

★ New modules
for health managers

Caring for women subjected to violence: A WHO training curriculum for health care providers. Revised edition, 2021

Participant handouts





Overview of participant handouts

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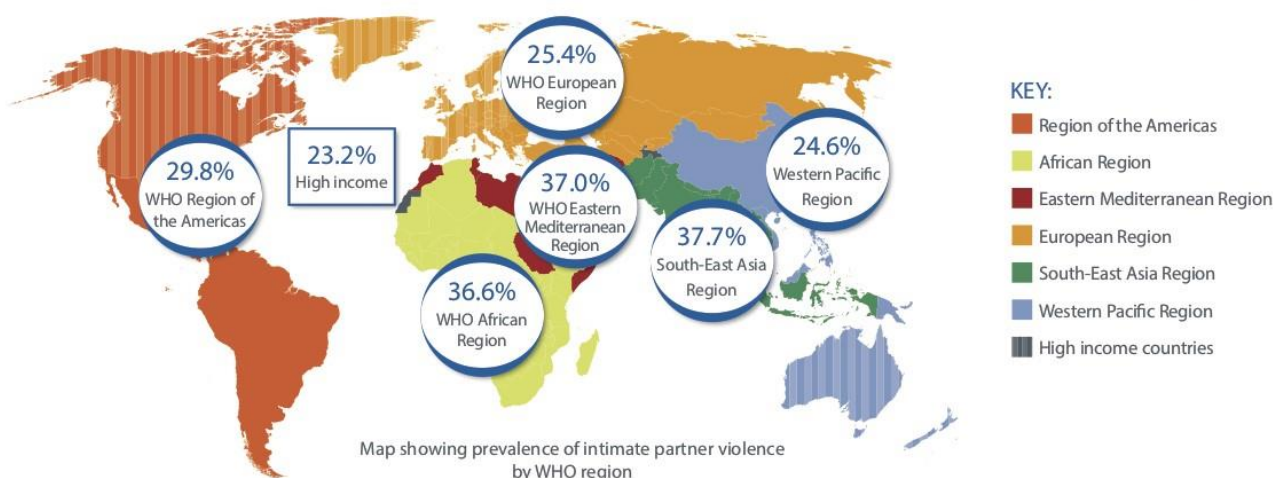
Session 1: Handout 1a

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



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



Session 1

Handout 1b: Addressing provider barriers to assessment of violence against women

Concern: Lack of time to assess and respond to abuse

Reflection: Assessing and responding to abuse can potentially be life-saving and can be done efficiently. Because violence affects health, understanding experiences and the consequences of violence can provide important insight into a patient's health and may reveal the underlying cause of the presenting issue.

Concern: Offending a patient

Reflection: Women who have been affected by violence are often waiting for an opportunity to speak about some aspect of what they are going through. Evidence shows that women do not mind being asked about abuse when it is done sensitively and without judgement, and that they mostly appreciate the provider's expression of care. Your patient may actually trust you more by knowing that you care about her health and safety.

Concern: Assumption that violence is not present in a given population due to characteristics such as socio-economic status, religion, culture

Reflection: Violence is pervasive across cultures, economic status and religious groupings. Check your assumptions and give your patients an opportunity to share their experiences.

Concern: Feeling powerless to help or "fix" the abuse

Reflection: Speaking in the right way with your patient provides important validation and can help her realize that help is available. It can be a powerful first step in seeking help. Know that your patient is in the best situation to determine what she should do, including nothing, until you meet with her again.

Concern: Uncertain that she will take action

Reflection: We can never be certain of patients' behaviour after they leave; we do not control what they do or do not do with the information we provide. For women experiencing abuse, it may take multiple interventions and discussions to achieve safety and well-being.

Conversations with providers are an important starting point. We can at least Listen, Inquire, Validate experiences, Enhance safety and provide Support.

Concern: Lack of continuity and inability to speak with the patient consistently

Reflection: Even speaking with a woman and making an initial contact can have an important impact on women experiencing abuse.

Concern: Not knowing enough about when and how to ask about abuse



Reflection: This curriculum will give you the tools you need to feel confident about broaching the subject with your patients.

Concern: Discomfort and lack of practice discussing violence against women

Reflection: Speaking with your patients about violence against women will become easier with training, time and practice.

Concern: Isn't my role primarily focused on physical health?

Reflection: Evidence has shown that abuse has a direct and measurable effect on multiple aspects of women's physical, mental, sexual and reproductive health. We as health-care providers have a role to play in protecting both the physical and mental health of our patients.

Concern: Feeling as though there is a lack of effective interventions

Reflection: There are advocacy- and community-based interventions that have been shown to reduce violence against women over time. Providing effective listening, validation and support through LIVES is a form of intervention and can be an important support for your patients.

