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

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Background

• 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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