CARE FOR VICTIMS OF SEXUAL VIOLENCE

- SITUATION WITH DISPLACEMENT OF POPULATION -

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INTRO

This pocket guide, conceived on the model of a "quick start manual" is part of a series dedicated to the activities to implement in the first phase of an emergency (0 to 3 months) with displacement of population.

It has the advantage of being short, simple and light (in your pocket)... and thus does not contain all the details.... which you will find in the different guidelines quoted in the pocket guide.

You consulted the guidelines and still do not have the information you are looking for? Do not hesitate to ask advise to your field coordinator and/or medical or technical coordinator.

There are technical sheets linked to this pocket guide. These technical sheets will facilitate you the implementation of the various activities. They are available on the DVD “Mémentos Urgence-Pocket Guide Emergency – MSF OCB” in the folder “Sexual Violence” and on the DVD “Sexual and Reproductive Health – MSF International”

On the DVD you will also find a library. Most books and documents cited in the chapter "References" are there in the file “Sexual Violence”!

Your Comments

…are more then welcome.

You do not see how to use one or the other sheet... perhaps because the sheet is badly designed or the insufficient explanations... your comments will help us to improve the tool.

You were confronted with particular situations which led you to adapt the strategy, you have tricks and easy ways, documents or comments which could enrich the next version of this DVD? Do not hesitate to contact us so that we can share your experience with everybody.

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# TABLE OF CONTENTS

Health care provided by MSF must imperatively and immediately include medical care for victims of sexual violence

- General Objective
- Specific Objectives
- Population at risk

## Prevention of sexual violence

- Objective
- Analysis of the situation
- Analysis of incidents
- Intervention

## Identification of sexual violence

- Objective
- Break the silence
- Inform on our offer of care
- Making the victims’ request for care easier
- Recognizing victims of sexual violence

## Medical intervention

- Objective
- Be prepared to receive victims of sexual violence
- Reception of a victim sexual violence
- How to conduct the medical interview
- How to conduct the medical examination
- Medico-legal evidences
- Completion of a medical certificate
- Treatment
- Psychosocial support
- Emergency social aid
- Follow-up
- Protection

## Testimonage

## References

## List of technical sheets on the DVD
Health care provided by MSF in refugee or displaced persons camp must imperatively and immediately include medical care for victims of sexual violence

- Refugees and displaced persons are particularly vulnerable to sexual violence throughout the period in which they live as refugees or displaced persons.
- Rape (which is only one of the many forms of sexual violence) requires urgent appropriate care.

→ Sheet : n°1 – Sexual violence in armed conflicts and population displacements
  n°2 – Definition and types of sexual violence

General objective

- To provide appropriate psycho-medico-social care for the victims of sexual violence, particularly for rape victims since this requires urgent medical attention due to the consequences on the person’s health.
  → Sheet : n°3 – Psycho-medico-social consequences of rape

Specific objectives

- Prevention of sexual violence
- Identification of sexual violence
- Medical treatment
- Testimonage

Population at risk

Sexual violence affects mainly women and girls, particularly when they are alone, in precarious situation,…. Equally it is mainly women and girls who attend consultations; for this reason we shall in all cases identify the victims of sexual violence as female. However, it should be born in mind that in some circumstances (e.g. prisons) men and boys may also be victims of sexual violence.

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1 It must also be part of the package of care provided in all the other contexts where MSF is working, but the pocket guides are written for contexts with displaced persons and refugees
Objective

- To take measures to limit the risk of sexual violence

Actions of prevention aiming to minimise the risk of sexual violence should be based on:

Analysis of the situation

- What are the causes and risk factors
  - The causes and/or risk factors are related to:
    - The person herself *(e.g. a woman on her own and unable to make ends meet)*,
    - The society in which she is living or from which she originates *(legal, religious, cultural reasons)*,
    - The context *(war, migration,…)*,
    - The situation in which the person finds herself *(refugee camp, detention centre…)*
  - The analysis of the situation requires familiarity with the culture and context.

  ➔ Sheet: n° 4 – Non-comprehensive list of the causes and risk factors
  ➔ Sheet: n° 5 - Guideline to gather information on the context and the perception of sexual violence

Analysis of incidents

- Surveillance and data assessment
  - Identify security incidents, factors or risk of sexual violence *(e.g. troops circulating within the camp)*
  - Identify situations in which sexual violence occurs: where, when, who *(e.g. women collecting wood in the forest on their own)*

  ➔ Sheet: n° 6 – Record of security incidents
  ➔ Sheet: n° 7 – Follow-up form of the acts of sexual violence

Intervention comprises 4 constituents:

1. Logistics installations
2. Community Measures
3. Recruitment and supervision of staff
4. Lobbying
1. Logistics installations

1.1. Site planning and shelters

- The site should ideally be located at a reasonable distance from the border, places where rebel troops withdraw, military camps,…or from anywhere else which could be source of insecurity.
- Involve the refugees/displaced persons (men and women) in the site planning, particularly in the location of water and hygiene services.
- Prefer one-family shelters to multi-family or group shelters.
- For people alone (unaccompanied children, elderly women,…) create groups of shelters supervised by a member of the community.
- Provide space for social activities (schools, sports fields, religious centres…)

See also: Pocket Guide “The Priorities”

1.2. Water and Hygiene

- Make sure sanitation facilities are not too far either from the centre, nor from the living quarters.
- Ensure separate showers and toilets for men and women.
- Ensure that toilets and showers can be locked.

See also: Pocket Guide “The Priorities”

1.3. Distribution of food and Non-Food Items (NFI)

- Involve men and women in the distribution of food and NFI.
- By involving the representatives of the refugees and a good information, ensure that general aid distribution does not lead to crises or conflicts which could result in violent attacks on the beneficiaries.
- Ensure safe access to the distribution site.
- Ensure that daily workers do not have access to the goods to be distributed, so that the risk of exchanging aid for sexual favours is minimised

See also :Pocket Guide “ NFI Distribution”

N.B. In most cases MSF is not involved in site planning, provision of shelters and general distribution of food and NFI. However, we need to bear these elements in mind when constructing and organising our health care centres and, if necessary, when lobbying the organisations responsible for this part of the programme.

2. Community measures

Community measures are established in collaboration with:

- Male and female representatives of the refugees/displaced persons
- « Influential » members of the community (schoolteachers, religious leaders,…)
- Male and female representatives of the native population

2.1. Security

- Involve men and women of the community in security questions what specific and pacific steps can be taken by men and/or women to improve security in high-risk areas (e.g. communal collection of wood overseen by a man responsible for security, …)

2.2. Involve the native population

- The native population must be involved in all aspects (location and development of the site, information, security) and should also benefit from the aid services. If this population is not taken into consideration, feelings of frustration may build up, leading to retaliation against the displaced persons/refugees.
3. Recruitment and supervision of staff

3.1. Policy of recruitment in favour of women

- Maintain the ratio of 50% women in both the medical and non-medical field.
- In some areas this ratio will be higher: pre-natal consultations, nutritional centres, … home visitors and community health workers. These women are responsible for providing information on the refugee/displaced person population as a whole, which is comprised of 80% women and children. Only women can provide details of the health of the women in general and of cases of sexual violence in particular.

N.B. In most of our centres of operation, access to education for girls is limited. We naturally tend, therefore, to fill qualified (and often non-qualified) positions with men! The job of home visitor requires only basic knowledge and illiteracy should not be an obstacle: the team can create a collection of data adapted to this type of person.

3.2. Brief the teams on the ethical attitude to adopt with the beneficiary population

- The rules of ethics should be included in the internal rules and regulations. They should also be mentioned in the job descriptions. On engagement, adherence to these rules must be stressed and the fact that breaking these rules will be considered a serious misdemeanour entailing grave consequences depending on the incident (dismissal, legal action,…).

