8. Health and Community Services

Sectoral activities

Minimum Prevention and Response Interventions

8.1 Ensure women’s access to basic health services
8.2 Provide sexual violence-related health services
8.3 Provide community-based psychological and social support
**Guidelines for Gender-based Violence Interventions in Humanitarian Settings**

**Background**

In times of crisis, health care services are often severely affected or disrupted. Lack of coordination, overcrowding, security constraints, and competing priorities can contribute to an even greater decrease in available and accessible health services, especially for women and children. Well-functioning and accessible health services also make a difference to women’s ability to reduce risks to their and their children’s health. Being able to protect her own and her family’s health will not only promote women’s general well-being, but it will also contribute to information sharing and community awareness of reproductive health issues, including prevention and response to sexual violence.

Although most survivors/victims of sexual violence do not disclose the abuse to anyone, some will talk with a health provider if health services are physically/geographically accessible, confidential, sensitive, accommodate private consultations, and of good quality. Health centres may serve as a first “neutral” location to provide information and counselling on women’s and girls’ reproductive health. Women may be more able to access this type of information if it is within the context of basic health care, and not provided by specialty or separate programmes.

Services must also be available for immediate assistance to survivors/victims (see also Action Sheet 8.2, Provide sexual violence-related health services) to minimise the harmful consequences of sexual violence. Consequences include severe emotional and physical trauma; unwanted pregnancies; complications of abortions; complications of pregnancy due to trauma or infections; complications of delivery and neonatal problems such as low birth weight, for which emergency obstetric care services need to be put in place.

**Key Actions**

The following actions apply to the health sector; that is, organisations implementing health programmes, including Primary Health Care (PHC). The health sector identifies a focal point who participates regularly in the GBV working group and reports on the sector’s achievement of the key actions. The focal point participates in cross-cutting functions led by the GBV coordinating agencies and working groups, as described in Action Sheets for Coordination, Assessment and monitoring, Human resources, and Information education communication.

1. Implement the Minimum Initial Service Package of reproductive health in emergency situations (MISP). The MISP is a series of actions needed to prevent reproductive health-related morbidity and mortality in the early phase of emergency situations. See Action Sheet 1.3, Ensure Sphere Standards are disseminated and adhered to and the IAWG Inter-Agency Field Manual for Reproductive Health in Refugee Situations, chapter 2. The objectives and activities of the MISP are:
   - Identify an organisation(s) and individual(s) to facilitate the coordination and implementation of the MISP.
   - Prevent and manage the consequences of sexual violence.
   - Reduce HIV transmission by:
     - Enforcing respect for universal precautions against HIV/AIDS
     - Guaranteeing the availability of free condoms.
   - Prevent excess neonatal and maternal morbidity and mortality by:
     - Providing clean delivery kits for use by mothers or birth attendants to promote clean home deliveries
     - Providing midwife delivery kits to facilitate clean and safe deliveries at the health facility
     - Initiating the establishment of a referral system to manage obstetric emergencies.
   - Plan for the provision of comprehensive reproductive health services, integrated into primary health care as the situation permits.

2. Conduct or participate in rapid situational analyses. (See Action Sheet 2.1, conduct coordinated rapid situation analysis.) A rapid analysis of the health services should take place to address the accessibility for women and the availability and capacity of health services to respond to the needs of women. The analysis should include questions related to:

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**ACTION SHEET**

8.1  Ensure women’s access to basic health services

Sector: Health and Community Services

Phase: Minimum Prevention and Response
• The number, location, and health care level of functioning health facilities
• Numbers of health staff at the different levels, disaggregated by sex
• The range of services provided related to reproductive health
• Obstructions to women’s and children’s access to the services, such as issues of discrimination, security, costs, privacy, language, cultural (e.g. need for permission or accompaniment of male relative)
• Known reproductive health indicators and existing challenges to women’s health