Concern: Inquiring about abuse may lead to other responsibilities such as testifying in legal proceedings for which you are unprepared

Reflection: Know the legal implications of what health-care providers must do when they identify or respond to violence against women. Partner with community organizations, if needed, to find this information.

Concern: Personal history of violence may impact comfort/willingness to talk about violence with the patient

Reflection: Health-care providers are not immune to experiencing (or perpetrating) violence against women. Find resources you can use to discuss violence you might have experienced. Doing so can make you a more empathetic and effective health-care provider.



Session 1

Handout 1c: Why does the health-care provider response matter?¹

- Women in many settings identify health-care providers as the professionals they trust to disclose abuse and other personal matters.
- Violence against women is linked with poor health outcomes.
- Health-care settings 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 well-being.
- A 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 of 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 own 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.

¹ Chang et al., 2005; Chang et al., 2010; WHO clinical handbook, 2014.



Session 2

Handout 2a: 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 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 oneself 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 in her relationship.

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



Session 2

Handout 2b: Barriers to seeking care¹

Most commonly mentioned reasons for not seeking help

- The violence was normal or not serious.
- She was afraid of consequences/threats/more violence.
- She was embarrassed or afraid of being blamed or not believed.
- She was afraid of bringing shame on her family.
- She may fear economic hardship or manipulation.

Most commonly mentioned reasons for seeking help

- She could not endure any more.
- She was badly injured.
- Her partner had threatened or hit her children.
- She had been encouraged by friends or family.

¹ WHO multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization; 2005.



Session 3

Handout 3: Pocket LIVES card

Copy or cut out this reminder card and fold for your pocket.



Asking about violence

You might say: "Many women experience problems with their husband or partner, but this is not acceptable."

You might ask:

- "Are you afraid of your husband (or partner)?"
- "Has he or someone else at home threatened to hurt you? If so, when?"
- "Has he threatened to kill you?"
- "Does he bully you or insult you?"
- "Does he try to control you – for example, not letting you have money or go out of the house?"
- "Has forced you into sex when you didn't want it?"

Signs of immediate risk

- Violence getting worse
- Threatened her with a weapon
- Tried to strangle her
- Beaten her when pregnant
- Constantly jealous
- "Do you believe he could kill you?"

Listen

Inquire about needs and concerns

Validate

Enhance safety

Support

Listen closely, with empathy, not judging.

Assess and respond to her needs and concerns – emotional, physical, social and practical.

Show that you believe and understand her.

Discuss how to protect her from further harm.

Help her connect to services, social support.



Session 4

Handout 4: Active listening principles

Listening is an interactive, engaging process whereby the listener focuses attention on the person to whom he/she is 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 he/she has heard and understood the message.
- Active listening is central to communication.

Types of questions

These types of questions are appropriate for eliciting relevant information:

Open-ended questions

An open-ended question is broad in scope and does not limit the area of inquiry.

For example: “What difficulties are you having?”

- Open-ended questions elicit more information than the other types of question.
- It is helpful to start interactions with open-ended questions and then, depending on the answers, move to focused and closed questions.

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?”

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 a particular 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 previous 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 being 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.



Session 5

Handout 5: 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 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 kill you?”

