Trauma-informed care for abortion providers treating sexual violence survivors in humanitarian settings

AN ORIENTATION AND RESOURCES FOR FRONTLINE ABORTION TRAINERS AND HEALTH WORKERS

Ipas
Partners for Reproductive Justice

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Training materials overview

The toolkit materials include the following:

Access course materials on the Ipas humanitarian site here: https://www.ipas.org/resource-library/humanitarian-settings/. If you have any difficulties accessing materials or have questions about how to use any of these tools, please email TArequests@ipas.org.

Introduction to trauma-informed care for abortion providers treating sexual violence survivors in humanitarian settings[1, 2]

The world is facing multiple concurrent humanitarian emergencies that stem from conflict, natural disasters or pandemics. In such crises, women and girls may encounter disruptions in their social and family structures or livelihoods and, in turn, experience greater gender and reproductive health disparities. Increases in the risk of gender-based violence (GBV) and barriers to accessing contraceptive methods, safe abortion or other sexual and reproductive health (SRH) services make it challenging for women and girls to manage their lives during humanitarian crises.

1 IAWG. (2018). Interagency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings: https://iawgfieldmanual.com/manual

2 Elrha. (2021). Gap analysis of Gender-Based Violence in Reproductive Health Settings: https://www.elrha.org/researchdatabase/gap-analysis-of-gender-based-violence-in-humanitarian-settings/

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Gender-based violence is "an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between men and women. It includes acts that inflict physical, sexual or mental harm or suffering, threats of such acts, coercion and other deprivations of liberty."[1]

How prevalent is sexual violence during crises? And what impact does it have on women and girls? One in five refugee and displaced women experience sexual violence in humanitarian settings. Common perpetrators of this violence are intimate partners, acquaintances, aid workers in positions of power or militant groups using rape as a weapon of war. The health impact of GBV on the reproductive lives of women and girls includes—but is not limited to—unwanted pregnancy, unsafe abortion, pregnancy complications, STIs and HIV/AIDs. In the absence of prevention, mitigation or treatment, these outcomes can lead to maternal morbidity or mortality. Each of these issues are addressed in the Minimum Initial Service Package (MISP) with the goal of reducing maternal mortality through improved access to life-saving reproductive health care. This includes provision of comprehensive abortion care to the full extent of the law.

Survivors of crises and sexual violence typically experience multiple forms of trauma during and following the acute event. The standard of care for clinical management of rape survivors is provided in the Clinical Management of Rape and Intimate Partner Violence Survivors: Developing protocols for use in humanitarian services document—created by the World Health Organization (WHO), the United Nations Population Fund (UNFPA), the United Nations High Commissioner for Refugees (UNHCR) and the Inter-Agency Field Manual on Reproductive Health for Humanitarian Settings (IAFM).[2,3] However, non-GBV specialists and other SRH frontline providers can enhance their service delivery by providing trauma-informed care throughout their interaction with a client.

1 International Rescue Committee. (2020). Interagency Gender-Based Violence Case Management Guidelines Providing Care and Case Management Services to Gender Based Violence Survivors in Humanitarian Settings.

2 World Health Organization (WHO), United Nations Population Fund (UNFPA), United Nations High Commissioner for Refugees (UNHCR). Clinical management of rape and intimate partner violence survivors: developing protocols for use in humanitarian settings. Geneva: World Health Organization; 2020.

3 See note 1, pg. 01 above

Why do abortion and SRH frontline providers need this approach? Reproductive health services that require pelvic exams may re-traumatize clients, which may hinder women accessing care. There is a high likelihood that clients in emergency or conflict settings are experiencing trauma, even if they do not disclose sexual or other forms of violence at the time of treatment. Trauma-informed care should be an existing standard for non-specialized GBV health-care workers. This approach is survivor-centered and strengthens the GBV and SRH response and prevention activities in complex humanitarian settings.

This trauma-informed care toolkit aims to improve care for survivors by increasing providers' capacity to respond to the complex problem of sexual violence and GBV in humanitarian settings. The toolkit provides essential information on the principles of trauma-informed service—guidance on trauma-informed counseling and how to create an environment that is receptive to providing trauma-informed reproductive health care and steps for strengthening the linkages between the SRH and protection sectors—to ensure every client feels reassured, respected and protected.

This toolkit is designed for abortion providers who might not have access to the fuller courses, may be at the receiving end of referrals for abortion care, may be receiving abortion care training or will find application of the content helpful to their ongoing abortion services.

The toolkit is designed to complement other key training resources focused on care of sexual violence survivors, such as the Clinical Management of Sexual Violence Survivors in Crisis Settings created by the Inter-Agency Working Group on Reproductive Health in Crises (iawg.net) and the WHO curriculum, Caring for women subjected to violence: A WHO curriculum for training health-care providers. The toolkit builds on previously published materials with a unique focus on the intersection of trauma-informed care and abortion care.

