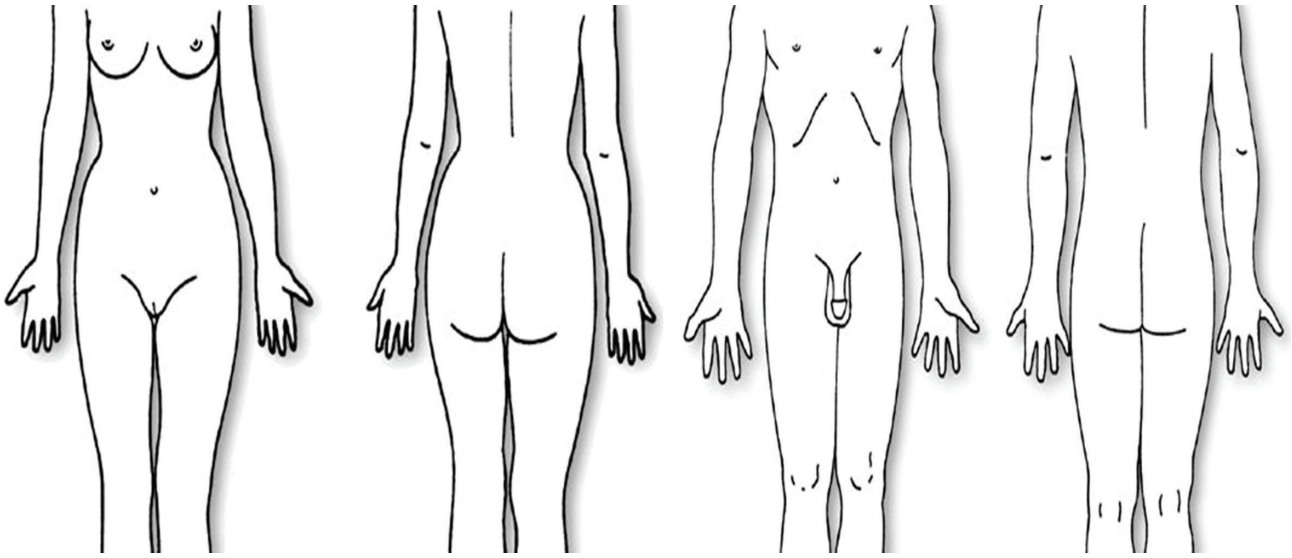
You can also gather information by asking general questions:

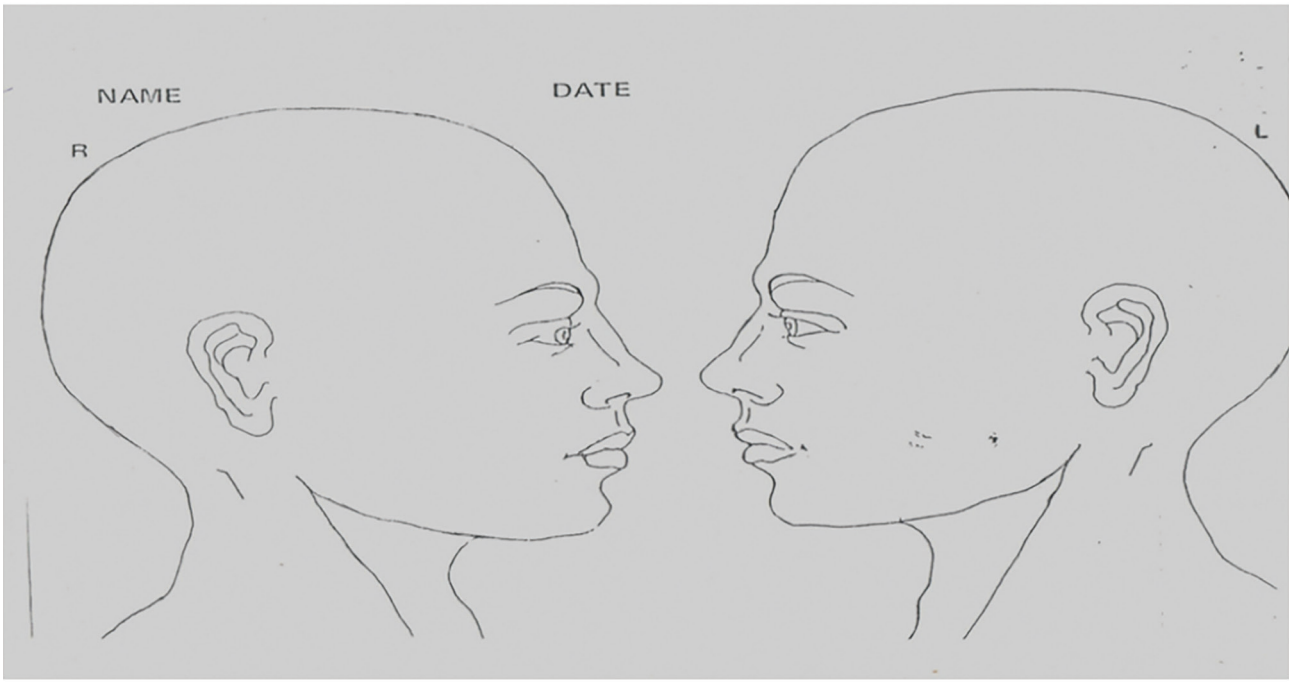
- "How do you feel?"
- "How have things changed for you?"
- "Are you having any problems?"
- "Are you having any difficulties coping with your daily life?"