⇒ Sheet : n°8 – MSF ethic

4. Lobbying

The States, the UNHCR (and in some cases also the ICRC) are responsible for the protection of refugees and displaced persons.

4.1. The question of the safety of women should figure regularly on meeting agendas and the following points highlighted:

- Maintain an adequate number of protection officers on the site
- Issue identity documents to reduce the risk of abuse linked to identification checks by the armed forces or police
- Reinforce security measures for high-risk groups
- Train the armed forces and police in matters of respect for the rights of women

4.2. Report security incidents and acts of sexual violence so that the UNHCR and/or the ICRC can improve the protection services

⇒ see also chapter 11 : Protection

4.3. Working in partnership

- With the protection officers of the UNHCR and/or the ICRC as well as the UNHCR supervisors of reproductive health and community activities.
- With the organisations responsible for the organisation and management of the camps.

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1 Home visitors are people responsible for collecting simple data for their area, such as: births, deaths, sick children,... whilst the community health workers’ function is to inform and educate the population on health matters.
IDENTIFICATION OF SEXUAL VIOLENCE

Objective

➢ to facilitate victims’ request for care

Emergency situations, states of war and/or ongoing crises are all associated with a high rate of incidents of sexual violence. And yet, often we do not see the victims, or rarely, in our health care centres. Why?

- In many societies there is a « law of silence » surrounding sexual violence and often the victims themselves refuse to report the assault for fear of reprisals or social stigma.
- Too often the population, and in particular the victims of sexual violence, do not know about the services we offer.
- When victims decide to approach the health centre, they often find it hard to say what has happened to them and may complain of psychosomatic symptoms, for example.

In emergency situations we could:

<table>
<thead>
<tr>
<th></th>
<th>Break the silence</th>
<th>Inform on our offer of care guaranteeing confidentiality and security</th>
<th>Smooth the way for the victims’ request for care</th>
<th>Train ourselves and our health staff to recognise these victims</th>
</tr>
</thead>
</table>

1. Break the silence

We must show and let it be known that we are concerned for the victims of sexual violence and that we can offer them medical help.

This activity is to be carried out in collaboration with:

- home visitors and community health workers
- matron from the community
- male and female representatives of the refugees/displaced persons
- « influential » members of the community (schoolteachers, religious leaders, police,…)
- male and female representatives of the native population

1.1. Awareness of the general population

- men and women (adults and adolescents), refugees/displaced persons, as well as the native population should all be informed of the problem of sexual violence.

1.2. Awareness of the most vulnerable people

- organise information sessions designed specifically for women (with adapted HP material):
  - at ante-natal and/or reproductive health consultations
  - in nutritional centres
  - within existing women’s groups, both within the refugee/displaced persons camps and the native population
  - etc...

N.B. Although access to information may often be difficult, it should not automatically be assumed that the female population will be resistant to any attempt to deal with the problem of sexual violence. In some cases women immediately spread the word about MSF’s proposition, to the utter
amazement of the expatriate teams who were more embarrassed than the victims when raising the subject.

1.3. Awareness of national and expatriate staff

- The first step will, of necessity, consist in a full review of the various cultural and traditional rules which are observed in the operating context so that a common definition of what all understand by sexual violence can be established.

_N.B. The temptation is great (especially among the expatriates) to put it down to « cultural relativism » or explaining sexual violence as a cultural difference, but rape is an act of aggression which is interpreted in sexual terms and is prohibited in the vast majority of the societies in which we are active._

➔ See documents and powerpoint presentations for training on SGBV on the DVD, in the library, folder “sexual violence”, file “training”:

2. Inform on our offer of care

The population must be informed on our offer of care stressing confidentiality. The message must be relayed in a manner appropriate to the context (message via homes visitors, community health workers, the radio, religious or other leaders, brochures, …) and should include the following :

- What services are available
- Why victims of sexual violence should attend the health centre
- Guarantee of the confidentiality
- The importance to come as quickly as possible after the attack
- Where and who to ask for at the health centre
- Accessibility (ideally 24/24h and 7/7 days)
- Free care

➔ Sheet : n°9 – Example of message for the population

3. Making the victims’ request for care easier

3.1. Self-help networks

- Set up groups within the community (women’s groups already existing, or to be set up) and/or appoint key people to increase the number of reference points directing towards the health centre

3.2. Each member of the team must be able to be a referent if it is informed of sexual violence

- To this end, all team members (included the guards who are the first people patients meet at the entrance to the health centre) will receive detailed information in the care to be provided. The risk of victims being stigmatised and the need for total confidentiality are to be stressed.

3.3. Medical staff should encourage requests

- In situations where sexual violence is frequent, members of the medical staff when recording a patient’s medical history during consultation, should question all women using a phrase such as :

  « Because sexual violence is so common, I am questioning all the women I see. Have you, too, been subject to this form of violence?”

3.4. Alternative patient’s circuit

- Design the patient’s circuit so that victims :
  . do not have to explain to many people why they come
  . do not have to wait hours to be received

➔ See also p.14 : 1.7 Organisation of the care
4. Recognizing victims of sexual violence

Medical staff should be trained to recognize the victims of sexual violence who do not mention the aggression during consultation:

- Be alert to signs of physical violence. These may be the result of the actual assault or may caused by subsequent aggression on the part of the family. Male members of a family sometimes assault a woman rape victim on the basis that she is no longer pure.

- Be alert to all physical abrasions (e.g. marks on the wrists of someone who has been held down by force) or symptoms (e.g. STI, adolescent pregnancy, incomplete abortion, fistula…) which may be the result of rape, or other wounds which do not tally with the explanation given by the patient (e.g. the mother who claims that a child is sore between her legs as a result of a fall from a bike?)

- Be alert to vague complaints or chronic symptoms of no apparent physical origin.

- Be alert to the warning signs of psychological problems (sleep problems, loss of appetite,…), and signs of acute or post-traumatic stress.

  ➔ Sheet : n°10 –Psychological reactions to a traumatic incident

- Listen carefully to a person who claims/is claimed to be possessed by evil spirits, or who has been accused, or accuses herself, of having broken a taboo or ancestral rule. Cultural elements, resulting from customs, religious or moral values, can be used as vectors for the expression of mental suffering.
MEDICAL INTERVENTION

Objective

➢ To provide appropriate care as rapidly as possible following the aggression in order to minimise the consequences whilst guaranteeing confidentiality and security.

Stages of treatment:

1. Be prepared to receive victims of sexual violence
2. Reception of a victim of sexual violence
3. How to conduct the medical interview
4. How to conduct the medical examination
5. Medico-legal evidences
6. Completion of a medical certificate
7. Treatment
8. Psychosocial support
9. Emergency social aid
10. Follow-up
11. Protection

1. Be prepared to receive victims of sexual violence

Do not wait for reports of sexual violence in the area, or for a victim at the door of your health center, to be prepared. You should be prepared as soon as possible after your arrival in the location.

Sheet: n° 11 – “Be prepared” : Offering a minimum package of care to victims of sexual violence in 10 steps & The barriers for implementing activities to respond to the needs of victims and how to overcome them.

1.1. Staff recruitment

- Identify a female member of the national staff willing and able to receive and accompany the patients throughout the procedure, and which moreover could be used as interpreter
- Identify a member of the medical staff willing and able to deal with this type of case. In all cases and in whatever the structure in which we are working¹, this person must be a member of MSF staff and in sensitive contexts (political, ethnical) it should be an MSF expatriate.

  Ideally, the doctor should be of the same sex as the victim (N.B. Male victims of sexual violence often prefer to be examined by a woman. Ask each victim whether he/she would prefer to be examined by a male or female clinician). If no female doctor is available, clinicians (mid-wives, clinical officers or nurses) should be able to handle consultations for the female population and establish the medical procedure. If it is really not possible to find a clinician of the appropriate sex, it may be suggested to the patient that she be accompanied by a matron or another person of her choice.

