MINISTRY OF HEALTH

National Guidelines on Management of Sexual Violence in Kenya

3rd Edition, 2014

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Forward

Sexual Violence is a serious public health and human rights concern in Kenya. It affects men and women, boys and girls and has adverse physical and Psycho-social consequences on the survivor. The post election violence experienced in 2008 following the disputed 2007 presidential elections, that saw a wave of sexual abuse targeted at women and girls, was perhaps the clearest manifestation of the gravity of sexual violence in Kenya. Sexual Violence and its attendant consequences threaten the attainment of global development goals espoused in the Millennium Development Goals and national goals contained in Vision 2030 as well as the National Health Sector Strategic Plan II, as it affects the health and well being of the survivor. Of concern is the emerging evidence worldwide that Sexual Violence is an important risk factor contributing towards vulnerability to HIV infection. The National Plan for Mainstreaming Gender into the HIV/AIDS strategic plan for Kenya has identified sexual violence as an issue of concern in HIV transmission, particularly among adolescents. This calls for comprehensive measures to address issues of Sexual Violence and more importantly meet the diverse and often complex needs of the survivors and their families.

Comprehensive care for Sexual Violence ranges from medical treatment which includes management of physical injuries, provision of emergency medication to reduce chances of contracting sexually transmitted infections including HIV and provision of emergency contraception to reduce chances of unwanted pregnancies. It also entails provision of psycho-social support through counseling to help survivors deal with trauma and legal assistance to assist the survivor access justice, as well as includes provision of evidentiary requirements for the criminal justice system.

These National Guidelines have been designed to give general information about management of sexual violence in Kenya and focus on the necessity to avail quality services that address all the medical, psychosocial, legal needs of a survivor of sexual violence in both stable and humanitarian contexts. Although these needs are interrelated, attempt has been made to group the Guidelines into chapters that can easily be accessed for easy reference.

The Guidelines recognize the fact that children form a significant proportion of survivors of sexual violence and make special provisions for them that address their unique aspects, distinct from those of female and male adults. The Guidelines also highlight the need to provide quality services to perpetrators, as an effort towards HIV/STI management and provision of necessary forensics evidence as required.

The Guidelines should be available in all health care facilities and it is our sincere hope that their implementation will comprehensively address the needs of survivors of Sexual Violence in Kenya.

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Acknowledgements

These guidelines are as a result of collaborative efforts of various government sectors, partner organizations and individuals. I therefore take this opportunity to appreciate the effort of the officers from the Ministry of Health, Division of Reproductive Health (DRH) who coordinated and provided leadership to the development of these guidelines. I especially acknowledge the Task Force on the Implementation of the Sexual Offences Act (TFSOA), for the continued technical support and advice to the legal processes, and the policy advocacy that saw the gazettement of the Sexual Offences Act Medical (treatment) regulations, 2012.

The development and subsequent revisions to these guidelines were guided by the Gender and Sexual Reproductive Health Rights Technical Working Group (GSRHR TWG) of the DRH under the leadership of Dr Pamela Godia. This included members from various government ministries, professional associations and civil society organizations drawn from different sectors involved in sexual and gender based violence response, all of whom contributed considerably to the production of these guidelines. I therefore acknowledge the following organizations, government ministries and departments who volunteered technical expertise and resources to facilitate the review process: Ministry of Health, TFSOA, NGEC, LVCT Health, GIZ, MSF France, KNH, UNFPA, Population Council, Abantu for Development, GVRC, KWCWC, FHI 360, CHUVREC, APHIA Plus Nairobi- Coast, KMWA, Pathfinder International, CDTD, SHOFCO and AOCASP UNGASS Kenya.

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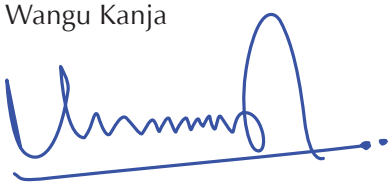

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Executive Summary

Kenya is a signatory to the international human rights instruments and standards such as the International Conference on Population and Development (ICPD) and the Millennium Development Goals (MDGs) that have been enshrined in the Constitution enacted in 2010. These instruments obligate governments to put in place measures to address sexual violence. Kenya has put in place provisions for laws and policy documents emanating from specific sectors, including: The Sexual Offences Act 2006, the National Policy on Gender and Development and National Reproductive Health Policy and the National Reproductive Health Strategy. These policy documents have provided the policy framework from which this specific guidelines have been developed. It is against this background that the Ministry of Health in collaboration with other stakeholders decided to develop comprehensive guidelines that can adequately respond to the complex and often diverse needs of survivors of sexual violence and bridge the existing gaps in the sector. The main goal is to ensure that the needs of survivors are addressed as much as possible.

