Clinical management of rape and intimate partner violence in emergencies

Training curriculum for health workers

Web Annex B. Participant job aids

World Health Organization

HEALTH CLUSTER

UNFPA

UNHCR The UN Refugee Agency

Suggested citation. Web Annex B. Participant job aids. In: Clinical management of rape and intimate partner violence in emergencies: training curriculum for health workers, facilitator guide. Geneva: World Health Organization; 2024. https://doi.org/10.2471/B09164. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at https://iris.who.int/.

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This publication forms part of the WHO document entitled *Clinical management of rape and intimate partner violence in emergencies: training curriculum for health workers, facilitator guide*. It is being made publicly available for transparency purposes and information.

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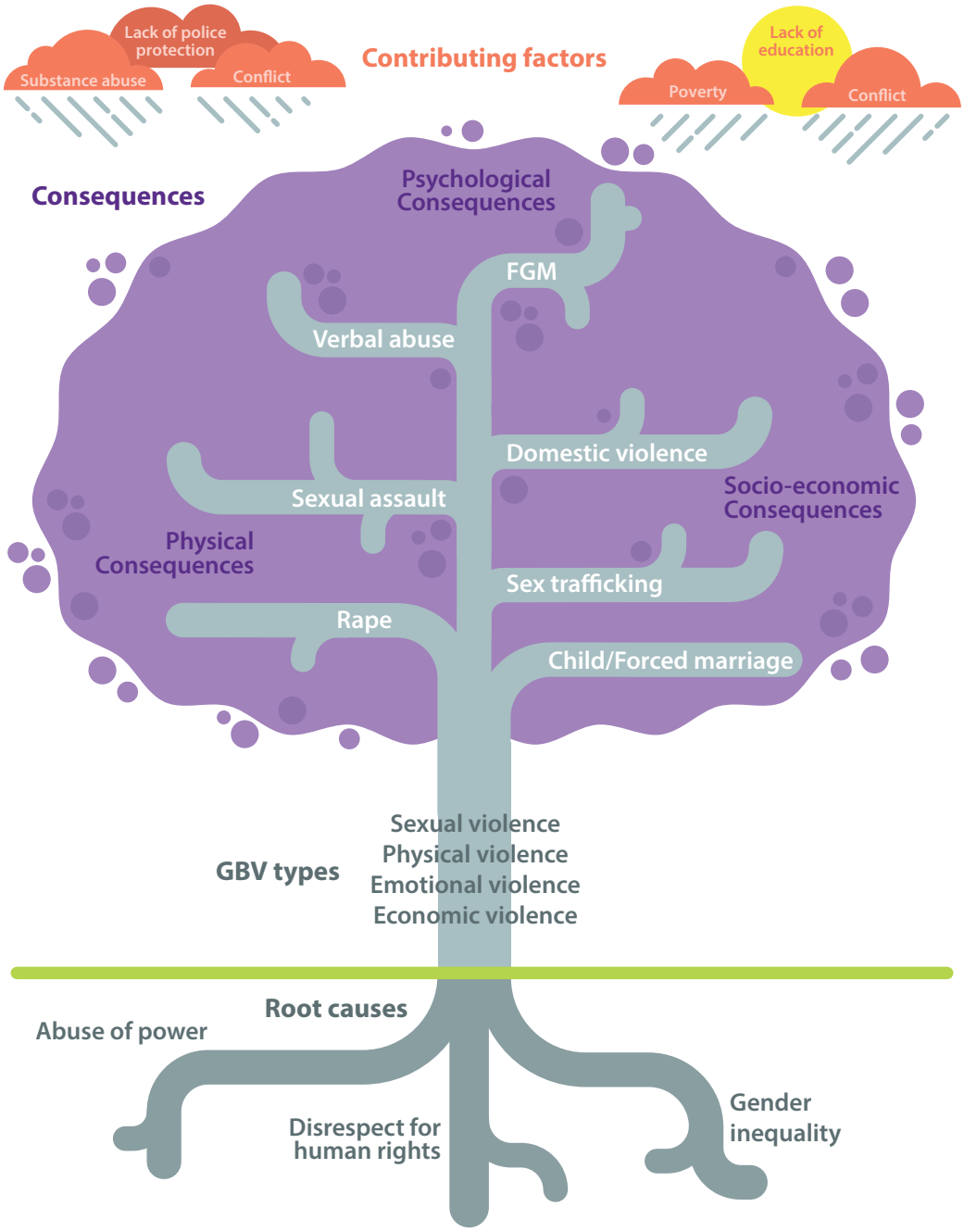
Job aid 1a. The GBV tree



Source: UNFPA and UNICEF. Boys on the move: the toxic GBV tree. New York: UNFPA; 2019 (https://eeca.unfpa.org/en/publications/boys-move-toxic-gbv-tree).

Job aid 1b. Addressing barriers to sexual violence and IPV response for health workers

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 as part of routine health care. 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. Not all aspects of a response to sexual assault or rape have to be dealt with in one consultation or by the same health worker. Where there are other health workers in the same facility, in line with division of roles and responsibilities, tasks can be shared.

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 health worker's expression of care. Your patient may actually trust you more by knowing that you care about her health and safety.

Concern: Assuming that violence will not be present in a population with characteristics such as high socio-economic status, a certain religion, and a particular type of 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: As a health worker, it is not your role to "fix" the abuse or solve the "problem" of violence in your patient's life. Remember that violence is an act where power and autonomy are forcibly taken away from the survivor. By listening to her with empathy, believing her story, offering a validating or non-judgemental response, assuring her of confidentiality, and offering her information and options that help her to make decisions (i.e. respecting her self-determination), you are ensuring that the survivor can reclaim the sense of agency and power that was taken away from her. This is an important step in the survivor's healing process.

Concern: Uncertain that she will take action

Reflection: We can never be certain how patients will behave after they leave; we do not control what they do or do not do with the information we provide. For survivors of sexual violence and IPV, it may take multiple interventions and discussions to achieve safety and well-being. Conversations with health workers are an important starting point. We can at least **L**isten, **I**nquire, **V**alidate experiences, **E**nhance safety, and provide **S**upport.

Concern: Lack of continuity and inability to follow up

Reflection: It may be difficult for survivors to return for follow-up consultations, especially in a humanitarian context, where mobility is restricted or where they may be on the move. In such a situation, do as much as you can in the first consultation to address their immediate medical needs and offer first-line support. Even if that is the only opportunity, offer health care with empathy, addressing their most important needs, and avoid retraumatizing them.

Concern: Not knowing enough about when and how to ask about suspected IPV

Reflection: The training you receive will give you the tools you need to feel confident about broaching the subject with your patients. Reviewing the materials the job aids, especially job aids 4a and 7a, can help refresh your knowledge in the months and years ahead. Remember, with practice over time, you will find it easier to recognize the signs and symptoms associated with IPV and to know how to ask questions with empathy.

Concern: Discomfort and lack of practice discussing GBV

Reflection: Talking to your patients about GBV will become easier with training, time and practice.

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

Reflection: Evidence has shown that sexual violence and IPV have a direct and measurable effect on multiple aspects of survivors' physical, mental, sexual and reproductive health. We as health workers 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: Providing effective listening, validation and support through LIVES is a form of intervention and can be an important support for your patients – even in contexts where additional interventions or referral services are limited.

Concern: Responding to sexual assault may require you to testify in court proceedings, for which you are unprepared

Reflection: It is important to be aware of your legal obligation to testify in court if the survivor reports sexual assault and seeks legal redress. To be better prepared to testify, it is important to document the details carefully in a structured format as part of medico-legal documentation.

Concern: Personal history of violence may impact your willingness to talk about violence with the patient and make this sort of conversation difficult for you

Reflection: Health workers are not immune to experiencing (or perpetrating) sexual violence and IPV. Focus on clinical protocols and best practice such as LIVES. Doing so can make you a more empathic and effective health worker. Support is available if you are experiencing heightened stress or anxiety as a result of caring for survivors of sexual violence and IPV.