¹ In emergency situation, one will privilege the installation of a MSF structure. However, in certain circumstances, we will have to work in structures of the Ministry of Health.
Ethnical and cultural considerations should also be borne in mind when appointing the clinician.

- Give a clear job description to the staff directly involved in care for victims of sexual violence (medical and psychosocial care providers, health promoter, ...)

1.2. Training of staff involved in care for victims of sexual violence

- All health centre staff (triage, reception, consultation, pharmacy, dressing, ... but also guards, drivers, ...) must receive appropriate training including:
  - confidentiality and the obligation of professional secrecy,
  - trauma and its psychological consequences, and how to approach victims in such a way that they feel reassured and comforted,
  - the « alternative circuit » (see below, point 1.7) which must ensure that victims are seen quickly, avoiding stigma.

- Training should be adapted to the terms of reference of each category of staff (receptionist, home visitors, community health workers, matron, clinicians, interpreter, ...) involved in care for victims.

- Additional sessions should be organised if problems arise with the implementation of this activity.

1.3. Data and document confidentiality

- All documents (medical records, medical certificates, ...) must be kept in a safe or securely padlocked trunk, to which only the person in charge of the programme has the key.

- No document (except the medical certificate) should show the victims’ names – use codes.

- No information or document may be disclosed without the victim’s consent and authorisation of the medical coordinator.

1.4. Medical equipment and drugs

- Make sure all the necessary equipment, drugs and vaccines are to hand (e.g. a kit ready in a box) – Don’t forget drugs for CHILDREN.

- The equipment and drugs must be available at the place of consultation (except for vaccines which are to be refrigerated).

1.5. Legal Procedure

- Find out what the legal position is regarding abortion in the case of pregnancy resulting from rape.

- Find out what the legal procedure is if the person wishes to take legal action.

- Have available the names of the reference persons within the organisations able to conduct the victims through the legal process (UNHCR, ICRC, Marie Stopes International, Local NGO, ...)

1.6. Psychosocial support

- Have available offers of psychological and/or social support from national and international organisations as well as women’s groups.

- Set up a referral system for patients to organisations providing adequate psychosocial support.
- In emergency situations, it is highly likely that no suitable support will be available from another organisation. In this case, support must be organised by MSF.

*N.B. All medical staff must be able to provide psychosocial support (not to be confused with therapy) mainly based on listening and empathy. See also chapter 8.*

1.7. Organisation of the care
- To avoid patients being stigmatised and the possible risk of reprisals to which they could be subject, care of rape victims must not take place in a location identifiable as such. Instead, a broader-based programme such as mother and child care, or ANC should include this service,…
- What should the victims say when presenting at the health centre? The “code system” as already been tested in some locations: through the health promotion activities or the home visitors, the message is passed that if someone is victim of sexual violence and wants to see a doctor at the health centre (s)he has just to say “the code”. This code can be “I need to see the psychologist” (*code used in Haiti*) or any other code that will ensure confidentiality.
- To avoid keeping these patients waiting unnecessarily, all women attending “for women’s problems” could, at the triage stage for example, be oriented towards the ANC, whether the problems are related to gynaecology, pregnancy,… or sexual violence. Thereafter, some could be re-directed to general consultation if necessary.

1.8. Setting up a suitable location
- Choose a discreet place which will ensure confidentiality and privacy (*a door which closes, curtains with the windows*).
- All treatment (from reception to follow-up) must be administered in the same place.
- Separate (*with a screen, curtain,…*) the place where the reception and interview take place from the location of the medical examination.
- For children, make the consultation room more child friendly. Add toys, colourful posters,… so that it looks less like a medical consultation room.
- Provide for the patient’s need to wash and change clothes after the examination. Also provide latrines reserved for women close to the place of consultation.

2. Reception of a victim of sexual violence
The way in which a victim of sexual violence is received is crucial:
- If the person is well received, she will feel reassured and confident in the ensuing care and treatment (*medical, psychological, social, legal*) and this will help her recovery.
- If, on the other hand, she is not well received (*in a hurry, by untrained or unavailable staff,…*) she may regard the examinations and treatment as another assault on her person.

How to receive a victim of sexual violence
- **Bear in mind that this may be the one and only interview** (*most victims of rape do not attend consultations, and those who do only come once or twice*). Care must therefore be taken with this first meeting and as much time as needed be devoted to listening, informing, examining, treating, supporting, advising, proceeding at the patient’s own pace.

- **Ideally one person should receive and accompany the patient throughout the procedure**, and this in addition to the clinician who will be in charge of the interview (*in collaboration with the person that received the patient*), and the medical examination. Should the victim so wish, a person of her choice may accompany her throughout.

*N.B. if the person arrives accompanied, take her aside and check with her whether she wishes the companion to be present during the examinations.*
- If the victim is a child: initially the child may be reassured by the presence of a family member. However, once a feeling of trust has been established, try to interview the child alone, particularly if violence is suspected within the family.

- Receive the person without delay in a quiet place (minimise interruptions from outside and the number of people present at the interview).

- Introduce yourself and invite the person to do the same.

- Assure her of the total confidentiality of the care.

- Make sure the person feels safe. If she feels insecure she will not be in a fit psychological state to deal with the interview and the medical examination. She needs to be assured that all necessary steps will be taken to guarantee her safety and that of her children, if necessary (e.g. by hospitalisation, even if there are no medical reasons for it).

  → See also chapter 11 : Protection

- Explain the various stages of the treatment, why each step is important, and how this will help you to give the best care for her by adapting the treatment to her individual situation. Tell her also that you will be taking notes.

- Tell her she may ask questions at any time.

- Explain to the victim that she may choose at any stage to accept or refuse an examination. Throughout the treatment it is her choice whether to continue and her wishes will be respected.

- Make sure the victim is comfortable: ask her whether she is at ease or whether something is bothering her (if so, adjust conditions according to her response); offer her a drink, blanket, handkerchiefs, a chance to wash (after the medical examinations if you intend to collect medico-legal evidence), ...

- Never leave the person alone at any stage of the treatment

- Check regularly on how she is feeling and whether she has any questions.

3. Conducting the medical interview

3.1. How to conduct an interview

A relationship of trust needs to be established by:

- Showing respect
  - The person has suffered an extremely traumatic experience. Her ability to survive the incidence and her courage in seeking medical help merit the health staff’s full respect.
  - The person also probably feels a lack of self-worth, isolation, and rejection by her family circle at the time when she arrives at the health centre. The respect you show her will help in her recovery.

- Not judging her
  - Believe the victim without judging her: the role of the clinician is not to prove that what she says is true, nor whether rape has actually occurred.
  - Neither should health staff judge the person on the basis of her reaction during the assault (no resistance,...) or after the assault (not seeking help,...). Listening with an open-minded and accepting attitude will enable the patient to express herself more freely.
  - Victims often harbour feelings of guilt as to their behaviour, believing that they could have done something to avoid the assault. It is important to stress that sexual
violence is a violation of the person’s rights and that it is the perpetrator who is guilty. When people are paralysed by fear or are unable to escape from the attack, they are reacting in the only way possible for them to the shock of the moment, and their lack of resistance may often save their lives.

- **Guaranteeing confidentiality**
  
  - Assure the person that confidentiality is guaranteed by all persons present (*clinician, interpreter*) and that no information will be released without her authorisation.

- **A empathic attitude**
  
  - Put yourself in the victim’s place and try to understand what she is feeling. N.B. ask the person how she is and what she is feeling ; she may not necessarily feel the same as you would in her situation ; each person reacts differently to a similar incident.