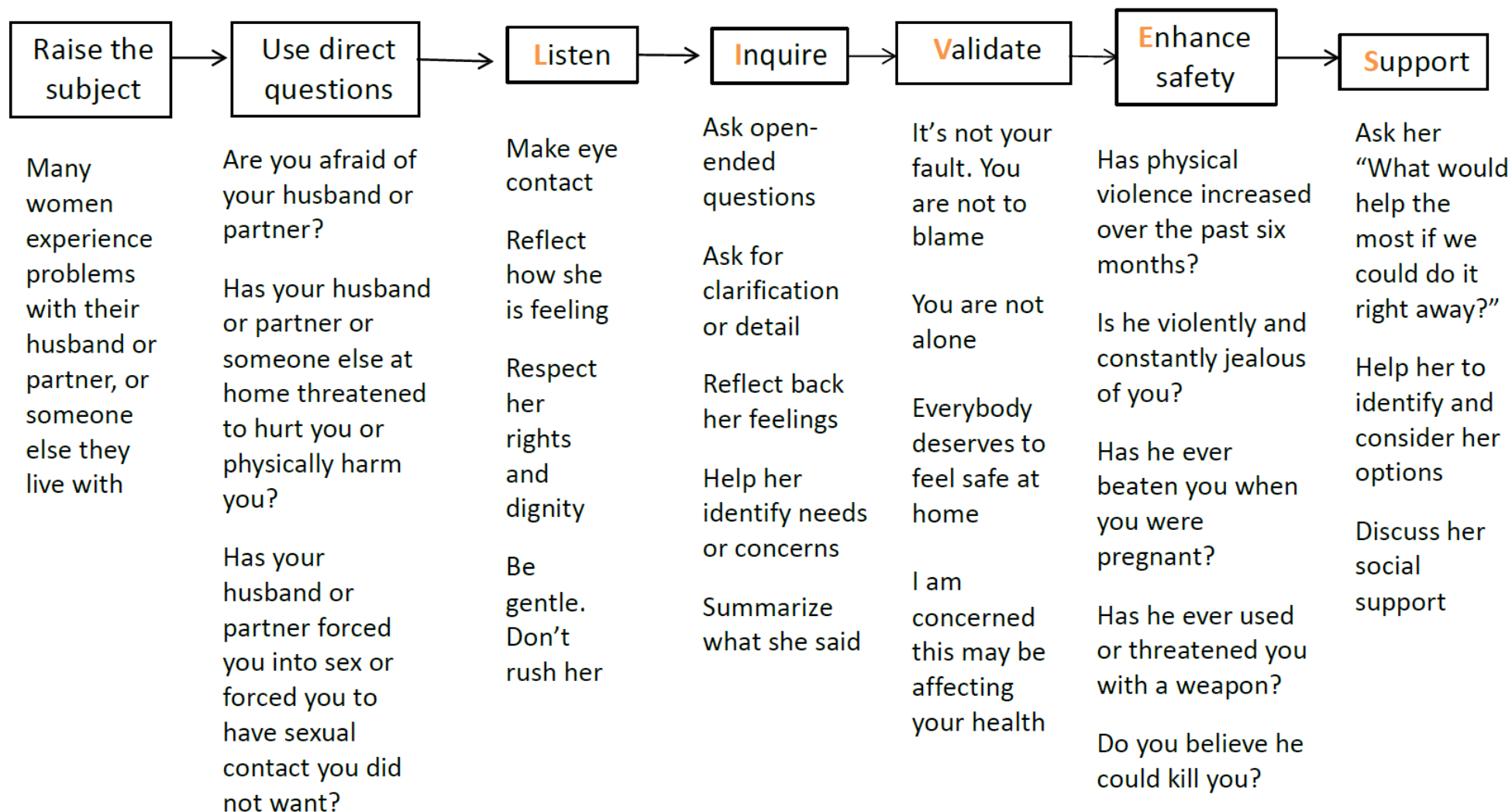
What to do if you suspect violence, but she doesn’t disclose it:

- Do not pressure her. Give her time to decide what she wants to tell you.
- Tell her about services that are available if she chooses to use them.
- Offer information on the effects of violence on women’s health and their children’s health.
- Offer her a follow-up visit.



Session 6

Handout 6a: Communication skills and pathway





Session 6

Handout 6b: Health-care providers' common questions

Here are answers to some questions that health-care providers often ask about working with women subjected to violence.

“Why not offer advice?”

What is important to women is to be listened to and to have an opportunity to tell their story to an empathetic person. Most women do not want to be told what to do. In fact, listening well and responding with empathy are far more helpful than you may realize. It may be the most important thing you can do. Women need 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 stay in violent relationships. It is important not to judge her and not to urge her to leave. She has to make that decision herself in her own time. Reasons for not leaving include:

- She depends on her partner’s income. In some societies it is difficult for a woman to earn her own living.

- She believes that children should be raised with a father and thinks that her own 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 woman for what happened. Blaming the woman will get in the way of your giving her good care. Violence is never appropriate in any situation. There is no excuse or justification for violence or abuse. Just because a woman 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 her. (See page 29.) 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 her needs and concerns, strengthening her social support and enhancing her safety. Also, you can help her 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 to the police?”

Respect her decision. Let her know that she can change her mind. However, evidence of sexual assault must be collected within 5 days. Let her know if there is someone she can talk to further about her options and help her make the report if she chooses to.

“How can I promise confidentiality if the law says I have to report to the police?”

If your law requires you to report violence to the police, you must tell her this. You can say, for example, “What you tell me is confidential, that means I won’t tell anyone else about what you share with me. The only exception to this is.....” As a health-care provider, learn about the specifics of the law and conditions in which you are required to report (for example, the law may require reporting rape or child abuse). Assure her that, outside of this required reporting, you will not tell anyone else without her permission.

“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 woman 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 very hard to keep seeing both partners when violence and abuse is happening in the relationship. Best practice is to try to get a colleague to see one of them, while ensuring that 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 woman, 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 where she can go is particularly important.
- Depending on the country’s legal situation you may be obliged to report the risk to the police.
- Ask if there is a trusted person you can include in the discussion and whom you can alert to the risk.