Job aid 1c. Why does health worker response matter?

- Integrating sexual violence and IPV into humanitarian response, including the work of the health cluster, can help survivors living through humanitarian emergencies to access life-saving health care.
- Sexual violence and IPV are associated with poor health outcomes, including outcomes related to physical, mental and sexual and reproductive health.
- Health services may be the first point of contact for survivors of sexual violence and IPV.
- Survivors in many settings identify health workers among the professionals they trust and to whom they would be willing to disclose their experience of abuse.
- When a health worker asks about IPV, it can raise their patient's awareness that healthy relationships matter for their health and well-being.
- Asking about violence when health indicators are present can normalize identification questions and reduce feelings among survivors that they are being judged.

  Note: The World Health Organization does not recommend universal screening, but rather recommends clinical screening based on presentation and history.
- Receiving information about sexual violence and IPV in the form of posters, brochures or flyers may allow survivors to maintain a sense of autonomy in how they discuss violence with health workers. It offers them an opportunity to address their situation according to their own stage of readiness.
- When health workers raise the issue of violence with their patients as necessary for their good health and well-being, it can relieve worries about stigma and judgement.
- Health workers' expressions of concern and support can validate survivors' experiences, help them recognize abuse, and inspire them to act to keep themselves safe.

Source: WHO, UNFPA, UN Women. Health care for women subjected to intimate partner violence or sexual violence: a clinical handbook. Geneva: World Health Organization; 2014 (https://iris.who.int/handle/10665/136101).

Job aid 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 is 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 on her partner.
- **Isolation:** A woman may feel she has nowhere to go or no one to turn to for support.

Job aid 2b. Barriers to seeking care following sexual violence and IPV

Most commonly mentioned reasons for not seeking help

- The violence was normal or not serious.
- She was afraid of consequences, threats or more violence.
- She was embarrassed or afraid of being blamed or not believed.
- She was afraid she would bring shame on her family.
- She feared 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.
- She was worried she would become pregnant.
- She was afraid of contracting HIV.

Job aid 3a. LIVES pocket card

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

Listen	Listen closely, with empathy, not judging.
Inquire about needs and concerns	Assess and respond to her needs and concerns – emotional, physical, social and practical.
Validate	Show that you believe and understand her.
Enhance safety	Discuss how to protect her from further harm.
Support	Help her connect to services, social support.

FOLD

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?"	**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?"

Job aid 4a. Active listening principles

Listening is an interactive, engaging process whereby the listener focuses attention on the person to whom s/he 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 s/he 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 whether you want to press charges and whether you want a referral for a support group?"

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 s/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 eye contact as frequently 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.

Job aid 5a. Referral directory template

Referral information could include names, types and contact details of locally available referral services, e.g. police, social services, child or women's protection services.

Referral directory			
Type of service	**Organization/name**	**Contact details**	**Responsible for/ mechanism of follow-up**

Job aid 5b. Core legal and policy requirements worksheet

Pre-populate with context-specific information, citing relevant laws and regulations.

Action: 1. Gather information about the following laws and regulations			
	Yes	**No**	**Notes or details about the laws, regulations or policy provisions**
Are there criminal law provisions related to sexual violence, rape or child sexual abuse (e.g. in the penal code of the country)?			
Are there legal (criminal or civil) provisions related to IPV/domestic violence/family violence (e.g. in the penal code of the country)?			
Are there laws or policies related to protection from sexual violence and sexual harassment in the work place?			
Does the law allow women subjected to IPV or sexual assault/rape to be provided with information and abortion services? *If yes, are there other regulatory or policy barriers that limit their access to abortion (e.g. third-party consent, conscientious objection, minimum waiting times or a requirement to have a police report filed)?*			
Are there regulatory or policy barriers that limit access to emergency contraception for women subjected to sexual assault (e.g. lack of inclusion of emergency contraception in national essential medicines list)?			
Are there laws, regulations or policies that limit or pose barriers to access to sexual assault or rape services for groups that are marginalized? For example, for: a. People in same-sex relationships (e.g. laws criminalizing same-sex relationships) b. People with disabilities (e.g. regulations requiring third-party consent) c. Migrants, refugees (e.g. requiring ID to access services) d. Ethnic minorities or indigenous groups.			

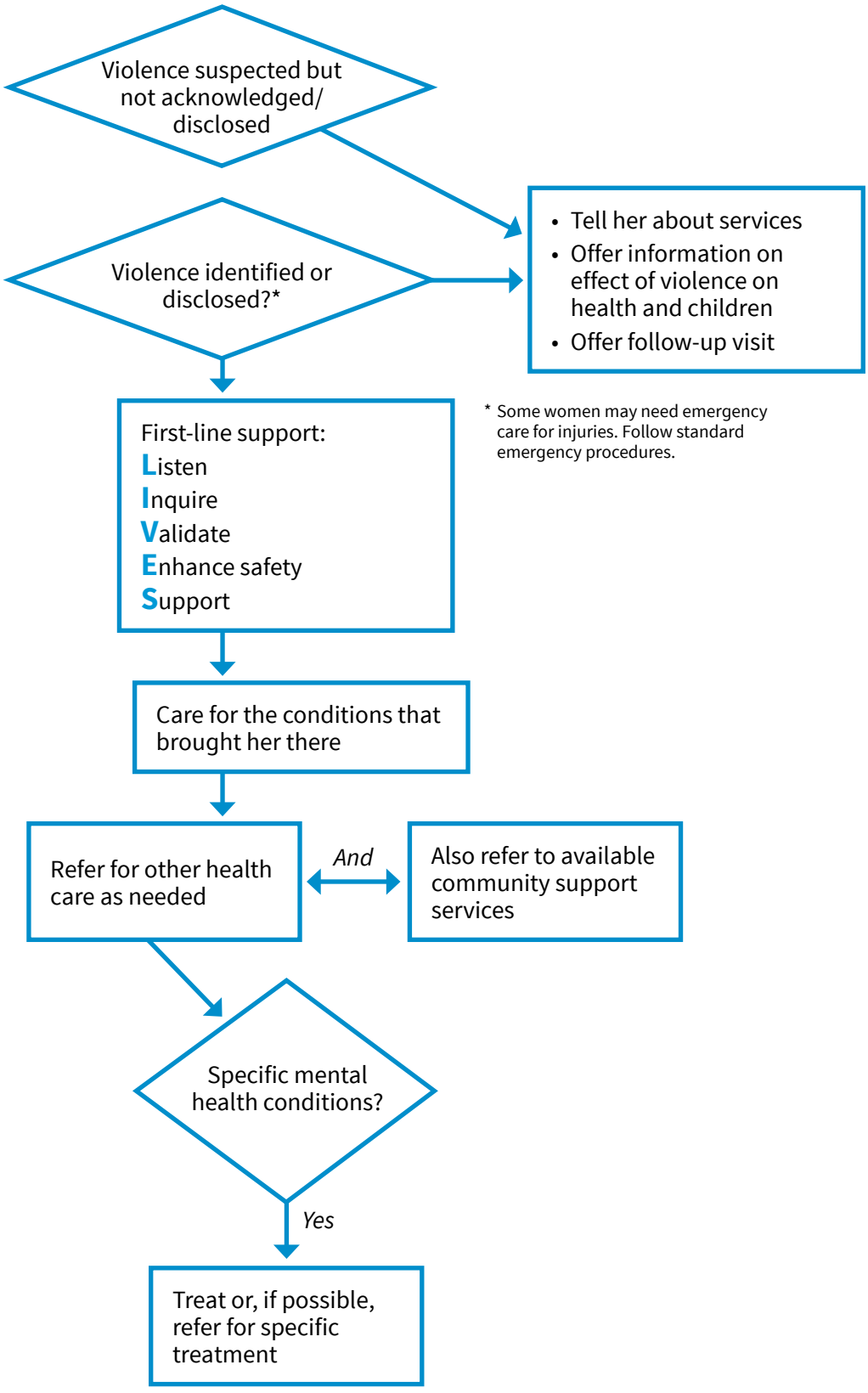
Action 2. Identify the legal obligations of health workers in relation to addressing sexual violence and IPV