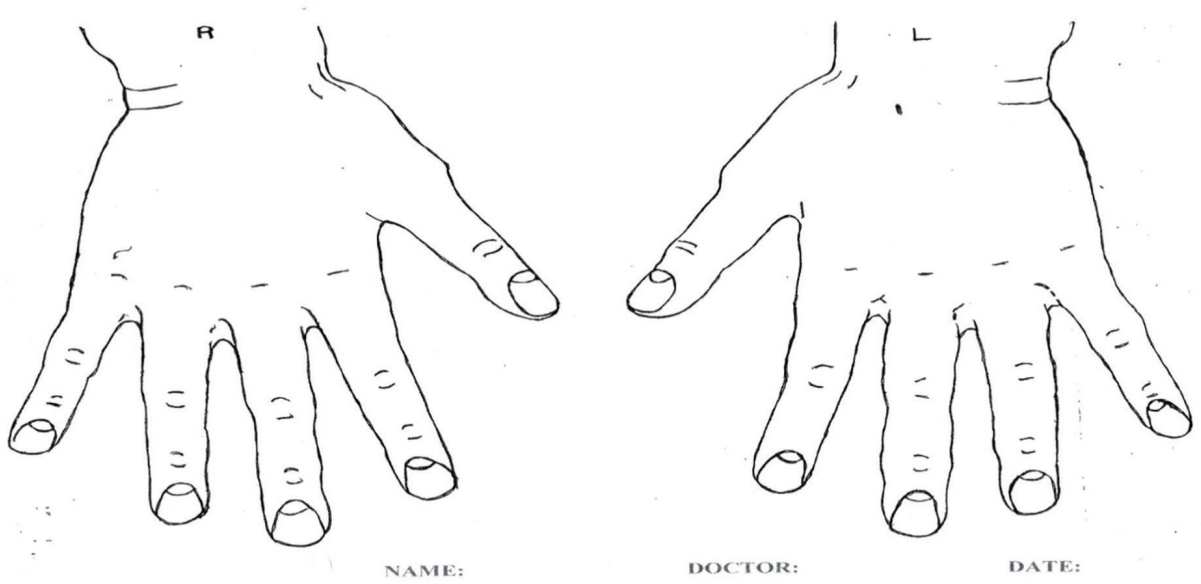
If your general assessment identifies problems with mood, thoughts, or behaviour, and she is unable to function in her daily life, she may have more severe mental health problems. She should be referred to a specialist with the capacity to help the survivor.