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INTRODUCTION TO TRAUMA-INFORMED ABORTION CARE:

Facilitator Agenda*

Time	Session	Preparation and Materials Needed
45 minutes	**Introduction & Framing** • Welcome & Introductions • Agenda overview • Group Agreements • Administer Pre-test	Facilitator Materials • Slides 1–3 Participant Handouts • Pre-tests
30 minutes	**Module 1: Introduction to Sexual Violence**	Facilitator Materials • Slides 4–12 Participant Handouts • The Shadow Pandemic—Violence Against Women and Girls and COVID-19
45 minutes	**Module 2: Intersection of trauma, gender-based violence and abortion**	Facilitator Materials • Slides 13–21 Participant Handouts • IAWG MISP Quick Reference • IAWG SAC in the MISP brief
1.5 hours	**Module 3: Trauma-informed care and abortion clinical services** • Rapid exercise—Asking about violence • Activity 1—Role play with clinical case studies	Facilitator Materials • Slides 22–39 • Clinical Case Studies—Facilitator Version Participant Handouts • WHO Job Aid - LIVES • Clinical Case Studies—Participant Version • Trauma-Informed Care Direct Observation Feedback Form
1.75 hours	**Module 4: Referral pathways and service integration** • Activity 2—Care and referral pathways • Activity 3—Service delivery/ integration case studies	Facilitator Materials • Slides 40–48 • Service Delivery/Integration Case Studies—Facilitator Version Participant Handouts • Confidential Consent for Release of Information and Referral Form • WHO Job Aid—Pathway for care for IPV • WHO Job Aid—Pathway for initial care after assault • Service Delivery/Integration Case Studies—Participant Version
30 minutes	**Module 5: Care for Caregivers** • Activity 4—Practicing Self-Care	Facilitator Materials • Slides 49–55
45 minutes	**Module 6: Closing** • Review key messages • Activity 5—Closing Reflections • Appreciations • Administer post-test and workshop feedback form	Facilitator Materials • Slides 56–61 Participant Handouts • Post-tests • Workshop feedback form

* This can be used as a stand-alone training, or the sessions can be integrated into an existing training. The content can be consolidated depending on the audience and training timeline.

Time should be added for breaks and lunch per local customs.

Instructional PowerPoint presentation: Trauma-informed services for abortion providers treating sexual violence survivors in humanitarian settings

The PowerPoint slides include content about sexual violence and trauma-informed care and their intersections with abortion, for frontline providers treating sexual violence survivors in humanitarian settings. They provide a definition of trauma-informed care and contextualize it within the broader GBV movement for sexual and reproductive health and rights. This content will strengthen participants' understanding of service delivery considerations for sexual assault survivors seeking abortion services. This PowerPoint can be adapted to align with any abortion training in humanitarian settings and can also be adapted for training in development settings. The modular style is meant to conform to a variety of training needs and contexts with roughly 6.5 hours of content for a full day with breaks.

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Objectives

By the end of these modules, participants should be able to:

1. Articulate the terminologies and definitions related to sexual violence and trauma-informed care.
2. Describe the intersection of sexual violence and abortion.
3. Integrate trauma-informed counseling techniques into abortion counseling.
4. Conduct trauma-informed care at the time of providing abortion services.
5. Describe roles and responsibilities of frontline health-care workers providing abortion services to survivors of sexual violence.
6. Articulate appropriate referral pathways for trauma survivors and provide clients with an introduction to additional services and referrals, if desired.
7. Advocate for better integration of SRH clinical and protection services.
8. Name risks of burnout from working with survivors and identify actions that can help maintain well-being in the midst of work-related stress.

Module 1: Introduction

Contextualizes the prevalence of forms of GBV and provides the definition of trauma.

Module 2: Intersecton of trauma, gender-based violence and abortion

Describes the intersection of GBV with abortion and the health impact of GBV on unwanted pregnancy, unsafe abortion and maternal morbidity and mortality.

Module 3: Trauma-informed care and abortion clinical services

Provides abortion frontline providers with counseling and trauma-informed abortion care guidance when providing care in humanitarian settings.

Module 4: Referral pathways and service integration

Describes the importance of establishing active referral pathways for survivors accessing abortion services and integrating other humanitarian services, where feasible.

Module 5: Care for caregivers

Describes the risk of caregivers developing stress-related conditions, such as burnout, compassion fatigue or vicarious trauma and offers steps providers and organizations can take to mitigate those risks.

Module 6: Closing

Summarizes the key messages and content frontline health care workers should be familiar with when integrating trauma-informed care into abortion service delivery in humanitarian settings.

Trauma-informed care case studies and facilitator's guide for skills practice and service integration

Includes six case studies—three clinical and three on service integration and referrals—that reflect the needs of survivors seeking abortion services and referrals in humanitarian settings.

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TRAUMA-INFORMED ABORTION CARE:

Clinical Case Studies for Facilitators

Notes for facilitators: These case studies are for small group work and discussions. Use these case studies together with the trauma-informed care direct observation form. You do not need to use all the cases; choose the cases that are most useful to your participants. The small group leaders or the facilitator can use the bullet points to generate more discussion about the case. Do not share the bullet points for the cases with participants before the discussion.