	Yes	No	Notes or details about the laws, regulations or policy provisions
For example, are there laws or policies that specify or obligate health care for survivors of sexual violence and/or IPV?			
Do laws or regulations mandate reporting individual cases of sexual assault/rape or IPV to the police or other relevant authorities (e.g. social services, protection officers)?			
Are there laws relating to the age of sexual consent laws or statutory rape that criminalize adolescents who have consensual sex as rape? *If yes, what is the age specification in these laws?* *At what age can adolescents give informed consent or does the law not require caregiver/parental consent to access health care for sexual assault or rape?*			
Are health workers authorized to perform forensic examination and provide testimony in court in cases of sexual assault or rape? *If yes, which health workers are authorized?*			

Action 3. Identify any temporary provisions/amendments applicable during times of humanitarian emergencies or crises

	Yes	No	Notes or details about the laws, regulations or policy provisions
Are there amendments to the above provisions in the law that are amended or suspended during times of humanitarian crises? *If yes, please list which provisions are amended/suspended or enabled (e.g. curfews, requiring people to carry ID papers).*			

Job aid 6a. Summary pathway of care for survivors of IPV



Job aid 6b. Sample statements on asking about violence

Here are some general questions you can ask to raise the subject of violence before you ask more specific 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:

- "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?"

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.

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.

Job aid 6c. Frequently asked questions about IPV

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 empathic 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.

How did she get herself into this situation?

It is important to avoid blaming the woman for what happened. Blaming her 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 that can help her and that are still functioning within the health-care system as well as through the health or protection clusters and/or SRH working group if one has been established.

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 it. (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.

Job aid 7a. LIVES in response to IPV: communication skills and pathways

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 at home threatened to hurt you or physically harm you? Has your husband or partner forced you into sex or forced you to have sexual contact you did not want?	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 over the past six months? Is he violently and constantly jealous of you? Has he ever beaten you when you were pregnant? Has he ever used or 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: Caring for women subjected to violence: a training curriculum for health care providers. Geneva. World Health Organization; 2021 (https://www.who.int/publications/i/item/9789240039803).

Job aid 7b. LIVES + CC

The acronym “LIVES + CC” (LIVES for children, adolescents and their caregivers) can remind you of these key components in responding to children and adolescents, where maltreatment has been disclosed. The LIVES + CC approach can be applied regardless of whether the child or adolescent or the caregiver has disclosed violence.

Listen	Listen to the child or adolescent closely with empathy and without judging in a private space.
Inquire	Assess and respond to needs, wishes and concerns - emotional, physical, social and practical.
Validate	Show the child or adolescent that you understand and believe them, and that they are not to blame for what happened.
Enhance safety	Protect the child or adolescent from further harm. Enhance the safety of the child or adolescent.
Support	Facilitate support by connecting children and adolescents to formal and informal support services.
Child and adolescent friendly environment	Create a child and adolescent friendly environment by training providers and improving service readiness to provide survivor-centred care.
Caregiver support	Provide support to non-offending caregivers to support the child or adolescent.

Source: Responding to child maltreatment: a clinical handbook for health professionals. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/361272). Licence: CC BY-NC-SA3.0 IGO.

Job aid 8a. IPV safety risk assessment

Affirmative (yes) responses to **at least three** of these questions indicate a high immediate risk of severe harm:

1. Has the violence happened more often or become worse over the past 6 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?

Job aid 8b. Safety planning tool

As a health worker, you can help the survivor write a safety plan for herself and her children. Ask her whether it is safe for her to keep the written safety plan, as the survivor may risk further retaliation if the plan is found by the perpetrator.

If the survivor has decided to leave her partner, the safety plan can help her develop an approach to do so in a way that will reduce the risk of harm for herself and her children as much as possible.

Safety planning job aid		
Safety planning		**Survivor's notes**
Safe place to go	If you need to leave your home in a hurry, where could you go?	
Planning for children	Would you go alone or take your children with you?	
Transport	How would you get there?	
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 the items together in a safe place, or leave them with someone in case you need to leave quickly?	
Financial	Do you have access to money? 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 to you with assistance if they hear sounds of violence coming from your home?	
Discuss how to remain safer at home	Are there techniques to de-escalate conflicts at home that you are using or can use?	
	If you cannot avoid heated discussions, are there rooms or areas in your home where you feel safe or less safe? Stay away from rooms with objects that can be used as weapons, e.g. knives or sticks.	

Safety planning		Survivor's notes
Managing conversations that can provoke violence	Discussions about contraception, STIs or HIV status can provoke violence from a partner. How could you have these conversations safely (e.g. by finding a time when both partners are relaxed, ensuring children are occupied or elsewhere, finding a room or location you can easily leave if you need to, asking a health worker or trusted person to mediate or be present or nearby to help)?	
Keeping confidential information safely	Are there devices or information that could provoke violence if your partner found them (e.g. phones, text messages, emails, medical records, medication, prescriptions or numbers of hotlines)?	
	How could you keep these discreetly so that your partner or children do not access them (e.g. by protecting passwords, using good hiding places, keeping things with trusted family, friends or neighbours – out of the house, but still accessible)?	

Adapted from: Health care for women subjected to intimate partner violence and sexual violence: A clinical handbook. Geneva: World Health Organization, 2014; and Herman, R. et al. Integrating gender-based violence first line response into sexual and reproductive health services: an implementer's toolkit. Pathfinder International; 2023 (https://www.pathfinder.org/publications/integrating-gbv-first-line-response-into-srh-services/)

Job aid 8c. Special considerations for children and adolescents – LIVES + CC

Remember

- Help the child to feel safe. Start with neutral questions about a toy, their favourite activities, friends or school.
- Young people can be particularly aware of the sex of their health worker. Strive to offer children and adolescents a choice of gender where their health worker is concerned.
- Be mindful of word choice, and use vocabulary that is appropriate to a child or adolescent's age and stage of development. Using small figurines, dolls or stuffed animals can allow for play-based sharing of events.
- Young children may communicate best by drawing pictures and then describing them.
- Frequently reinforce that the child is not in trouble and has done nothing wrong.
- Include a non-offending adult in risk assessment, safety planning and referrals to social support and other services.

Job aid 8d. Assessing adolescent capacity for autonomous decision-making

The following rights of the child need to be balanced in supporting child and adolescent survivors of sexual abuse: the best interests of the child and evolving capacities. Specifically, adolescents have the right to:

- Be physically and emotionally safe
- Have their privacy and confidentiality respected and protected during care
- Information that is appropriate to their age
- Informed consent and assent
- Autonomy, including being offered choices regarding decisions to be made about their care
- Receive non-discriminatory care regardless of their sex, ethnicity, gender identity, sexual orientation and disability status, among others
- Participation including in shared decision-making about the care they receive.

Indications of capacity	Level of impact or risk	Notes of the health worker to explain assessment
Explore with the adolescent their situation		
Whether or not they want to involve their family/caregiver and/or any partner (e.g. dating partner, spouse if married, sexual partner).	High risk may be a situation where they do not want to involve anyone. Low risk may be a situation where there is at least one other person they wish to involve.	
Whether there are vulnerabilities that are harming or can harm them (e.g. suicidal thoughts, substance misuse, mental distress/illness, conflicts or neglect in the home).	High risk may be a situation where more than one or more of these situations is present.	
What resources do they already have (e.g. positive family support, friendships, a trusted adult in their life, attending school, engaged in school, social, community, sports activities)?	High level is where they have more than one of these resources available.	
Assess their decision-making capacity		
Are they able to understand their situation and options including the information being provided, the diagnosis or tests or examination that has to be done, treatment to be provided?	High level is where they demonstrate verbally that they understand what is being explained and also how it will impact them, their health and their life.	