Session 9

Handout 9a: Good practice statements on medical history, physical examination and documentation of findings¹

GOOD PRACTICE STATEMENT 2

In line with the principle of “do no harm”, when the medical history is being obtained and, if needed, a forensic interview is being conducted, health-care providers should seek to minimize additional trauma and distress for children and adolescents who disclose sexual abuse. These actions include the following:

- minimizing the need for the child or adolescent to repeatedly tell their history of sexual abuse, as it can be re-traumatizing;
- for reasons of confidentiality and safety, interviewing the child or adolescent on their own (i.e. separately from their caregivers), while offering to have another adult present as support;
- building trust and rapport by asking about neutral topics before delving into direct questions about the abuse;
- conducting a comprehensive assessment of their physical and emotional health; this is critical, as the child or adolescent’s account of what happened to them provides important information to facilitate appropriate decisions for conducting examinations and investigations, assessing injuries and providing treatment and/ or referrals;
- asking clear, open-ended questions without repetitions; in some settings, while there may be requirements to document some information for reporting the abuse, it is important not to insist that the child or adolescent answers or discloses information that may cause them trauma or compromise their safety;
- using language and terminology that is appropriate to age and non-stigmatizing,² and training interpreters where needed;
- allowing the child or adolescent to answer questions and describe what happened to them in a manner of their choice, including, for example, by writing, drawing or illustrating with models.

GOOD PRACTICE STATEMENT 3

When conducting physical examinations and, where needed, forensic investigations, health care providers should seek to minimize additional harms, trauma, fear and distress, and respect the autonomy and wishes of children or adolescents. These actions include the following:

¹ Responding to children and adolescents who have been sexually abused: WHO clinical guidelines. Geneva: World Health Organization; 2017 (<https://www.who.int/reproductivehealth/publications/violence/clinicalresponse-csa/en/>, accessed 28 July 2018).

² Stigmatizing words and labels will vary by setting. However, health care providers should avoid words that imply that the survivor is to blame for the violence.



- maximizing efforts to have the child or adolescent undergo only one examination, in order to minimize the trauma;
- offering information about the implications of positive or negative findings of the physical examination and forensic investigations;
- minimizing delays while conducting the examination in accordance with the child's or adolescent's wishes (for example, not rushing them);
- during the examination, explaining what will be done prior to each step;
- offering choice in the sex of the examiner, where possible;
- as is standard practice, making sure that there is another adult present during the examination;
- using age-appropriate visual aids and terms to explain the examination procedures;
- using examination instruments and positions that minimize physical discomfort and/or psychological distress;
- collecting forensic evidence in a way that is based on the account of the sexual abuse and on what evidence can be collected, stored and analysed; it should be done with informed consent from the child or adolescent and non-offending caregivers, as appropriate.

Actions that are medically unnecessary or are likely to increase harms or distress for the child or adolescent and, hence, are not to be undertaken, are as follows:

- carrying out the so called "virginity test" (also known as the "two-finger test" or per-vaginal exam). It has no scientific validity (i.e. does not provide evidence of whether or not a sexual assault took place), increases distress and harms to those examined and is a violation of their human rights;
- speculums or anosscopes and digital or bimanual examinations of the vagina or rectum of a pre-pubertal child are not routinely required, unless medically indicated; if a speculum examination is needed, sedation or general anaesthesia should be considered.

GOOD PRACTICE STATEMENT 4

Health-care providers should accurately and completely document the findings of the medical history, physical examination and forensic tests, and any other relevant information, for the purposes of appropriate follow-up and supporting survivors in accessing police and legal services, while at the same time protecting confidentiality and minimizing distress for children or adolescents and their caregivers. These actions include the following:

- using a structured format for recording the findings;
- recording verbatim statements of the child or adolescent and the non-offending caregivers, when applicable, for accurate and complete documentation of disclosures of abuse;
- noting down discrepancies between the child's or adolescent's and the caregivers' account, without interpretation;



- recording a detailed and accurate description of the child's or adolescent's symptoms and injuries;
- where no physical evidence is found, noting that absence of physical evidence does not mean that abuse did not occur;
- documenting the child's or adolescent's emotional state, while noting that no particular state is indicative of sexual abuse;
- seeking informed consent, as appropriate, for taking any photographs and/or videos, after explaining how they will be used;
- handling all collected information confidentially (for example, sharing information only after obtaining permission from the child or adolescent and caregiver and only on a need-to-know basis, in order to provide care; storing the information securely in a locked cupboard or a password protected file; anonymizing identifying information; and not disclosing any identifying information about a specific case to those who do not need to know, and especially not to the media).



Session 9

Handout 9b: Preparing to gather the story¹

Background/rationale

Telling others about the experience of sexual assault is often stressful, embarrassing and difficult. It can also be challenging for the person listening to the account. The aim of this job aid is to provide some suggestions to prepare individuals to whom the story of sexual violence is told. If someone is willing to talk about what happened and is comfortable with you hearing their account, it suggests that they trust you with this information. It is essential to respect and maintain this trust. Anyone obtaining the story must be trained to interview victims of sexual violence.