These guidelines have been designed to give general and easy to read information about management of sexual violence in Kenya, and focus on the necessity to avail services that address the needs of survivors and perpetrators, be they medical, psycho-social, legal or referrals to additional support services. The guidelines cater for the needs of children owing to the fact that they comprise a significant percentage (about 60%) of the cases that present in health facilities. In this regard, all aspects of child sexual abuse management that differ from those of adults have been singled out, and where possible, integrated into the content of the information outlined in each section. Sexual abuse of children presents a unique phenomenon - the dynamics are often very different from those of adult sexual abuse, and therefore abuse of this nature cannot be handled in the same way as adults. For example, children tend to disclose as part of a process rather than a single event. They do so over a longer period of time compared to adults.

Although these needs are interrelated, attempt has been made to group the guidelines into chapters that can easily be accessed for ease of reference.

The clinical management chapter details out procedures relating to clinical management of sexual violence from the first point of contact with a survivor. Guidance to health care providers on obtaining informed consent and assent has been provided. Treatment options for various management have been updated and well-illustrated for ease of reference. A section on follow up of survivors, beyond the first clinical visit has also been added.

The psychosocial chapter highlights the necessary considerations for psychosocial support including preparation for treatment, prophylaxis, criminal justice system and follow up counselling with clear ethical considerations. It further delves into the rape trauma protocol to guide the delivery of trauma counselling and hopefully, enable health

care providers and counselors address psychosocial challenges faced by survivors as comprehensively as possible, including providing information on the rights of survivors of sexual violence.

Forensic management which is essential in helping survivors access justice by ensuring availability of credible evidence that sexual violence indeed took place and help link or delink the alleged perpetrator to the crime, is also elaborately covered in the guidelines. Information on appropriate collection and preservation of specimens has been elaborated upon as well as the need for proper documentation and the maintenance of the chain of evidence. The importance and role of the health care provider as an expert witness in court is strongly addressed, in accordance to the SOA medical (treatment) regulations 2012. These regulations states that sexual violence survivors should be treated free of charge at public health facilities and also make it mandatory for a "designated person" who examines survivors of sexual violence to fill the both the PRC and P3 forms. The designated person can either be an enrolled or registered nurse, registered clinical officer or medical doctor as defined by their respective registrations acts.

The guidelines further provide information on the humanitarian issues relating to sexual violence and how best to manage sexual violence in crisis contexts. Key issues to be considered in such contexts have been highlighted. Quality Assurance (QA) and Quality Improvement (QI) which are a core component of any service delivery are also covered in the guidelines, and a sample support supervision tool provided to aid in the supervision of PRC services.

Additional annexes include the revised Post Rape Care register, a tool that is expected to facilitate comprehensive data collection at the facility level; for this register to be comprehensively filled in, close collaboration is required from the various PRC service delivery points including the OPD, In-patient, Laboratory, Pharmacy and counselling units. The PRC register is accompanied by a monthly and cohort summary to facilitate the flow of data from facility to the national level.

Acronyms

ABC	Abacavir
AIDS	Acquired Immune Deficiency Syndrome
ALT	Alanine Aminotransferase
ART	Anti Retroviral Therapy
ATV	Atanovir
BD	Twice a day
CCC	Comprehensive Care Clinic
Cr	Creatinine
D4T	Stavudine
DNA	Deoxyribonucleic Acid
DRH	Division of Reproductive Health
EC	Emergency Contraception
ECP	Emergency Contraceptive Pills
GBV	Gender Based Violence
GBVRC	Gender Based Violence Recovery Centre
GVRC	Gender Violence Recovery Center
Hb	Haemoglobin
HCP	Health Care Provider
HIV	Human Immuno-Deficiency Virus
HTC	HIV Testing and Counselling
HVS	High Vaginal Swab
IDPs	Internally Displaced Persons
IRC	International Rescue Committee
LFTs	Liver Function Tests
LPV/r	Lopinavir/ritonavir
LVCT	Liverpool VCT Care and Treatment, Kenya
MDGs	Millennium Development Goals
MOH	Ministry of Health
MSF	Medicins Sans Frontieres