Are they able to reason about the different options or choices to be made?	High level is where they are able to understand the different treatments, investigations, actions they have to take and able to make decisions based on pros and cons of each option (e.g. pros and cons of involving a caregiver about sexual assault versus not).	
Are they able to appreciate the impact of different options to their personal situation and circumstances?	High level is when they are able to demonstrate understanding of how the different choices fit into or will affect their personal situations and circumstances (e.g. impact of taking emergency contraception versus not).	
Are they able to freely express their choice or decision?	High level is when they are able to explain their decision in light of the information and the consideration of the pros and cons.	

For additional guidance see:

WHO clinical guidelines for responding to children and adolescents who have been sexually abused. World Health Organization; 2017.

WHO tool for health-care providers – assessing and supporting adolescents' capacity for autonomous decision-making in health care settings; web annex: an algorithm for health-care providers. World Health Organization; 2021.

Job aid 9a. Sample history and examination form for sexual assault

CONFIDENTIAL CODE:

Medical History and Examination Form - Sexual Violence

1. GENERAL INFORMATION

First name:		Last name:
Address:		
Sex:	Date of birth (dd/mm/yy):	Age:
Date / time of examination: /		In the presence of:

In case of a child, include: name of school, name of parents or guardian

2. THE INCIDENT

Date of incident:	**Time of incident:**
Description of incident (survivor's description)	

Physical violence	**Yes**	**No**	**Describe type and location on body**
Type (beating, biting, pulling hair, etc.)			
Use of restraints			
Use of weapon(s)			
Drugs/alcohol involved			

Penetration	**Yes**	**No**	**Not sure**	**Describe (oral, vaginal, anal, type of object)**
Penis				
Finger				
Other (describe)				

	Yes	**No**	**Not sure**	**Location (oral, vaginal, anal, other)**
Ejaculation				
Condom used				

If the survivor is a child, also ask: Has this happened before? When was the first time? How long has it been happening? Who did it? Is the person still a threat? Also ask about bleeding from the vagina or the rectum, pain on walking, dysuria, pain on passing stool, signs of discharge, any other sign or symptom.

3. MEDICAL HISTORY

After the incident, did the survivor	Yes	No		Yes	No
Vomit?			Rinse mouth?		
Urinate?			Change clothing?		
Defaecate?			Wash or bath?		
Brush teeth?			Use tampon or pad?		
Contraception use					
Pill			Condom		
Injectable			Sterilization		
Intrauterine device			Other		
Menstrual/obstetric history					
Last menstrual period (dd/mm/yy)			Menstruation at time of event		
	Yes	**No**			
Evidence of pregnancy			Number of weeks pregnant	.....weeks	
Obstetric history					

History of consenting intercourse (only if samples have been taken for DNA analysis)		
Last consenting intercourse within a week prior to the assault	Date (dd/mm/yy)	Name of individual:
Other health-related conditions		
History of female genital mutilation, type		
Allergies		
Current medication		

Vaccination status	Vaccinated	Not vaccinated	Unknown	Comments
Tetanus				
Hepatitis B				
HIV/AIDS status	Known		Unknown	

4. MEDICAL EXAMINATION

Appearance (clothing, hair, obvious physical or mental disability)			
Mental state (calm, crying, anxious, cooperative, depressed, detached, other)			
Weight:	Height:	Pubertal stage: Prepubertal ☐ Pubertal ☐ Mature ☐	
Pulse rate:	Blood pressure:	Respiratory rate:	Temperature:
Physical findings Describe systematically, and draw on the body pictograms (Annex 5), the exact location of all wounds, bruises, petechiae, marks, and so on. Document type, size, colour, form and other particulars. Be descriptive but do not interpret the findings.			
Head and face		Mouth and nose	
Eyes and ears		Neck	
Chest		Back	
Abdomen		Buttocks	
Arms and hands		Legs and feet	

5. GENITAL AND ANAL EXAMINATION

Vulva/scrotum	Introitus	Anus
Vagina/penis	Cervix	Bimanual/rectovaginal examination
Position of patient (supine, prone, knee-chest, lateral, mother's lap)		
For genital examination:	For anal examination:	

6. INVESTIGATIONS DONE

Type and location	Examined/sent to laboratory	Result

7. EVIDENCE TAKEN

Type and location	Sent to.../stored	Collected by/date

8. TREATMENTS PRESCRIBED

Treatment	Yes	No	Type and comments
Wound treatment			
Emergency contraception			
Sexually transmitted infection prevention/treatment			
Post-exposure prophylaxis for HIV			
Tetanus prophylaxis			
Hepatitis B vaccination			
Other			

9. COUNSELLING, REFERRALS, FOLLOW-UP

General psychological status

	Yes	No
Survivor plans to report to police OR has already made report		
Survivor has a safe place to go to		
Survivor has someone to accompany them		
Counselling or psychological intervention provided:		
Referrals: Case management/psychosocial services ☐ Police ☐ Legal services ☐ Mental health services ☐ Other ☐		
Follow-up required:		
Date of next visit:		
Name of health worker conducting examination/interview:		
Title:	**Signature:**	**Date:**

Job aid 10a. Post-rape physical examination checklist

Look at all the following	Look for and record
Physical examination checklist	
• General appearance • Hands and wrists, forearms, inner surfaces of upper arms, armpits • Face, including inside of 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	
• Genitals (external) • Genitals (internal examination, using a speculum) • Anal region (external)	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

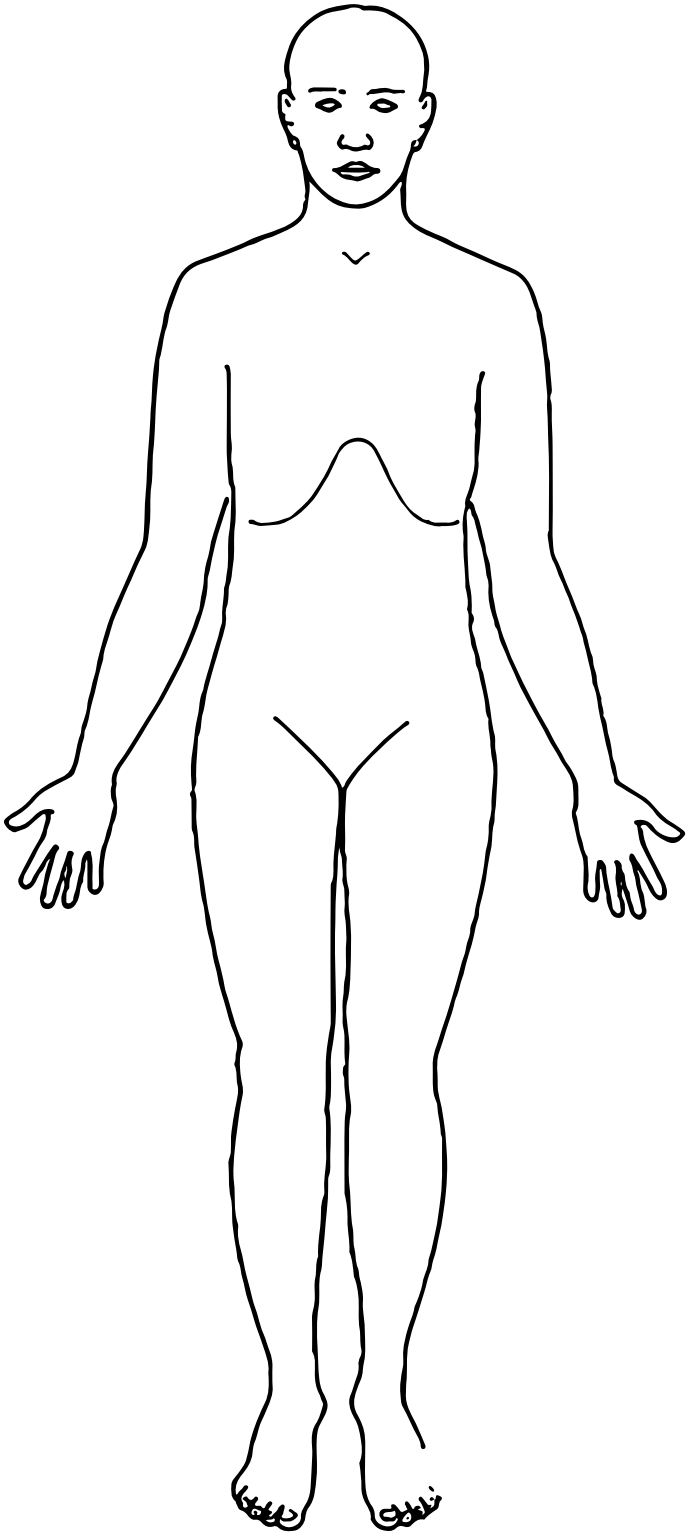
Job aid 10b. Injury documentation checklist