3. Ensure health services are accessible to women and children.
   • Make basic health care services available to all affected populations, including refugee, internally displaced, and host populations.
   • Locate health services within walking distance of communities and on safe access roads. (See Action Sheet 7.1, Implement safe site planning and shelter programmes.)
   • Make opening times convenient for women and children (household duties, water and wood collection, school times).
   • Set up a private consultation/examination room for women and girls.
   • Recruit female staff where possible.
   • Provide 24-hour access for complications of pregnancy and sexual violence services.
   • Ensure that all languages in the ethnic sub-groups are represented among health providers or that there are interpreters for each ethnic subgroup.
   • Establish evacuation plans for medical reasons, or mobile clinical services where locally available services cannot provide the needed clinical services.
   • Carefully consider access for girls, taking into consideration cultural issues. For example, girls of a certain age, or unmarried, may not be permitted to participate in reproductive health services, so girls’ presence in those areas of a health centre will be noted and questioned, which prevents anonymity, confidentiality, and access.

4. Motivate and support staff.
   • Ensure all staff are aware of and abide by medical confidentiality. (See Action Sheet 4.2, Disseminate and inform all partners on codes of conduct.)
   • Provide staff at health centres and hospitals with clear protocols and sufficient supplies and equipment.
   • Inform health staff on female genital mutilation, which may affect the health of women and girls, and make protocols available on how to manage health consequences.
   • Put in place an efficient and supportive supervisory system.

5. Involve and inform the community.
   • Involve women in decisions on accessibility and on an appropriate, non-offensive, non-stigmatising name for sexual violence services.
   • Make the community aware of services available at the health centre. (See Action Sheet 10.1, Inform community about sexual violence and the availability of services.)
   • Ensure men’s access to health care and counselling, and provide them with information about women’s reproductive health and about the health risks to the community of sexual violence.

Key Reference Materials

   http://www.rhrc.org/resources/general%5Ffieldtools/iafm_menu.htm


Background

The health care provider’s responsibility is to provide appropriate care to survivors/victims of sexual violence, to record the details of the history, the physical examination, and other relevant information, and, with the person’s consent, to collect any forensic evidence that might be needed in a subsequent investigation. It is not the responsibility of the health care provider to determine whether a person has been raped. That is a legal determination.

Health care services must be ready to respond compassionately to survivors/victims of sexual violence. The health coordinator should ensure that all staff are sensitised to sexual violence and are aware of and abide by medical confidentiality. Health care providers (doctors, medical assistants, nurses, etc.) should establish an agreed-upon protocol for the care of rape survivors/victims, and this protocol should be in line with relevant national protocols and accepted international standards (see key reference materials below). Health care providers must know how to provide care according to established protocols and have the necessary equipment and supplies. For more information and detailed guidance on the actions in this Action Sheet, see Clinical Management of Rape Survivors, Developing protocols for use with refugees and internally displaced persons. (See Key References below.)

Female health care providers should be recruited as a priority, but a lack of trained female health workers should not prevent the provision of services for survivors of rape.

All health care providers must be aware of relevant laws and policies governing health care providers in cases of sexual violence. For example, there may be laws that permit legal abortion in cases of sexual violence. In addition, health care providers will interact with the police in cases where the survivor/victim (or in the case of a child, her family) wishes to pursue legal justice. In many countries, there are police forms that must be completed by the health care provider. Providers need to know how to complete these forms. Some countries have laws mandating health care providers to report cases of sexual violence to police or other authorities. These laws present difficult challenges to the health care providers in terms of medical confidentiality and respect for the survivor’s/victim’s choice if she does not want to pursue legal action and does not want anyone to know about the abuse. When there are mandatory reporting laws in place, many survivors do not disclose sexual violence to health care providers because of fears of public scrutiny.

Another consideration related to legal action is that the health care provider may be required to testify in court about the medical findings observed during the examination. With this in mind, it is often prudent to have a national health care provider conduct the exam because s/he will most likely be available if case comes to court (international staff rotate out more quickly).