Clinical Case Study 1: Provision of trauma-informed care for survivors of sexual violence who need abortion or contraceptive services

Maria is a 17-year-old refugee in "Camp Imagineria" who was married at 13 years of age and has two children under the age of five. She has been living in "Camp Imagineria" with her husband and children for three years. In the counseling session she informs you that she is pregnant but does not want to be. She does not know her last menstrual period and is unsure how far along she is in pregnancy. She feels generally very distressed and overwhelmed but does not specify why.

Maria needs a pelvic examination to determine the age of the pregnancy and what kind of services you can offer her. How would you like to proceed?

Notes for facilitators: Small group discussions may include some or all of the following points:

- Ask about exposure to violence or coercion in or outside of Maria's home
- Use the LIVES method
- Follow the 10 steps for trauma-informed examination when examining Maria
- Discuss Maria's options for abortion with her
  - Provide trauma-informed abortion care if she chooses

- Ask Maria if she would like to discuss contraception with you
- Discuss referrals to additional supportive services

Clinical Case Study 2: Provision of trauma-informed care for survivors of sexual violence who need abortion or contraceptive services

Maya is a 22-year-old refugee who lives with her husband in Imaginaria Refugee Camp. Maya was referred to you by a psychosocial support organization. She discloses that she was raped 14 weeks ago and fears that she is pregnant and does not know what her options are. She does not know her last menstrual period and is unsure how far along she is in pregnancy.

Maya needs a pelvic examination to determine if she is pregnant and what kind of services you can offer her. How do you intend to proceed?

Notes for facilitators: Small group discussions may include some or all the following points:

- Ask if Maya sought care or received any treatments at the time of the rape and manage clinical interventions appropriately
- Talk to Maya about her perception of her own safety
- Follow the 10 steps for trauma-informed examination when examining Maya
- Discuss Maya's options for abortion with her in accordance with the law
- Provide trauma-informed abortion care if she chooses
- Ask Maya's permission if she would like to discuss contraception with you.
- Discuss referrals to additional supportive services for survivors of sexual violence
- Talk to Maya about abortion self-care

Clinical Case Study 3: Provision of trauma-informed care for survivors of sexual violence who need postabortion care services

Amina is a 17-year-old unmarried woman living in Imaginaria Refugee Camp with her three younger siblings. They had to flee their home due to nearby fighting and have been separated from their parents for many months. There are many peacekeepers stationed around the camp and

Amina became friends with one man. After several weeks of a casual friendly relationship, the man forced Amina to have sex with him against her will and she became pregnant.

Amina comes to the health center with some vaginal bleeding and feeling feverish and unwell. Upon examination, you find she has a fever of 38°C and a tender lower abdomen but no rebound tenderness or abdominal guarding. Although her last menstrual period was 11 weeks ago, her uterus size is about 8 weeks. Additionally, she reports that three days ago she swallowed some traditional herbs and put two pills in her vagina that she got from a local woman.

Amina requires an assessment including a pelvic examination to determine what kind of services she needs and what services you can provide for her. How do you intend to proceed?

Notes for facilitators: Small group discussions may include some or all the following points:

- Assess for and manage shock if indicated
- Make sure Amina has adequate pain control
- Give antibiotics as indicated
- Follow the 10 steps for trauma-informed examination when examining Amina
- Provide trauma-informed postabortion care with MVA
- Ask if Amina sought care or received any treatments at the time of the forced sex and manage clinical interventions appropriately
- Talk to Amina about her perception of her own safety
- Ask Amina if she would like to discuss contraception with you
- Discuss referrals to additional supportive services for survivors of sexual violence
- Talk to Amina about abortion self-care

TRAUMA-INFORMED ABORTION CARE:

Clinical Case Studies for Participants

Clinical Case Study 1: Provision of trauma-informed care for survivors of sexual violence who need abortion or contraceptive services

Maria is a 17-year-old refugee in "Camp Imagineria" who was married at 13 years of age and has two children under the age of five. She has been living in "Camp Imagineria" with her husband and children for three years. In the counseling session she informs you that she is pregnant but does not want to be. She does not know her last menstrual period and is unsure how far along she is in pregnancy. She feels generally very distressed and overwhelmed but does not specify why.

Maria needs a pelvic examination to determine the age of the pregnancy and what kind of services you can offer her. How would you like to proceed?

Clinical Case Study 2: Provision of trauma-informed care for survivors of sexual violence who need abortion or contraceptive services

Maya is a 22-year-old refugee who lives with her husband in Imaginaria Refugee Camp. Maya was referred to you by a psychosocial support organization. She discloses that she was raped 14 weeks ago and fears that she is pregnant and does not know what her options are. She does not know her last menstrual period and is unsure how far along she is in pregnancy.

Maya needs a pelvic examination to determine if she is pregnant and what kind of services you can offer her. How do you intend to proceed?

Clinical Case Study 3: Provision of trauma-informed care for survivors of sexual violence who need postabortion care services

Amina is a 17-year-old unmarried woman living in Imaginaria Refugee Camp with her three younger siblings. They had to flee their home due to nearby fighting and have been separated from their parents for many months. There are many peacekeepers stationed around the camp and

Amina became friends with one man. After several weeks of a casual friendly relationship, the man forced Amina to have sex with him against her will and she became pregnant.

