Clinical care for sexual assault survivors: the use of a multimedia training tool

Triple rule-out MDCT-angiography for chest pain in emergency room

Analyse qualitative du conseil médical donné par les médecins généralistes et urgentistes du Service d’aide médicale urgente

A disconcerting leg: a case of deep vein thrombosis with negative D-dimers

Cardiac arrest caused by torsades de pointes?

La médecine d’urgence et le droit au Liban

Les urgences médicales en ophtalmologie

Toxicité des cathinones de synthèse
ABSTRACT

Introduction: Sexual assault rises as a global public health in conflict-affected populations where chaos prevails and gender based violence becomes as a strategy of war. The health effects of sexual violence include unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs), physical and psychological trauma, and social stigma. Training health care providers (HCPs) has been prioritized by humanitarian actors globally to improve the quality clinical care to survivors of sexual violence. However, few studies have evaluated the effectiveness of training interventions in refugee and post-conflict settings.

Methods: A four to five days “training of trainers” (ToT) was provided to relevant community health workers, nurses, midwives, doctors and other relevant field workers working in conflict-affected environments in Jordan, Turkey, Syria and Lebanon using the “Clinical care for sexual assault survivors (CCSAS) multimedia training tool” developed by International Rescue Committee (IRC).

Results: Overall, six ToTs took place; they included general practitioners, obstetrician/gynecologists, pediatricians, psychologist, forensic physicians, nurses, social workers, midwives, and program officers. In Jordan, 50 participants (two groups of 25) have completed the training; the group improved by 142% on average at post-test in knowledge and attitudes to care for survivors (25% on average of correct answers at pretest, 60.5% on average at posttest). A second ToT in Jordan included 22 participants who have improved by 57.6% on average (50.3% vs. 79.3%). The third ToT in Turkey included 13 participants who have improved by 47% on average (38.5% vs. 56%). A forth ToT took place in Lebanon where 19 participants have improved by 62.5% on average (56% vs. 91%). The fifth ToT in Syria, included 18 participants who have improved by 46.2% on average (52% vs. 76%). And the sixth ToT took place in Turkey where nine participants have improved by 82.6% on average (46% on vs. 84%).

Discussion: All participants have successfully completed the training and showed improvement at the posttests. However, key challenges and limitations identified included logistics at the preparation and recruitment stages, language barrier and differences in cultural or religious views. Key barriers to quality care identified included poor or lack of access to services, lack of trained staff, lack of privacy and confidentiality and lack of essential resources and treatment including emergency contraception and HIV post-exposure prophylaxis (PEP) as well as unclear referral mechanism. Action plans were developed by participants to address these barriers and follow-up to evaluate progress was planned.

Conclusion: The CCSAS multimedia training tool showed an initial positive impact and has demonstrated effectiveness in promoting compassion and competence among trained HCPs and improving quality of clinical care for sexual assault survivors in such humanitarian settings. On-going technical and psychosocial support, long-term behavior change interventions, supply chain management, monitoring and evaluation, and interventions to raise awareness and identify survivors of sexual assault are needed in addition to the training to ensure quality clinical care is delivered to sexual assault survivors.
INTRODUCTION

Sexual assault is a global public health and human rights challenge, and a particular threat to refugee and conflict-affected populations [1-3]. In fact, in such setting, where chaos prevail, gender based violence (GBV) emerges as a war strategy and weapon [4-5]. The health effects of sexual violence have been well documented and include unwanted pregnancy, unsafe abortion, sexually transmitted infections (STIs) including human immunodeficiency virus (HIV), physical injury, psychological trauma, and social stigma [6]. Timely access to quality clinical care, delivered by competent and compassionate health care providers in a confidential care delivery setting, is essential to begin a survivor’s physical and emotional healing and reduce the risk of adverse consequences in the long-term.

Training health care providers (HCPs) has been prioritized by humanitarian actors globally as a key component in improving the delivery of quality clinical care to survivors of sexual violence and there has been increasing demand to build an evidence base around training tools and methods effective in humanitarian settings [7]. Evaluations of training programs to date have demonstrated effects on the quality of clinical care delivery and health and psychosocial outcomes for survivors in well-resourced medical settings [8-10]. However, few studies have evaluated the effectiveness of training interventions in refugee and post-conflict settings.

MATERIALS AND METHODS

In order to meet the urgent need to increase the knowledge and awareness on how to properly and efficiently care for sexual assault survivors, a four to five days “training of trainers” (ToT) was provided to relevant community health workers, nurses, midwives, doctors and other relevant field workers working in conflict-affected environments where displaced populations are facing such humanitarian crisis. Trainings took place in Amman, Antakya, Derek and Beirut.