Key points

- Make sure that the immediate environment is secure and private.
- Ensure that any medical, psychological and safety issues have been addressed.
- Provide a trained interpreter if needed and with the consent of the victim/survivor.
- Ensure that victims have access to and choice of a same-sex interviewer.
- Acknowledge the difficulty in telling the account, which will include embarrassment, fear and patchy recollections; and respect cultural, religious and ethnic sensitivities.
- Ensure that the victim is comfortable speaking and is not doing so under coercion.
- Seek the victim's informed consent to document (in writing, photographs/videos, recording devices) the details she/he tells you and to hold this information securely until a later date, and ensure she/he knows to whom you may pass it on. Explain how information may be used and any limits to confidentiality.
- Stress the importance of being truthful and of the value of her/his account.
- Allow the victim to have another person present (obligatory for children) if they wish.
- Offer emotional and social support during the process.
- Allow the victim to tell her/his account when and how she/he wishes. Respect her/his choice if she/he wishes to stop at any time.
- Be sensitive to cultural, ethnic and religious needs of victims and/or their caregivers. Be aware that female and male victims may have different needs and concerns, and respond to these (i.e. be gender sensitive).

Above all else – listen with empathy and allow a free narrative.

Some questions that could be asked of the person telling her/his story:

- Personal information (ideally supported by official identification papers) – name, address, telephone number, email address. How does the victim wish to be contacted?

¹ WHO, UNODC. Strengthening the medico-legal response. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1&isAllowed=y, accessed 21 July 2018).



- Is she/he a victim or witness? Is she/he recounting details of what happened to her/him or to another person (if the latter, then details of that other person should also be recorded)?
- Setting of the assault – when, where, what time and date, how many times, were there any other witnesses (and if so, who), were any photographs or other recordings made?
- Details of the assault – health providers should focus on details relevant to the provision of medical care. Specific information about perpetrators for the purpose of legal processes should be gathered by trained investigators. The victim can be asked to provide as many details as possible about what happened before, during and after the assault – in particular, details of any penetration, any acts of humiliation, other assaultive events, restraint or detention, threats or blackmail, assaults or threats to friends, family or other members of the community.

Additional resources

- Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings. Geneva: World Health Organization; 2012 (WHO/RHR/HRP/12.16; http://apps.who.int/iris/bitstream/10665/75175/1/WHO_RHR_HRP_12.16_eng.pdf, accessed 9 May 2014).
- Guidelines for medico-legal care of victims of sexual violence. Geneva: World Health Organization; 2003 (http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/, accessed 9 May 2014). United Nations Office on Drugs and Crime (UNODC) and United Nations Children's Fund (UNICEF) tools for child victims and witnesses
- UNODC, UNICEF. Handbook for professionals and policymakers on justice in matters involving child victims and witnesses of crime. New York: United Nations; 2009 (<http://www.unrol.org/files/Handbook%20for%20Professionals%20and%20Policymakers%20on%20Justice%20in%20Matters%20involving%20Child%20Victims%20and%20Witnesses%20of%20Crime.pdf>, accessed 9 May 2014).
- UN Economic and Social Council Resolution 2005/20 of 22 July 2005. Guidelines on justice in matters involving child victims and witnesses of crime. New York: United Nations; 2005 (<http://www.refworld.org/docid/468922c92.html>, accessed 9 May 2014).
- UNODC, UNICEF. United Nations guidelines on justice in matters involving child victims and witnesses of crime. Online training (<http://www.unodc.org/justice-child-victims/>, accessed 9 May 2014).
- UNODC, UNICEF. Justice in matters involving child victims and witnesses of crime: model law and related commentary. New York: United Nations; 2009 (http://www.unicef.org/albania/Justice_in_matters.pdf, accessed 9 May 2014).



Session 9

Handout 9c: Special considerations for medico-legal services for child victims¹

Rationale

In many settings affected by conflict, a significant proportion of victims of sexual violence are children (under the age of 18). Medico-legal care of children demands even stricter and more rigorous consideration of ethical and safety issues, as children are among the most vulnerable population subgroups.

Key points

- Only those who have had specialized training and experience in working with children (e.g. child-friendly communication, specialized exam techniques, evidence collection) should provide medico-legal services to children.
- Medico-legal evaluations (history-taking, examination, specimen collection and medicolegal report) should only be conducted on children if child-specific health and other services are accessible for referral.
- All medico-legal practitioners working with children should be aware of the relevant laws and policies in place in the setting, including those related to consent, mandatory reporting, definitions of sexual violence against children, and who can collect and provide medico-legal evidence in court.
- Where possible, children should be offered a choice of male or female examiner.
- A child should never be examined against his or her will unless the examination is essential for the provision of health care. Occasionally, examinations may need to be done under general anaesthesia, but this should only occur for health and not legal indications.
- Informed consent procedures must be child friendly, informed by legal age of consent, age, and level of understanding of the child.
 - Informed consent must be provided by a parent or guardian unless local laws state otherwise. In addition, children who are of an age to be able to understand the nature of the medico-legal process (i.e. are developmentally capable) should also be provided with information and given the opportunity to provide their informed assent.
 - Determining acceptable and appropriate ages when adolescents may be able to give consent without parental involvement requires understanding of the applicable laws, culture and context as well as careful evaluation of security in the setting.