Amina comes to the health center with some vaginal bleeding and feeling feverish and unwell. Upon examination, you find she has a fever of 38°C and a tender lower abdomen but no rebound tenderness or abdominal guarding. Although her last menstrual period was 11 weeks ago, her uterus size is about 8 weeks. Additionally, she reports that three days ago she swallowed some traditional herbs and put two pills in her vagina that she got from a local woman.

Amina requires an assessment including a pelvic examination to determine what kind of services she needs and what services you can provide for her. How do you intend to proceed?

TRAUMA-INFORMED ABORTION CARE:

Service Delivery/Integration Case Studies for Facilitators

Note for facilitators: These case studies are for small group work and discussions. You do not need to use all the cases; choose the cases that are most useful to your participants. The small group leaders or the facilitator can use the bullet points to generate more discussion about the case. Do not share the bullet points for the cases with participants before the discussion.

Service Delivery/Integration Case Study 1: Introducing trauma-informed abortion care as a service and treatment option for survivors of sexual violence

You are an abortion provider assigned to a primary health center in the Imaginaria refugee camp. At this primary health center, a variety of health-care workers provide different types of sexual and reproductive health services, including postabortion care (medical and surgical) and contraceptives. They do not yet offer induced abortions, although it is allowed by law.

How do you intend to introduce abortion services and integrate trauma-informed care in the facility?

Notes for facilitators: Small group discussions may include some or all the following points:

- Assess facility readiness—including infection prevention, supplies, medications and equipment—for abortion service introduction for survivors of sexual violence
- Assess current providers' uterine evacuation skills and willingness to provide abortion care
- Develop uterine evacuation skills among a necessary group of providers
- Introduce abortion values clarification activities for entire facility staff

- Organize trauma-informed care training for relevant wards or departments
  - Introduce job aid on the LIVES method
- Organize a uterine evacuation refresher training for identified service providers, which includes trauma-informed care
- Develop informational materials about the abortion services for users or community health workers or volunteers
- Organize an on-site mentoring program for sexual and reproductive health providers or women's protection providers on the new aspects of trauma-informed care

Service Delivery/Integration Case Study 2: Referral Pathway and Service Integration

You are the sexual and reproductive health coordinator for Imaginaria Refugee Camp where women and girls are experiencing high rates of gender-based violence. Multiple partners are implementing gender-based violence programming—some are focused on prevention and protection, some on clinical management of sexual violence survivors and others on providing safe abortion care—but there is a lack of coordination and standardized referral processes.

What steps should you take to integrate services for gender-based violence and sexual reproductive health services in this camp?

Notes for facilitators: Small group discussions may include some or all the following points:

- Bring issue to the SRH working group and/or coordination team in the Health Cluster
- Engage UNFPA, if not already involved, as UNFPA is the likely lead for this level of integration across GBV services
- Engage the GBV working group
- Engage GBV implementing partners from both the health and social services/protection sectors
- Capacity building:
  - Train SRHR staff on GBV
  - Train GBV staff on SRHR

- Coordination, collaboration, and partnership
  - support development of new partnerships
  - facilitate understanding of the project design and roles of all participating implementing partners; ensure each understands others' roles, not just their own
  - facilitate ongoing project communication and meetings
- Service delivery considerations
  - Contextualize implementation approaches
  - Provide information and awareness-raising including development and use of appropriate information, education and communication materials
  - Use values clarification activities for work on stigmatized services such as contraception and abortion
  - Incorporate screening for GBV
  - Incorporate clinical management of rape service to include trauma-informed abortion provision or referral
  - Establish efficient, safe and effective referral processes across GBV service sectors and implementing partners
- Monitoring and program support
  - Introduce tools in the GBV information management system
  - Establish regular monitoring and support visits to the implementing partners

Service Delivery/Integration Case Study 3: Referral Pathway and Service Integration

You are the midwife-in-charge at a primary health center [**OR** health lead for an implementing agency] in Imaginaria refugee camp. Trauma-informed abortion care has been introduced and is being implemented within your clinic [**OR** throughout your agency's service delivery points] but your staff has noted a lack of coordination and referrals throughout the camp for this care.

What steps should you take to advocate for better integration of services for gender-based violence and sexual reproductive health and rights in this camp?

Notes for facilitators: Small group discussions may include some or all the following points:

- Bring issue to the camp SRH coordinator and/or the SRH working group/coordination team
- Identify what barriers to integration exists and solutions to these barriers
- Advocate for clear policy, linkages and referral processes between the core areas of protection and health
- Advocate for inclusion of abortion provision and/or referral as needed for survivors
- Offer/share training materials on trauma-informed abortion care

TRAUMA-INFORMED ABORTION CARE:

Service Delivery/Integration Case Studies for Participants

Service Delivery/Integration Case Study 1: Introducing trauma-informed abortion care as a service and treatment option for survivors of sexual violence

You are an abortion provider assigned to a primary health center in the Imaginaria refugee camp. At this primary health center, a variety of health-care workers provide different types of sexual and reproductive health services, including postabortion care (medical and surgical) and contraceptives. They do not yet offer induced abortions, although it is allowed by law.

