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SEXUAL VIOLENCE: MEDICAL AND PSYCHOSOCIAL SUPPORT

Sexual Violence & Accountability Project
Working Paper Series

By

Lauren Harris
Julie Freccero

The Human Rights Center investigates war crimes and other serious violations of human rights and international humanitarian law. Our empirical studies recommend specific policy measures to hold perpetrators accountable, protect vulnerable populations, and help rebuild war-torn societies.

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ABSTRACT

This paper focuses on the medical and psychosocial aspects of sexual violence. It provides an overview of the consequences of sexual violence, barriers that victims[1] face in accessing services, protocols for treatment, and approaches to providing comprehensive care. The paper locates the medical/psychosocial treatment for sexual violence within a human rights framework and identifies the physical and psychological consequences. It sets out the medical and forensic measures that should be taken after sexual assault occurs and the ideal approaches to psychological care. Finally, the paper examines two main strategies for providing medical and psychosocial support services to survivors. The first is a "systems approach" which seeks to strengthen the response from the health sector overall by upgrading and reforming all levels of health care institutions and by expanding the role of nurses through sexual assault nurse examiner (SANE) programs. The second is an "integrated models" approach that combines existing resources to deliver comprehensive medical care to victims. Examples of integrated models include sexual assault response teams (SART) and "one-stop shops." The paper also describes specific strategies that can be used to increase access to care in areas affected by armed conflict and political unrest.

This paper is part of a Working Paper Series produced by the Sexual Violence and Accountability Project, at the Human Rights Center, University of California, Berkeley Law School. Along with three other Working Papers, it was drafted in preparation for the "Sexual Offences Act Implementation Workshop" to be hosted by the Human Rights Center in Kenya, in May 2011. It will be presented to the cross-sectoral stakeholders tasked with responding to sexual and gender-based violence in Kenya, to help contextualize discussion about medical and psychosocial support for survivors of sexual violence. We welcome your feedback, which can be sent to ktseelinger@berkeley.edu.

[1] The terms survivor and victim of sexual violence are used interchangeably throughout this paper.

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I. INTRODUCTION

> The World Health Organization (WHO) defines sexual violence as:
> any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work.[2]

The circumstances of sexual violence range widely, including (but not limited to) rape by strangers, within marriage or dating relationships, prostitution and sex trafficking, child marriage, and violent sexual acts including female genital cutting.[3] Roughly 24 percent of women will experience rape or attempted rape in their lifetime,[4] while 7 to 36 percent of female and 5 to 10 percent of male children will suffer from some form of sexual violence.[5] Sexual violence is associated with negative physical, sexual, and reprodutive health effects and is linked to profound long-term mental health consequences.

Sexual violence, including mass rape, may be deliberately implemented as a weapon of war. Victims in most war-torn settings face enormous challenges accessing care. In areas where medical services may have been weak or lacking before the conflict, care may be rendered inaccessible because of geographical distances and wanton destruction of medical facilities. Victims may also be reluctant to report sexual assualts due to stigma or fear of reprisals.

This paper describes some of the consequences of sexual violence and the barriers survivors face in receiving care in times of peace and armed conflict. It also reviews treatment guidelines and examines healthcare models for responding to sexual violence. We begin by locating the provision of care to victims of sexual violence within a human rights framework.

A. Human Rights Framework

Rape and other forms of sexual violence are considered violations of human rights and international humanitarian law and, in the context of war and political conflict, can amount to a "crime against humanity.[6] States are legally obligated to protect women from sexual violence in times of conflict, and provide survivors with appropriate medical and psychosocial services. The World Health

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[2] World Health Organization (WHO). *World Report on Violence and Health* (2002): 149.
[3] Ibid.
[4] See Shirely Kohsin Wang and Elizabeth Rowley, "Rape: How Women, the Community and the Health Sector Respond," Sexual Violence Research Initiative (SVRI), World Health Organization, 2007. For the full document and further informaiton on SVRI to go to http://www.who.int/gender.
[5] See David Finkelhor, "The International Epidemiology of Child Sexual Abuse," *Child Abuse & Neglect* 5 (1994): 409-417.
[6] International Criminal Court, "Rome Statute" (1998). See also background paper on jurisprudence of sexual violence.

Organization and the United Nations High Commissioner for Refugees have defined some of the rights and services that should be afforded to victims of sexual violences:[7]

- *Right to Health*: Every survivor has the right to quality reproductive healthcare services including prevention and management of sexually transmitted infections (STIs), HIV/AIDS, and pregnancy.
- *Right to Human Dignity*: Victims of sexual violence deserve to be treated with respect and dignity. This means they should be provided equitable access to medical care, privacy, confidentiality, clear information in their native tongue about possible interventions, and a safe clinical environment.
- *Right to Non-Discrimination*: Laws, policies, or practices should not discriminate against a victim of sexual violence on any grounds (including sex, ethnic group, and the like).
- *Right to Self-Determination*: Survivors of sexual violence should be able to make their own decisions about whether to receive treatment or an examination. It is important that a victim receive clear information about her options in order to make an informed decision.
- *Right to Information*: Information about possible options should be provided to each victim.
- *Right to Privacy*: Victims of sexual violence should be afforded complete privacy while giving their statements and undergoing a medical or forensic examination.
- *Right to Confidentiality*: All information related to a victim's health status should remain completely confidential.

II. MEDICAL AND PSYCHOSOCIAL CONSEQUENCES OF SEXUAL VIOLENCE

Mass violence, including sexual assault, may result in traumatic consequences for the individual victim, family members, and the broader community. The medical and psychosocial effects described below are not a comprehensive list but suggest the primary areas which healthcare workers and those providing psychsocial services can address.

A. Consequences to the Victim

Victims of sexual violence may suffer physical and psychological effects, sometimes lasting long after the assault. Rape is associated with a higher risk of contracting a sexaully transmitted infection (STI) including HIV/AIDS, and Hepatitis B and C.[8] Pregnancy occurs in approximately 5 percent of cases of unprotected intercourse, and could be more prevalent in cases of repeated exposure or multiple assailants. Emergency contraception prophilaxis should be made available to victims, and should be taken as soon as possible, preferably within 120 hours of the assualt. A U.S. study found that women carrying unwanted children are less likely to seek prenatal care and are more likely to abuse alcohol or drugs. Moreover, children who are carried to term are more likely to suffer from low birth weight, cognitive deficiencies, or

[7] WHO/UNHCR, *Clinical Management of Rape Survivors* (2004): 3-4.
[8] See the Center for Disease Control Treatment Guidelines for Sexual Assault and STDs (2006): http://www.cdc.gov/std/treatment/2006/sexual-assault.htm.

other developmental delays.[9] Such children often face stigma and discrimination.[10] Victims of gang rape and other assaults may suffer suffer gynecological damage. Survivors often face difficulties accessing necessary surgery, which may be expensive, dangerous, or geographically distant.

Victims of sexual violence may suffer from a host of short- and long-term psychological sequelae.[11] Rates of post-traumatic stress disorder (PTSD) are often high, especially among those who have experienced multiple assaults. The cumulative effect of sexual violence may result in increased rates of alcohol and drug abuse,[12] depression, and suicidal behavior.[13] Immediately after rape or other assualts, victims can experience shock, intense fear, numbness, confusion, feelings of helplessness, and/or disbelief, in addition to self blame and high levels of anxiety.[14] If family members or communities shun victims, such feelings can be exacerbated and work to extend the original trauma.

B. Consequences to Family, Children, and Community

Sexual violence can rend the fabric of families and communities. In many cultures, spouses or partners may abandon victims because of the shame and stigma associated with sexual assault. A pernicious but less well-documented consequence of sexual violence is the victim's reduced capacity for civic engagement or advocacy on her own behalf. This effect becomes more pronounced in cases of repeated exposure, especially during prolonged armed conflicts or in unstable political conditions. "This constriction in the capacities for active engagement with the world," writes psychiatrist Judith Herman, "is common even after a single trauma, becomes most pronounced in chronically traumatized people, who are often described as passive or helpless."[15]

Health economists have analyzed the economic costs of interpersonal violence, including intimate-partner violence, sexual violence, and child abuse.[16] Costs of sexual violence are difficult to calculate because a large percentage of incidents are likely to go under-reported or unreported altogether.

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[9] Robert A. Hummer, Kimberley A. Hack, and R. Kelly Raley, "Retrospective Reports of Pregnancy Wantedness and Child Well-Being in the United States," *Journal of Family Issues* 25 (2004): 404-428.
[10] Carpenter, R.C. *Born of War: Protecting Children of Sexual Violence Survivors in Conflict Zones*: Kumarian Press (2007), 2.
[11] See Evelyne Josse, "'They Came with Two Guns': the consequences of sexual violence for the mental health of women in armed conflict," *International Review of the Red Cross* 92/877 (2010): 177-95.
[12] Judith Herman, *Trauma and Recovery: The aftermath of violence—from domestic abuse to political terror* (New York: Basic Books, 1992), 44.
[13] Ibid, 94-95.
[14] Rebecca Campbel, Emily Dworking, and Giannina Cabral, "An Ecological Model of the Impact of Sexual Assualt on Women's Mental Health," *Trauma, Violence & Abuse* 10 (2009): 225-246.
[15] Herman, *Trauma and Recovery*, 90.
[16] See, among others, *The Economic Dimensions of Interpersonal Violence* (Geneva: World Health Organization, 2004); Making the Case for Domestic Violence Prevention Through the Lense of Cost-benefit (San Rafael, CA: Transforming Communities Technical Assistance, Training and Resource Center, 2005); Ko Ling Chan and Esther Yin-Nei Cho, "A review of cost measures for the economic impact of domestic violence," *Trauma, Violence, and Abuse* 11/3 (2010): 129-143.