¹ WHO, UNODC. Strengthening the medico-legal response. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1&isAllowed=y, accessed 21 July 2018).



- If there are mandatory reporting requirements in the setting, this information must be disclosed to the parent/guardian and the child during the informed consent process.
- A small child can be examined on her or his mother's lap. Older children should be offered a choice (sitting on a chair, on mother's lap, on bed).
- Health practitioners (and others) should not conduct virginity examinations or hymenal reconstruction; these activities cannot be supported scientifically or ethically.
- Do not use a speculum to examine pre-pubertal girls. It is painful and may cause injury.
- Do not carry out a digital examination on a child to assess anal sphincter tone – such assessments have no validity.
- Do not collect forensic evidence unless it can be stored securely and there are systems accessible for their analysis.

Additional resources

- Convention on the Rights of the Child. (1989) New York: United Nations General Assembly <http://www.unhchr.ch/html/menu3/b/k2crc.htm>.
- International Rescue Committee & UNICEF (2012) Caring for Child Survivors <http://gbvresponders.org/node/1542>.
- WHO (2007) WHO Ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva: World Health Organization <http://www.who.int/reproductivehealth/publications/violence/9789241595681/en/WHO/U>.
- NHCR/UNFPA (2009) Clinical management of rape survivors e-learning programme (also in French) <http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/L>.



Session 9

Handout 9d: The forensic medical examination¹

Background/rationale

The clinical assessment is an important component of the health service for victims of sexual violence. It provides an opportunity for clinical management, the documentation of findings and the collection of material required to assist a criminal investigation. By its very nature, the examination is time consuming, intrusive, possibly traumatizing to the victim, and often challenging. Careful explanation and consent to the procedure, and a compassionate and sensitive health-care worker are the cornerstones of a good service. Ideally, the forensic medical examination should be done at the same time as the provision of medical care. Health workers must be specifically trained and have supervised experience in order to conduct forensic medical examinations. While it may be the role of health workers to document injuries and to collect other forms of medico-legal evidence, it is not their role to determine whether sexual assault has occurred.

Key points

- Only providers who have been explicitly trained and supervised should undertake full forensic examinations. All health providers should be able to, as a minimum, provide care to the victim, as well as document the victim's story, conduct a medical examination and record any injuries.
- Only medico-legal evidence that can be collected, stored, analysed and used should be gathered, and only with the full informed consent of the victim.
- A careful explanation should be provided to the victim. This should include the reasons for, and the extent of, the proposed examination, any procedures that might be conducted, the collection of specimens and photography. A sensitive and specific explanation of any genital or anal examination is required.
- Prior to commencing the examination, it is important to ensure that the facility is clean and secure, a chaperone (agreed to by the subject) is present and all relevant equipment is accessible.
- Specific measures should be taken if the victim is a minor.
- Consent to undertake the examination should be obtained from the individual or their guardian. The consent should be specific to each procedure (and particularly the genital examination), to the release of findings and specimens, and to any photography. The victim may consent to some aspects and not others and may withdraw consent. The consent should be documented by signature or fingerprint.
- The hymen is a poor marker of penetrative sexual activity or virginity in post-pubertal girls.

¹ WHO, UNODC. Strengthening the medico-legal response. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1&isAllowed=y, accessed 21 July 2018).



- There is no place for virginity testing; it has no scientific validity and is humiliating for the individual.
- Digital examinations of the vagina and anus are rarely warranted. They should not be used to assess the tone or elasticity of the vagina or anus, or to comment on likelihood or frequency of penetration.
- The general appearance and functioning of the individual (demeanour, mental status, drug effects, cooperation) should be documented, as well as the identity of the examiner and the date/time/location of the examination.
- Any limitations to the examination (lighting, cooperation etc.) should also be documented.
- A comprehensive examination should be performed, directed by the history provided. The sites examined/not examined should be documented.
- All recent and old injuries should be recorded and described in detail, recording any pertinent negative findings.
- The victim should be informed that some injuries might become more visible after some days and that, if this happens, she/he should return for examination and documentation.
- A note should be made of any specimens collected, photography undertaken, diagnostic tests ordered or treatment initiated.
- The individual should be given a detailed explanation of the findings and their treatment and follow-up.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).
- Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. Geneva: World Health Organization; 2013 (<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/index.html>, accessed 9 May 2014).
- World Health Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees. Clinical management of rape survivors. E-learning programme. Geneva: World Health Organization; 2009 (<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/index.html>, accessed 9 May 2014).