Key Actions

Actors in the health sector should develop an agreed-upon protocol for care for survivors/victims of sexual violence. Health care providers in each health service should be trained in the use of the protocol. Activities of the protocol should include the following key actions:

1. Prepare the survivor
   - Before starting a physical examination, prepare the victim/survivor. In sensitive examinations may contribute to the emotional distress of the victim/survivor.
   - Introduce yourself and explain key procedures (e.g. pelvic exam).
   - Ask if she wants to have a specific support person present.
   - Obtain the consent of the victim/survivor or a parent if the victim is a minor.
   - Reassure the victim/survivor that she is in control of the pace of the examination and that she has the right to refuse any aspect of the examination she does not wish to undergo.
   - Explain that the findings are confidential.

2. Perform an examination
   - At the time of physical examination, normalise any somatic symptoms of panic or anxiety, such as dizziness, shortness of breath, palpitations and choking sensations that are medically unexplained (i.e. without organic cause). This means explaining in simple words that these
body sensations are common in people who are very scared after having gone through a very frightening experience, and that they are not due to disease or injury; rather, that they are part of experiencing strong emotions, and will go away over time when emotion becomes less.

• Conduct the medical examination only with the survivor’s consent. It should be compassionate, confidential, systematic, and complete, following an agreed upon protocol.

3. Provide compassionate and confidential treatment as follows

• Treatment of life threatening complications and referral if appropriate
• Treatment or presumptive treatment for STIs
• Post-exposure prophylaxis for HIV (PEP), where appropriate
• Emergency contraception
• Care of wounds
• Supportive counselling (see Action Sheet 8.3, Provide community-based psychological and social support for survivors/victims)
• Discuss immediate safety issues and make a safety plan
• Make referrals, with survivor’s consent, to other services such as social and emotional support, security, shelter, etc. (See Action Sheets 1.1, Establish coordination mechanisms and orient partners; 7.2, Ensure that survivors/victims of sexual violence have safe shelter; 8.3, Provide community-based psychological and social support for survivors/victims.)

4. Collect minimum forensic evidence

• Local legal requirements and laboratory facilities determine if and what evidence should be collected. Health workers should not collect evidence that cannot be processed or that will not be used.
• Counsel the survivor about taking evidence if she may eventually want to take the case to court. Ensure her that the information will only be released to the authorities with her consent.
• For all cases of sexual violence a careful written recording should be kept of all findings of the medical examination that can support the survivor’s story, including the state of her clothes. The medical chart is part of the legal record and can be submitted as evidence if the survivor decides to bring the case to court.
• Keep samples of damaged clothing (only if you can give the survivor replacement clothing) and foreign debris present on her clothes or body, which can support her story.
• If a microscope is available, a trained health care provider or laboratory worker can examine wet-mount slides for the presence of sperm, which proves penetration took place.

5. Checklist of supplies

See page 68.

Key Reference Materials


Checklist of Supplies

<table>
<thead>
<tr>
<th>1. Protocol</th>
<th>Available</th>
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<tbody>
<tr>
<td>• Written medical protocol in language of provider</td>
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<tr>
<th>2. Personnel</th>
<th>Available</th>
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<tbody>
<tr>
<td>• Trained (local) health care professionals (on call 24 hours a day)</td>
<td></td>
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<tr>
<td>• A “same language” female health worker or companion in the room during examination</td>
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<tr>
<th>3. Furniture/Setting</th>
<th>Available</th>
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<tbody>
<tr>
<td>• Room (private, quiet, accessible, with access to a toilet or latrine)</td>
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<td>• Examination table</td>
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<td>• Light, preferably fixed (a torch may be threatening for children)</td>
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<tr>
<td>• Access to an autoclave to sterilise equipment</td>
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<thead>
<tr>
<th>4. Supplies</th>
<th>Available</th>
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<tbody>
<tr>
<td>• “Rape Kit” for collection of forensic evidence, including:</td>
<td></td>
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<tr>
<td>✓ Speculum</td>
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<tr>
<td>✓ Tape measure for measuring the size of bruises, lacerations, etc.</td>
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<tr>
<td>✓ Paper bags for collection of evidence</td>
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<tr>
<td>✓ Paper tape for sealing and labeling</td>
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<tr>
<td>• Set of replacement clothes</td>
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<tr>
<td>• Resuscitation equipment for anaphylactic reactions</td>
<td></td>
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<tr>
<td>• Sterile medical instruments (kit) for repair of tears, and suture material</td>
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<tr>
<td>• Needles, syringes</td>
<td></td>
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<tr>
<td>• Cover (gown, cloth, sheet) to cover the survivor during the examination</td>
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<tr>
<td>• Sanitary supplies (pads or local cloths)</td>
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<tr>
<th>5. Drugs</th>
<th>Available</th>
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<tr>
<td>• For treatment of STIs as per country protocol</td>
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<td>• PEP drugs, where appropriate</td>
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<tr>
<td>• Emergency contraceptive pills and/or IUD</td>
<td></td>
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<tr>
<td>• For pain relief (e.g. paracetamol)</td>
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<tr>
<td>• Local anaesthetic for suturing</td>
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<tr>
<td>• Antibiotics for wound care</td>
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<tr>
<th>6. Administrative supplies</th>
<th>Available</th>
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</thead>
<tbody>
<tr>
<td>• Medical chart with pictograms</td>
<td></td>
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<tr>
<td>• Consent forms</td>
<td></td>
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<tr>
<td>• Information pamphlets for post-rape care (for survivor)</td>
<td></td>
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<tr>
<td>• Safe, locked filing space to keep confidential records</td>
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Background