Studies have largely focused on developed, high-income countries rather than low-income countries that are often sites of armed conflict.[17] Studies of the cost of rape in the United States estimate a per incident cost of $85,000 (2001), including direct costs of medical care, life insurance payments, victim compensation costs (jury awards), indirect costs of employment and workers' productivity, psychological costs, lost earnings, and opportunity costs of time.[18] To our knowledge, no study has examined specifically the economic cost of widespread sexual violence during war or periods of political unrest.

III. CLINICAL MANAGEMENT OF SURVIVORS OF SEXUAL VIOLENCE: PROTOCOLS FOR TREATMENT

Healthcare providers can play a vital role in responding to cases of sexual violence. In doing so, they should pay particular attention to recording details of the survivor's history and injuries, collecting evidence of recent trauma and/or sexual contact, providing care to prevent sexual transmitted infections (STIs), evaluating and addressing the risk of pregnancy and, if needed, refering the victim to appropriate psychological services.[19] While specific guidelines, protocols, or implementation strategies may vary, the management and provision of health care to victims should include the following procedures: physical documentation and patient history, medical treatment, collection of forensic evidence, and psychosocial care.

A. Physical Documentation and Patient History

In addition to performing a complete physical examination and conducting appropriate diagnostic tests, it is vital that the physician or other healthcare providers obtain any information that may be relevant for the victim's continued care. This often includes the patient's history and details about the incident and succeeding events.[20] National guidelines dictate how comprehensive the interview should be. In the United States, for example, the medical interview may be very detailed, including questions about specific sexual acts and events leading up them.[21] In settings where time constraints or privacy is an issue, the most basic history should include:

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[17] A1999 study found total costs of violence ranged from 1% to 25% of gross domestic product in various Latin American countries in 1997. See *The Economic Dimensions of Interpersonal Violence* (Geneva: World Health Organization, 2004), 14.
[18] *Economic Dimensions*, 22.
[19] World Health Organization/United Nations High Commission for Refugees, *Clinical Management of Rape Survivors: Developing protocols for use with refugees and internally displaced persons* (2004), 1.
[20] The California Clinical Forensic Medical Training Center, *Compassionate Care: An Overview of the Sexual Assault Clinical Forensic Examination: For Criminal Justice Professionals and Victim Advocates* (Davis, CA: University of California, Davis, 2008).
[21] US Department of Justice, *A National Protocol for Sexual Assault Medical Forensic Examinations: Adults/ Adolescents* (2004).

1) general information about the victim,
2) a description of the incident, and
3) a description of the actions a victim has taken since the incident (including whether or not he/she bathed, urinated, defecated, douched, vomited, or changed clothes). It is also important to know the victim's HIV status and risk of pregnancy (i.e., whether she is using contraceptives).[22]

B. Medical Treatment

Medical treatment for survivors of sexual violence is time-dependent. If a survivor seeks medical care within 72 hours of the sexual assault, the medical practitioner should do everything possible to treat immediate injuries and STIs and prevent HIV transmission, pregnancy, tetanus and Hepatitis B and C.[23] Victims of rape should be given antibiotics to treat gonorrhoea, Chlamydia, and syphilis. If other STIs are prevlaent in the area (such as trichomoniasis or chancroid) the medical practitioner should also administer preventive treatment for these infections. Post-Exposure Prophylaxis (PEP) should be given to a victim to prevent HIV depending on the nature of the sexual assault (for example, whether there was penetration and/or if injuries were sustained).[24] Tetanus prophylaxis should be given if the survivor's skin has been broken (if she has not yet been vaccinated). Because the vaccine is expensive and requires refrigeration, decisions about whether to provide hepatitis B prophylaxis are often based on the setting. For example, if the local practice is to immunize infants, later vaccination may not be necessary.[25] It should, however, be given if at all possible where immunization is not customary. Hepatitis B is spread through vaginal fluid and semen and thus the risk of acquiring the disease increases significantly in cases of rape.[26]

Pregnancy is one of the most common concerns for women who have been sexually assaulted. Emergency contraceptive pills can reduce this risk between 56 and 95 percent depending on how soon medication is taken. Research indicates that it should be taken as soon as possible after exposure and within 120 hours of the incident to have any effect.[27] If emergency contraceptive pills are unavailable, multiple estrogen/progesterone or progesterone-only birth control pills can be taken in its place. The specific amounts vary depending on the type or brand of the contraceptive.[28] If a victim comes forward within five days of the sexual assault, it is possible to insert an IUD to prevent pregnancy (up to 99% effective).

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[22] WHO/UNHCR, *Clinical Management of Rape Survivors*.
[23] World Health Organization *Guidelines for medico-legal care for victims of sexual violence* (2003).
[24] WHO/UNHCR, *Clinical Management of Rape Survivors*, 20-21.
[25] Ibid, 23.
[26] Szmuness W, Much MI, Prince AM, Hoffnagle J, Cherubin D, Harley E, Block G, "On the role of sexual behavior in the spread of hepatitis B infection," *Annals of Internal Medicine* 83/4 (1975): 489.
[27] H. von Hertzen, G. Piaggio, et al. "Low dose mifepristone and two regimens of levonorgestrel for emergency contraception: a WHO multicentre randomised trial," *The Lancet* 360/9348 (2002): 1803-1810.
[28] Ibid.

If a victim comes to the clinic after 72 hours, treatment alternatives are more limited. At this point, the victim may have acquired an STI, in which case treatment should be provided in addition to conducting a complete physical examination and providing psychological assistance. Victims should also be referred to voluntary testing and counseling services to learn about their HIV status and to take appropriate measures.[29]

C. Forensic Evidence Collection

Whenever, possible, the collection of forensic documentation should include both physical and psychological evidence. Medical personnel should be as objective as possible in their collection of forensic evidence and conduct the examination only with the patient's consent. The actual evidence to be collected is contingent upon the capacity to analyze, preserve, and use it.[30] A country's laws and policies also determine who is qualified to perform a forensic examination.

As medical practitioners often are the first responders to victims of sexual violence, they should be familiar with domestic laws and international guidelines governing forensic evidence collection. The WHO recommends that evidence not be collected if it will not be processed or used for prosecution purposes. Survivors of sexual violence should never be subjected to invasive procedures for no reason (and certainly not without their informed consent.)[31] Others argue, however, that any evidence, forensic or otherwise, that could potentially lead to a prosecution should be properly collected and stored (see "Investigations and Prosecution" paper). [32]

If possible, forensic evidence should be collected at the time of medical examination and treatment and by the same provider in order to limit the amount of potential trauma a victim might experience while retelling his or her story. Hillary Larken, a medical practitioner who attends to victims of sexual violence at Highland General Hospital in Oakland, California said, "It's a very intrusive exam and very uncomfortable for the victim. It's really important that nurses keep that in mind."[33] Most protocols recommend that forensic evidence—including sperm, blood, hair, and saliva samples—be collected no more than 72 hours after the incident. Moreover, the quality of the specimens may vary significantly depending on whether the victim has showered, urinated, or changed clothes—all data that should be gathered during the documentation of personal history.[34]

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[29] L. Zhou and B. Xiao, "Emergency contraception with Multiload Cu-375 SL IUD: a multicenter clinical trial," *Contraception* 64/2 (2001): 107.
[30] WHO/UNHCR, *Clinical Management of Rape Survivors* (2004).
[31] Ibid.
[32] Joseph Kaberia, Kenya National Commission for Human Rights, personal correspondence (June 2010).
[33] Hillary Larken, Highland General Hospital, Oakland, CA, personal correspondence (April 2010).
[34] World Health Organization, *Guidelines for medico-legal care for victims of sexual violence* (2003).

Evidence should be collected in a systematic way, using established terminology and objective methods. Types of samples that can be collected as evidence include:

- *Evidence of injury:* Trauma to the genital area or other parts of the body should be documented in pictograms or photographs.
- *Clothing:* Items of clothing that are torn or that may contain spermatozoa or other bodily fluids. Replacement clothing should be provided to the survivor.
- *Foreign material:* Any organic material, like leaves or grass.
- *Hair:* Hair can be taken from the victim, either her own or foreign, on the body or genital region.
- *Sperm and seminal fluid:* Swabs should be taken from anywhere on the body where penetration occurred (includes vagina, anus, and mouth).
- *DNA:* Any place where foreign DNA can be found (bite marks, sanitary pads, condoms, fingernail scrapings, etc.) should be analyzed.
- *Blood and/or urine:* To test for pregnancy or screen for toxicology.[35]

Cameras may be used to photograph physical injuries on the body. However, medical practitioners should fully respect the wishes of those who do not want to be photographed.