NHSSP	National Health Sector Strategic Plan
NVP	Nevirapine
OB	Occurrence Book
OPD	Out Patient Department
PDT	Pregnacy Diagnostic Test
PEP	Post Exposure Prophylaxis
PRC	Post Rape Care
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
QI	Quality Improvement
QID	Four times a day
RTV	Ritanovir
SDP	Service Delivery Point
SGBV	Sexual & Gender Based Violence
SGPT	Serum Glutamate Pyruvic Transaminase
STIs	Sexually Transmitted Infections
SOA	Sexual Offences Act (2006)
SV	Sexual Violence
TDF	Tenofovir
TDS	Thrice a day
TT	Tetanus Toxoid
TIG	Tetanus Immunoglobulin
U+Es	Urea and Electrolytes
VCT	Voluntary Counselling and Testing
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

Definition of Terms

Terms	Definition
Defilement	An act which causes penetration of a child's genital organs (A child is any one below the age of 18 years).
Designated persons	For purposes of the SOA, designated persons are Nurses and Clinical Officers registered under the various laws and acts of parliament.
Genital organs	Includes the whole or part of male or female genital organs and for the purposes of the act of sexual violence includes the anus.
Informed consent (medical)	Where the health care provider has disclosed all relevant information in regard to the proposed course of treatment to the patient so that the patient can then arrive at a choice as to whether or not to proceed with the same.
Informed consent (legal)	Where a person has all relevant information in regard to a certain course of action prior to agreeing to that action. For this consent to be legally valid the person has to be an adult of sound mind.
Post Rape care form	This is a document that should be filled in triplicate by medical practitioners or either of the designed persons for purposes of medico- legal documentation following sexual violence.
Penetration	Partial or complete insertion of the genital organs of a person or an object into the genital organs of another person.
Rape	An act done which causes penetration of one person's genital organs with the genital organs of another without their consent or where the consent is obtained by force, threats or intimidation of any kind.
Survivor	Any person who has undergone violence (in this case sexual violence) and has lived through the experience. A survivor is also known as a 'victim' according to the SOA.

Sexual Assault	Any act where a person unlawfully and purposely uses an object or any part of his body (except his/ her private parts) or any part of an animal, to penetrate the private parts of another person without permission. (The only exception is where such penetration is carried out for proper and professional hygienic or medical reasons)
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work

[1] **For the purpose of this guideline, sexual violence refers to rape, attempted rape, defilement, attempted defilement, sexual assault and attempted sexual assault.**

Medical Management

Medical Management

1. Introduction

Medical management of sexual violence survivors is essential in mitigating against adverse effects of the violence. It is aimed at managing any life threatening injuries and providing other post-rape services to reduce the chances of the survivor contracting any sexually related infections and pregnancy. **The management of any life threatening injuries, and extreme distress should take precedence over all other aspects of post-rape care.** However, the management of minor cuts and abrasions should not delay the delivery of other more time dependent treatments.

Health care providers should be aware that the Kenyan law entitles medical care to survivors of sexual violence as well as suspects, convicts or witnesses of sexual offences. Therefore, a perpetrator or alleged perpetrator seeking medical treatment should be accorded the necessary treatment and care as would a survivor.

This chapter highlights the procedures of clinical management of sexual violence including the ethical considerations.The procedures cover the needs of adult males, adult females and children (boys and girls).

General considerations

- Introduce yourself to the survivor.
- Reassure the survivor that he/she is in a safe place now.
- Explain the steps of the procedures you are about to undertake.
- Obtain written informed consent or thumb print.
- Obtain medical history.
- Examine the survivor from head to toe.
- Take both medical and forensic specimens at the same time.
- Record your findings in the PRC forms and register.