How do you intend to introduce abortion services and integrate trauma-informed care in the facility?

Service Delivery/Integration Case Study 2: Referral Pathway and Service Integration

You are the sexual and reproductive health coordinator for Imaginaria Refugee Camp where women and girls are experiencing high rates of gender-based violence. Multiple partners are implementing gender-based violence programming, some focused on prevention and protection, some on clinical management of sexual violence survivors, and others providing safe abortion care, but there is a lack of coordination and a standardized referral process in place.

What steps should you take to integrate services for gender-based violence and sexual reproductive health services in this camp?

Service Delivery/Integration Case Study 3: Referral Pathway and Service Integration

You are the midwife-in-charge at a primary health center [**OR** health lead for an implementing agency] in Imaginaria refugee camp. Trauma-informed abortion care has been introduced and is being implemented

within your clinic [**OR** throughout your agency's service delivery points] but your staff has recognized the lack of coordination and referrals throughout the camp for this care.

What steps should you take to advocate for better integration of services for gender-based violence and sexual reproductive health and rights in this camp?

Direct observation feedback form

The direct observation feedback form integrates the “LIVES” method and trauma-informed care into the suggested flow of an abortion service delivery encounter. It is designed to be used in role-play with three trainees rotating through the roles of patient, provider and observer. It can be used with the toolkit case studies that are focused on clinical care to allow trainees to practice their skills.

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TRAUMA-INFORMED ABORTION CARE:

Direct Observation Feedback Form

	Activity	Yes	No	Comments
ESTABLISHING SAFETY AND CONNECTION USING LIVES METHOD This is the first step of high-quality trauma-informed care. Strong interpersonal communication and rapport are key to providing this care using the LIVES method and helping a patient feel safe and comfortable. Please assess the person playing the provider role against the following questions.				
1	**Did the provider take the time to establish empathy & rapport with the patient?** (i.e., did they do anything that helps patient feel comfortable and safe like: ensure privacy? model kindness? provide non-judgmental care and treatment? provide individualized information and interactive counseling?)			
2	**Did the provider ask the patient if they came with someone, and if they would like that person to join them during the information session?**			
3	**Did the provider LISTEN to the patient effectively?** (i.e., did they do things like: make eye contact with the patient? give them full attention? reflect how they are feeling? be gentle and patient? speak without judgment?)			
4	**Did the provider INQUIRE about the patient's condition and needs?** (i.e., did they do things like: ask open-ended questions? ask for clarification/detail? reflect back patient's feelings? help identify emotional, physical, social needs or concerns? summarize what patient said?)			
5	**Did the provider VALIDATE the patient and show them they understand and believe them?** (i.e., did they use phrases similar to the following: it's not your fault? you are not to blame? you are not alone? everybody deserves to feel safe? I am concerned this may be affecting your health?)			
6	**Did the provider ENHANCE the patient's safety?** (i.e., did they ask questions like: has your experience of physical violence increased in the last 6 months? have you ever been beaten when you were pregnant? has anyone ever threatened you with a weapon? do you believe someone could kill you?)			
7	**Did the provider SUPPORT the patient?** (i.e., did the provider ask patient what they could do to help right away? did the provider help patient connect to information, services and social support?)			

	Activity	Yes	No	Comments
PROVIDING ENHANCED SUPPORT This section is ensuring that the support provided to the patient explains the referral process, includes consent and full explanation of the patient's rights and conforms to local legal requirements for providing abortion care or other SRH services. Please assess the person playing the provider role against the following questions.				
8	**Did the provider utilize the referral form and explain the referral process in detail?**			
9	**Did the provider utilize the consent form for the abortion service and explain in detail the rights of the person?**			
ASSESSING THE PATIENT'S HEALTH This section helps ensure proper confidentiality, privacy and taking of the patient's medical history before any examination takes place. Please assess the person playing the provider role against the following questions.				
10	**Did the provider ensure privacy and confidentiality for the patient?** (i.e., did they do thing like: close any doors or windows? ensure there were no other providers or people in the room without the consent of the patient? tell the patient that they will keep all information confidential?)			
11	**Did the provider ask the patient their medical history, including timing of the incident and last menstrual period?**			
12	**If the patient comes within 72-120 hours of the incident, did the provider offer emergency contraception, treatment for STIs and post-exposure prophylaxis (PEP) for HIV or referral services?**			
10 STEPS OF TRAUMA-INFORMED CARE This section ensures that providers follow proper procedures of trauma-informed care when performing the pelvic exam and/or if an abortion procedure is provided. Please assess the person playing the provider role against the following criteria.				
13	**Did the provider establish rapport before the exam?**			
14	**Did the provider invite the patient to suggest measures that will make them more comfortable with the exam and procedure?**			
15	**Did the provider ask if the patient would like someone to accompany them during the exam?**			
16	**Did the provider allow the patient to choose the gender of the provider if they prefer it?**			