- **Showing patience**
  
  - Do not hassle the person ; on the contrary, let her express herself at her own pace, and show that you are listening.
  - Do not interrupt her but try to keep the interview to the subject, if necessary.
  - Allow for silences (*but not so long that it becomes uncomfortable for the victim*), hesitation, repetition,…

- **Showing quality physical presence**
  
  - Eye contact : always turn your head towards the person and look at her.
  - Body position : sit facing the person, close enough for eye contact but far enough away for her not to feel threatened.

  *N.B. : the acceptability of eye contact and the degree of distance/proximity in interpersonal relations vary greatly from one culture to another. Check with members of your national staff what is the acceptable attitude*

  - Make sure you do not adopt an attitude which is offensive to the culture (*e.g. show the soles of your shoes in Morocco, cross your legs in Sri Lanka,…*).
  - Make sure your non-verbal behaviour corresponds to your verbal behaviour ; beware of uncontrolled mimeticities of disgust, disapproval,…
  - Make gentle movements, use a soft tone of voice without being monotonous, and avoid sudden changes in volume which could perturb the person.
  - Do not touch the person (*e.g. a comforting hand on the shoulder*), because victims of sexual violence often fear physical contact, at least in the early stages following the assault.

- **Attentive and active listening**
  
  - Give the person your full attention and show her you are listening and interested by the quality of your physical presence, as well as by verbal signs (*e.g. “mmm”, “I see”, “Yes”,…*)
  - To encourage the person to carry on talking and to show you are following her train of thought, apply « re-formulation » which means expressing back to the patient the content of what she has said (*in other words, summarising what she said*).
  - Listen carefully to what the person is saying by trying to capture the meaning of her words and phrases, of what she means (*if necessary, check with her that you have understood what she meant*) ; also, observe her body language, the sound of her voice, her movements, expressions, silences,…
  - Do not concentrate solely on understanding the facts, but discern what she is feeling, her sentiments and emotions.

- **An effective questioning**

  There are several types of question, each with a different purpose :
• **Open questions** *(e.g. how are you feeling ?)* encourage free expression. Specifically they allow the person to express her feelings. This type of question should be used wherever possible. However, if the person is not relaxed *(at the beginning of the interview when emotionally charged subjects are raised,...)*, she will find it difficult to respond to this type of question.

• **Open questions with suggested responses** *(e.g. how are you feeling at the moment? Afraid? Angry ? or were you in a state of shock ?)* may help people who find it difficult to respond to open questions.

• **Closed questions** to which the only response is yes or no or responding with facts *(e.g. how old are you ?)* limit self-expression. It is easy to answer these questions and they may therefore be useful in beginning the interview *(to get going)* or when raising emotionally charged subjects. However, these questions should not be used to any great extent or the person will feel she is being submitted to an interrogation.

• **Questions beginning with the word « Why »** *(e.g. why did you do that at that moment ?)* should be avoided as they will often seem like an implied accusation rather than an actual question.

• **Leading questions** which suggest the « right » answer should also be avoided. Don’t say « Are you feeling all right ?», which will lead the person to respond « Yes, I am all right ».
   Rather say « How are you feeling ? », which leaves the person free to choose her response.

- **Accept physical and emotional reactions**
  The reactions of a rape victim may be varied *(agitation, depression,...)*. She may feel fear, anger, helplessness, shame, sadness,... and may express her feelings in tears, shouting, silence, aggression,... all of which may make you uncomfortable. However, you must :
  • Allow the person to express her feelings. *(If, for example, she cries, don’t say « you mustn’t cry » but remain calm and show you are with her ; offer her a handkerchief,...If the person is suspicious or aggressive don’t take it personally ).
  • Reassure the person by explaining that her physical and emotional reactions are normal in view of the trauma she has suffered.

  ➔ **Sheet : n°14 – Attitudes to adopt towards the feelings expressed by patients**

- **Adjust your attitude according to the characteristics of the victim.**
  Dealing with children, adolescents or male victims of sexual violence is often more complex and your attitude needs to be appropriate to each individual case.

  ➔ **Sheet : n°15 – Helping children, adolescents, and male victims of sexual violence**

3.2. Before beginning the interview

- Explain the objective of the interview *(importance of understanding the circumstances of the assault in order to provide appropriate treatment).*
- Remind the victim of sexual violence that she has the right to terminate the interview at any time.
- If the person refuses to talk about the assault, don’t pressurise her but explain that the health staff will always be available if she wants to talk at a later date.
- Study any papers the victim may give you *(particularly if she has come from a police station or another organisation)* to avoid asking questions which have already been recorded.

3.3. The interview

**Objective of the interview:**

- To understand, as accurately as possible, what has happened in order to assess the physical and psychological trauma suffered during the assault.
- To assess the psychological state of the victim.

**Recording general information.**
- This may be a way of « getting things going » for the victim, as she is not immediately faced with distressing questions, but simple facts. It is one way of establishing a relationship of trust which is crucial to the remainder of the interview. Do not neglect this stage by going through it like an official in an administration department, for example!

**Description of the facts**
- Ask the victim to describe exactly what happened.
- When the victim has given her account, explain to her that you need to know in detail what happened so that you can assess possible physical damage, which is why you need to ask some more specific questions. This is the time to reassure her that everything said during the interview will be strictly confidential.
- If the victim does not reply to a question or is clearly ill-at-ease, do not persist. On the contrary, reassure her by saying you understand how difficult it is to talk about such a painful experience and that she is not obliged to answer all the questions if she feels uncomfortable with them.

**Medical history**
- Seek the complaints of the person during and after the aggression (*abdominal, vaginal pain, burning on urination,…*).
- Question the victim on :
  - Her medical, surgical, gynaecological history,…
  - The form of contraception used
  - Her previous vaccination (*tetanus, hepatitis B*)
  - Known allergies
  - Consumption of alcohol, drug, medication (*before, during, after the assault,…*)
  - Etc….

⇒ **Sheet : n° 16 –Medical History and examination form**

**Psychological assessment**
- Look for signs of acute or post traumatic stress
- Look for signs of associated disorders
- Observe her behaviour .
- Ask about previous psychiatric history : does the patient take psychotropic drugs which may affect her appearance and/or behaviour?

⇒ **Sheet : n°10 – Psychological reactions to a traumatic incident**

### 4. Conducting the medical examination

To conduct this type of examination (more specifically a vaginal examination to see, for ex. if a penetration has taken place) is not easy. That’s why, we strongly advice you to be trained on this type of examination

#### 4.1. Objective of the medical examination
- To assess the type, extent and severity of the injuries in order to provide the appropriate care.
- To produce a medical certificate.
- If required, to collect medico-legal proof.
4.2. Code of conduct

- No examination should be carried out without the express agreement of the victim of sexual violence, whether child or adult. (n.b. The consent of the victim should not be necessarily in writing. To require a written agreement may add a psychological barrier or be simply unfeasible as we often work in contexts where the illiteracy rate is quite high)

→ See example of consent form in sheet n°21

- The person must be prepared for the medical examination, by explaining the procedure and its importance, stressing that she may ask questions and halt the examination at any time.
- Always explain at each stage, what is going to be done and ask her permission before proceeding.
- Respect the person’s modesty by only partially uncovering her through each stage of the examination.
- Be gentle at all times
- Be careful not to ask the person to adopt a position which could remind her of the assault.
- Reassure the person on her physical integrity, explaining the reasons for the pain and assuring her of her recovery, without giving her false hopes (« your pain in the arm is caused by bruising and will disappear in a few days, etc… »).
- Record all the results and observations in a as clear and exhaustive way as possible on the medical history and examination form. The location and size of the wounds will be indicated on the pictograms.

4.3. The examination

The composition of the physical examination will depend on how promptly the victim has attended the health centre (See detailed medical examination procedure on sheet 17).

