



WOMEN'S
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COMMISSION

Community-based Medical Care for Survivors of Sexual Assault: Building the Evidence

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Research. Rethink. Resolve.

Background

- Consultation on Reproductive Health Technologies in Crisis Settings, May 2008.
 - Increased risk of sexual violence for women and girls in crisis settings, with subsequent risks.
 - Medical care for those who have survived sexual violence can be limited.



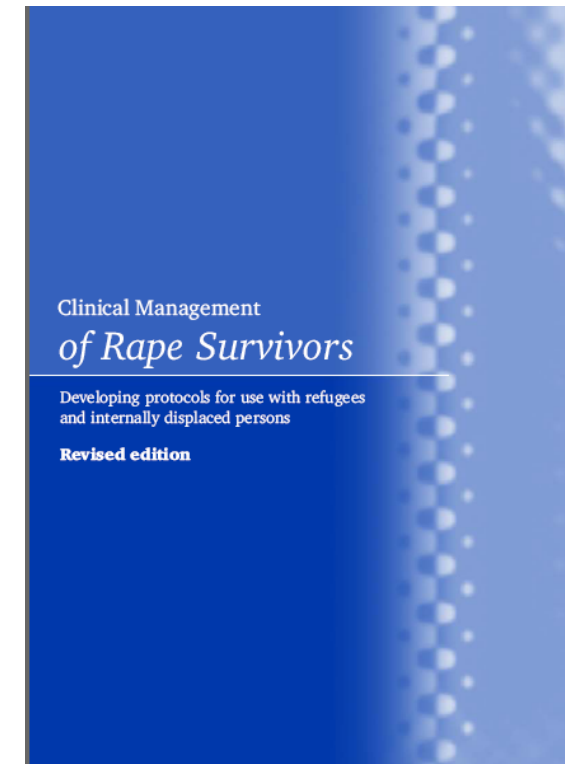
Pilot study questions

- Can community-based medical care be a **safe and feasible option of care** for survivors of sexual assault in a setting where insecurity and other challenges act as barriers to facility-based care?
- What are the challenges to providing care in this manner?



WHO protocol for clinical care for survivors of sexual assault

- Minimum medical examination
- Minimum forensic evidence
- Compassionate and confidential treatment
- Comprehensive treatment



Pilot project

- Community health workers to provide clinical care as defined by WHO protocol
- Partners
 - Global Health Access Program (GHAP)
 - Burma Medical Association (BMA)
 - Karen Department of Health and Welfare (KDHW)



Pilot project

- Build off an existing task-shifting model for maternal health care:
 - GHAP's MOM (Mobile Obstetric Maternal Health Workers) Project and tiered system:
 - Maternal health workers
 - Health workers
 - Traditional birth attendants (TBAs)
- Four sites, Karen State, Burma



Ethical and practical questions

- Developing a feasible and practical community-based package of care per existing protocol, evidence and logistical constraints.
- Maintaining confidentiality and security for participants.
- Thinking through legal ramifications of community-based care.
- Ensuring “do no harm”.



Overcoming ethical and practical challenges

- Engaging in training and sensitization.
- Focusing on medical care.
- Providing minimum care per WHO protocol.
- Reducing documentation in the field and spelling out information sharing procedures.
- Keeping the pilot small.



End-line activities

- In-depth interviews with key stakeholders
- Focus group discussions among:
 - Pilot site health workers
 - Non-pilot site health workers trained in clinical care
 - Traditional birth attendants (TBAs)
 - Community members, primarily women of reproductive age and men



Preliminary findings

- Health workers showed eagerness in educating lower cadres (TBAs) and the community about GBV, sexual assault and the availability of care.
- Health workers demonstrated knowledge of clinical care.
- Concept of confidentiality was well understood.
- Health worker safety was not reported as a concern.
- Domestic violence was discussed within the scope of sexual assault.

“The community does not know, but they need to know that GBV is a serious issue that has caused deaths...Now we know more about GBV and treatment, and can provide care and information to the community.”

Pilot site health care worker



Discussion

- Lack of survivors reporting is a major barrier to assessing safety of the approach.
- More awareness-raising is needed to inform communities on the benefits and availability of care.
- TBA and community feedback to be available for analysis in October 2011.

“Before, health workers and community members were not interested in GBV because they thought it was a normal occurrence. The health workers wanted to run away from the topic. Now they are very interested, know more and have more experience.”

CBO staff



Next steps

- Expand and sensitize communities to increase likelihood of survivors reporting.
- Cold chain may allow the project to explore more than minimum care.
- Possible replication of the pilot in other crisis-affected settings to further the evidence-base.
- Provision of PEP by community health care workers is a key component of post-rape care in settings with higher HIV prevalence.

“Violence will happen any time. If we can introduce to other areas, the health workers can prevent consequences for survivors.” CBO staff



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- Community health care workers of pilot study
- Community members in pilot sites





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