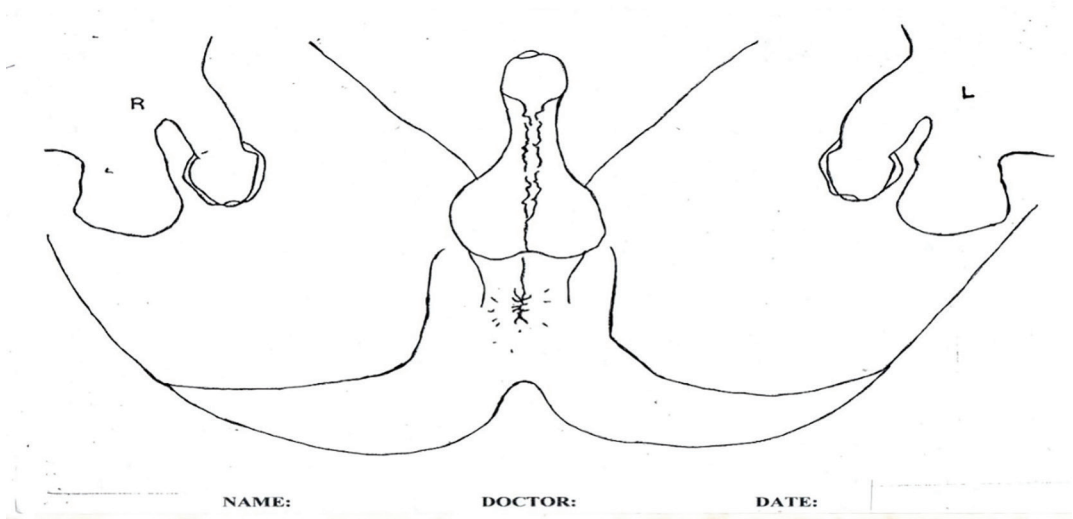
Source: World Health Organization (WHO). 2014. *Health Care for Women Subjected to Intimate Partner Violence or Sexual Violence. A Clinical Handbook.*