4.3.1. The victim arrives less than a week after the assault

- Always look at the patient before you touch her, and note her appearance and mental state.
- Begin the examination with the vital signs (pulse, blood pressure, respiratory rate and temperature). This initial assessment may reveal serious medical complications which require urgent treatment and indicate hospitalisation.
- Physical examination:
  - Examine minutely and systematically the patient’s body
  - Look for signs that are consistent with the victim’s story (bites, punches, signs of restraint on her wrists,…)
- Examine the genital area, anus and rectum: An examination of the genital area is necessary to establish the extent of the injuries. This examination must be carried out according to the characteristics of the patient (see sheet 17). Depending on how the examination is carried out, it might be seen by the patient as a recognition of the assault and thus partially help her physical recovery; or on the other hand, it might be a reminder of the assault she has suffered.
  - Bear in mind that even when the examination takes place immediately following the rape, identifiable injuries are visible only in less than 50% of cases.
  - The examination should always be carried out wearing gloves (universal precautions).

4.3.2. The victim comes to the health centre more than one week following the assault

- Physical examination: If the victim complains of certain symptoms, a full medical examination is carried out as at 4.3.1.
- Examination of the genital area: If the assault occurred more than a week previously and the victim shows no signs of bruising or laceration or symptoms (e.g. vaginal/anal discharge or ulcers), a genital examination is not indicated.
However, the victim may feel that she has been wounded. In this case, a detailed examination will reassure the victim that she has no physical injuries which will give her psychological relief.

Sheet : n° 16 – Medical history and examination for m
Sheet : n° 17 – Protocol of medical examination
Sheet : n° 18 – Pictograms

5. Medico-legal evidences

5.1. Objectives
- To confirm a recent sexual contact
- Proof of the use of force or constraint
- Confirmation of the facts stated by the victim of sexual violence
- Possible identification of the perpetrator

In an emergency, the conditions required for obtaining samples will rarely be met. However, in all cases it is possible to obtain a minimum of proofs confirming the facts stated by the person:

- Record the person’s story in a medical file
- Note your observations during the clinical examination
- Complete a medical certificate

If, in your context, it is possible to obtain more specific medico-legal evidences, refer to sheet 19

Sheet : n° 19 – Procedure for obtaining medico-legal evidences

6. Completing a medico-legal certificate

- The medico-legal certificate is obligatory for the clinician and a right of the victim.
- It is covered by medical secrecy: it is personal and confidential.
- It is the only document which may help to prove the offence. The victim must be able to assert her rights before a national or international tribunal (so that the perpetrator can be convicted and/or the victim gets financial compensation).
- It can help the victim to get refugee status

Completing a medical certificate takes time and adds a further constraint in the achievement of the medical humanitarian mission. Further, many doctors are not used to deal with these formalities. As a result, various excuses are often given for not providing the victims with these certificates.

Sheet : n° 20 – The need for establishing a medico-legal certificates whatever the context

6.1. How to produce a medico-legal certificate?

- The medical certificate must conform to the laws in force in the country (format, person qualified to produce it, ...). However, in some contexts these conditions may not be available (in time of war, collapse of the State, ...). If this is the case, use the standard form on sheet 21 (which can be adapted if necessary) adhering closely to the rules. The legality of MSF’s medical certificates has been accepted by tribunals in many countries in which they have been used by victims.

Sheet : n° 21 – Protocol for filling out, handling and storage of medical legal certificates for victims of sexual violence

6.2. The person to whom the medico-legal certificate should be submitted

The certificates must be drawn up in duplicate (= 2 originals should be made, both signed by the medical practitioner who performed the medical examination).
- **One copy goes to the victim.**
  In some situations it may be inadvisable or even dangerous for the victim to keep the medical certificate on her person. In any case it is up to the victim to decide whether she wishes to receive a medical certificate. If not, the two copies should be filed together in the archives.

- **Another copy will be sent to headquarter in Brussels and will be used at a later date to authenticate the certificate delivered to the victim.** This copy should be kept on file throughout the period in which the person has the right to lodge a complaint. Find out from the national legal department low long this period would be *(normally over 10 years).*

  *N.B. If the assault can be considered to be a war crime or a crime against humanity, and if the assault occurred in a country signed up to the Rome Statute on the International Penal Tribunal or by an assailant who is a national of one of the signatory countries of this Statute, and so long as the crime was committed subsequent to the signature of the country in question, the crime will be considered “imprescriptible”, meaning that the person may lodge her complaint at any time up until her death.*

  → **Sheet : n°21 – Protocol for filling out, handling and storage of medical legal certificates for victims of sexual violence**

### 7. Treatment

#### 7.1. Objectives

- To treat injuries caused by the assault.
- To prevent the risk of tetanus infection.
- To prevent and/or treat incidences of sexually transmitted infections: mainly HIV, hepatitis B, gonorrhoea, chlamydia, syphilis, cancroids and trichonomiasis.
- To prevent a possible pregnancy through emergency contraception.
- To ensure a termination of pregnancy on request, if necessary.
- To treat pain.
- Pharmacological treatment of psychological disorders.

Some victims turn up a long time after the assault. This may vary from a few days to a few weeks, or even years after the incident. It may be because no suitable care service was available at the time of the assault, or from fear, or shame,…

Medical and psychological care is important both for those arriving immediately following the assault and for those coming a long time afterwards. However, care will be adapted according to the time when the patient attends.

→ **Sheet : n°22 – Summary table of the psycho-medico-social care**

#### 7.2. Treatment of injuries

- Clean lacerations, cuts and abrasions with 0,9% sodium chloride, starting with those that are cleanest and gradually progressing to the dirtiest
- Remove dirt and any faecal matter as well dead or damaged tissue.
- Check whether cuts should be stitched.
- Stitch clean cuts within max. 24 hours. After this time, they should heal by secondary cicatrization or a delayed primary suturing.
- Do not stitch very dirty cuts.
- In the presence of badly contaminated cuts, administer antibiotics; if pain is present give analgesics.

→ **Sheet “Medical Protocol for Sexual Violence, p.20”**

→ **N.B. On the DVD, in the library, folder “Sexual Violence”, file “General Guidelines MSF” you will find the Medical Protocols in 4 languages: English, French, Spanish and Arabic**
7.3. Treating pain

- In all cases you must be concerned by the pain felt by the patient and remember that:
  - Pain is a subjective sensation and will be expressed in various ways depending on the patient, her age and her culture
  - Unless totally impossible, only the patient can assess the intensity of her pain.

- Treatment will depend on the type and intensity of the pain. It may be both etiologic and symptomatic when a curable cause is found; it will be only symptomatic in other cases.

See Clinical Guideline – MSF - 2010

7.4. HIV Prophylaxis

Post-Exposure Prophylaxis and counselling maximum 72 hours after the assault.

Risk assessment

The decision to propose PEP must be based first of all on the risk related to the nature of the exposure, and not on the risk of the rapist being HIV positive.

See Sheet “Medical Protocol for Sexual Violence – p.3-4”

Proposing PEP to the patient

The information provided to the person concerned must cover:
- The risk of HIV transmission and the potential benefits of PEP.
- The treatment: duration, possible side effects, the importance of complying with the treatment even if side effects are present.

### Important

The prescription of PEP cannot be excluded in cases involving displaced populations or transit camps on the pretext that optimal monitoring of conformity to the treatment cannot be ensured. In fact, these situations usually generate floods of incidents of sexual violence and, require a specific response more than any other situation.

The PEP prescription must never be conditional on agreement to the performance of an HIV test.

The person decides to accept the PEP:

- refer to the PEP protocol.