Feature	Notes
Classification	Clinical wound type: abrasion, contusion, laceration, gunshot, incised wound, etc.
Site	Anatomical position and location
Size	Measure and record dimensions (length, height, width)
Shape	Describe the shape in geometric terms (linear, curved, irregular, semi-circular, etc.)
Surrounds	Note the condition of the surrounding or nearby tissues (e.g. bruised, swollen)
Colour	Particularly relevant when describing bruises as can give indication of age
Course	Comment on indications of apparent direction of the force applied (e.g. in bullet wounds, abrasions)
Contents	Note the presence of any foreign material in the wound (e.g. grass, glass, dirt, fingernails)
Age	Comment on any evidence of healing. Never try to estimate or record a quantitative age as this is impossible to determine from physical examination, even by advanced practitioners
Borders	Note the characteristics of the edges of wound(s) (e.g. jagged, angled, vertical)
Depth	Give an indication of the depth of the wound. If measurement is not possible, provide an estimate and note that it is an estimate

Source: World Health Organization, United Nations Population Fund, United Nations High Commissioner for Refugees. Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331535). License: CC BY-NC-SA 3.0 IGO.

Job aid 10c. Injury documentation pictograms

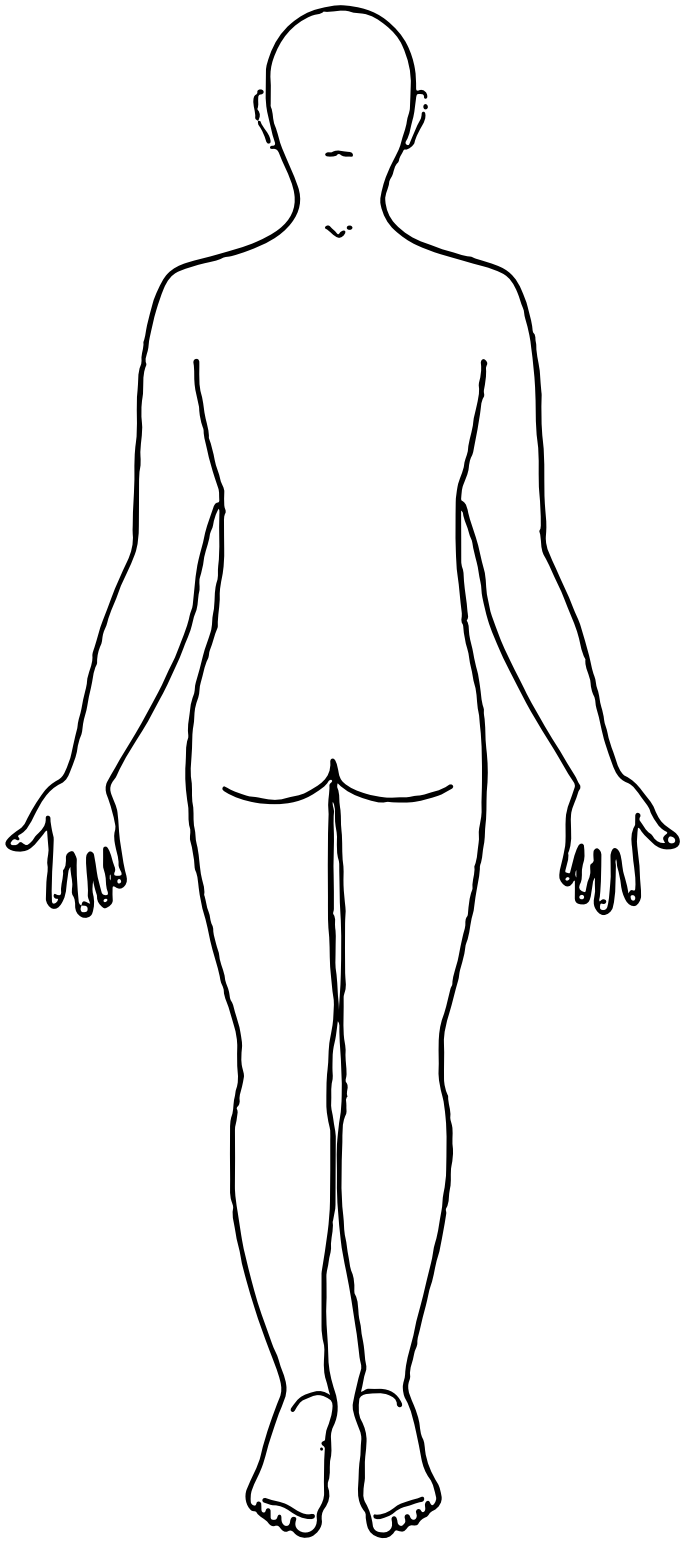
Right **Left**



Patient ID Code: _____ Examining provider: _____

Date of examination: _____

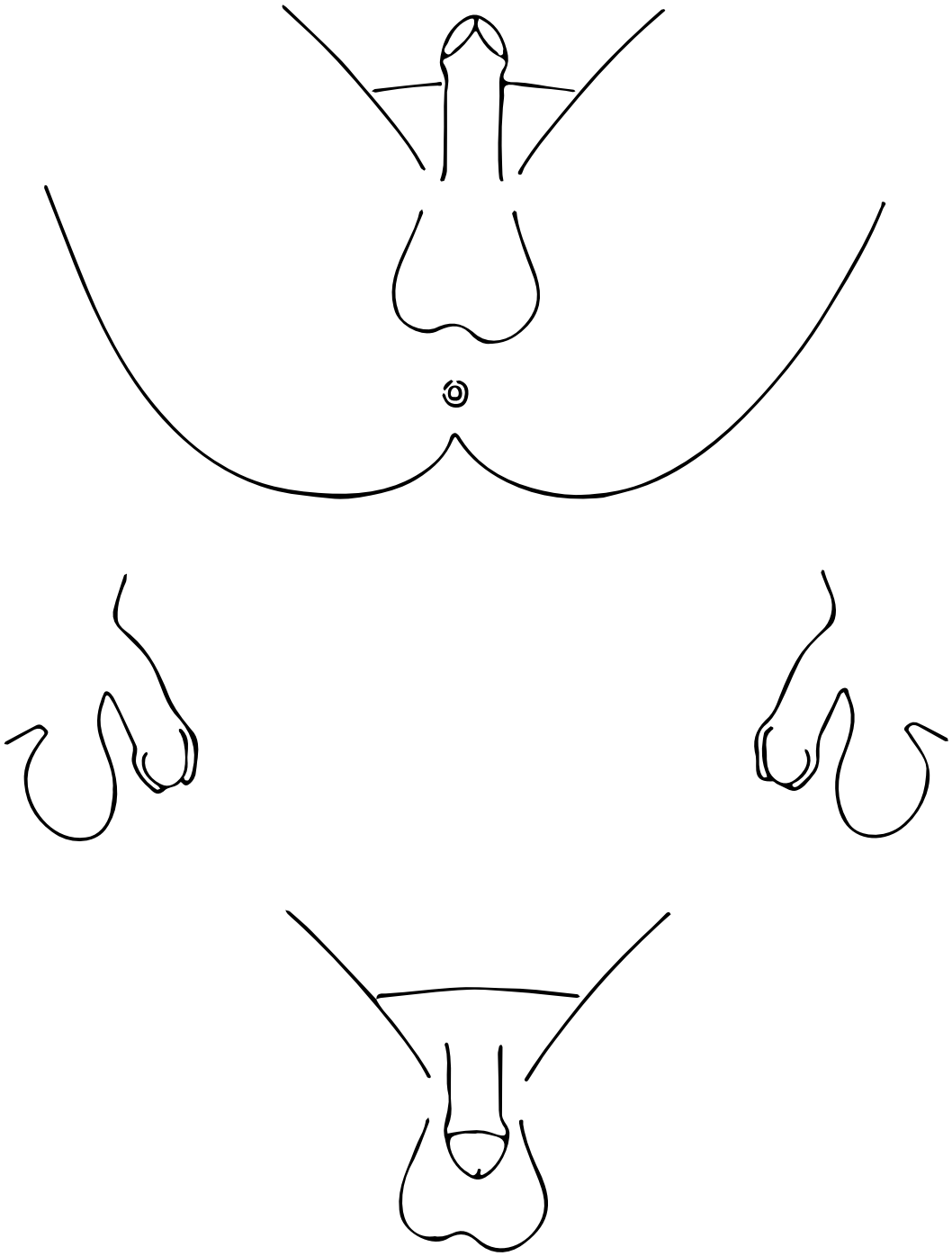
Left **Right**



Patient ID Code: _____ Examining provider: _____

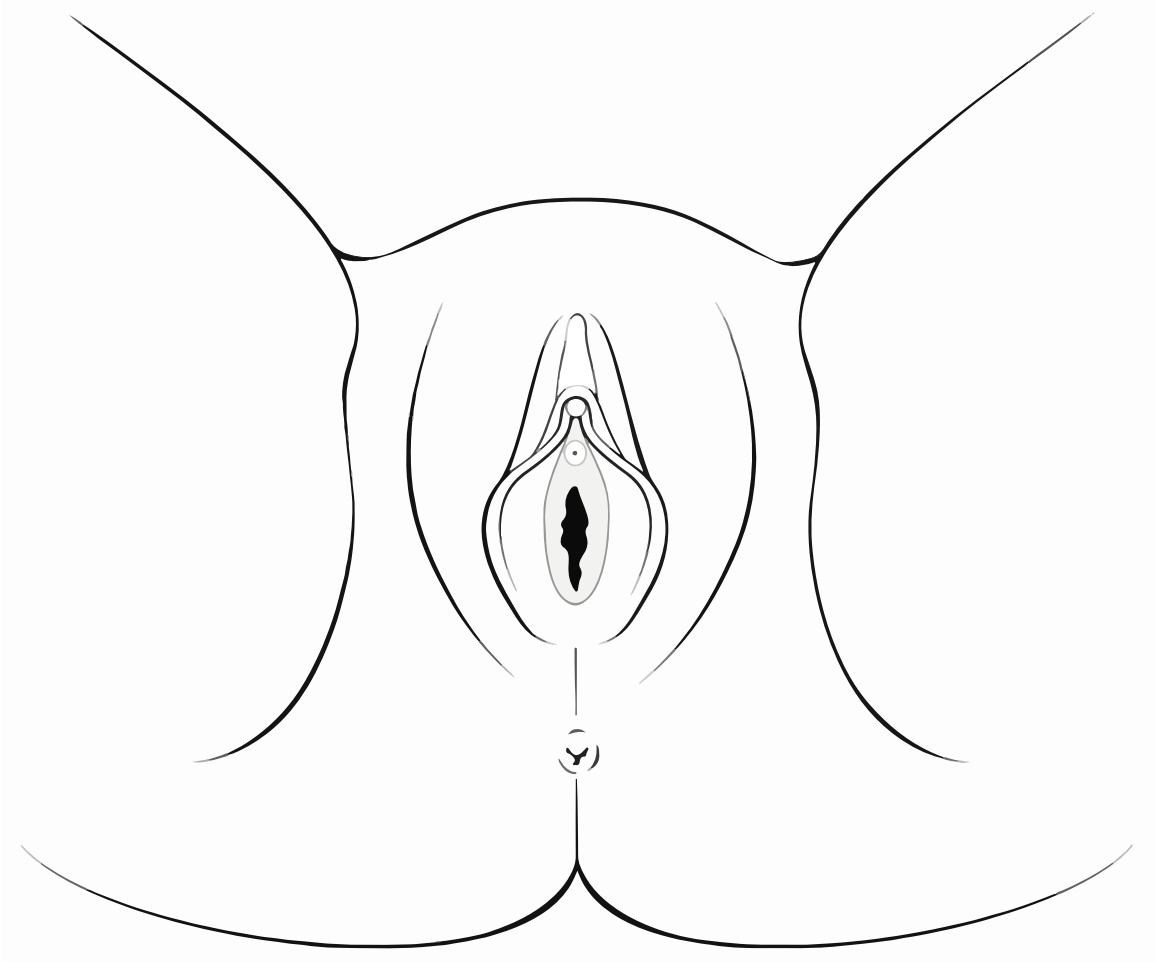
Date of examination: _____

Right **Left**



Patient ID Code: _____ Examining provider: _____

Date of examination: _____

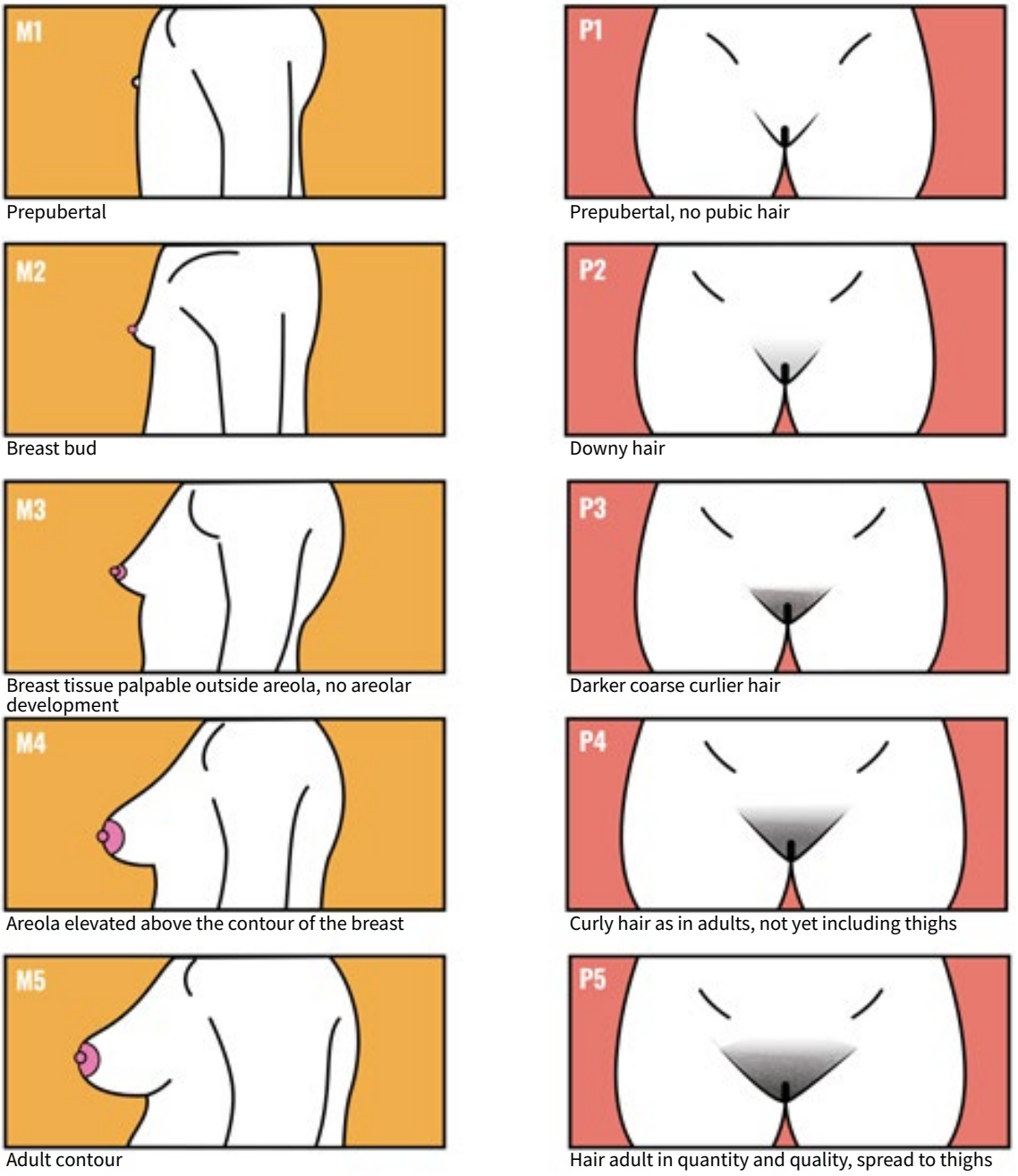


Patient ID Code: _____ Examining provider: _____

Date of examination: _____

Job aid 11a. Tanner stages of development in girls

Note: At the beginning of puberty, girls who reach Tanner stage 2 or thelarche (i.e. with onset of secondary breast development) or Tanner stage 3 (i.e. breast development becomes more elevated) may face the risk of an unwanted pregnancy as a result of sexual assault or rape because they are likely to be ovulating even prior to the onset of menstruation.



Source: Responding to child maltreatment: a clinical handbook for health professionals. Geneva: World Health Organization; 2022 (https://iris.who.int/handle/10665/361272). Licence: CC BY-NC-SA3.0 IGO.

Job aid 11b. Post-exposure prophylaxis for HIV protocols