Sexual violence involves physical and psychological trauma. Survivors/victims may experience an array of psychological consequences, such as sadness and depression; self-blame; somatic distress; sexual problems; mood swings, anger and anxiety-related problems (sleeplessness, fearfulness, stress, and fear of “going crazy”). For most survivors, these experiences are normal emotional responses to trauma. Especially with social and emotional support, many survivors learn to cope and the distress decreases over time.

In some cases, the survivor/victim may experience intense psychological distress and dysfunction suggesting mental disorder. These women should be referred to a health provider for evaluation and treatment.

There are also social consequences. Most societies tend to blame victims of sexual violence. Social stigma, isolation, and rejection — including by husbands and families — are serious consequences, often making emotional recovery difficult due to withdrawal from day-to-day activities and from social support.

Emotional support and/or counselling include confidential and compassionate listening; gentle reassurance that the incident was not the survivor’s fault and that the emotions are normal responses to an extreme event. This type of support can often be made available in communities through existing natural helpers such as TBAs, midwives, and family members (e.g. a sister or aunt). Sometimes religious leaders can play an important role in providing community support for survivors.

Not all survivors/victims need or want emotional support, counselling, or help with social reintegration. Nevertheless, access to psychological and social support must be available, even in early stages of an emergency. This requires:

- Collaboration with family, community, and religious support systems

Key Actions

The following actions apply to the health and community services sectors, that is all organisations implementing health, psychological, and/or social services. The health and community services sectors each identify a focal point who participates regularly in the GBV working group, and reports on the health/community services sectors’ achievement of the key actions in this Action Sheet. The focal points also participate in cross-cutting functions led by the GBV coordinating agencies and working groups, as described in Action Sheets for Coordination, Assessment and monitoring, Human resources, and Information education communication.

1. Identify and mobilise appropriate existing resources in the community, such as TBAs, women’s groups, religious leaders, and community services programmes.

   - Discuss issues of sexual violence, survivors’ needs for emotional support, and evaluate the individuals, groups, and organisations available in the community to ensure they will be supportive, compassionate, non-judgmental, confidential, and respectful to survivors.
   - Establish systems for confidential referrals among and between community-based psychological and social support resources, health and community services, and security and legal sectors as described in Action Sheet 1.1, Establish coordination mechanisms and orient partners.

2. At all health and community services, listen and provide emotional support whenever a survivor discloses or implies that she has experienced sexual violence. Give information, and refer as needed and agreed by the survivor.

   - Listen to the survivor and ask only non-intrusive, relevant, and non-judgmental questions for clarification only. Do not press her for more information than she is ready to give (e.g. do not initiate a single-session psychological debriefing). Note that she may describe the event out of sequence, and details may change
as her emotional state changes. This does not indicate that she is lying but rather that she is emotionally upset.