The adopted training method was the “Clinical care for sexual assault survivors (CCSAS) multimedia training tool” developed by International Rescue Committee (IRC) as a unified training tool aiming to improve clinical care for and general treatment of sexual assault survivors by providing medical instruction and encouraging competent, compassionate, and confidential care for sexual assault survivors in low-resource settings. The training was intended to improve the quality of clinical care for sexual assault survivors in diverse humanitarian settings.

As per the recruitment of HCPs and other relevant trainees, the process included opening a general call for application entailing the following subsections:

- Receiving the patient and preliminary assessment
- Obtaining informed consent and taking the history
- Performing a physical exam
- Treatment and disease prevention
- Caring for male survivors
- Caring for young survivors

This section is intended to provide guidance on how to assess the clinic’s resources, organize the staff and materials needed to care for survivors and map out referral network.

Section 4: Team Preparation

This section is intended to provide relevant skills to be able to conduct a compassionate, competent, and confidential forensic examination, to obtain forensic specimens that can be used as evidence and to properly document and store collected evidence to ensure permissibility in court.

Training methods

Trainings were co-facilitated by clinical and GBV specialists experienced in working with sexual assault survivors using the multimedia training tool in a standardized way according to the methodology presented in a facilitator’s guide. This guide – which can be downloaded online for free – allowed for the training to be unified whether in the content, timelines, ideas for exercises and workshop animation, etc, it also allowed for the training to be reproducible, and for trainees to have same skills and standard forms to use (such as drug treatment protocols, medical history and exam forms, and systematic clinical pathway of care delivery (Figure 1). As such, the training was facilitated using multiple methods to engage participants and reinforce messages (Figures 2 to 5). It is also worth noting that the training was delivered with professional translation from English to Arabic and Arabic to English and all training materials were distributed to participants in both English and Arabic. As such, the following tools were adopted during the training:

Videos reenactment of interactions between health workers and survivors of sexual assault was used to model best practice of competent, compassionate, confidential care. Documentary style interviews with clinical care experts from around the world offered first hand perspectives on working with sexual assault survivors. Videos generated active discussion among participants about how to best care and interact with survivors.

Section 5: Forensic Examination

This section is intended to describe the consequences of sexual assault and how one can help a survivor start to heal.

Section 3: Direct Patient Care

This section contains directions on direct patient care including the following subsections:

- Caring for young survivors
- Caring for male survivors
- Treatment and disease prevention
- Performing a physical exam
- Obtaining informed consent and taking the history
- Receiving the patient and preliminary assessment

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Section 2: Responsibilities of non-medical staff

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Section 3: Direct Patient Care

This section contains directions on direct patient care including the following subsections:

- Caring for young survivors
- Caring for male survivors
- Treatment and disease prevention
- Performing a physical exam
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- Receiving the patient and preliminary assessment

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Chapter 2
Preparing & Presenting

- Take to private consultation room.
- Offer comfort and understanding.
- Treat wounds, give pain control.
- Explain procedures and get informed consent.
- Take medical history.
- Conduct physical exam.
- (Obtain samples for forensic evidence)
- Treat or repair genital injuries as necessary.

(Obtain samples for forensic evidence)

- Counsel on the possible health consequences.
- Give ECPs (up to 120 hours) if at risk for pregnancy.
- Give prophylaxis for STIs.
- Give PEP.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

Stabilize and transfer.
- Consider ECPs, PEP, tetanus and Hepatitis B immediately.

Patient medically stable?
- Needed treatment can be given at this facility?
- Within 72-120 hours?

- Stabilize and transfer.
- Counsel on the possible health consequences.
- Follow protocols for diagnosis and treatment of STIs.
- Give tetanus prophylaxis if indicated.
- Give Hepatitis B vaccine if available.

Discharge counseling and teaching:
Make sure the survivor has a safe place to go. Reassure her that the assault was not her fault and that conflicting emotional reactions are normal. Connect her to counseling, protection and legal services. Encourage a follow-up visit in two weeks. Give clear simple instructions for medications, wound care, etc.

Document the exam and treatment thoroughly. Keep all documents and evidence confidential and secure.

Patient assessed immediately. Crisis team or other designated clinician notified.

Figure 1: Clinical pathway for the treatment of sexual assault survivors.