All evidence should be documented on a standardized form that can be provided to the survivor and/or transferred to law enforcement with the consent of the survivor. At a minimum, the certificate should include the name and signature of the examiner, the victim's name, and the date and time of the examination.[36] Other items to be included, if if time and resources permit, are the survivor's narrative of the assault, findings of the clinical examination, nature of the samples taken, and a conclusion. This certificate is often vital for a successful prosecution, especially in situations where it may be the only evidence a survivor has to prove her case.[37] While it is not necessarily a requirement, in humanitarian settings, it can be helpful and safer for the health care provider to keep a copy of the forensic evaluation on file.

D. Psychosocial Care

Often the psychological needs of victims of sexual violence are overlooked, even in settings that offer medical services.[38] With that in mind, healthcare providers should be aware of the factors that influence the psychological impact on vicitims of sexual violence. These can include

- Whether the victim is a child or an adult

[35] WHO/UNHCR, *Clinical Management of Rape Survivors* (2004): 15.
[36] WHO/UNHCR, *Clinical Management of Rape Survivors* (2004).
[37] However, the WHO Sexual Violence Research Initiative reports that studies conducted primarily in industrialized countries suggest that medico-legal evidence has been of limited importance to courts in determining legal outcomes. Approximately one-third of studies reported that the presence of ano-genital trauma or the collection of biological and non-biological samples was related to a successful prosecution, and no studies demonstrated a positive relationship between legal outcome and the detection of sperm. See Janice Du Mont and Deborah White, "The Uses and Impacts of Medico-Legal Evidence in Sexual Assault Cases: A Global Review," *WHO/Sexual Violence Research Initiative* (2007): 1-2.
[38] J. Astbury and R. Jewkes, "Sexual Violence," *Routledge Handbook of Global Public Health* (2011): 411.

- A victim's socio-biological characeteristics
- A victim's perception of their rights and and their status
- Prior history of trauma, sexual or otherwise
- Prior mental health issues
- The relationship of the offender to the victim
- A victim's appraisal of the circumstances of the violence (e.g., threat to life, self-blame)
- A victim's coping mechanisms
- Positive social support
- Cultural background
- Perceived and actual response of society, including any formal services approached, to disclosure of sexual violence[39]

The main approaches used to treat adult victims of sexual violence are traditional cognitive behavioral interventions; group therapies including stress inoculation; assertion training; supportive psychotherapy; and one-on-one counseling. For children, effective methods include art therapy and (in the case of Developmental Trauma Disorder) the establishment of safety and competence, addressing traumatic re-enactments, and integration and mastery of mind and body.[40]

Before beginning any form of therapy or psychosocial treatment, it is important to identify the type of disorder the victim suffers. It was believed for many years that the most common disorder associated with sexual violence was Post-Traumatic Stress Disorder (PTSD). In reality, only about 50 percent of the psychological disorders resulting from sexual violence are PTSD-related.[41] Studies show that depression and anxiety may be more common outcomes, particularly long after the acute effects have become less apparent and less present.[42] These disorders often cause people to withdraw from friends and loved ones. Children specifically can acquire "Developmental Trauma Disorder," a diagnosis now being field-tested in trials in the United States as it better fits the response of children to acute and chronic trauma than the adult-derived PTSD.[43]

Diagnosing a victim with a particular disorder requires screening, a process that can be done by a physician or other qualified medical personal during the medical or forensic examination. In instances where a traumatic event has happened to multiple people within the same community (sexual violence during a conflict, for example) it is sometimes helpful to conduct screenings in schools or other

[39] These factors are taken from Thomas Callender and Liz Dartnall, "Mental Health Responses for Victims of Sexual Violence and Rape in Resource-Poor Settings," Sexual Violence Research Initiative, World Health Organization, January 2011, 2.
[40] Bessel A. van der Kolk, "Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories," *Psychiatric Annals* 35 (2005): 401-406, at 404.
[41] Herbert Schreier, personal communication, October 2010.
[42] W. Yule, O. Udwin, and K. Murdoch, "The Ëjupiterísinking: Effects on Children's Fears, Depression and Anxiety," *Journal of Child Psychology and Psychiatry* 31/7 (1990): 1051-61.
[43] B.A. van der Kolk, et al., "Proposal to Include a Developmental Trauma Disorder Diagnosis for Children and Adolescents in Dsm-V," *Official submission from the National Child Traumatic Stress Network Developmental Trauma Disorder Taskforce to the American Psychiatric Association. Retrieved on October* 15, 2009: 2009.

community settings.[44] When screening, it is important to recognize that co-morbidity is common, meaning a survivor might suffer from more than one syndrome.[45] Further, there is also the possbility that a survivor may seem relatively free of traumatic responses, but will exhibit symptoms some time in the future, and family and professionals may not recognize this as the result of earlier trauma. Research has also demonstrated resilience in the face of even mass trauma and markers for who will and will not be intensively affected are currently being investigated.[46]

Basic criteria that can be used to identify each disorder are as follows:

- *Post-Traumatic Stress Disorder*: In addition to identifying the presence of a specific traumatic event, diagnosing PTSD requires the presence of three specific symptoms[47]: 1) Re-experiencing of the trauma in the form of recurrent recollections or nightmares about the traumatic experience. In young children this can take the form of repeated play patterns where they express different aspects of the traumatic event. 2) "Numbing" and constant avoidance of things that remind the victim of the traumatic event such as avoiding talking about the event, inability to recall important parts of the traumatic experience, decreased interest in activities, detachment from friends and family, and feeling that their future is hopeless. 3) Hyperarousal, expressed in at least two of the following symptoms: difficulty falling or staying asleep, angry outbursts, difficulty concentrating, hypervigilance, and increased startle reaction. Young children with PTSD also often demonstrate symptoms of aggression, behavior that is oppositional, regression in their developmental skills, separation anxiety, and unexplained fears.[48] Screening strategies for PTSD depend on the age of the victim and should take place no less than one month after the traumatic event.[49]

- *Depression Disorder*: While many formal screening tools are available, depression can be identified by asking two specific questions about anhedonia and mood: 1) Has the victim felt down, depressed, or hopeless over the past two weeks? 2) Has the victim felt little interest or pleasure in doing activities that he or she enjoyed in the past?[50] In the case of children, a caretaker can take on the responsibility of answering these questions.[51] The severity of the depressive disorder should also be assessed, especially if the victim is contemplating substance abuse or suicide.

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[44] Judith Cohen et al. "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder." *Journal of the American Academy of Child and Adolecent Psychiatry* 49/4 (2010): 414-430 at 416.

[45] Duncan Campbell et al. "Prevelance of Depression- PTSD Comorbidity: Implimentations for Clinical Practice Guidelines and Primary Care-based Initiatives," *Society of General Internal Medicine* 22 (2007): 711-718.

[46] Herbert Schreier, personal communication, October 2010.

[47] Although the DSM IV requires symptoms from all three clusters for diagnosis, the ICDM requires only two. Recent research has demonstrated that the presence of symptoms in two clusters predicts the severity of outcomes as well as the presence in three. This requirement is still under debate.

[48] Judith Cohen et al., "Practice Parameter for the Assessment and Treatment of Children and Adolescents with Posttraumatic Stress Disorder," *Journal of the American Academy of Child and Adolecent Psychiatry* 49/4 (2010): 414-430 at 416.

[49] In order to screen for PTSD, the person conducting the evaluation must determine whether or not the patient suffered a trauma. They should then use the SDM-IV-TR diagnostic criteria (separate for adults and children), the Juvenile Victimization Questionnaire, or the PTSD for Preschool-Age Children 18-item checklist

[50] Agency for Healthcare Research and Quality. *The Guide to Clinical Preventative Services: Recommendations of the U.S Preventative Services Task Force* (2010-2011).

[51] Comprehensive diagnostic tools for screening can be found in the "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition."