Session 9

Handout 9e: Medico-legal evidence in sexual violence¹

Background/rationale

All parties involved in managing cases of sexual assault should be aware of the evidence that might be collected or require interpretation. The objectives of evidence collection can include: to prove a sexually violent act and some of its circumstances, to establish a link between the aggressor and the victim, to link facts and persons to the crime scenes, and to identify the perpetrator. Only medico-legal evidence that can be collected, properly stored, analysed and used should be gathered, and only with the full informed consent of the victim.

Key points

- The physical examination is primarily conducted to address health issues. If it is performed within 5 days of the assault, there may be value in collecting forensic specimens. All examinations should be documented.
- Penetrative sexual activity of the vagina, anus or mouth rarely produces any objective signs of injury. The hymen may not appear injured even after penetration has occurred. Hence, the absence of injury does not exclude penetration. The health practitioner cannot make any comment on whether the activity was consensual or otherwise.
- There are different purposes and processes for the collection of specimens for health (pathology) and legal (forensic) investigations. Pathology specimens are analysed to establish a diagnosis and/or monitor a condition. Forensic specimens are used to assess whether an offence has been committed and whether there is a linkage between individuals and/or locations. Pathology specimens may have a significant forensic importance, especially if a sexually transmitted infection is found.
- The forensic laboratory requires information about the specimen (time, date, patient name/ID number, nature and site of collection) and what is being looked for.
- Forensic specimens: the account of the assault will dictate whether and what specimens are collected. If in doubt, collect. Persistence of biological material is variable. It will be affected by time, activities (washing) and contamination from other sources. The maximum agreed time interval (time of assault to time of collection) for routine collection is:
 - skin including bite marks – 72 hours;
 - mouth – 12 hours; ○ vagina – up to 5 days; ○ anus – 48 hours;
 - foreign material on objects (condom/clothing) – no time limit; ○ urine (toxicology) 50 mL – up to 5 days;

¹ WHO, UNODC. Strengthening the medico-legal response. Geneva: World Health Organization; 2015 (https://apps.who.int/iris/bitstream/handle/10665/197498/WHO_RHR_15.24_eng.pdf?sequence=1&isAllowed=y, accessed 21 July 2018).



- blood (toxicology) 2 × 5 mL samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate.
- Hair – cut scalp hair may be useful if there is concern of covert drug administration.
- Careful labelling, storage and chain-of-custody recording is required in all cases.
- Samples should not be placed in culture media and should be dry before being packaged.
- Clothing (especially underwear) and toxicological samples should be collected if required.
- Photographs provide a useful adjunct to injury documentation. Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital photographs are taken) need to be addressed and agreed with the victim.
- Sexual violence should be considered during an autopsy examination. Documentation and specimen collection should occur in such cases.
- If sexual assault results in a pregnancy, then consideration should be given to collection of specimens for paternity testing.

Additional resources

- Guidelines for medico-legal care for victims of sexual violence. Geneva: World Health Organization; 2003 (<http://whqlibdoc.who.int/publications/2004/924154628X.pdf>, accessed 9 May 2014).
- World Health Organization, United Nations Population Fund, Office of the United Nations High Commissioner for Refugees. Clinical management of rape survivors. Elearning programme. Geneva: World Health Organization; 2009 (<http://www.who.int/reproductivehealth/publications/emergencies/9789241598576/en/index.html>, accessed 9 May 2014).
- United Nations Office on Drugs and Crime. Guidelines for the forensic analysis of drugs facilitating sexual assault and other criminal acts. New York: United Nations; 2011 (<http://www.unodc.org/unodc/en/scientists/guidelines-for-the-forensic-analysis-ofdrugs-facilitating-sexual-assault-and-other-criminal-acts.html>, accessed 9 May 2014).



Session 13

Handout 13a: Pros and cons of contraceptive methods in the context of violence

Method	Pros	Cons	Discussion points
Injectable contraceptive (depot shots)	<ul style="list-style-type: none"> - Does not leave any signs on the skin - No supplies to store 	<ul style="list-style-type: none"> - With 2- and 3-month types, monthly bleeding often stops after a time - Another injection needed every 1,2 or 3 months, depending on type 	<ul style="list-style-type: none"> - Are you concerned that your partner may track your periods? - Do you think you could go for re-injection visits without fail?
Implant	<ul style="list-style-type: none"> - Works well for several years - Usually, no follow-up required - No supplies to store 	<ul style="list-style-type: none"> - Sometimes can be felt and seen under the skin of the arm - May cause spotting or changes in menstrual bleeding (often improves after 3 months) 	<ul style="list-style-type: none"> - Are you concerned that your partner may track your periods?
Copper or LNG IUD	<ul style="list-style-type: none"> - Remains out of sight in the uterus - Copper IUD works well for at least 12 years; LNG-IUD, for 3-5 years - Usually, no follow-up required - No supplies to store 	<ul style="list-style-type: none"> - Copper IUDs often increase menstrual flow - Hormonal IUs can make periods lighter or stop - Caution if woman has current STI or high STI risk - Partner may feel ends of strings in cervix 	<ul style="list-style-type: none"> - Are you concerned that your partner may track your periods? - Do you think that you may have an STI or likely to get an STI?
The pill	<ul style="list-style-type: none"> - Does not leave any signs on the skin - Little effect on menstrual bleeding 	<ul style="list-style-type: none"> - Must be taken every day - Pills/packaging must be kept in a safe place 	<ul style="list-style-type: none"> - Do you have a safe place to keep the pills?