Figure 2: Summary by one of the trainees in ToT 1 in Jordan \NSouaiby©

Figure 3: Group exercise performed by ToT 3 in Turkey \NSouaiby©

Figure 4: Active discussion among trainees in ToT 5 in Lebanon \NSouaiby©

Figure 5: Role play performed by trainees in ToT 6 in Turkey \NSouaiby©
Case studies conveyed issues for discussion and opportunities to assess comprehension. Text cards provided detailed technical information about best practices and standards of care.

Group exercises allowed participants to role play active listening skills, responding to common emotional reactions of survivors, talking with suicide survivors, obtaining informed consent, and documenting care on a medical history and exam form with pictograms.

Summaries allowed each participant to summarize a part of the training giving them the opportunity to address the group as a trainer which was challenging for some of them but very conclusive.

RESULTS

A “CCSAS ToT” was conducted with the International Medical Corps (IMC) and the Ministry of Health (MoH) in Amman, Jordan, in November 2011. A total of 50 participants, divided in 2 groups of 25 (A and B) attended the training. They represented IMC and MoH Jordan. IMC and MoH clinic staff attending the training included general practitioners, obstetrician and gynecologists, pediatricians, psychologist, forensic physicians, nurses, social workers, midwifes, and program officers.

Groups A and B each has successfully completed the training; they improved by 142% on average at posttest in knowledge and attitudes to care for survivors (25% on average of correct answers at pretest, 60.5% on average at posttest). This could be explained by the very low knowledge at the pretest, and that the training information and skills were mainly attained.

Another ToT was conducted in this same year in Jordan. A total of 22 participants attended the training representing IMC, IRC Jordan, IRC Iraq, and the United Nations Population Fund (UNFPA). IMC clinic staff attending the training included general practitioners, obstetricians and gynecologists, pediatricians, psychiatrists, nurses, pharmacists, case managers, and program officers. IMC management also attended the first day of training. Seven men and fifteen women attended. Participants successfully completed this training and improved by 57.6% on average at posttest in knowledge and attitudes to care for survivors (50.3% on average of correct answers at pretest, 79.3% on average at posttest). In April 2015, the CCSAS ToT was conducted in Derek, Syria. A group of 18 participants successfully completed the training. They were all physicians (including surgeon, dentist, gynecologist, two family physicians and two emergency physicians) except one social worker.

The group improved by 82.6% on average at posttest, in knowledge and attitude towards survivors (46% on average of correct answers at pretest, 84% on average at posttest). This was the best result in terms of knowledge, amongst all groups that were trained in the last four years in Jordan, Lebanon, Turkey and Syria.

Table 1 presents a summary of results of pretests and posttests conducted (aslo highlighted in graph 1) and shows the level of improvement in the trainees (as shown in graph 2). As such it reflects the effectiveness of the training itself as the higher percentages of improvement were observed among the lowest knowledge at pretest.

<table>
<thead>
<tr>
<th>Training (Country)</th>
<th>n=</th>
<th>Pretest results (%)</th>
<th>Posttest results (%)</th>
<th>Improvement (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ToT 1 (Jordan)</td>
<td>25</td>
<td>25</td>
<td>60.5</td>
<td>142</td>
</tr>
<tr>
<td>ToT 2 (Jordan)</td>
<td>22</td>
<td>50.3</td>
<td>79.3</td>
<td>57.6</td>
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<tr>
<td>ToT 3 (Turkey)</td>
<td>13</td>
<td>38.5</td>
<td>56</td>
<td>45.5</td>
</tr>
<tr>
<td>Tot 4 (Lebanon)</td>
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<td>56</td>
<td>91</td>
<td>62.5</td>
</tr>
<tr>
<td>ToT 5 (Syria)</td>
<td>18</td>
<td>52</td>
<td>76</td>
<td>46.2</td>
</tr>
<tr>
<td>ToT 6 (Turkey)</td>
<td>9</td>
<td>46</td>
<td>84</td>
<td>82.6</td>
</tr>
</tbody>
</table>

Table 1: Summary table showing for each training of trainers (ToT), the number of participants along with the pretests, posttests results and percentage of improvement in each group.
The first two sections of the training generated active discussion about common myths: men cannot control sexual urges, a woman may be to blame for sexual assault because of the way she dressed, and if a husband forces his wife to have sex it is not sexual assault [11]. Participants discussed challenges faced in protecting survivors’ rights to privacy and confidentiality. They also discussed the fact that when women in this region are arrested, they are automatically labeled as sexually assaulted which can cause harm to them once free [12].