- *Anxiety Disorder*: Anxiety is generally characterized by apprehension, cued or spontaneous panic attacks, irritability, poor sleeping, avoidance, and inability to concentrate. More specifically, there are three main types of anxiety disorders: panic disorder causes intermittent episodes of panic or anxiety, agoraphobia causes anxiety triggered by external stimuli, and generalized anxiety disorder is a continuous manifestation of the symptoms listed above.[52] Among children, anxiety disorders often lead to difficulty in school and in their social interactions with other children.[53] While it may be difficult to distinguish a particular anxiety disorder without an extensive evaluation, basic screening tools can be highly effective in discriminating between adults and children with and without acute anxiety.[54]

- *Developmental Trauma Disorder*: Bessel van der Kolk proposed this disorder in 2005 as an alternative diagnosis to PTSD among children. Children with this disorder have experienced or witnessed repeated and severe episodes of violence. The criteria include impaired normative developmental competencies related to arousal regulation, sustained attention, learning, coping with stress, maintaining a sense of personal identity, and involvement in relationships. Children suffering from developmental trauma disorder also display at least two of the three PTSD symptoms and show evidence of functional impairment.[55]

Treatment for psychological disorders relating to sexual violence varies significantly in both approach and cost. Some treatments have proven effective for treating multiple types of psychological disorders while others address symptoms related to very specific syndromes. Regardless of the disorder, patients should be provided with a safe place and an "outlet," such as a trained psychologist or a family member or a group of friends, where they can share their feelings about the traumatic experience.[56] In the United States, victims of sexual violence who are seen by a medical practitioner are assigned a caseworker trained in the area of gender violence. "Sometimes it may be appropriate [for a survivor] to go to someone...knowledgeable about their culture," a caseworker at Highland General Hospital in Oakland, California said. "Everyone is different. We don't talk about assault the whole time, we talk about their lives. You need to find that right connection with whoever that person is. Not everyone is going to connect with everyone."[57]

Formal and informal counseling services have proven effective in addressing the psychological needs of victims experiencing depression, anxiety, and/or PTSD. In some countries, formal counseling services are built into existing medical and forensic services. While less common, other programs have

[52] National Institute for Health and Clinical Excellence. *Anxiety: Management of anxiety (panic disorder, with or without agoraphobia, and generalized anxiety disorder) in adults in primary, secondary and community care* (2004).
[53] Ellin Simon et al., "Screening for anxiety disorders in children," *European Child and Adolencent Psychiatry* 18 (2009): 625-634.
[54] Ibid, 631.
[55] Bessel van der Kolk, R. Pynoos, et al., "Proposal to include a developmental trauma disorder diagnosis for children and adolescents in DSM-V," Official submission from the National Child Traumatic Stress Network Developmental Trauma Disorder Taskforce to the American Psychiatric Association. Retrieved on October 15, 2009.
[56] Herbert Schreier, personal communication (October 2010).
[57] Wendy, Highland General Hospital, Oakland, CA, personal correspondence (April 2010).

been developed independently. An example of a formal counseling program integrated into a more formal health system is Liverpool VCT.[58] Although designed specifically for HIV services in Kenya, the program provides counseling and support to victims of sexual violence and their partners. Some of the services include support groups, individual counseling, and a 24-hour hotline. Informal counseling services operate on different levels within many communities, ranging from women's support groups to faith- and community-based group interventions.

Group therapy has also proven to be effective in addressing symptoms of depression and anxiety. This approach is common in developing countries where social stigma and lack of resources and counselors make it difficult to receive one-on-one counseling sessions from qualified professionals. A study conducted at the University of Missouri compared three different types of group therapy among 37 rape victims: stress inoculation, assertion training, and supportive psychotherapy. They found very little difference in outcomes among the types of therapies; in all cases the patients showed significant improvements on all measures.[59] Another study among 26 students who were exposed to violence in California concluded that "group participation was associated with improvements in post-traumatic stress and complicated grief symptoms, and academic performance."[60]

The method currently considered most effective for treating adults and children with PTSD is a trauma-based approach, which includes cognitive-behavioral methods that directly target the traumatic event.[61] The methodology generally involves retelling the event in explicit detail, a process that helps the victims "relive" the experience within a safe environment.[62] One variation of this trauma-based strategy is called Narrative Exposure Therapy (NET), where the survivor constructs a narration about their entire life from birth to the present, exploring the traumatic experiences within this context. A randomized control trial among Rwandan and Somali refugees in Uganda showed a 70 percent reduction in PTSD symptoms after completing NET. This study not only demonstrated the effectiveness of the treatment, but also the feasibility of having lay counselors administer psychotherapy.[63]

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[58] Liverpool Voluntary Counseling and Testing: http://www.liverpoolvct.org/.
[59] P. Resick, C. Jordan, et al., "A comparative outcome study of behavioral group therapy for sexual assault victims," *Behavior Therapy* 19/3 (1988): 385-401.
[60] W. Saltzman, R. Pynoos, et al., "Trauma-and grief-focused intervention for adolescents exposed to community violence: Results of a school-based screening and group treatment protocol," *Group Dynamics* 5 (2001): 291-303.
[61] National Institute for Clinical Excellence, *Posttraumatic Stress Disorder,* Gaskell and the British Psychological Society (2005).
[62] Ibid.
[63] Frank Neuner et al., "Treatment of Posttraumatic Stress Disorder by Trained Lay Counselors in an African Refugee Settlement: A Randomized Control Trial," *Journal of Consulting and Clinical Psychology* 76/4 (2008): 686-694.

Art therapy has been used in a range of cultural settings where children have experienced sexual violence or other traumatic events. A study conducted by the Children's Hosptial Research Center in Oakland, California on the effects of art therapy on children suffering from PTSD showed a reduction in acute stress symptoms.[64] The Chapman Art Therapy Treatment Intervention, or CATTI, was facilitated in a one-on-one session with 31 children for approximately one hour. Children were encouraged to draw in a way that "relat[ed] his or her own unique story in a manner that was consistent with his or her level of graphic, perceptual, and cognitive development."[65] After completing the piece of art, the child then retold the event using his or her drawings. At this point numerous issues were addressed, including misconceptions, rescue and revenge fantasies, shame or guilt, traumatic reminders, and coping and reintegration strategies.[66]

Psychological treatment for children affected by Developmental Trauma Disorder differs from treatments for PTSD, depression, or anxiety. Child victims of sexual assault should have their attention diverted away from the person responsible for the assault and any situation that may remind them of the traumatic incident. They must be taught to feel safe and competent by retraining them to focus on things that bring them pleasure rather than resorting to habitual feelings of fight or flight that may have evolved from the trauma. Psychologists and teachers can play a very important role in addressing traumatic re-enactments by providing the child with a sense of safety when he or she acts out. The overall goal of this therapy is to help the child master the feeling of being calm and in control. Psychologist Bessel A. van der Kolk has found that "children with 'frozen' reactions need to be helped to re-awaken their curiosity and explore their surroundings."[67] Tasks and games can help a child regain the knowledge and feeling of relaxation and physical mastery.

IV. BARRIERS TO MEDICAL AND PSYCHOSOCIAL TREATMENT

Victims of sexual violence often face insurmountable barriers if they seek care. These challenges are even greater in conflict settings, where existing health infrastructure may be nonexistent or inaccessible. Among the barriers:

- A lack of capacity within hospitals and clinics often prevents victims of sexual violence from receiving appropriate and timely treatment. Victims who go to a clinic may not be able to see the nurse or doctor until days later, narrowing the already small window of opportunity to address the medical consequences of sexual assault.

[64] L. Chapman, D. Morabito, et al., "The Effectiveness of Art Therapy Interventions in Reducing Post Traumatic Stress Disorder (PTSD) Symptoms in Pediatric Trauma Patients," *Art Therapy: Journal of the American Art Therapy Association* 18/2 (2001): 100-104.
[65] Ibid, 102.
[66] UNICEF and other child welfare agencies have used art therapy in many refugee settings.
[67] Bessel A. van der Kolk, "Developmental Trauma Disorder: Toward a rational diagnosis for children with complex trauma histories," *Psychiatric Annals* 35 (2005): 401-406, at 404.

- Medical care may be unavailable in close proximity to the assault, making it difficult or expensive for victims to seek immediate treatment or follow-up care.
- A lack of education about the 72-hour window for treating sexually transmitted infections (STIs) may reduce the likelihood that victims seek immediate medical care.
- Survivors must negotiate and interpret not only the assault itself but the responses of their society to disclosure of the assault. This, in turn, may inhibit surivivors from going to health clinics. Moreover, resistance to the idea of seeing a psychologist or a counselor often prevents survivors from receiving services for psychological issues relating to a sexual assault.
- Staff turnover rates (especially for government health positions) may be very high. This results in inconsistent provision of care and requires constant, repeated training.
- In general, governments and health-related organizations provide little funding for psychosocial services. Although mental healthcare is gradually becoming more accepted, government-operated health clinics and nongovernmental health organizations often are more focused on the physical effects of sexual violence (pregnancy and HIV) than on the psychological effects.

V. MEDICAL BARRIERS TO ACCOUNTABILITY

Health facilities are generally ill-equiped and lack properly trained staff to collect and store forensic evidence. Although the procedures are straightforward and the basic materials required for collecting evidence are not expensive (manila envelopes, swabs, slides, forms for recording injuries), staff must be trained in—and facilities equipped for—collecting and storing evidence.

In some countries, a doctor's signature is required on documentation forms, an impractical requirement since rural areas may have only one doctor in the entire province. In Nairobi, for example, the situation is even more complicated. Instead of (or in addition to) having a hospital physician fill out the post-rape care (PRC) form, a victim must also have the police doctor (only one in the entire city) sign the form. Because the police doctor sees patients from all over the city suffering injuries from a variety of accidents (assault, motor vehicle accidents, etc), the process to see this doctor requires standing outside his office in a line, often for many days. Doctors often refuse to fill out the PRC form because they are either uncomfortable or unwilling to serve as an expert witness in court.