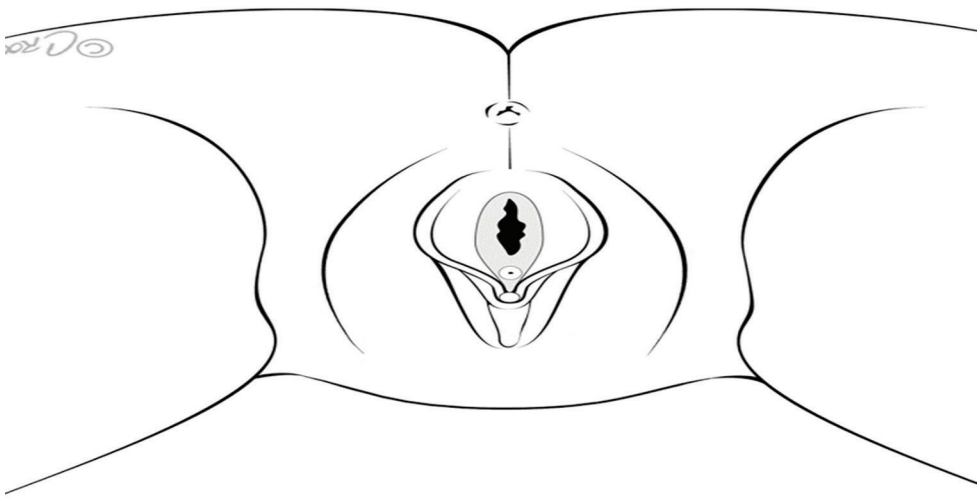
Handout 12: Pictograms



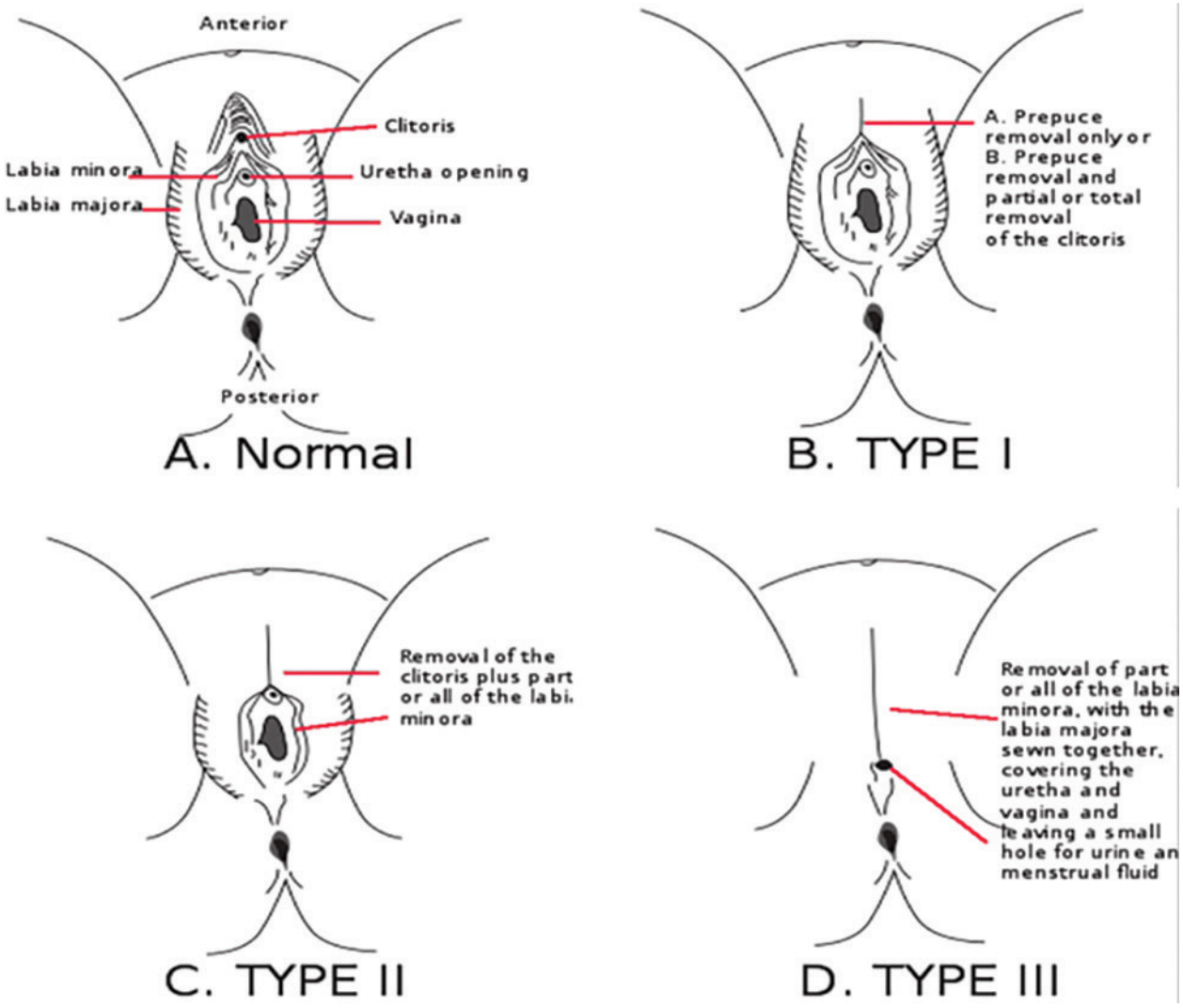



R
L
NAME:
DOCTOR:
DATE:


R
L
NAME:
DOCTOR:
DATE:



Type of FGM:



Source: Republic of Sierra Leone Ministry of Health and Sanitation (MOHS-SL), Forthcoming, *National Clinical Guidelines for Management of Survivors of Sexual and Gender-Based Violence.*