The following are examples of post-exposure prophylaxis (PEP) protocols used for preventing HIV infection after rape. These examples do not outline all the care that may be needed. If it is not possible in your programme to provide PEP, refer the survivor as soon as possible (within 72 hours) to a clinic where this service can be provided.

- HIV PEP should be offered and initiated as early as possible for all individuals with an exposure that has the potential for HIV transmission, preferably within 72 hours.
- An HIV PEP regimen with two antiretroviral medications is effective, but three drugs are preferred.
- Pregnancy is not a contraindication to PEP. A three-medication regimen is recommended for pregnant women. While dolutegravir appears to be safe in pregnancy, there are concerns that exposure to dolutegravir in the peri-conception period may be associated with neural tube defects. This concern should be balanced against the better efficacy and tolerability of the medications overall. Efavirenz is a safe and effective alternative for women during pregnancy, though side-effects may affect completion rates.

Choice of HIV PEP regimen should consider the antiretroviral medications already being procured within national HIV programmes. Below is the WHO-recommended preferred regimen for HIV PEP for adults and adolescents. Dolutegravir is recommended as the third drug for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third drug options.

PEP for adults and adolescents over 10 years (over 30 kg)			
Three-medication regimen recommended	Dose/ tablet	Dosage	Duration
Lamivudine[a] + tenofovir	300 mg/300 mg	1 tablet once daily	28 days
Plus			
Dolutegravir[b]	50 mg	1 tablet once daily	28 days

PEP for children under 10 years (under 30 kg)																
	Zidovudine and lamivudine[c]				**AND**	**Lopinavir and ritonavir**								**OR**	**Dolutegravir[d]**	
Weight	Tablet of 60 mg zidovudine and 30 mg lamivudine		Tablet of 300 mg zidovudine and 150 mg lamivudine			Tablet of 100 mg lopinavir and 25 mg ritonavir			Oral liquid containing 80 mg/ml of lopinavir and 20 mg/ml of ritonavir			Pellets or granules (40 mg lopinavir and 10 mg ritonavir)[e]		50 mg tablet	
kgs	am	pm	am	pm		am	pm		am	pm	or	am	pm	Once/day	
3.0–5.9	1	1			and	NR*	NR*	or	1 ml	1 ml	or	2	2		
6.0–9.9	1.5	1.5			and	NR*	NR*	or	1.5 ml	1.5 ml	or	3	3		
10.0–13.9	2	2			and	2	1	or	2 ml	2 ml	or	4	4		
14.0–19.9	2.5	2.5			and	2	2	or			or	5	5		
20.0–24.9	3	3			and	2	2	or			or			or	1
25.0–29.9			1	1	and	3	3	or			or			or	1

[a] Or emtricitabine.

[b] Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options for PEP.

[c] Abacavir plus lamivudine or tenofavir plus lamivudine are alternatives.

[d] Dolutegravir is recommended as the third medication for HIV PEP. When available, atazanavir plus ritonavir, darunavir plus ritonavir, lopinavir plus ritonavir and raltegravir may be considered as alternative third medication options for PEP. Dolutegravir 50 mg can be used once daily from 20 kg.