In conflict settings, victims may come to the hospital only months after the assault, making it impossible to receive treatment or for the doctor to collect forensic evidence. It may be unsafe for victims to leave their homes, or, if the violence was ethnically motivated, victims may hesitate to seek treatment if the doctor is from another ethnic group. Healthcare providers can begin to overcome these barriers by

- Identifying a team of professionals and volunteers either within or outside the affected community to work with vicitims;
- Holding regular coordinating meetings to link all the important sectors (medical, psychosocial, law enforcement, legal services, UN peacekeepers, etc.) so referrals can be made efficiently;
- Identifying available supplies (durgs, labs, other materials) and existing laws and protocols;
- Identifying safe shelters and witness protection programs for victims and potential vicitims and family members in need of protection and security; and

- Developing a protocol for managing sexual violence and training healthcare providers on how to follow it.[68]

VI. PROVIDING COMPREHENSIVE CARE TO SURVIVORS OF SEXUAL VIOLENCE: PROMISING PRACTICES

Hospitals and community health centers are often the first institutions to receive victims of sexual violence. As such, they are strategically situated to assist survivors in accessing other important community-based services such as legal aid, police, and shelter. The availability of post-rape treatment and services, as well as the attitudes and approaches by health providers can affect the long-term physical and psychological health and safety of survivors.[69] However, initiatives to respond to sexual violence within the health sector have been extremely limited relative to those within other sectors, and very few initiatives have been rigorously evaluated.[70] The following provides an overview of two health facility–based strategies which which have been well-documented and effective in strengthening the health sector's response to sexual violence.

A. Strengthening the Health Sector Response

i. A "Systems Approach"

Research on interventions to address sexual violence through the health sector suggest that without institutional reform and system-wide support throughout an organization, one-time training efforts for health providers rarely have a long-term impact on the quality of care.[71] Instead, advocates argue for the implementation of a "systems approach," which involves a process of review and reform at all levels of an organization including changing systems and procedures, policies and protocols; upgrading infrastructure and equipment; and using data collection systems.[72] The approach emphasizes training all levels of staff, including management, direct service providers, and administrators, to ensure the delivery of essential services (medical and forensic) in a caring and sensitive environment that aims to reduce further trauma to the survivor. These initiatives generally also involve the development and use of

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[68] WHO/UNHCR, *Clinical Management of Rape Surviovors* (2004): 2.
[69] Sarah Bott, Alessandra Guedes, Maria Cecilia Claramunt, and Ana Guezmes, "Improving the Health Sector Response to Gender-Based Violence: A Resource Manual for Health Care Professionals in Developing Countries," *International Planned Parenthood, Western Hemisphere Region* (2004): 3-4. http://www.ippfwhr.org/node/288.
[70] Alessandra Guedes, "Addressing Gender-Based Violence from the Reproductive Health/HIV Sector: a Literature Review and Analysis," *USAID*, (2004): i-iv. http://www.igwg.org/pdf04/AddressGendrBasedViolence.pdf.
[71] Lori Heise, Mary Ellsberg, and Megan Gottemoeller, "Ending Violence against Women," *Population Reports* L, no.11 (1999): 35. http://www.infoforhealth.org/pr/l11/violence.pdf.
[72] Ibid.

a community-based network of referrals to other services including shelter, legal aid, and psychosocial support.

In 1999, the International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR) implemented a systems approach to address sexual and gender-based violence within three of its member organizations in Latin America: Profamilia in the Dominican Republic, Instituto Peruano de Paternidad Responsible/The Peruvian Institute of Responsible Parenting (INPPARES) in Peru, and Asociacion Civil de Planificacion Familiar/The Civil Association for Family Planning (PLAFAM) in Venezuela. The regional initiative, which also included limited participation by Bem Estar Familiar (BEMFAM) in Brazil, was a coordinated effort to improve the capacity of sexual and reproductive healthcare delivery programs to respond to the needs of sexual violence survivors.[73] Participants in the initiative developed standard protocols, procedures, screening tools, and evaluation mechanisms for addressing sexual and gender-based violence as well as common strategies for training and educating staff and health providers. Further, they focused on making comprehensive improvements to their healthcare institutions to support the incorporation of these changes.[74]

In order to integrate these new processes, these organizations reviewed and made changes to their entire health programs, including clinic infrastructure, patient flow, clinical history forms, data systems, and community partnerships and referral directories.[75] Evaluations found that this initiative improved provider attitudes and practices, increased patient confidentiality, and benefited survivors of physical and sexual violence by improving the overall quality of care and increasing access to other services such as legal aid and psychosocial support.[76] In 2004, IPPF/WHR produced a manual titled *Improving the Health Sector Response: A Resource Manual for Health Professionals in Developing Countries* based on lessons learned from this project.[77] Although this initiative was resource-intensive and implemented on a large scale, this manual provides detailed guidelines, tools, and resources for implementing institutional changes in low-income settings.

ii. Expanding the Role of Nurses

Increasing the capacity and scope of responsibilities of nurses in responding to cases of sexual violence is a key strategy to ensure that survivors receive sensitive and comprehensive care. Survivors

[73] Sarah Bott, et al., "Improving the Health Sector Response to Gender-Based Violence: A Resource Manual," 6-7.
[74] Alessandra Guedes, Sarah Bott, and Y. Cuca, "Integrating Systematic Screening for Gender-Based Violence into Sexual and Reproductive Health Services: Results of a Baseline Study by the International Planned Parenthood Federation, Western Hemisphere Region," *International Journal of Gynecology and Obstetrics* 78 (2002): S58-S59.
[75] Ibid.
[76] Sarah Bott, Andrew Morrison, and Mary Ellsberg, "Preventing and Responding to Gender-Based Violence in Middle and Low-Income Countries: A Global Review and Analysis," *World Bank Policy Research Working Paper* no. 3618 (2005): 27. http://papers.ssrn.com/sol3/papers.cfm?abstract_id=754927.
[77] The complete manual is available at: http://www.igwg.org/pdf04/AddressGendrBasedViolence.pdf.

often experience secondary trauma while seeking care in hospital emergency rooms. They may wait for long periods of time before receiving care, and are often treated by providers lacking knowledge or training in assisting survivors of sexual violence.[78] Nurses with specialized training in clinical care and forensic services for survivors of sexual violence can address these gaps within health care institutions.

In the United States, Sexual Assault Nurse Examiners (SANE) are registered nurses with advanced education in forensic examination trained to act as first responders to survivors of sexual violence.[79] The first SANE programs were established by nurses in Minnesota, Tennessee, and Texas in the late 1970s in response to the inadequacy of traditional emergency room care in addressing the needs of survivors of sexual violence. Since the widespread replication of this model in the 1990s, SANE programs have been established in hundreds of hospitals throughout the United States.[80] SANE programs operate differently according to location and coordinated response protocols within communities; however, most SANE programs use a pool of nurses who are available on call 24 hours-a-day, 7 days-a-week. When a survivor enters the emergency room, an on-call SANE is paged to meet the survivor and assess her need for emergency medical care. If a SANE is not currently at the hospital, an on-call SANE will usually respond within 30 to 60 minutes. Once serious injuries have been treated and patients are stabilized nurse examiners begin the medical and forensic examination.[81]

During the examination, nurse examiners:

- Document the patient's history and incident report;
- Assess the patient's psychological health and need for services;
- Conduct a physical examination and document the extent to which patients have sustained injury (including taking forensic photographs);
- Collect and preserve all forensic evidence according to procedures;
- Provide treatment for STIs, emergency contraception, and other necessary care; and
- Assist patients in safety planning and provide referrals to psychosocial support and other community-based services.[82]

Nurse examiners also provide emotional support and initial crisis counseling.[83] If a survivor would like to report the incident, the nurse examiner can contact a police officer to facilitate the process.

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[78] Linda E Ledray, "Sexual Assault Nurse Examiner (SANE) Development and Operation Guide," *U.S. Department of Justice: Office for Victims of Crime: Sexual Assault Resource Service* (1999): 5. See http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.
[79] Ibid, 7, 22.
[80] U.S. Department of Justice, Office of Justice Programs: Office for Victims of Crime, "Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims," *OVC Bulletin* (2001): 3.
[81] Ibid.
[82] Ibid, 3-4.
[83] Linda E Ledray, "Sexual Assault Nurse Examiner (SANE) Development and Operation Guide," 9.

Nurse examiners often work with prosecutors and provide testimony at trials on the forensic evidence they have gathered during the examination.[84]

In 1996, representatives from SANE programs in the U.S. and Canada formed the International Association of Forensic Nurses (IAFN) to develop and disseminate information about forensic nursing, SANE education guidelines, and standards of practice for SANE programs.[85] Studies have found that the presence of nurse examiners within hospitals has significantly increased the quality of care provided to survivors of rape and sexual assault. Such improvements include prompt and sensitive attention, reductions in psychological trauma, and enhanced evidence collection resulting in more successful prosecutions.[86] Recent research also suggest that nurse examiners improve the quality of care provided to pediatric and adolescent survivors of sexual violence.[87]

The Sexual Assault Nurse Examiner (SANE) Development and Operation Guide, produced by the U.S. Department of Justice's Office for Victims of Crime in 1999, provides extensive guidance and information for developing SANE programs including policies and procedures, funding and staffing information, and strategies for program implementation.[88] The Sexual Assault Resource Service website provides information and resources to assist institutions develop or improve existing SANE programs and facilitate knowledge-sharing among SANE programs.[89]

The Kenyatta National Hospital in Nairobi, Kenya has established a SAFE program in its Gender Based Violence Recovery ward. SANE-certified nurses guide victims through the various procedures (counseling, medical treatment, and forensic examination)[90] and have established a system to insure that at least one member of the team is on call at all times.