	Activity	Yes	No	Comments
17	**Did the provider explain the bimanual and speculum exam process before starting?** a. Did the provider ensure that each of these steps is necessary for the care being provided? b. Did the provider inform the patient that the exam and/or the procedure will stop if they feel uncomfortable and provide an opportunity for the patient to decline this care? c. Did the provider assure the patient that they have control over the pace of the exam and/or procedure?			
18	**Did the provider tell the patient about each step of the exam and/or the procedure right before it happens?**			
19	**Did the provider keep the patient's body covered, exposing only the areas being examined?**			
20	**Did the provider encourage the patient to use abdominal breathing to relax the pelvic floor muscles?**			
21	**Did the provider rest the hands for bimanual exam or the unopened speculum against the client's genitals so that they get used to the sensation before the hand or speculum is inserted and opened? You can also allow the patient to help guide the speculum if they desire.** a. Did the provider use lubricant and/or the smallest possible speculum (if available)? This is especially important if the patient is post-menopausal.			
22	If the patient did not want to continue the exam or procedure, did the provider stop, inquire about the patient's needs, and proceed when they were ready?			
POST-EXAMINATION PROCEDURE This section ensures that providers deliver appropriate care and attention following the pelvic examination and or abortion service. Please assess the person playing the provider role against the following questions.				
23	**If a discussion about referrals during counseling was incomplete or not conducted, did the provider follow-up with the patient about any referrals?**			
24	**Did the provider offer contraceptive counseling, or confirm that the woman received contraceptive counseling, and prepare to provide her with her method of choice?**			

	Activity	Yes	No	Comments
25	Did the provider discuss with the patient a plan or story that might be acceptable to their abuser regarding their contraceptive method or abortion? a. Did the provider ask if the patient needs a contraceptive method that they can hide from their abuser? b. Did the provider explain what the patient should tell an abuser about seeking medical care after or during a medical abortion if they start bleeding heavily? (i.e., did they do things like: teach the patient that no one can tell whether they are having a miscarriage versus an abortion? Inform the patient could say they are just having a heavy period (that is too heavy if there is a problem)? c. Did the provider confirm that the patient can safely return for an appointment, and if not, discuss with the patient how they might accommodate them for care?			

Referral and informed consent form

The referral form, which includes provider and client copies, allows both the client and provider to remain informed of the type of referral(s), the contact information of the provider and the client and details of the referral service(s). This form also includes informed consent procedures to ensure the client is in control of her care and actively chooses the selected services and referrals she prefers to be provided by the health worker.

TRAUMA-INFORMED ABORTION CARE:

Confidential Consent for Release of Information and Referral Form

This form should be described to the client (or guardian with the client's approval) in their primary language. Sections A-C contain background information likely given during your consultation. Sections D-F should be read and fully explained and discussed with the client to fully ensure that they agree to proceed and that you are able to ensure confidentiality and security. It should be clearly explained to the client that they can choose any or none of the options listed and that they can change their mind at any point in the process.

☐ Routine ☐ Urgent Date of Referral (DD/MM/YY): .....

A. Your referring facility /agency	
Agency/Organization:	Contact:
Phone:	Email:
Location:	

B. Client information	
Name:	Phone (if available):*
Age:	Address/Location (if available):*
Identified Gender:	
Language:	
Notes:**	

* If client is not comfortable sharing this information, it is not required to complete the referral. Use discretion when asking questions and utilize counseling resources for talking to clients effected by trauma.

** Use this space for including any additional information necessary and/or useful for the receiving agency, such as capacities of the client that may affect their ability to access or receive services (e.g. cognitive impairments, physical disabilities and so on.)

C. Background Information/Reason for Referral	
Has the client been informed of the referral? ☐ Yes ☐ No* (if no, explain below)	Has the client been referred to any other organizations? ☐ Yes* (if yes, explain below) ☐ No
Background, services provided and reason for referral. **Please ensure the client is comfortable sharing and having this in writing.**	

* Use this space if the client did not consent for referral due to being unconscious and in need of emergency life-saving services.

D. Consent to Referral & Release Information (Please read with client and answer any questions before they sign below)
I, _____ (client name), understand that the purpose of the referral and sharing this information with _____ (receiving agency) is to ensure my safety and to make sure I receive the services I need. The service provider, _____ (referring agency), has clearly explained the procedure of the referral to me and has listed the exact information that is to be shared. By signing this form, I authorize this referral and exchange of information. I understand that shared information will be treated with confidentiality and respect and shared only as needed to provide the assistance I request. I understand that releasing this information means that a person from the agency or service ticked below may come to talk to me. At any point, I have the right to change my mind about sharing information with the designated agency / focal point listed below.
Signature of Client:
Date (DD/MM/YY):
If required by local laws,* signature of Guardian:
Date (DD/MM/YY):

* Providers and referring agencies should document consent to the full extent of local laws. If no policy exists regarding consent, international standards for documenting consent should be adhered to. [Note: International Standards do not require consent from an adult to receive services.]