  *N.B. For refugee/displaced populations, do not hesitate to give full treatment at the first consultation because the risk they won’t come back is higher than this risk with a “normal” population. Of course this should be done with good explanation and you still should give an appointment for a next consultation.*

The person decides not to accept the PEP:

- invite the person for a second consultation 24 hours later; so long as this is within the timescale of 72 hours post-exposure.

  *In all cases the patient should be at least be informed of the risk of infection and the high risk of transmission linked with a primo-infection. The use of condoms should be recommended.*

See Sheet: “Medical Protocol for Sexual Violence – p.5-6”

HIV Test

In an emergency situation an HIV test should not be suggested to the person for the following reasons:
- Risk of discovery a previous HIV positive status at a time of great emotional distress
- **Impossibility of providing a confirmation test.**
- Taking PEP will not affect the efficiency of further treatments in an already HIV positive patient and poses no problem.

If the emergency occurs in a place in which we have a programme for taking care of HIV patients, and referral of this person to the programme is possible, an HIV test could be suggested, but:

- The test should not under any circumstances delay the PEP treatment *(which would be interrupted if the HIV test is positive and replaced by a classic HIV treatment).*
- Depending on the emotional/psychological state of the person, it might be better not to suggest the test at the first consultation but raise the subject at the second or third consultation.

### 7.5. Emergency Contraception

**Maximum 120 hours after the assault**

Emergency contraception must be automatic for all women of childbearing age *(from the onset of puberty, first period)* if they were not already pregnant prior to the assault

⇒ *Sheet:* “Medical Protocol for Sexual Violence – p.9-10”

**There are 2 regimes of emergency contraception**

- **Emergency Contraceptive Pill**: ECP regimens are highly effective if taken within 72 hours. These may be administered between 72 and 120 hours after sexual intercourse but efficacy decreases with time. If ECP is not available we can also give high dosages of regular contraceptive pill.
- **Intrauterine Contraceptive Devices**: Insertion of an IUD becomes effective immediately after insertion. It is highly effective in preventing a pregnancy if the patient presents within five days after unprotected sex. But as it present contra-indications, especially in case of sexual violence, it only should be used if ECP is not available.

**Advice to the patient**

In all cases, a family planning method should be suggested. After a sexual aggression, the patient needs time to recover psychologically. A premature pregnancy could destabilise her further and delay her return to physical, sexual and psychological integrity.

**Detection of an existing pregnancy**

If a pregnancy is detected within 120 hours of the assault, the patient must be informed that:

- This pregnancy could in no way be the result of the assault *(pregnancy can only be detected minimum 2 weeks after insemination).*
- The follow-up must be attentive to avoid the complications which could result from the rape


**More than 120 hours after the assault**

Emergency contraception is no longer effective after 120 hours.

**Assessment of the gynaecological condition of the patient**

At this stage the gynaecological status of the patient must be evaluated in order to discover a possible pregnancy. If pregnancy is confirmed you need to try to ascertain the date of conception. Once this is established, the patient needs, with the help of the clinician, to decide what action she wishes to take as regards this pregnancy.

Several options are possible:
- **The patient wishes to keep the baby**
  Pre-natal care will be carried out at normal pre-natal consultations. Particular attention must be paid to the risk of complications linked to any possible sequels of the assault.

- **The patient does not wish to keep the baby neither to interrupt the pregnancy**
  Ensure pregnancy follow-up, put the patient in touch with an organisation (religious, women’s group, NGO, orphanage) with a view to later adoption.

- **The patient wishes to abort and abortion is legal in the country**
  Ensure safe abortion is carried out according to the national medical protocols.

- **The patient wishes to abort but it is illegal in the country**
  First of all you must ascertain what precisely is laid down in the law. Although abortion may be illegal in some countries, it may be permitted in certain special cases:
  - If there is an immediate threat to the mother’s life
  - If the mother’s physical or mental health is at risk
  - If the pregnancy is a result of rape or incest

  ➔ See, in the library on the DVD, folder “Sexual Violence”, file "context": Country fact sheets reproductive health.

If it is really impossible to classify the patient in a category for legal abortion, the procedure for each individual case should be discussed with the medical coordinator, bearing in mind MSF’s policy:

```
Resolution of the MSF International Council – 21 November 2004

• The provision of reproductive health care is essential to all MSF general medicine programmes
• In spite of recent progress and efforts, this care is still rarely available to patients in MSF programmes
• **The availability of safe abortion should be integrated as a part of reproductive health care in all contexts when it is relevant**
• MSF’s role in termination of pregnancy must be based on the medical and human needs of our patients
• Care providers who, because of their own convictions, cannot perform an abortion, should assure proper referral without judging the woman’s decision or trying to make her change her mind.
```

In countries in which the national legal system has broken down (armed conflict,…), international human law comes into force. This legislation will protect doctors performing medical interventions according to medical deontology and in the patients’ best interests.

**In all cases appropriate psychological support must be provided**


### 7.6. STI prophylaxis

STIs increase the risk of HIV transmission. The particular feature of STIs, especially gonorrhoea and Chlamydia, is that they are asymptomatic in more than 60% of cases among women, compared with 10% among men. The risk that victims of sexual violence are infected with an STI due to the rape is very real.

For these reasons all rape victims are to be given:

➔ **Automatic treatment for Chlamydia, Gonorrhoea, Syphilis, Cancroids and Trichomoniasis**

7.7. Tetanus prophylaxis

The risk of tetanus infection depends on the nature and violence of the assault. However, within the specific framework of a rape, maximum protection against tetanus infection must be ensured.

➔ Automatic vaccination in cases where the vaccination status is unknown or incomplete

In addition, where there are open wounds, you need to assess whether it is necessary to administer human tetanus immunoglobulin.

If the patient arrives some time after the assault, vaccination will have no effect on an illness contracted during the rape. We do recommend, however, vaccinating the person against tetanus, as it may have a beneficial effect on her future health, even if the complete calendar of vaccination can not be guaranteed, since the two first doses provide nearly 80% protection.

➔ Sheet : “Medical Protocol for Sexual Violence – p.16-17”

7.8. Hepatitis B prophylaxis

Hepatitis B is a viral hepatitis. The hepatitis B virus is disseminated throughout the world with prevalence varying from one country to another. Transmission in adults is usually via blood or through sexual relations. Hepatitis B is also transmitted from mother to child.

The risk of contamination by hepatitis B is significantly higher than contamination by HIV.

➔ Automatic vaccination in cases where the vaccine status is unknown or incomplete

Vaccination should be administered as soon as possible after the assault. However, it can be effective on a disease contracted during the rape if administered no more than 3 months after the assault.

If the person arrives more than 3 months after the assault, we still recommend vaccinating her against hepatitis B as it may have a beneficial effect on her future health, and this if the chance that we can complete vaccination is good and resources (vaccines) to do so are not scarce.


7.9. Pharmacological treatment of psychological disorders

In some severe cases, pharmacological treatment may be needed in conjunction with psychological care (see chapter 8 below).

N.B.:

- Certain symptoms (anxiety, depression,…) are common in the early stages following a trauma, a bereavement, a loss and do not necessarily require treatment but may be alleviated through supporting interviews.

- In all cases, medicinal treatment is only one part of the overall care, which must include other therapies: listening, supporting interviews, bearing in mind social factors.

And faced with apparently psychiatric symptoms, remember to:

- Eliminate a possible organic infection (e.g. hypoglycaemia can cause a state of agitation,…)

- The use of toxic substances: Intoxication by, or withdrawal from, some drugs can cause symptoms which seem psychiatric in origin.

- Coded cultural manifestations: the behaviour may seem pathological but may be quite usual in a given culture.

➔ Sheet : n°23 – Protocol for psycho-pharmacological treatment
8. Psychosocial support

Objective

- To aid the process of psycho-social recovery

Psychological care begins in the first few minutes of reception and should continue for as long as the victim wishes it.