New and active discussions were also generated about the need to have programs responding to violence against men in detention centers and camps. Trainees said that they are receiving more and more case of sexual violence against boys and this is due to the lack of programs reserved to them. Usually programs targeted mainly girls [13].

Another critical issue concerning the reporting of rape cases to authorities was discussed: By law, reporting is mandatory without the consent of the survivor which doesn’t adhere to ethics. In some regions where nongovernmental armed forces control the ground, the “non-official authorities” request and oblige care workers to share their findings. This can harm the principles of confidentiality.

In section 3, participants appreciated resources of WHO international drug treatment protocols, medical history and exam forms, and systematic clinical pathway of care delivery. They also commented on learning mental health needs of survivors and communication techniques: active listening skills for history taking and conducting the exam. They acquired new techniques to approach psychosocial cases since Psychosocial support is not always accepted by the community.

Real and concrete cases related to collective rape and its devastating consequences were discussed: pregnancy out of rape, prohibition of abortion in the absence of any alternative to help women.

In section 4 all participants show interest to apply this training in their different settings. This section guided them through developing an action plan for the improvement of services for sexual assault survivors. Participants were coached to map the future eventual trainings to be conducted with their referral networks, to conduct a training checklist of resources needed (logistics, recruitment, agenda, objectives, etc.). They also discussed action plans to address gaps and barriers in the management of future cases and shared their assessments with the trainer to identify common challenges and responses.

In section 5 covering the legal aspects and the importance of forensic evidence, basic principles were developed. Trainees showed interest and were convinced that forensic evidences could be helpful to the international community when liabilities are searched.

Furthermore, in the evaluation of the training, when asked to list the topics that were not discussed during the training, but that were relevant to their work, participants wanted to learn more about SGBV in the context of Syrian crisis and which protocols are applicable in Syria. Moreover, they showed interest in building a network from different actors in SGBV field inside Syria, all of which to be linked to a central focal point. In fact, a call-in hotline was provided in order to maintain communication with relevant trainees and doctors in order to provide medical advice for sexual assaults cases which highlights the positive impact of the training and the high confidence in trainers. Also, with the consent of trainees, feedback on training and improvement of trainees were discussed via social media (skype, whatsapp, etc.) with relevant management.

As for “the ability to apply new acquired skills into their work”, most felt “more confident” about handling SGBV cases as discussed in the training, while others were “less confident” because of lack of resources (absence of funding, inappropriate settings, etc.) to develop such programs.

As for having “concrete plans to apply their new acquired skills”, suggestions included performing training and capacity building for hospital staff, doctors, Non Governmental Organization (NGO) staff and other relevant stakeholders. Also, they suggested providing training in Primary Healthcare Centers (PHC) and building networks to link relevant stakeholders for future collaboration, in addition to providing private setting to ensure privacy of the survivor. But most importantly, throughout this workshop, trainees became more aware of the importance of mental health counselling to victims especially at an early stage because of its inferring consequences (nightmares, sleep quality, distress, quality of life impairment, etc.) [10;14].

Finally, trainees wished to seek further support and communication from IRC and other international and local NGOs in order to be able to efficiently apply acquired knowledge.
DISCUSSION AND RECOMMENDATIONS

Overall, the recruitment of trainees was good. They were all very motivated and followed the whole training without complaints and expressed what a great experience it was for them. In fact, it was beneficial to have participation from groups that were diverse in specialty, background, age and gender. Active and open discussion was generated and participants learned from one another's clinical and counseling expertise as well as one another's beliefs and values.

There was a sense of cooperation and commitment from all candidates. They were friendly, with a good team spirit. Participants were also very helpful and had valuable interventions during the sessions.

However, based on initial findings from the evaluation and training, key challenges were identified. They included limitations on the different levels, starting from the organization phase of the training, where choice of location and other logistics including transportation of trainees or trainer were encountered especially in Derek, and during the implementation phase of the training where language was a key barrier in the first ToT provided. In fact, although training provided by a highly experienced and competent GBV expert, and although a professional translator was present at the training, the language remained a barrier in the active discussion however this was taken into consideration in other ToTs where trainings were the trainer was bilingual with Arabic as a native language. Moreover, the need for an Arabic tool has pushed efforts from IRC, The United Nations Children's Fund (UNICEF) and ABAAD to translate the facilitator's guide. A first draft is developed but is not yet published as some terminologies need to be adapted to the context taking into consideration some words sensitivity.