2. Obtaining Consent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent is obtained by ensuring that the survivor fills the consent form. (annex1). In practice, obtaining informed consent means explaining all aspects of the consultation to the survivor. It is crucial that patients understand the options open to them and are given sufficient information to enable them make informed decisions about their care. Particular emphasis should be placed on the matter of the release of information to other parties, including the police. Examining a person without their consent could result in the healthcare provider in question being charged with violence or trespass of the survivor's privacy. **The results of an examination conducted without consent cannot be used in legal proceedings**. Consent for children, unconscious and mentally ill survivors can be given by their care giver.

Table 2.1: Informed consent/ assent guidelines (IRC 2012)

Age Group (Years)	Child	Caregiver	If No Caregiver Or Not In Child's Best Interest	Means
0-5	-	Informed Consent	Other trusted adult's or case-worker's informed consent	Written Consent
6-11	Informed Assent	Informed Consent	Other trusted adult's or case worker's informed consent	Oral Assent, Written Consent
12-14	Informed Assent	Informed Consent	Other trusted adult's or child's informed assent. Sufficient level of maturity (of the child) can take due weight.	Written Assent, Written Consent
15-18	Informed Consent	Obtain informed consent with child's permission	Child's informed consent and sufficient level of maturity takes due weight	Written Consent

3. History Taking and Examination

History taking and examination of the survivor should be undertaken immediately in a safe and trusting environment. For a survivor who cannot be examined immediately because of the extent of the trauma experienced, s/he should be given first aid and then referred to a trauma counselor for emotional support.

Before starting and at every step of the physical examination, take time to explain to the survivor all the procedures you will be performing and why they are necessary. Show and explain to the survivor the instruments to be used and give her/ him a chance to ask any questions. A family member or friend can be allowed to be present throughout the examination if the survivor so wishes. If a survivor declines all or part of the physical examination, you must respect her/ his decision; allowing the survivor a degree of control over the physical examination is important for her/ him recovery.

Both medical and forensic specimens should be collected during the course of the examination. Make sure that the survivor understands that s/he can stop the procedure at any stage if it is uncomfortable. Always address the survivor's questions and concerns in calmly, in a non-judgmental and empathetic manner.

The findings of medical history, examination and sample collection should be carefully and precisely documented in the PRC form (Annex 5).

3.1 History Taking for Adults

In history taking, the health care provider should ask questions that will generate the following information:

Sexual violence history

- The date and time of the sexual violence
- The location and description of the type of surface on which the violence occurred
- The name, identity and number of assailants
- The nature of the physical contacts and detailed account of violence inflicted
- Use of weapons and restraints
- Use of any medications/drugs/alcohol/inhaled substances
- Use of condoms and lubricants
- Any subsequent activities by the survivor that may alter evidence e.g. Bathing, douching, wiping, the use of tampons and changes of clothing
- Any symptoms that may have developed since the violence e.g. Genital bleeding, discharge, itching, sores or pain
- Current sexual partner/s
- Last consensual sexual intercourse

Gynaecological history:

- Last menstrual period
- Number of pregnancies
- Use (and type) of current contraception methods

Male- specific history

- Any pain or discomfort experienced in the penis, scrotum or anus
- Any urethral or anal discharge
- Difficulty or pain on passing urine or stool

3.2 Head to Toe Examination for Adults

A systematic, "Head-to-toe" physical examination of the survivor should be conducted in the following manner: *(The genito-anal examination is described separately)*.

- First, note the survivor's general appearance and demeanor. Take the vital signs, i.e. pulse, blood pressure, respiration and temperature. Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
- Inspect the face and the eyes.
- Gently palpate the scalp to check for tenderness, swelling or depression.
- Inspect the ears,not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp.

- Carefully examine the neck.The neck area is of great forensic interest; bruising can indicate life-threatening violence.
- Examine the breasts and trunk with as much dignity and privacy as can be afforded.
- Inspect the forearms for defense related injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body, and include bruises, abrasions, lacerations and incised wounds.
- Examine the inner surfaces of the upper arms and armpit or axilla for bruises.
- Recline the position of the survivor and for abdominal examination, which includes abdominal palpation to exclude any internal trauma or to detect pregnancy.
- While in the reclined position, examine the legs, starting with the front.
- If possible, to ask the survivor to stand for inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing.
- Collect any biological evidence with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibres, grass and soil).