A 450-bed hosptial in rural South Africa has developed a systems-based approach to addressing post-rape care, with an emphasis on expanding the role of nurses. Known as "Refentse" or "We Shall Overcome," the project is a collaborative initiative of the Population Council, the Rural AIDS and Development Action Research (RADAR) at the University of Witwatersrand, the London School of Hygiene and Tropical Medicine, and the George Institute for International Health.[91] The hospital serves as a referral site for surrounding clinics and receives a high volume of rape cases. The goal of the project was to design and evaluate a nurse-driven model for improving post-rape care in a resource-constrained

[84] USDOJ: Office for Victims of Crime, "Sexual Assault Nurse Examiner (SANE) Programs" 3-4; 7-8.
[85] Ibid, 3.
[86] Ibid, 1-2.
[87] K. Bechtel, E. Ryan, and D. Gallagher, "Impact of Sexual Assault Examiners on the Evaluation of Sexual Assault in a Pediatric Emergency Department," *Pediatric Emergency Care* 24/7 (2008): 442-447.
[88] The complete guide is available at http://www.ojp.usdoj.gov/ovc/publications/infores/sane/saneguide.pdf.
[89] See www.sane-sart.com.
[90] Elizabeth Mukisa, personal communication (June 15, 2010).
[91] Julia C. Kim, et al., "The Refentse Model of Post-Rape Care: Strengthening Sexual Assault Care and HIV Post-Exposure Prophylaxis in a District Hospital in Rural South Africa," *The Population Council* (2009): 2. http://www.popcouncil.org/pdfs/frontiers/FR_FinalReports/SouthAfrica_RADAR.pdf

hospital serving a large rural population.[92] In order to ensure a holistic, institutional approach, a Project Advisory Committee comprised of hospital management, nurses, HIV services, doctors, social workers, and police was established to strengthen and coordinate post-rape management within the hospital. The Project Advisory Committee then drafted a Hospital Rape Management Policy, supported by the hospital CEO and all relevant senior management. The policy was based on national guidelines and included specific protocols for the administration of post-exposure prophylaxis (PEP). Training workshops were held for senior managers and healthcare providers on attitudes about rape. Trainings were also held to increase the role and capacity of nurses in providing post-rape care including forensic services. In order to reduce delays and trauma to victims, post-rape care services were centralized within a designated room of the hospital, which included all clinical tools, post-rape treatments, and medications. Finally, a range of activities were implemented to increase community awareness of the services available (PEP, HIV tests, emergency contraception, etc.) and of the importance of seeking medical care immediately following an incident of sexual assault.[93]

The quantitative and qualitative evaluations found that the Refentse project has been able to improve substantially the quality and range of sexual assault services for a modest cost and utilizing existing resources.[94] The evaluations also found that, after training programs, nurses were able to play an expanded role in providing post-rape care. Prior to the implementation of Refentse, the role of nurses in post-rape management was limited to pulling medical charts and recording patients' vital signs. After the intervention, however, nurses documented rape history, provided trauma counseling, administered PEP and pregnancy tests, provided a treatment package and counseling on medications, and referred survivors to support services in the community. Although the study found limitations in the capacity of nurses to conduct forensic examinations due to the length of time and extensive training required, many nurses also assisted doctors in providing forensic services.[95]

The Refentse project illustrates the way in which a comprehensive systems-level approach to addressing sexual violence can be implemented in a resource-poor setting. The success of the Refentse project also demonstrates the importance of expanding the role of nurses as a key strategy for increasing access to comprehensive post-rape care, especially in rural areas where few doctors may be available.

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[92] Julia C Kim, et al., "Comprehensive Care and HIV Prohylaxis After Sexual Assault in Rural South Africa: The Refentse Intervention Study," *British Medical Journal: Quality Improvement Report* 338 (2009): 1559. http://www.bmj.com/content/338/7710/Practice.full.pdf

[93] Julia C. Kim, et al., "The Refentse Model of Post-Rape Care, " 4.

[94] Ibid., 17-18.

[95] Julia C. Kim, et al., "Comprehensive Care and HIV Prophylaxis After Sexual Assault in Rural South Africa," 1560.

iii. Health Care Financing Initiatives to Increase Access

In recent years, development agencies have shown a growing interest in supporting voucher programs, also known as "output-based programs" or "demand-side financing," to increase access to critical health services such as reproductive health and family planning by the lowest income sectors of society. Unlike the traditional healthcare financing models that provide free or low-cost services through public health facilities, voucher programs provide economic power directly to individuals for purchasing specific medical services.[96] The vouchers are made available to low-income residents at an affordable rate and can be exchanged for a defined set of health services. Participating healthcare providers serve patients in exchange for the vouchers, and are reimbursed for their services at a competitive rate. Voucher programs require that providers meet high quality standards to participate in the program, while patients can seek care at any contracted provider.[97] Reproductive health voucher programs have been piloted in several countries, including Kenya, Tanzania, Uganda, and India.[98]

The Reproductive Health Output-Based Aid voucher program in Kenya, first implemented in the rural areas of Kisumu, Kiambu, and Kitui and in two slums of Nairobi, Korogocho and Viwandani, includes support for sexual violence services. The program is administered by Price Waterhouse Coopers with funding from the German Development Bank. Individuals who fall below a certain poverty threshold are eligible to purchase vouchers for family planning services and safe motherhood services including antenatal, delivery, and postnatal care.[99] Since victims of sexual violence should receive free support, the program partnered with the Gender Violence Recovery Centre at the Nairobi Women's Hospital to provide reimbursement for treatment of cases documented at the center. The Centre offers specialized counseling and medical services for survivors of gender-based violence. To ensure quality, Price Waterhouse Coopers, the voucher management agency, conducts regular assessments to ensure that services provided at the Centre adhere to the National Guidelines of Medical Management of Rape/Sexual Violence in Kenya.[100] There are plans to establish satellite centers in Mombasa, Kisumu, and in two settlement areas in Nairobi.[101]

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[96] USAID, "Insights from Innovations: Lessons from Designing and Implementing Family Planning/ Reproductive Health Voucher Programs in Kenya and Uganda," *PSP One Technical Report Series* (2009): 7.
[97] Population Council, "About RH Vouchers," accessed January 14, 2011. Available at http://www.rhvouchers.org/about/.
[98] USAID, "Insights from Innovations," 7-8.
[99] KFW Entwicklungsbank, "Kenya – Vouchers for Health." Available at http://www.kfw-entwicklungsbank.de/EN_Home/Countries,_Programmes_and_Projects/Sub-Saharan_Africa/Kenya/Project_-_Vouchers_for_Health.jsp.
[100] Institut für Gesundheits- und Sozialforschung GmbH, "OBA Programme Kenya: Final Report on Baseline Study," *IGES* (2005): 11-173.
[101] Ibid, 73-75.

Despite the growing popularity of voucher programs, limited information exists on the effectiveness of the initial reproductive health voucher pilot programs.[102] A report by USAID on Kenya's Output-Based Aid program and Uganda's Reproductive Health Voucher Project (which provides vouchers for the treatment of STIs and safe-motherhood services) found that voucher programs were feasible to implement, the private sector was willing to meet the needs of new clients when they received revenue, and both public and private voucher service providers invested in making quality improvements including improving infrastructure, supplies and equipment.[103] In Kenya, both providers and patients have noted the benefits of the program. Doctors can treat low-income patients without having to shoulder the cost, while patients have the freedom to choose the public or private facility or doctor that they trust.

Still, voucher programs face significant challenges. Chief among them is the range of functions required to administer the programs on a large scale. These functions include technological tools to simplify voucher distribution, the processing of claims, and payments to providers; setting reimbursement rates correctly to ensure provider responsiveness to patients; and developing and sustaining marketing campaigns to generate awareness of vouchers.[104] The Population Council recently undertook an initiative to evaluate reproductive health voucher programs worldwide.