E. Services Requested*		
General health services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
SRH services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
GBV services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
MHPSS services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Food & Livelihoods services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Legal assistance services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Safe House/ Shelter	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	

Protection services	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Other....	**Receiving Facility/ Agency**	
	Agency/Organization:	Contact (if known):
	Phone:	Email:
	Location:	
Please explain any other requested services:		

* Some referrals may have overlapping services and/or may not be available in all contexts. Check all relevant boxes.

F. Details of Referral
Does the client consent to follow-up communications after their referral visit? ☐ Yes ☐ No If yes, what mode of communication does the client prefer? (explain below)
Referral delivered for client via: ☐ Phone (emergency only) ☐ E-mail ☐ Electronically (e.g. App or database) ☐ In Person
Follow-up communications expected between referring agencies via: ☐ Phone ☐ E-mail ☐ In Person By date (DD/MM/YY):

Name and signature of recipient: _____ Date received (DD/MM/YY): _____

Pre- and post- training survey

The pre- and post- training survey assess changes in participants' knowledge and attitudes regarding sexual violence, abortion and trauma-informed care before and after the training.

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TRAUMA-INFORMED ABORTION CARE:

Pre- and post- training survey

INSTRUCTIONS: Please respond below based on your current knowledge and attitudes. Please circle only **one response** for each question.

1. True or False. One-third of women worldwide will experience physical and/or sexual violence by a partner or a non-partner at some point in their lives.
2. True or False. Abortion is often overlooked in the care and treatment of survivors of sexual violence.
3. True or False. Approximately 1 in 5 refugee and displaced women experience sexual violence.
4. True or False. Gender-based violence is linked to many poor health consequences, including unwanted pregnancy, unsafe abortion, and maternal mortality.

5 True or False. According to the Minimum Initial Service Package and the Inter-Agency Field Manual for Sexual and Reproductive Health in Crisis, abortion services are a critical component of caring for survivors of sexual assault.

6 True or False. Abortion providers are mandated to report incidents of sexual violence to police in humanitarian crises.

7. True or False. The role of abortion providers is to push their clients to disclose their experience with sexual violence.

8 True or False. Abortion providers should utilize the LIVES method and trauma-informed practices for all women regardless of their choice to disclose or not to disclose their sexual violence or trauma.

9. True or False. Abortion providers should not receive informed consent from the client to provide abortion care or referrals for other services

10. True or False. Most countries in the world have at least one indication for abortion.

11. True or False. The WHO encourages health workers to raise the topic of violence with all women and girls.

12. True or False. The WHO LIVES method describes how to assess physical injuries due to sexual violence.

13 True or False. Allowing the client to have someone accompany them during an exam, if they wish, is one of the 10 steps of trauma-informed care.

14. True or False. It is important that all health, social and psychological services are provided in one facility to best meet sexual assault survivors' needs.

15. True or False. "Doing no harm" is an expression that conveys the need not to pressure clients to disclose information when they are not ready.

The remaining questions relate to your current practices before and after this training. Please circle the number on the scale that best fits whether you strongly agree, agree, are unsure/don't know, disagree, or strongly disagree with each statement.

16. I feel confident and comfortable assisting with and/or providing trauma-informed care.

Strongly Disagree	Disagree	Unsure / Don't Know	Agree	Strongly Agree
1	2	3	4	5

17. I feel comfortable asking patients about their experience of gender-based violence.

Strongly Disagree	Disagree	Unsure / Don't Know	Agree	Strongly Agree
1	2	3	4	5

18. I know when and how to report incidences of physical or sexual violence among my patients.

Strongly Disagree	Disagree	Unsure / Don't Know	Agree	Strongly Agree
1	2	3	4	5

19. It is important that providers be aware of their own mental, physical and emotional health when caring for survivors of gender-based violence.

Strongly Disagree	Disagree	Unsure / Don't Know	Agree	Strongly Agree
1	2	3	4	5

20. I know how to identify burnout or trauma in myself or other providers that offer sexual reproductive health or abortion care services

Strongly Disagree	Disagree	Unsure / Don't Know	Agree	Strongly Agree
1	2	3	4	5

TRAUMA-INFORMED ABORTION CARE:

Pre- and post- training answer key for facilitators

Note to faciliatators: This test will help assess changes in participants' knowledge and attitudes resulting from the workshop. Please apply the test one time prior to any instruction or learning sessions, and then another time after the training is over. You can use the post-training test results to plan additional support activities for your participants.

1. True
2. True
3. True
4. True
5. True
6. False
7. False
8. True
9. False
10. True
11. False
12. False
13. True
14. False
15. True

Additional resources

Resources and handouts for participants

Several resources have been included in this package to provide additional reference and reinforcement of key issues for participants. They can be included as handouts, if necessary and relevant to your context. These include:

- Caring for women subjected to violence: A WHO curriculum for training health-care providers Handout 6a: Communication skills and pathway (WHO Job Aid on the LIVES Method)
- WHO Job Aid: Pathway for care for IPV (p. 38)
- WHO Job Aid: Pathway for initial care after assault (p. 65)
- UN Women: The shadow pandemic—violence against women and girls and COVID-19
- IAWG MISP Quick Reference Guide
- IAWG Safe Abortion Care in the MISP Brief

Below are additional resources on abortion, gender-based violence and trauma-informed care that may be helpful for your trainings.