[e] Lopinavir plus ritonavir liquid can also be used, although it needs a cold-chain during transport and storage. The lopinavir plus ritonavir heat-stable tablet formulation must be swallowed whole and should not be split, chewed, dissolved or crushed. The adult 200 mg or 50 mg tablets could be used for patients 14.0–24.9 kg (1 tablet every morning and 1 tablet every evening) and for patients 25.0–34.9 kg (2 tablets every morning and 1 tablet every evening). Lopinavir plus ritonavir pellet formulation should not be used in infants younger than 3 months. More details on the administration of lopinavir plus ritonavir pellets can be found at http://apps.who.int/iris/bitstream/handle/10665/193543/FactsheetIATT_WHO_UNICEF_ lopinavir_eng.pdf. While limited experience exists with using lopinavir plus ritonavir granules, this formulation is approved for use from 2 weeks of age.

Job aid 12a. Stress reduction techniques

Slow breathing technique

- Try to keep your eyes closed. Sit with your feet flat on the floor.
- First, relax your body. Shake your arms and legs and let them go loose. Roll your shoulders back and move your head from side to side.
- Put your hands on your belly. Think about your breath.
- Slowly breathe out all the air in your lungs through your mouth, and feel your belly flatten. Now breathe in slowly and deeply through your nose, and feel your belly fill up like a balloon.
- Breathe deeply and slowly. You can count 1–2–3 on each breath in and 1–2–3 on each breath out.
- Keep breathing like this for about 2 minutes. As you breathe, feel the tension leave your body.

Progressive muscle relaxation technique

- Curl your toes and hold the muscles tightly. Breathe deeply; count to 3 while holding your toe muscles tight. Relax your toes and let out your breath. Breathe normally and feel the relaxation in the toes.
- Do the same for each of these parts of your body in turn. Each time, breathe in deeply as you tighten the muscles, count 1–2–3, then relax and breathe out slowly.
- Hold your leg and thigh muscles tight . . . 1–2–3
- Hold your belly tight . . . 1–2–3
- Make fists with your hands . . . 1–2–3
- Bend your arms at the elbows and hold your arms tight . . . 1–2–3
- Squeeze your shoulder blades together . . . 1–2–3
- Shrug your shoulders as high as you can . . . 1–2–3
- Tighten all the muscles in your face . . . 1–2–3

Job aid 12b. Assessment for moderate-to-severe depressive disorder

If a survivor is experiencing any of these conditions, provide basic psychosocial support and refer to a specialist for further care.