- If the survivor/victim expresses self-blame, care providers need to gently reassure her that sexual violence is always the fault of the perpetrator and never the fault of the victim/survivor.
- Assess her needs and concerns, giving careful attention to security; ensure that basic needs are met; encourage but do not force company from trusted, significant others; and protect her from further harm. (See Action Sheets 3.2, Provide security in accordance with needs and 8.2, Provide sexual violence-related health services.)
- Ensure safety; assist her in developing a realistic safety plan, if needed. (See Action Sheet 7.2, Ensure that survivors/victims of sexual violence have safe shelter.)
- Give honest and complete information about services and facilities available.
- Do not tell the survivor what to do, or what choices to make. Rather, empower her by helping her problem-solve by clarifying problems, helping her identify ways to cope better, identifying her choices, and evaluating the value and consequences of those choices. Respect her choices and preferences about referral and seeking additional services.
- Discuss and encourage possible positive ways of coping, which may vary with the individual and culture. Stimulate the re-initiation of daily activities. Encourage active participation of the survivor/victim in family and community activities. Teach relaxation techniques. Discourage negative ways of coping; specifically discourage use of alcohol and drugs, because trauma survivors are at high risk of developing substance abuse problems.
- When feasible, raise the support of family members. Families (those who are not the perpetrators) can play a key role in supporting victims/survivors emotionally and practically. For example, they may help victims/survivors to return to usual daily activities (e.g. child care, job, household work, school) after physical recovery of sexual violence. Conversely, families can contribute to increased emotional trauma if they blame the survivor for the abuse, reject her, or are angry at her for speaking about the sexual violence.

3. Address the special needs of children.

- Persons interviewing and assisting child/adolescent survivors should possess basic knowledge of child development and sexual violence.
- Use creative methods (e.g. games, story telling, and drawing) to help put young children at ease and facilitate communication.
- Use age-appropriate language and terms.
- When appropriate, include trusted family members to ensure that the child/adolescent is believed, supported, and assisted in returning to normal life.
- Do not remove children from family care in order to provide treatment (unless it is done to protect from abuse or neglect).
- Never coerce, trick, or restrain a child whom you believe may have experienced sexual violence. Coercion, trickery, and force are often characteristics of the abuse, and “helpers” using those techniques will further harm the child.
- Always be guided by the best interests of the child.

4. [For health care providers only] Regarding psychotropic therapy for adult victims/survivors, provide medication only in exceptional cases. See Chapter 6 of Clinical Management of Survivors of Rape for guidance. Of note, benzodiazepines — which may quickly lead to dependence in trauma survivors — are often over-prescribed. Caution is required.

5. Organise psychological and social support, including social reintegration activities.

- Always adhere to the guiding principles for action:
  - Ensure safety and security.
  - Guarantee confidentiality.
  - Respect the wishes, choices, and dignity of the survivor/victim.
  - Ensure non-discrimination.
  - Any training in psychological support/counselling should be followed by supervision.

- Advocate on behalf of the victim/survivor with relevant health, social, legal, and security agencies if the victim/survivor provides informed consent. When appropriate, organise confidential escorting to any service needed.
- Initiate community dialogues to raise awareness that sexual violence is never the fault of the victim/survivor and to identify solutions to honour killings, communal rejection, and isola-
tion. Collaborate with BCC/IEC efforts in Action Sheet 10.1, Inform community about sexual violence and the availability of services.

• Provide material support as needed via health or other community services.

• Facilitate participation and integration of survivors in the community. This may be done through concrete, purposeful, common interest activities (e.g. aid projects, teaching children) and activities that enhance self-sufficiency.

• Encourage use of appropriate traditional resources. If feasible, collaborate with traditional healers or clergy, who, respectively, may conduct meaningful cleansing ceremonies or prayer for sexual violence survivors/victims. Many such practices can be extremely beneficial; however, ensure that they do not perpetuate blaming-the-victim or otherwise contribute to further harm to the survivor/victim.

• Link with other sectors. Additional key community social support actions are covered in action sheets for Coordination, Protection; Shelter, Site planning and non-food items; and Behaviour change communication/information, education, and communication.

Key Reference Materials