- CHCS. (2021). Trauma- Informed Care Implementation Resource Center: https://www.traumainformedcare.chcs.org/trauma-informed-care-basics/?gclid=CjwKCAiA9vOABhBfEiwATCi7GEI-BKuY2RE61q9FRmYaO4vSaM8ZjbWI5rGHuasybqWKY7yOvV6QdRoCio8QAvD_BwE
- GBV Guidelines. (2021). Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action—Reducing risk, promoting resilience and aid recovery: http://gbvguidelines.org/en/

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- GBVIMS. (2021). Gender-based violence information management system: https://www.gbvims.com/
- Ipas. (2020). Medication Abortion Self-Care: A guide for community accompaniment to support women. Chapel Hill, NC: Ipas https://www.ipas.org/abortionwithpills
- Ipas. (2016). Comprehensive Abortion Care Reference Manual: https://www.ipas.org/resource/woman-centered-comprehensive-abortion-care-reference-manual-second-edition/
- IAWG. (2018). Interagency Field Manual (IAFM) on Reproductive Health in Humanitarian Settings: https://iawgfieldmanual.com/manual
- IAWG and Jhpiego. (2021). Clinical Management of Sexual Violence Survivors in Crisis Settings: A Training Course for Health Care Providers. New York: Interagency Working Group on Reproductive Health in Crises. https://iawg.net/resources/clinical-management-of-sexual-violence-survivors-in-crisis-settings
- IAWG and Women's Refugee Commission. (2019). Minimum Initial Service Package (MISP) For Sexual and Reproductive Health (SRH) in Crisis Situations: a Distance Learning Module. https://iawg.net/resources/minimum-initial-service-package-distance-learning-module/about-the-distance-learning-module
- NSVRC. (2017). Building Cultures of Care: A guide for sexual assault services programs: https://www.nsvrc.org/sites/default/files/publications_nsvrc_building-cultures-of-care.pdf
- RHAP. (2015). Contraceptive Pearl: Trauma-informed Exams: https://workbook.pressbooks.com/chapter/trauma-informed-care-during-procedures/
- Sultana, S., Tofigh, S., Chowdhury, R., Rubayet, S., Samandari, G., & Edelman, A. (2020). Expanding Access to Comprehensive Abortion Care in Humanitarian Contexts: Case Study from the Rohingya Refugee Camps in Bangladesh. *International Perspectives on Sexual and Reproductive Health, 46* (Supplement 1), 45-52. doi:10.1363/46e0820: https://www.guttmacher.org/journals/ipsrh/2020/12/expanding-access-comprehensive-abortion-care-humanitarian-contexts-case-study
- UCSF. (2020). Trauma-informed care during procedures: https://workbook.pressbooks.com/chapter/trauma-informed-care-during-procedures/
- WHO. (2020). Clinical Management of Rape and Intimate Partner Violence Survivors: Developing protocols for use in humanitarian services: https://www.who.int/reproductivehealth/publications/rape-survivors-humanitarian-settings/en/
- WHO. (2019). Caring for women subjected to violence: A WHO curriculum for training health-care providers. https://www.who.int/reproductivehealth/publications/caring-for-women-subject-to-violence/en/

- WHO. (2014). Healthcare for women subjected to intimate partner violence or sexual violence: A clinical handbook: https://www.who.int/reproductivehealth/publications/violence/vaw-clinical-handbook/en/
- WHO. (2017). Strengthening health systems to respond to women subjected to intimate partner violence or sexual violence: A manual for health managers: https://www.who.int/reproductivehealth/publications/violence/vaw-health-systems-manual/en/
- WHO. (2017). Responding to children and adolescents who have been sexually abused: WHO clinical guidelines: https://www.who.int/reproductivehealth/publications/violence/clinical-response-csa/en/
- WHO. (2022). Abortion care guideline. World Health Organization. https://apps.who.int/iris/handle/10665/349316

TRAUMA-INFORMED CARE FOR ABORTION PROVIDERS TREATING SEXUAL VIOLENCE SURVIVORS IN HUMANITARIAN SETTINGS

Workshop feedback form

Instructions

Please rate the workshop on each item using the scale below. Use the comments section to provide more information about the rating and suggestions for improvement.

5 = strongly agree 4 = agree 3 = neutral 2 = disagree 1 = strongly disagree

The workshop was well-organized _____

Comments:

The facilitators were well-prepared. _____

Comments:

I would choose the same facilitators again. _____

Comments:

The workshop was interesting and useful. _____

Comments:

The workshop materials (handouts, worksheets, etc.) were effective. _____

Comments:

There were enough opportunities for discussion. _____

Comments:

The break, lunch and other logistical arrangements were satisfactory. _____

Comments:

What suggestions can you make to improve the content of this workshop in the future?

Your general comments and suggestions:

Thank you for your participation!

P.O. Box 9990 Chapel Hill, NC 27515 USA

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