Handout 13a: Health Facility Checklist

Minimum standards for providing services to survivors of sexual violence				
	Questions	**Yes**	**No**	**Comments**
✓	**Checked items are the WHO minimum requirements**			
	Leadership, governance, and accountability			
	Do health care providers and health managers support addressing survivors of violence (for example, are they willing to provide care, supportive of sending staff to trainings)?			
	Are there confidential mechanisms to receive feedback from survivors of violence, including any grievances or violations of rights in the health facility (for example, a helpline, complaint box, etc)?			
	Is there a workplace policy addressing discrimination and violence, including sexual harassment faced by health care providers themselves?			
	Budgeting and financing			
	Is there a budget allocated for provision of care/services (for example, for staff training, procuring specific commodities)?			
	Health workforce			
	Are there health care providers whose job descriptions assign them specific responsibilities to address GBV services?			
✓	**Have health care providers received training on responding to survivors of violence?**			
	Are there mechanisms to provide ongoing mentoring, supervision, and support to health care providers?			
	Infrastructure and medical products			
✓	**is there space (for example, a room or area) available for a private and confidential consultation (that is, ensures the survivor cannot be seen or heard from outside?)**			
	Are there medicines, equipment, and other supplies available?			
	Service delivery			
✓	**Are there written protocols/SOPs for the provision of health care to women subjected to violence?**			
	Is there a minimum package of care being provided (that is, identification of survivors of intimate partner violence, first-line support, clinical care for sexual assault, basic psychosocial support)?			

	Information, monitoring and evaluation			
	Are indicators and data to monitor the health response to survivors of violence being collected, compiled, and used to improve services?			
✓	**Are there intake forms/registers and confidentiality mechanisms (for example, secure storage and removal of identifying information) for recording information about survivors' experiences of violence and care received?**			
	Multisectoral coordination and community engagement			
✓	**is there a referral system in place across the different health services and between health and other sectors (for example a referral directory, information offered to survivors about available services)?**			
	Have other services (for example, police) and organizations (for example local NGOs working on GBV) been informed about available health services?			

Source: World Health Organization (WHO), 2017b, *Strengthening Health Systems to Respond to Women Subjected to Intimate Partner Violence or Sexual Violence: A Manual for Health Managers*

Handout 13b: Key Considerations When Assessing Standard of Service Delivery Settings

Infrastructure 	■ The service delivery point for IPV and SV should: ■ Have an aesthetic layout and be welcoming. ■ Allow for both auditory and visual privacy, for example, a room with a door rather than curtains or screens. ■ Be thermally neutral (neither too hot nor too cold). ■ Be clean, with clean equipment and linen. ■ Have proper lighting, for example, fluorescent light that is neither too bright nor too dim. ■ Have immediate access to soap and clean water. ■ Have immediate access to a clean toilet and shower. ■ Have a table, desk, and examination couch. ■ Have a phone where possible. ■ Have access to a separate support room for the survivor's escort to wait.
Personnel 	■ An ideal approach to managing IPV and SV is that emergency, medical-legal, and psychosocial services are provided simultaneously in the same location and as much as possible by the same trained health care providers. ■ A best practice would be to utilize an "on-call" schedule, whereby a designated person is a first responder to the need for IPV and SV services, as and when required. ■ As has been highlighted in Handout 7b, the first responder to IPV and SV may be a trained nurse or midwife, medical doctor, or clinical counsellor. ■ Another best practice would be to have an updated directory of specific service providers to strengthen referral and linkages to child protection services as developed in module 7.
Equipment and Supplies 	■ The facility should be equipped to manage any acute medical conditions or emergencies and to offer a range of laboratory and counselling services. ■ If the health facility does not offer these services, there should be ready access to a range of medical-forensic services that may be required through referral to service providers or reverse referral mechanisms where the service provider is called to provide the service at the health facility where the survivor has reported. ■ Refer to table Handout 13c for a comprehensive list of medical equipment.