Also, it is worth noting that cultural or religious differences were observed while conducting the trainings in different countries and sometimes within the same country (for e.g. North east Derek vs. Damascus). This was reflected in the expressing beliefs and point of views pertaining to virginity, the use of sensitive words sensitivity.

Moreover, challenges faced at the stage of spreading this acquired knowledge in conflict-affected areas where it is mostly needed but where the implication of authorities and political party is absent because of ongoing conflict and instable political context where armed forces prevail.

Key barriers to quality care identified included poor or lack of access to services, lack of trained staff, lack of privacy and confidentiality and lack of essential resources and treatment including emergency contraception and HIV post-exposure prophylaxis (PEP) as well as unclear referral mechanism. Action plans were developed by participants to address these barriers and follow-up to evaluate progress was planned.

It is also worth noting that a one-to-one evaluation was performed by the trainer. Results were not included as to preserve the privacy and confidentiality of the evaluation, however general main key points and findings were reflects in the overall recommendations provided hereafter:

- Providing a refresher training (of two to three days) in a four-six months period from the date of the first training, followed by an assessment and coaching that aims to support the trainees in translating the knowledge gained from the training into feasible actions. This process will predominantly focus on developing a clear action plan for the process of receiving and caring for the survivor, using a participatory approach. This was partially started with the group and can be pursued by trainees themselves.
- Disseminating the CCSAS multimedia training tool among humanitarian actors on a wide scale to improve the quality of care for sexual assault survivors through improved knowledge, confidence, and attitudes among HCPs and improved facility preparedness.
- Promoting community awareness of CCSAS services available, throughout poster display and patient information materials, etc.
- Performing screening for sexual assault cases taking place in order to better assess the magnitude of the problem especially that literature and studies on SGBV in the Middle east are scarce.
- Referring survivors directly to a designated private consultation room with privacy sign or locked or guarded door to ensure.
- Maintaining survivors' medical records with a code and store in a separate locked cabinet.
- Conducting on-going refresher trainings in CCSAS among all relevant staff.
- Disseminating job aides such as drug treatment protocols and clinical care pathways as well as medical history and exam forms with pictograms to guide care.
- Accompanying CCSAS training with on-going technical support to ensure knowledge and confidence in direct patient care for sexual assault survivors is sustained; long-term behavior change interventions to address identified gaps in HCP sensitization and negative attitudes related to sexual assault; supply chain management to ensure health facilities are equipped with necessary supplies to provide services; monitoring and evaluation to ensure quality of care is sustained; and interventions to raise awareness and identify survivors of sexual assault for improved access to CCSAS.
- Coordinating with the United Nations Population Fund and other international parties to obtain PEP kits where needed.
- Using adjusted dosages of registered contraceptives for the purpose of emergency contraception [15].
- Disseminate referral protocols for services within IMC and external referrals to MoH and other advanced medical, counseling, forensic, and legal services.
- Enhancing CCSAS training pertaining to psychosocial care and support for survivors; clinical treatment protocols; validated monitoring and evaluation tools; awareness raising materials; and tools for identifying survivors of sexual assault.

CONCLUSION

The CCSAS multimedia training tool showed an initial positive impact and has demonstrated effectiveness in promoting compassion and competence among trained HCPs and improving quality of clinical care for sexual assault survivors in such humanitarian settings. The evaluation revealed limitations.
in the capacity of HCPs and quality of care for sexual assault survivors in low-resource settings. Aspects of the training that were more effective included respecting survivors' universal rights, obtaining informed consent, conducting a medical history, performing a physical exam, while training components focusing on beliefs about sexual assault, treatment and disease prevention, care for child survivors, and care for male survivors need to be improved. However, It was also of utmost importance to unify the “CCSAS language” as to having a standard PEP and emergency contraception protocols to follow and to for trainees to develop relevant skills and know-how, in addition to acquiring the necessary resources including PEP kits and emergency contraception which are often lacking in resource limited and conflict affected settings.

Finally, on-going technical support, long-term behavior change interventions, supply chain management, monitoring and evaluation, and interventions to raise awareness and identify survivors of sexual assault are needed in addition to the training to ensure quality clinical care is delivered to sexual assault survivors. More follow up and refresher workshops need to be performed. However, it is to be taking into consideration that various countries have different sets of laws, policies and procedures and/or lack of ones in the case of conflict areas. Local, national and internationals efforts need to combine their resources and support to ensure optimal corrective actions and follow up.

AUTHOR’S NOTE

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REFERENCES