Moderate-to-severe depressive disorder is likely if A, B and C are present for at least two weeks

A. The woman has had at least one of the following core symptoms:

- persistent depressed mood (for children and adolescents: either irritability or depressed mood)
- markedly diminished interest in or pleasure from activities, including those that were previously enjoyable

B. The woman has had several of the following additional symptoms to a marked degree, or many of the listed symptoms to a lesser degree:

- disturbed sleep or sleeping too much
- significant change in appetite or weight (decrease or increase)
- beliefs of worthlessness or excessive guilt
- fatigue or loss of energy
- reduced ability to concentrate and sustain attention on tasks
- indecisiveness
- observable agitation or physical restlessness
- talking or moving more slowly than normal
- hopelessness about the future
- suicidal thoughts or acts

C. The woman has considerable difficulty with daily functioning in any of the following aspects of daily life:

- personal, family, social, educational/school, occupational/work, household/domestic, or other (ask about each of these different aspects/activities)

If moderate-to-severe depressive disorder is likely:

- Rule out and manage any physical conditions that can resemble depressive disorder, such as anaemia, malnutrition, hypothyroidism, stroke and medication side-effects (e.g. mood changes from steroids)
- Rule out and manage other mental health conditions (e.g. alcohol and drug use)
- Rule out a history of manic episode(s) that may have included symptoms such as:
  - » elevated (intensely happy) or irritable mood
  - » decreased need for sleep
  - » racing thoughts, increased activity, rapid speech
  - » impulsive or reckless behaviour (e.g. making important decisions without planning, excessive spending)
  - » inflated self-esteem

  If she experienced these symptoms and they interfered with daily functioning for at least one week, or if there is a history of hospitalization or of confinement because of these symptoms, consult a specialist.
- Rule out normal reactions to the violence or to major loss (e.g. bereavement, displacement). The reaction is more likely a normal reaction if:
  - » there is marked improvement over time without clinical intervention
  - » there is no previous history of moderate-to-severe depressive disorder or manic episode
  - » symptoms do not impair daily functioning significantly

Job aid 12c. Assessment of post-traumatic stress disorder (PTSD)

PTSD is likely if A, B, C and D are present about one month after the violence.

A **Re-experiencing symptoms:** Repeated and unwanted recollections of the violence, as though it is occurring in the here-and-now (e.g. through frightening dreams, flashbacks or intrusive memories accompanied by intense fear or horror)

B **Avoidance symptoms:** Deliberate avoidance of thoughts, memories, activities or situations that remind one of the violence (e.g. avoiding talking about issues that are reminders of the violence, or avoiding going back to places where the violence happened)

C **A heightened sense of current threat:** Excessive concern and alertness to danger or reacting strongly to loud noises or unexpected movements (e.g. being "jumpy" or "on edge")

D **Considerable difficulty with daily functioning** in personal, family, social, educational/school, occupational/work, household/domestic or other important areas of daily life

If PTSD is likely:

- Rule out and manage any physical conditions that could explain symptoms of PTSD (e.g. physical symptoms associated with distress, such as heart palpitations, headaches, gastric upset, insomnia)
- Rule out and manage other mental, neurological and substance use conditions (e.g. moderate-to-severe depressive disorder, suicidal thinking or alcohol and drug use)
- Rule out normal reactions to the violence. The reaction is more likely a normal reaction if: there is marked improvement over time without clinical intervention and symptoms do not impair daily functioning significantly

Note: Immediately after a potentially traumatic experience such as sexual assault, most survivors experience psychological distress. For many survivors these are passing reactions that do not require clinical management. However, when a specific, characteristic set of symptoms (re-experiencing, avoidance and heightened sense of current threat) persists for more than a month after the event, the survivor may have developed PTSD.

Job aid 15a. Forensic examination and evidence collection tips

Forensic examination is, by its very nature, time consuming and intrusive, possibly traumatizing to the survivor, and often challenging. Careful explanation should be provided about the procedure as part of informed consent. Empathy, listening, observing for non-verbal cues from the patient and respecting their decisions of whether to continue or not are cornerstones of a survivor-centred approach. Ideally, the forensic and physical examination should be done at the same time along with provision of medical care. While it may be the role of health workers to document injuries and collect forensic evidence, it is not their role to determine whether sexual assault has occurred. Instead, health workers should objectively describe their observations and plausible explanations (e.g. presence of semen in the vagina is consistent with sexual intercourse, or bruises on the wrist are consistent with use of restraint).

- Only health workers who have been explicitly trained and mandated, should undertake full forensic examinations.
- If a health worker is not trained or mandated to conduct a forensic examination, they can still take medical history, history of the incident, conduct a full physical examination and provide treatment and care.
- Only forensic evidence that can be collected, stored, analysed and used should be gathered, and only with the full informed consent of the survivor (see the list below for evidence validity windows after assault). Analysis of forensic evidence requires specialized laboratories and technicians and is not available in many contexts.
- The account of the assault should dictate whether and what forensic specimens are collected. If in doubt, collect.
- Persistence of biological material is variable and will be affected by time (see the box below), activities (e.g. washing, bathing) and contamination from other sources.
- 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.
- The survivor should be given a detailed explanation of the findings and their treatment and follow-up and a medico-legal certificate should be issued.

Forensic specimens and maximum interval time for collection

- Skin, including bite marks – 72 hours
- Mouth – 12 hours
- Vagina – up to 5 days
- Anus – 48 hours
- Foreign material on objects (e.g. condom, clothing, rope fragments, fingernails) – no time limit
- Urine (toxicology) 50 ml – up to 5 days
- Blood (toxicology) 2 x 5 ml samples – up to 48 hours in tubes containing sodium fluoride and potassium oxalate
- Hair (scalp hair may be useful if there is concern of covert drug administration)
- Clothing (especially underwear) should be collected if required
- Photographs provide useful adjunct to injury documentation, but should only be taken with consent and respecting privacy, sensitivities and confidentiality
- If sexual assault results in a pregnancy, then consideration should be given to collection of specimens for paternity testing
- Sexual violence should be considered in an autopsy examination. Documentation and specimen collection should be considered in such cases.

Sources: WHO and UNODC. Strengthening the medico-legal response to sexual violence. Geneva: World Health Organization; 2015 (https://iris.who.int/handle/10665/197498).

World Health Organization, United Nations Population Fund & United Nations High Commissioner for Refugees. Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: World Health Organization; 2020 (https://iris.who.int/handle/10665/331535). License: CC BY-NC-SA 3.0 IGO.

Job aid 16a. Post-training action plan

Activity What activities will be needed to reach the goal?	**Desired outcome** What will each activity lead to?	**Resources needed** Space; equipment; material; funds; HR	**Responsible** Person or organization	**Start** Start date	**End** Due date	**Challenges/Notes**
Example (Goal 1): Become confident maintaining eye contact during clinical history while still making accurate, detailed records						
Practise LIVES	Improved survivor satisfaction and uptake	LIVES pocket card	Self	Immediately	Ongoing	Difficulty finding time to discuss safety and facilitate
Identify a social worker or a counsellor who can assist with safety assessments, planning and facilitating social support	Finding time to focus on listening, inquiring about needs and offering validation and ensuring that the survivor gets all aspects of the first-line support (LIVES) intervention	Additional facility staff to task share some aspects of LIVES	Self (with supervisor support)	Initial request by X date	Colleague to be trained by	Only one staff member currently scheduled during overnight hours Arrange for a teleconsultation for patients arriving after hours.

Goal 2:						
Goal 3:						
Goal 4:						

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Email: srhavp@who.int

Website: https://www.who.int/health-topics/violence-against-women

www.who.int