Whether or not a psychologist is present in the team, appropriate psychosocial support must be provided adapted to the victims’ situation and/or referral to other organisations who can provide assistance be suggested.

8.1. Psychosocial support organised by MSF

In an emergency, it is highly likely that no adequate psychosocial support can be provided by another organisation (MSF being often the only organisation present at the outset of the crisis). In this case, MSF must organise this care.

All medical staff should be able to provide psychosocial support for a victim of sexual violence, but also for victims of other types of violence (war wounded,…) as well as patients in distress (refugees who have lost everything, women whose husbands have been killed, abandoned children,…) because psychological well-being is part of good health.

In the case of sexual violence, psychosocial support for the victims is all the more important since the consequences of these assaults on their mental health are serious and persistent if no support is provided. In addition victims of sexual violence often receive no support from their families (they may even be isolated and/or rejected) compared with victims of bereavement, for example.

Are we up to it?

Words beginning with “psy” often frighten medical staff who are not psy. Their fear comes from a lack of knowledge of this field, and the fear of being swamped by the person’s feelings and/or problems without knowing how to react and being unable to give an immediate technical answer, etc.…. 

How do we break through this barrier?

Inexperience: psychosocial support must not be confused with therapy. It is not a matter of “curing” someone with sophisticated therapy, but accompanying her/him through an extremely difficult time in her/his life. This consists simply in listening to them with respect and empathy, just as you did during the medical interview (see. 3.1. How to conduct an interview)

Fear of being overwhelmed by the person’s emotions: We are all uncomfortable when someone expresses their intense feelings (often also compared to our own emotions). Our uneasiness comes from the fact that we do not know what to do to stop it. But should it be stopped? We all know how good it feels to “let it all out”, to cry or yell blue murder when everything has gone wrong! Or, on the other hand, how unexpressed emotions can eat away inside us for days, weeks or months… The best reaction is to allow these emotions to come out, staying attentive and showing respect and empathy. We may also reassure the person that her emotions/reactions are quite normal following such an assault.

We may also all on occasion (even the psy’s) feel fragile (tired…) or find it more difficult to bear every day all this sufferings. For this reason, it is useful to share our work experiences regularly with a team member who is not involved in the situation.

Fear of not being able to give an immediate technical response: Apart from a few concrete actions which you may adopt (emergency social assistance, protective measures), your best immediate technical response is: psychosocial support! Indeed, listening to someone with respect and empathy may not be as “visible” as stitching a wound, but it is just as “miraculous” in that it shows the difference between the “before” and the “after”.
Who should provide this psychosocial support?

Ideally the clinician who has examined the patient: as mentioned in point 2 (Reception of a victim of sexual violence), only one person should handle the whole procedure so as to establish a relationship of trust.

If this is not possible, appoint a member of the national or expatriate staff who is willing to assume this task. In this case, the rules are the same as for the choice of clinician, i.e.:
- Someone of the same sex as the victim (if necessary accompanied by an interpreter also of the same sex as the victim)
- A member of MSF staff (whatever the context in which we are working), and, in sensitive situations (political, ethnical,…), this person should be an MSF expatriate.

If the need is huge (numerous cases of sexual violence), do not hesitate to ask headquarters for help (an expatriate psy position to ensure psychosocial follow-up or to train a member of the national or expatriate staff).

When should psychosocial support be provided?

At each follow-up consultation (see chapter 10: Follow up) and more often, if necessary, depending on the needs and wishes of the victim. Always stress to the person that she is free to come:
- More often
- Less often
- When she likes

8.2. Psychosocial support in partnership with another organisation

If national or international organisations are present in the area and provide adequate psychosocial support, it may be possible to refer our patients to these organisations.

N.B.: Referral does not simply mean “providing an address”. You should accompany the patient on her first visit to the new service. Neither does referral mean “handing over” the patient. If she returns to see you, even though you have referred her to another service, it means she trusts you and you must therefore continue to give her psychosocial support.

How do you assess the adequacy of the service provided by another organisation?

It is obviously difficult to assess the quality of the interviews and/or therapy provided. It is, however, possible to check on some aspects, such as team training, methods used,…and also check with other known actors present in the area as to the credibility of the organisation.

Establish a system of referral

Once one or more organisations providing adequate psychosocial support have been identified, you need to establish a system of referral. Ideally, either you accompany the patient on her first visit to the new organisation, or a member of the organisation comes to the health centre for the first interview.

9. Emergency social assistance

In some cases the victim may have fled, taking nothing with her, and with only the torn or soiled clothes she has on her back. She may also be without stocks of food, belongings, a roof over her head,… She must then receive immediate practical material assistance (possibly with the help of other organisations handling distribution and/or protection).
10. Follow-up

Objectives

- Assess the efficiency of the treatment given
- Look for signs and symptoms of pregnancy in case emergency contraception has failed
- Propose an HIV test if conditions warrant it (*confirmation test, pre- and post-test counselling, treatment available*).
- Evaluate the impact of the attack on the psychological state of the victim
- Evaluate the cicatrisation of lesions
- Propose legal proceedings in regard to the attack
- Update vaccination
- Ensure psychological follow-up

Each follow-up must be individualized and meet the patient’s needs. A minimum of 3 visits should be suggested, based on the timetable on sheet 26, stressing that the person may attend:

- More often
- Less often
- When she likes

Follow-up may take place at the health centre or at the victim’s home – whichever she chooses. In all cases, you must ensure no stigma is attached and that the support does not invade the victim’s private life.

→ Sheet : n°26 – Timetable for follow-up of victims of sexual violence

Frequently, the victim will not attend the follow-up consultations fixed during the first visit. It is therefore important that during this first visit (s)he should be given all the advice and explanations necessary for her/him to understand the importance of the follow-up visits. The patient should also be given an information sheet outlining the important points in regard to follow-up and treatment so that (s)he understands what to do or check even if (s)he was confused or not able to capture all that was happening to her/him at the first visit. In areas where illiteracy is the norm, the message should be transmitted orally to the victim and to a person of trust chosen by the victim, since she is often stressed and in no fit state to remember all the information given to her during the first consultation.

→ Sheet : n°27 – Example of message to be given at first consultation

All aspects of the follow-up (*medical, psychosocial, legal,.....*) will be conducted at the same time to prevent the person should come to often

Legal proceedings

Legal proceedings should only be suggested if a reliable legal system exists which would make a legal procedure possible.

In most cases, victims do not wish to lodge a complaint:

- For fear of social stigma,
- Because police forces, if they exist, may have the reputation of being guilty of sexual assault themselves,
- Because the procedure is not normally confidential,
- Because in most countries, lodging a complaint before a tribunal is expensive
- Because the « legal system » is often reluctant to consider rape as a crime,
- Etc....

In all cases, seek the advice of reference persons within the UNHCR and/or ICRC who could then accompany the person throughout the legal stages if she wishes to pursue the matter legally.
11. Protection

11.1. Objective

- To help the victim which feels in danger to be put in safety.

Conditions for the victim’s security need to be determined with her, and the most suitable solution found for her particular situation, depending on the environment and possibilities. MSF should never decide for the victim to appeal to the UNHCR, ICRC or other organisations. The victim alone must decide when and how she wishes to be helped.

N.B. : if the victim is a child or an adolescent, and the assailant a member of the family still living in close proximity to the child or adolescent, it is up to us to take protective steps and in this case we can take the initiative of appealing ourselves to the UNHCR or ICRC.

The danger may be objective (e.g. the assailant is a relative or someone living very close to the person) or subjective (a feeling of danger for no specific reason). In both cases, the person needs help with both psychosocial support and protection.