B. Comprehensive Post-Rape Care: Integrated Delivery Models

Innovative program models that incorporate medical, forensic, psychosocial support services and referrals to community-based providers into the delivery of post-rape care services within hospitals, health centers, or clinics can increase access to comprehensive care and facilitate timely access to justice. Such integrated programs are regarded as best practices in addressing sexual violence, as they enable survivors to access a range of services in one location, reduce trauma and provide specialized care, and serve as the bridge or medico-legal linkage between sectors by documenting, collecting, and delivering evidence to the criminal justice system.

i. Sexual Assault Response Teams (SARTs): Highland Hospital

A Sexual Assault Response Team (SART) is an interdisciplinary team of individuals working collaboratively to provide comprehensive and specialized care to victims of sexual violence. While SART teams vary, they generally comprise a nurse examiner (or SANE) trained in forensic evidence collection; a counselor, case manager or advocate; a law enforcement officer; and a prosecutor. The goals of SARTs

[102] USAID, "Insights from Innovations," 8.
[103] Ibid., 29-33.
[104] Ibid.

are to provide coordinated, trauma-informed care to survivors of sexual violence, as well as to increase reporting to law enforcement and the conviction of offenders.[105]

In the original program developed in California, SART members (a nurse examiner, police officer, and advocate) are called to respond to the hospital emergency room as soon as a survivor of sexual violence arrives. Members respond as a team to interview and document the survivor's initial statement so the survivor is only required to provide an account of the incident once. After this initial interview, the police officer remains outside the examination room while the SANE collects forensic evidence. The evidence is then turned over to the police and the SANE provides the necessary medical and psychosocial referrals. The advocate provides emotional support to the victim throughout the process and coordinates referrals to legal aid, shelter, and other services. SART programs often meet regularly to discuss cases after the initial emergency room intervention.[106] To date, SART program protocols have primarily been developed and implemented in the United States.

At Highland General Hospital in Oakland, California, the Emergency Department is staffed with a SART around the clock to assist adult and child survivors of sexual violence. The hospital's Sexual Assault Center is also available 24 hours a day to provide advice and referrals by phone. The hospital receives an exceptionally high volume of sexual assault survivors and the SART program has received recognition as a national best practice for replication in hospital emergency room units throughout the country.[107]

SART programs have benefitted hospitals by providing rapid follow-up services to survivors of sexual assault after incidents, which frees up more time for physicians and nurses to serve other emergency room patients.[108] The SART-based approach has been found preferable to the single healthcare provider, as it is effective in meeting the diverse needs of survivors as well as in providing a support system for caregivers.[109] In addition, SART programs reduce the number of times victims have to recount incidents of sexual violence.[110] However, a significant limitation of the California SART model is that in order for survivors of sexual violence to receive the forensic examination free of charge, a police report must be filed in accordance with California state law. According to Lisa Jackson, Director at

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[105] National Sexual Violence Resource Center, "Sexual Assault Response Teams," accessed November 2, 2010, http://www.nsvrc.org/projects/154/sexual-assault-response-teams-sart.
[106] Linda E Ledray, "Sexual Assault Nurse Examiner (SANE) Development and Operation Guide," 13-14.
[107] Alameda County Medical Center, "Sexual Assault Center." Available at http://www.acmedctr.org/sexualassaults.cfm?M1=1&M2=5&M3=0&P=1556.
[108] Kentucky Association of Sexual Assault Programs, "Developing a Sexual Assault Response Team: A Resource Guide for Kentucky Communities" (2002): A83. Available at http://kyasap.brinkster.net/Portals/0/pdfs/SANE-COMMUNITYRESOURCE.pdf.
[109] Kentucky Association of Sexual Assault Programs, "Developing a Sexual Assault Response Team" (2002): A82.
[110] Linda E Ledray, "Sexual Assault Nurse Examiner (SANE) Development and Operation Guide," 13.

Highland General Hospital, this policy prevents many survivors who may not be ready to file a police report from accessing forensic services.[111]

ii. One-Stop-Shop: Thuthuzela Care Centers

"One-Stop-Shops" are specialized facilities designed to provide a wide range of services for survivors of sexual violence in a single location. The one-stop-shop model of service provision, generally located within or connected to a hospital, offers medical and forensic services, psychosocial counseling, legal aid, case management and referrals, and police services on site. The Thuthuzela Care Centers (TCCs), named after the Xhosa word for "comfort," in South Africa, are a good example for managing cases of sexual violence and delivering post-rape care. The first TCC was established in 2000 by the National Prosecuting Authority, in collaboration with the Department of Health, Social Development, Justice and Constitutional Affairs, and South Africa Police Services.[112] The TCCs assist survivors at each step, from emergency care to preparation for court, in order to minimize secondary trauma, reduce the overall length of time in finalizing cases, and improve conviction rates.[113]

TCCs are based in communities with relatively high incidences of rape and sexual assault. Upon arrival at the center, survivors receive trauma counseling from an on-site coordinator or nurse, an explanation of the procedures, and a medical examination, including collection of forensic evidence. Following these procedures, the victim is provided with the option of taking a shower at the center and changing into clean clothing. The victim provides a statement to an on-site investigator. Before leaving the facility, staff will provide the victim with post-exposure prophylaxis for HIV and emergency contraception, and an appointment for a follow-up visit. The survivor can also meet with a social worker to develop a safety plan, and if needed, referrals to community-based psychosocial services or shelter. If the victim decides to file a police report and bring the case to court, she can also meet with a prosecutor at the center for consultation.[114] UNICEF has partnered with TCCs to ensure that providers receive specialized training to provide support to children and has established child-friendly areas with toys and activities.[115]

TCCs are managed by an interagency team of representatives from the Departments of Health, Education, Correctional Services, Safety and Security, Social Development, and civil society

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[111] Lisa Jackson, interview by author, March 2010.
[112] USAID South Africa, "USAID South Africa Program in Support of PEPFAR: Thuthuzela Care Centres FY 2006" (2007).
[113] The National Prosecuting Authority of South Africa, "Thuthuzela Care Centres: Turning Victims into Survivors" 1-4. Available at http://www.info.gov.za/events/2009/TCC_2009.pdf.
[114] UNICEF, "Thuthuzela Care Centers," Accessed November 1, 2010, http://www.unicef.org/southafrica/hiv_aids_998.html.
[115] Ibid.

organizations in order to ensure a multi-sectoral and coordinated approach.[116] They also are located in close proximity to specialized sexual offences courts staffed with prosecutors, social workers, investigating officers, and magistrates trained specifically to handle cases of rape and sexual assault.[117] In early 2011, 17 Thuthuzela Care Centers operate in urban and rural areas, and plans are underway to expand this model throughout the country.[118]

According to a statement by Thoko Majokweni, the Director of the Sexual Offences and Community Affairs Unit, TCCs have improved the process of reporting and prosecuting crimes of sexual violence by increasing coordination and cooperation across the medical and legal sectors. TCCs have increased the reporting of sexual offenses, increased conviction rates, and decreased the length of time spent to prosecute and convict offenders from approximately 3 to 5 years to less than 6 months.[119] Despite the benefits of streamlining care for survivors of sexual violence, one-stop models have been criticized for creating a strain on local resources as they provide highly specialized services to a small subset of the population.

C. Increasing Access to Post-Rape Care in Humanitarian Settings

i. Mobile Clinics: Heal Africa's Emergency Response Teams

Heal Africa provides medical and psychosocial services to survivors of sexual violence in eastern Congo. The organization operates a teaching hospital in Goma specializing in gynecological surgery, maintains several safe shelters, and works with communities to develop strategies for prevention. When contacted by community members, Heal Africa teams respond as quickly as possible to provide emergency medical and psychosocial services to victims of sexual violence, many of whom live in remote areas and have no other source of medical care.[120]

Heal Africa ambulances respond in pairs for safety purposes, in the event that vehicles break down en route to remote locations or teams encounter violence. The vehicles are stocked with basic medical supplies and post-rape kits that include post-exposure prophylaxis for HIV and emergency contraception. Each ambulance travels with a physician or highly skilled nurse and a group of female counselors, most of whom are volunteers.

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[116] Ibid.
[117] National Prosecuting Authority of South Africa, "Thuthuzela Care Centres: Turning Victims into Survivors" 3.
[118] UNICEF, "List of Thuthuzela Care Centres" accessed October 20, 2010. Available at http://www.unicef.org/southafrica/protection_5080.html.
[119] UNICEF, "Thuthuzela Care Centers," accessed November 1, 2010. Available at http://www.unicef.org/southafrica/hiv_aids_998.html.
[120] UNICEF, "Partner 'Heal Africa' treats survivors of sexual violence in eastern DR Congo," accessed October 30, 2010. Available at http://www.unicef.org/emerg/drcongo_53151.html.