Session 13

Handout 13b: HIV disclosure counselling in the context of violence

HIV disclosure: Is there potential for violence?

- Does your partner know you are being tested for HIV?
- If you told your partner that you tested positive for HIV, how might he react?
- Are you afraid of his reaction?
- Do you think that your partner might harm you if you told him that your HIV test result was positive?
- Has your partner ever harmed you or threatened you?
- Has your partner ever threatened to kill you?

Planning for safer HIV disclosure

Timing: Discuss a suitable time – when your partner is not tired, under the influence of alcohol or other substances or stressed for other reasons.

Place: Discuss finding a place that gives privacy but other adults are close by.

Should others be present?

- In some cases having another adult present can be crucial.
- This should be someone the woman trusts and who knows her HIV status.
- This person's role should be to support the woman by observing/listening only. But if tension builds, this person can try to calm the tension and, if necessary, help the woman leave.
- Overhearing disclosure may be traumatic for children. It is important to find a space to talk without the children.

Finding the words and role playing: Help the woman find and practise words that tell of her HIV-positive diagnosis directly and simply, without blaming anyone.

Safe exit strategy: Help the woman develop an exit plan. If tensions escalate, how will she leave, and where will she go?

Opting not to disclose: In some cases it may not be possible to enhance a woman's safety. If her partner has ever threatened to kill her, the safest plan would be to avoid disclosing her HIV-positive status to him.

Session 17

Handout 17: Examples of health promotion messages

- Violence against women can have adverse consequences on the health of women and children in your communities.
- Violence against women is costly for your family or household and for communities.
- Violence against women can be prevented.
- Women's and girl's lives are of equal value as that of any other member of society.
- Healthy intimate relationships are those that are consensual, mutually respectful, mutual, based on equality and shared decision-making.
- All women and girls have the right to feel safe in their homes and in their communities and to live a life free of violence and coercion.
- All community members can prevent violence against women.
- If you know of someone in our communities experiencing violence, keep in touch with them to check if they are safe and ensure that it is safe for them to keep in touch with you. Find out what services for survivors of violence are available in your community. Make this information available to the survivor, and do so discretely without the abuser finding out. If a survivor needs urgent help, be prepared to call emergency services – health, police or a hotline.
- There are health services available to provide good quality, timely care to women and girls subjected to violence.
- Women and girls who experience violence should be supported to seek timely health services from the nearest health facility for physical and mental health conditions caused by violence.
- Women and girls seeking help their experience of violence should not be judged or blamed for being subjected to violence.
- Women and girls who seek health services are entitled to timely and respectful treatment and care from health providers.
- If survivors wish to report their experience of violence to legal authorities, they should be supported to do so and can ask the health care providers to help them in this process.

Caring for women subjected to violence: A WHO curriculum for training health-care providers

Examples of Health Promotion Messages in Health Care Settings

1. Uganda Health Facility



Caring for women subjected to violence: A WHO curriculum for training health-care providers

2. India



3. Afghanistan



Caring for women subjected to violence: A WHO curriculum for training health-care providers

4. Global campaign to support rape survivors seek timely care

Do You Know Why Every Hour Matters After Rape?


Every hour matters after rape to prevent many lifelong physical and mental health consequences. Here's what you need to know about the short window of time available to access critical services:

EVERY HOUR MATTERS
Speed is of the essence.

Together for girls
STRENGTH IN NUMBERS


72 Within 72 Hours:

Take **post-exposure prophylaxis medication (PEP)** within 72 hours of a rape for HIV prevention. After 72 hours, HIV testing is still important, as is appropriate treatment, counseling, and support.




120 Within 120 Hours:

Take **emergency contraception** within 120 hours for pregnancy prevention.




GO As Soon as Possible:



Get a **physical examination** to identify and treat injuries.

 Take **medications** to prevent other sexually transmitted infections (STIs).

Get **immunizations** to prevent tetanus and Hepatitis B (where available).


Medical professionals can collect **forensic evidence** to support criminal investigations if you choose to file a police report.

 You may be **referred to other services**, including the police, legal service providers, and case managers.

ANYTIME:

Counseling and other psychosocial support can help you work through trauma.



The sooner some post-rape medications are taken, the more likely they are to be effective. If you miss the timeframe for these medications, other health services and psychosocial support, can still be beneficial.

Learn more at everyhourmatters.org