11.2. Possible solutions which could be proposed

- Immediately : emergency accommodation (hospitalisation, women’s group able to ensure protection of the victim,…)
- ASAP : consult the protection officer (UNHCR or ICRC) on suitable long-term protective measures (removal, re-location, granting of refugee status and re-location to another country,…)

Protection of victims is included in the UNHCR and/or ICRC mandate (one or the other depending on the type of population – refugees, displaced persons, war victims, prisoners, unaccompanied children,…).

11.3. Transmission of data

If the person wishes to appeal to the UNHCR or ICRC for protective measures for herself, she must accept that relevant information, including her identity, will be transmitted to the protection officer of these organisations.

- Passing on information does not mean transmitting the full medical record, but only the relevant data.
- Information should be passed only to protection officers who are the only members of their organisation authorised to handle confidential information.

11.4. Protection of high-risk groups

In these cases we have to provide the organisations responsible for protection (UNHCR/ICRC) with the data at our disposal (records of security incidents, data collection forms on sexual violence) so that they can take the steps necessary to ensure and/or reinforce protection.

Data to be passed on should be:

- Totally anonymous (no name, address or other clues as to a person’s identity),
- Restricted to relevant data (e.g. useful to know that assailants are often soldiers; that attacks always occur in the evening when there is no protection around the camp; that victims are often women on their own, etc…but not, for example, useful to provide details of the type of assault or the resulting injuries…).

12. Evaluation

12.1. Objectives

- To evaluate the quality of the psycho-medico-social treatment of victims of sexual violence : Are we providing proper care ?
- To evaluate the programme implemented :
• Access to and utilisation of the service: do sexual violence victims use the service provided?
• Provision of service: does everything work according to plan (confidentiality assured, necessary material and human resources available, staff are trained, protocols known and adhered to, etc.)? Does the service provided meet the demand (are we able to provide appropriate care for all the victims who attend)?
• Impact: does the programme have a beneficial effect on sexual violence victims’ health (physical and mental)? Does it have an impact (through preventive and protective measures and témoignage) on the number of acts of sexual violence committed?

To modify our programme on the basis of the results of the evaluation: adjust the objectives of the treatment and/or the activities implemented.

12.2. Indicators

In order to carry out this evaluation, we need indicators. At the beginning of the programme these indicators should be identified and regularly checked.

To this end, we must first decide:

• What we need to evaluate: we do not need a large number of indicators resulting in vast broadsheets of data to impress the readers of our reports; rather we should select those which will enable us to make an evaluation of what we need to evaluate.

• What we can evaluate: It is not always possible to have indicators for evaluating what you want to evaluate. In other words, if you want to evaluate whether you are meeting a need, you have to know what the need is, e.g. the total number of rape victims for a given period. How can you identify this indicator, knowing that the majority of rape victims do not talk about the incident? In order to calculate the effect of your programme on the health of your patients, a lengthy follow-up of the patients is necessary, and the majority of rape victims, if they attend at all, do so only once or twice. etc....

• What we can analyse: it is obviously not merely a matter of data collection. Figures have to be analysed and conclusions drawn so that the programme implemented can be adjusted according to the results. While there is a minimum of data to be collected and analysed (see sheet 28), it is up to you to decide what additional data needs to be collected and analysed depending on your workload and the extent of the sexual violence problem in your context.

12.3. Data collection

Data should be collected:

- From the medical record and medical examination form (see sheet n°16)
- From the weekly or monthly activity reports (number of awareness sessions organised, number of staff members trained, stock availability,....)

Data on quality can also be collected from regular and random analyses of a sample selection of medical files: decide on a percentage of medical files to be analysed over a given period “t” and compare, for example, the treatment received with that which the patients should have received.

Where necessary, and if possible, further studies could be carried out:

- Of a number x of persons interrogated, how many knew of the existence of the service?
- Of a number x of women interrogated, how many knew that they should attend the health centre as quickly as possible after the assault in order to receive the most effective treatment?
- Etc....
12.4. Objectives/Indicators/Sources of information and Database

On sheets 28 and 29, you will find:

A table « Objectives/Indicators/Data » showing **the minimum data required according to the emergency periods and extent of sexual violence** in your context.

A database in which you simply enter your data, calculations and graphs being done automatically.

- **Sheet n°28 – Evaluation : Objectives/Indicators/Data**
- **Sheet n°29a – SGBV Database user’s manual**
- **Sheet n°29b SGBV Database (with automatic calculations and graphs)**
TEMOIGNAGE

Temoignage is an integral part of our medical humanitarian aid. The aim is to make known the suffering of the populations we are helping so that their living conditions can be improved and their rights respected.

Sexual violence is in all cases a violation of the Human Rights, a violation of the Geneva Conventions\(^1\) and may, in some cases, be considered under International Law as acts of torture, inhuman and degrading treatment, a war crime or crime against humanity\(^2\).

It is therefore clearly our duty, when we are aware of such facts, to do temoignage.

Our temoignage should be based on:
- What we see and hear when working in close proximity to the populations.
- The medical data we collect which demonstrates the consequences of disasters on the health of the population.

Our temoignage may take several forms depending on:
- The nature and importance of the incidents
- The context in which the incidents occur
- Whether protective measures have already been taken

Our first step is to inform the organisations responsible for protection (UNHCR, ICRC), so that they can take the action necessary to ensure and/or reinforce protection.

If these organisations do not react, or fall short, the Head of Mission and/or the Cell must pressurise these organisations to increase their efficiency in carrying out their mandate.

If rape is used as a weapon of war and/or a means of terrorising the civilian population, a policy of appropriate temoignage should be developed as quickly as possible by the Head of Mission, the Cell and the Communication Department.

See also: Bearing Witness: Strategies & Risks – The Basic Collection N° 2
Ten Points on Ethical and Safe Info Gathering in the Field: Interviewing people – some basic Guidelines

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\(^1\) Article 27 of the fourth convention regarding the protection of civilians in time of war - Geneva Convention

\(^2\) Article 1 of the Convention against torture and other punishments or acts of inhuman or degrading cruelty – Articles 7 and 8 of the Rome Statute of the International Penal Code
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LIST OF TECHNICAL SHEETS ON THE DVD

General
1. Sexual violence in armed conflicts and population displacements
2. Definition and types of sexual violence
3. Psycho-medico-social consequences of rape

Prevention
4. Non-comprehensive list of the causes and risk factors
5. Guideline to gather information on the context and the perception of sexual violence
6. Record of security incidents
7. Follow-up form of the act of sexual violence
8. MSF ethic
9. Example of message for the population
10. Psychological reactions to a traumatic incident

Preparing to receive victims of sexual violence
11. “Be prepared” : Offering a minimum package of care to victims of sexual violence in 10 steps &
   The barriers for implementing activities to respond to the needs of victims and how to
   overcome them.
12. Template job profiles for activities in response to the needs of sexual violence victims
13. Check-list : staff, medical & non-medical equipment, drugs and vaccines

Reception of a victim of sexual violence
14. Attitudes to adopt towards the feelings expressed by patients
15. Helping children, adolescents, and male victims of sexual violence

Conducting the medical examination
16. Medical history and examination form
17. Protocol of medical examination
18. Pictograms
19. Protocol for obtaining medico-legal evidences
20. Needs to establish a medico-legal certificate
21. Protocol for filling out, handling and storage of medical legal certificates for victims of
   sexual violence.

Treatment
22. Summary table of the psycho-medico-social treatment
23. Protocol for Psycho-pharmacological Treatment
   + Medical Protocol for Sexual Violence

Psychosocial support
24. Stages in psychosocial support
25. Assessment grid of organisations offering psycho-social support

Follow-up
26. Timetable for follow-up of victims of sexual violence
27. Example of message to be given at the first consultation

Evaluation
28. Evaluation :Objectives/Indicators/Data
29a. SGBV Database : User’s manual
29b. SGBV Database (with automatic calculations and graphics)