Over 80 women, many of whom have personally witnessed or experienced sexual violence, currently work as Heal Africa volunteers.[121] Counselors receive training in crisis counseling to minimize trauma, techniques to educate women on the risks of HIV and post-exposure prophylaxis, and triage to identify the individuals most in need of immediate medical attention. The doctor or nurse provides basic emergency medical care and transports those with more serious and complex injuries to the Heal Africa Hospital in Goma.[122]

According to Heal Africa's Director of Communications and Partnership Development, Bridget Nolan, the program has been successful largely due to their staff, almost entirely composed of Congolese providers and volunteers, who have established trust and are viewed as politically neutral by communities in the midst of conflict. Joseph Ciza, the coordinator of the SGBV mobile clinic program and highly skilled nurse, is widely recognized among these communities as the point of contact in emergency medical situations. For example, Ciza was immediately called by residents following the mass rape of over 300 women in August of 2010 and Heal Africa was the first to respond to the crisis.[123]

Although emergency response teams do not collect forensic evidence, the Heal Africa hospital plans to incorporate forensic examinations into the training of hospital staff. Heal Africa is also developing plans to establish a legal aid clinic at Université Libre des Pays des Grands Lacs, a Congolese law school, to serve as the medico-legal link to the Heal Africa hospital in Goma. In addition to responding to crises, emergency response teams also provide supplies and training to health providers in clinics in Goma and the surrounding areas that have been affected by war.[124]

Heal Africa's model of mobile emergency response teams offers a promising practice for reaching survivors of sexual violence in conflict settings with emergency medical care and crisis counseling during the critical 72-hour period following sexual assault. Using teams of local volunteers allows for more efficient use of program resources and establishes trust within a conflict-affected community. However, a lack of medical doctors in the area to staff emergency response teams remains a significant challenge.

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[121] Bridget Nolan, interview by author, October 21, 2010.
[122] Ibid.
[123] Ibid.
[124] Ibid. Also see Nicole D'Errico, Christopher M. Wake, Rachel M. Wake, "Healing Africa? Reflections on the Peace-Building Role of a Health-Based Non-Governmental Organization Operating in Eastern Democratic Republic of Congo," *Medicine, Conflict and Survival* 26/2 (2010): 145-159. Heal Africa works to increase access and improve the overall quality of care. The Heal Africa Hospital in Goma is a 155-bed facility with the largest pediatric-specific HIV clinic in the world. Through its safe motherhood program, the hospital trains nurses and village mid-wives to improve safe delivery practices and prevent mother-to-child HIV transmission. It works with communities in North Kivu to identify individuals most in need of medical care and connect them to treatment.

ii. Training Mobile Health Workers to Respond: The MOM Project

In 2005, the Mobile Obstetrics Maternal Health Workers Project (MOM) designed by the Johns Hopkins Center for Health and Human Rights and the Global Health Access Program, was launched in the town of Mae Sot on the Thai side of the Thai-Burma border to provide emergency obstetric care to women in the conflict-affected areas of eastern Burma. The MOM project was developed as an alternative to facility-based health care, which was becoming less feasible due to the armed conflict and the ensuing destruction of healthcare infrastructure. The project trained a cadre of mobile reproductive health workers to provide emergency obstetric care to women in their homes or in semi-permanent structures that are easily dismantled in the event of violence and population displacement.[125]

The MOM Project established a three-tiered collaborative network of community-based health workers. Skilled maternal health workers from local organizations were selected and received extensive training in the provision of basic emergency obstetric care, blood transfusions, and ante natal care. These health workers then returned to their communities and trained a second tier of local health workers to provide a subset of these services based upon their individual skills levels. In addition, they trained a third tier of less-skilled traditional birth attendants in safe delivery practices and newborn care. Training providers of different skill levels and the close communication among these groups increased health care services throughout war-torn areas of eastern Burma.[126]

This model of healthcare delivery emphasizes bringing care directly to populations, and the mobility of services allows for continuity of care among war-affected communities that may be cut off from healthcare services. The model also has the potential for replication and adaption to various cultural contexts, having been piloted in a number of different ethnic communities. An evaluation of this project is currently in progress, and it may be expanded beyond obstetric care to provide access to more comprehensive care in conflict settings.[127] The MOM project model provides a promising strategy for delivering post-rape care to survivors, as different tiers could address the range of levels of care involved in addressing sexual violence, from the treatment of complex medical injuries to the provision of PEP kits, counseling and education.

iii. Building Capacity for the Treatment of Traumatic Fistula

Traumatic gynecological fistula, a tear between a woman's vagina and rectum or bladder or both, is a condition that may result from violent rape or sexual assault, often in conflict and post-conflict settings. Women with fistula are often unable to control their flow of urine and feces, can no longer work or care

[125] Luke Mullany, et al., "The MOM Project: Delivering Maternal Health Services among Internally Displaced Populations in Eastern Burma," *Reproductive Health Matters* 16/31 (2008): 44-46.
[126] Ibid, 48-50.
[127] Ibid, 53-54.

for their families, and may be shunned by their husbands and communities. Isolation from the community can be devastating, even fatal, in many parts of the world. Fistulas can usually be repaired through a surgical procedure; however, a lack of institutional capacity and skilled medical providers often limit women's ability to access fistula services.[128] In 2005, the Acquire Project convened the first conference on traumatic fistula, in Ethiopia. Conference participants identified and discussed many of the gaps in resources, equipment, knowledge, and training opportunities for providers.[129]

The Acquire Project, in collaboration with EngenderHealth, is currently partnering with selected hospitals in Rwanda, Sierra Leone, DRC, Nigeria, Ethiopia, Ghana, Guinea, Bangladesh and Uganda to build local capacity for providing comprehensive fistula services.[130] The program supports upgrading infrastructure and equipment within fistula repair centers in hospitals, provides training for doctors and nurses in surgical fistula repair, as well as training for support staff to provide post-operative care and psychosocial counseling to patients. The project also aims to integrate the use of evidence-based practices and establishes systems for monitoring and evaluation. Nurses and hospital staff at the centers promote a caring environment, work with survivors of rape to develop plans for reintegration into their communities, provide them with transportation to and from the hospital, and connect them to other services such as legal aid, literacy, and vocational training.[131]

The Fistula Care Project of USAID and EngenderHealth provides support to the Heal Africa Hospital in Goma and the Panzi Hospital in Bukavu, two hospitals with expertise in treating fistula in the DRC, to improve and expand fistula services. In addition to providing fistula repair surgery and training other providers in the region, both hospitals provide transportation, follow-up counseling, and work with patients and communities to support the re-integration process.[132] The Health Africa Hospital has established a recovery center for women in need of medical observation after fistula repair, in which women receive ongoing psychosocial counseling and opportunities to engage in literacy classes, sewing, basket making, and other income-generating activities. Meeting the demand for fistula services with limited medical staff with expertise in fistula repair is an ongoing challenge. For example, at any given time, between 120 and 160 women await fistula repair at the Heal Africa hospital. Additionally over 70

[128] EngenderHealth/The Acquire Project, "Traumatic Gynecological Fistula: A Consequence of Sexual Violence in Conflict Settings: A report of a Meeting Held in Addis Ababa, Ethiopia, September 6-8, 2005" (2006): 1-2. Available at http://www.engenderhealth.org/files/pubs/maternal-health/TF-Report-English.pdf.
[129] Ibid.
[130] More information is available at http://www.acquireproject.org.
[131] P. MacDonald and M.E. Stanton, "USAID Program for the Prevention and Treatment of Vaginal Fistula," *International Journal of Gynecology and Obstetrics* 99 (2007): S112-S116.
[132] EngenderHealth, "The Fistula Care Project: Democratic Republic of the Congo." Available at http://www.fistulacare.org/pages/sites/congo.php#HEAL.

percent of the total patients at the Panzi Hospital are survivors of sexual violence, many of whom are in need of fistula services.[133]

VII. CONCLUSION

There is an urgent need to develop basic minimum standards and procedures for aiding victims of sexual violence that can be applied in (and are mindful of) varying cultural and social settings. Such a protocol should uphold fundamental human rights, including the right to seek legal remedies.[134] At a minimum, certain medicines, such as post-exposure prophylaxis for HIV and emergency contraception, should be part of a protocol. Provisions should also be made to ensure that healthcare providers are properly trained to gather patient information for the provision of medical and psychosocial care and, if consent is given, as evidence to be stored, analyzed, and eventually used in a court of law, if the patient so desires.

There is also an urgent need to break down the barriers that prevent physicians and other healthcare providers from providing care to survivors of sexual violence. Some of these barriers include lack of capacity of hospitals/clinics, insufficient medicine or resources, cultural barriers, lack of education about the clinical management of rape, confusion and lack of awareness of the 72-hour window for treatment, stigmitization, and laws that require only qualified doctors to provide treatment and documentation that could be provide by properly trained medical personnel.

Today a growing number of innovative are programs aimed at responding quickly to incidents of sexual violence and providing quality care to survivors. In this paper, we highlighted two such approaches. The first, the "systems approach," involves the process of review and reform at all levels of an organization including procedures, policies, equipment, and data collection systems, as well as expanding the role of nurses or lower level health practitioners through Sexual Assault Nurse Examiner (SANE) programs. Healthcare financing initiatives, such as voucher programs, can also be used to expand access and increase the quality of sexual violence services. The second, the "integrated model" approach, draws on institutions and organizations within a community to form a comprehensive care program. Two examples of integrated models are Sexual Assault Response Teams (SART) and "one-stop-shops." Other programs, such as mobile clinics or mobile health worker teams, can also be effective, especially in areas of armed conflict. Whatever the program, it is paramount that it be adaptable, open to change as new circumstances arise, and always respectful of the human rights of those entrusted to its care.

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[133] Ibid.

[134] Article 8 of the Universal Declaration of Human Rights provides that "[e]veryone has the right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law."

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