3.3. The Genito-Anal Examination for Adults

- Try to make the survivor feel as comfortable and as relaxed as possible.
- Explain to them each step of the examination. For example say, "I'm going to have a careful look. I'm going to touch you here in order to look a bit more carefully. Please tell me if anything feels tender."
- Examine the external areas of the genital region and anus, as well as any markings on the thighs and buttocks.
- Inspect the mons pubis; examine the vaginal vestibule paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum
- Take a swab of the external genitalia before attempting any digital exploration or speculum examination. Gently stretch the posterior fourchette area to reveal abrasions that are otherwise difficult to see.
- If any bright blood is present, gently swab in order to establish its origin, i.e. whether it is vulval or vaginal.
- Warm the speculum prior to use by immersing it in warm water.
- Insert the speculum along the longitudinal plane of the vulval tissues once the initial muscle resistance has relaxed.
- Inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising. Collect any trace evidence, such as foreign bodies and hairs if found.
- Suture any tears if indicated.
- Remove the speculum

Remember:

- Prepare/ assemble the PRC kit before the survivor comes in.
- If available, ensure a trained support person of same sex accompanies the survivor throughout the examination

4. History Taking and Examination for Children

General approach:

- Ensure privacy
- Approach the child with extreme sensitivity and recognize their vulnerability
- Identify yourself as a helping person
- Try to establish a neutral environment and rapport with the child before beginning the interview
- Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently from adults making interpretation of questions and answers a sensitive matter
- Ask the child if s/he knows why s/he has come to see you
- Ask the child to describe what happened or is happening to them in their own words (where applicable). Play therapy can be used where necessary.
- Always ask open-ended questions and avoid leading questions. Only use direct questioning when open-ended questions have been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity
- Prepare the child for examination by explaining the procedure and showing equipment; this helps to diminish fears and anxiety
- Encourage the child to ask questions about the examination
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination
- Stop the examination if the child indicates discomfort or withdraws permission to continue
- Consider interviewing the child and the care giver of the child separately

4.1 History Taking for Children

History should be obtained from a caregiver or someone who is acquainted with the child, or the child her/ himself. It is important to gather as much medical information as possible.

Older children, especially adolescents, are often shy or embarrassed to talk about matters of sexual nature. It is therefore good to allow them to be seen alone as this may encourage them to talk more freely.
When gathering history directly from a child, start with a number of general,non-threatening questions to create rapport then move on to questions specific to the incidence, as shown below.

- When did this happen?
- Was this the first time this happened or has it happened before?
- What threats were made? Or incentives were given?
- What part of your body was touched or hurt?
- Do you have any pain in your bottom or genital area?
- Is there any blood in your panties?
- Do you have difficulty or pain with voiding or defecating?
- Have you taken a bath since the sexual violence?
- When was the last time you had sexual intercourse? *(explain why you need to ask about this).*
- When was your last menstrual period? *(girls)*

4.2. Head to Toe Examination for Children

The physical examination of children should be conducted according to the procedures outlined for adults in section 3.2.

Before examination, ensure that consent has been obtained from the child and/ or the caregiver as per the table 2.1. If the child refuses the examination, it would be appropriate to explore the reasons for refusal.

When performing the head-to-toe examination of children, the following points are important:

- Record the height and weight of the child;
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum;
- Record the child's sexual development and check the breasts for signs of injury.
- Note: Consider examining very small children while on their mother's or care giver's lap. If the child still refuses, the examination may be deferred or even abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another violence to the child. Consider sedation or a general anaesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.

4.3. The Genito-Anal Examination for Girls

Whenever possible, do not conduct a speculum examination on girls who have not reached puberty. It might be very painful and cause additional trauma.

A speculum may only be indicated when the child has internal bleeding arising from a vaginal injury as a result of penetration. In this case:

- Help the child to lie on her back or side.
- Use a paediatric speculum and conduct the examination under general anaesthesia.
- Check for blood spots or trauma to the urethra.
- Examine the anus for bruises, tears or discharge.

You may need to refer the child to a higher level health facility for this procedure.

4.4 The Genito-Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis.
- Check for discharge at the urethral meatus (tip of penis).
- In older boys, pull back the foreskin to examine the penis. Do not force it since doing so can cause trauma, especially in younger boys.
- Help the boy to lie on his back or on his side and examine the anus for bruises, tears, or discharge.
- Avoid examining the boy in a position in which he was violated as this may mimic the position of abuse.
- Consider digital rectal examination only if medically indicated.