Diagnostics and Medication 	■ Essential medication required for the management of child sexual violence includes: ■ Rapid test kits for HIV, syphilis, and pregnancy. ■ Urinalysis. ■ Vaginal strips. ■ Treatment for sexually transmitted infections as per national guidelines. ■ Post-exposure prophylaxis for HIV as per national guidelines. ■ Emergency contraceptives (combined oral contraceptives, "morning-after pills", progesterone-only pills). ■ Tetanus toxoid. ■ Analgesics. ■ Antibiotics. ■ Antiemetics. ■ Supplies for wound care. ■ Hepatitis B virus vaccine. ■ Human papilloma virus vaccine.
Tools and Documentation 	■ Any survivor who reports to the health facility for care should have a written record of the visit. ■ Records should include a medical and forensic report, diagrams of any findings, and, if available, photographs. ■ All aspects of the care should be documented including consent forms, the medical forensic history, findings from the physical assessment, evidence collected, any testing or treatment rendered, photographic images obtained during the examination, counsellor's notes, and any follow-up care and referrals given. ■ If the health care provider is called to testify in any criminal justice proceedings, they may use the reports and medical procedure documentation to recall the patient encounter. ■ The Ministry of Health and Sanitation has developed standard tools for consenting and collecting data for survivors of violence. These include: ▪ Informed consent form. ▪ Adult medical certificate. ▪ Child medical certificate.

The essential equipment and supply requirements for providing IPV and SV services

A locally assembled evidence collection kit (post-rape care kit) as recommended by the national programme	■ Evidence collection kits (refer to Handout 13c for content).
Essential supplies: items that need to be replaced on a routine basis	■ Forensic supplies: paper bags, evidence tape for sealing bags. ■ Powder-free, non-sterile exam gloves. ■ Sanitary towels. ■ Wound management supplies. ■ Culture supplies. ■ Lubricant. ■ Hospital gowns. ■ Extra clothes for survivors whose clothes may be collected for evidence.
Essential equipment: capital equipment and durable items that last for several years	■ Examination table/bed/stretcher that allows for positioning in lithotomy in a private room. ■ Specula for adults and children, preferably for use in post-pubertal girls but where necessary can be used for examination of pre-pubertal girls. ■ Waste disposal equipment. ■ Handheld magnifying glass. ■ A non-digital camera, if possible, and facility capacity to store intimate images securely if obtained. ■ Light source. ■ Secure record storage cabinets.
Administrative supplies:	■ Protocol/SOP/guidelines for care. ■ Job aids (for example, flow charts, algorithms, pictograms). ■ Consent forms. ■ Documentation forms (for example, medical intake forms, referral forms, police forms for forensic evidence, medico-legal certificates). ■ Referral directory. ■ Information, education, and communication (IEC) materials.

Handout 13c: Contents of the Post-Rape Care Kit

Item	Use	Items to assemble from the facility	To buy one-off	To buy routinely
Powder-free gloves (clean gloves)	To avoid contamination.	✓		
Sterile gloves	For the sterile procedures such as collecting HVS.	✓		
Six stick swabs	For taking the HVS and/or anal swabs from the survivor.	✓		
Masking tape	For sealing the brown envelopes in which the specimens have been stored.			✓
Brown envelopes	For collecting samples and proper storage of collected specimens.			✓
Tape measure	For measuring the physical injuries found on the survivor if any.		✓	
Needles & syringes	For the collection of blood samples.	✓		
Urine bottles	For the collection of urine samples.	✓		
Vacutainer tubes	For the collection of blood samples.	✓		
Speculum	For the collection of specimens from the vaginal cavity.	✓		
Labels	For labelling the brown envelopes with the details of the specimens stored inside.			✓
Pregnancy testing kit	To test for pregnancy.	✓		
Seal lock bags	For proper storage of collected specimens.			✓
Green towels	One for wiping hands during the sterile procedure, and another for placing beneath the patient's buttocks.			✓

Source: Adapted from Kenya Ministry of Public Health & Sanitation, Ministry of Medical Services, 2014, *National Guidelines on Management of Sexual Violence in Kenya.*



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