The information provided on collection of medical and forensic specimens in adults (section 3.3) equally applies to children.

- When did this happen?
- Was this the first time this happened or has it happened before?
- What threats were made? Or incentives were given?
- What part of your body was touched or hurt?
- Do you have any pain in your bottom or genital area?
- Is there any blood in your panties?
- Do you have difficulty or pain with voiding or defecating?
- Have you taken a bath since the sexual violence?
- When was the last time you had sexual intercourse? *(explain why you need to ask about this).*
- When was your last menstrual period? *(girls)*

Summary of findings to be documented after examination of a survivor of sexual violence:

General examination

- Document the state of clothes- the colour, whether stained or torn, where they were taken to
- Document vital signs of the survivor

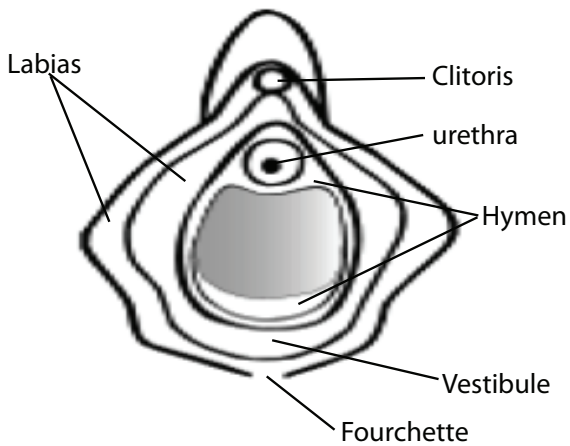
Mental assessment

Document as per the psychological assessment form, see Annex 5 section B

Systemic examination

Document details of the:

- **Central nervous system**- level of consciousness, affect
- **Musculo-skeletal system**- physical disabilities, posture control and gait, swellings, bruises, lacerations, dislocations, bite marks, scratches on the body of survivor from head to toe.
- **Perineum-** The perineum consists of the clitoris, labia majora and minora, vagina, mons pubis, introitus, fossa navicularis, vestibule, hymen, penis, prepuce, scrotum, urethra, anus, gluteal region, inner medial thighs.
- In the above areas, document:
  - Any tenderness, bruises, abrasions, cuts, teeth -marks, scratch marks bleeding, discharge, old scars (question their source if any)
  - Details of the anus- shape, dilatation (sphincter muscle tone), fissures, faecal matter on perianal skin, bleeding from rectal tears.
  - Details of the hymen- shape, position, colour, and type e.g. Cribriform, septal, cresent shaped, carunculae.
  - Position and size of tears e.g. At 3 o'clock 1 cm etc.



Investigations are carried out for two purposes:

i. To know the general condition of the survivor
ii. For forensic evidence purposes

Investigations done on various specimens (urine, blood and swabs) will include:

Urine
- Urinalysis- microscopy
- Pregnancy test
- Spermatozoa

Blood
- HIV Test
- Haemoglobin (Hb) level
- Liver Function Tests (where possible)
- VDRL
- Hepatitis B

Anal Swab

High Vaginal Swab

Oral Swab
- For evidence of spermatozoa

Note: Specimens to check for spermatozoa should only be collected when a survivor presents to the health facility within five days of sexual violence.

On collection of the forensic evidence, the health care provider should preserve it for appropriate storage and hand it over to the police for further investigations and processing in the court of law. More information on forensic evidence is available in Chapter Four.

5 Management of Physical Injuries

General wound care

- Clean any tears, cuts and abrasions and remove dirt, faeces, and dead or damaged tissue.
- Decide if any wounds need suturing. Suture clean wounds within 24 hours. After this time they will have to heal by second intention or delayed primary suture.
- Do not suture very dirty wounds. If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief.
- If there are any breaks in skin or mucosa, tetanus prophylaxis should be given unless the survivor has been fully vaccinated.

Genital wound care

- Clean abrasions and superficial lacerations with antiseptic and either dress or paint with tincture of iodine, including minor injuries to the vulva and perineum.
- If stitching is required, stitch under local anaesthesia. If the survivor's level of anxiety does not permit, consider sedation or general anaesthesia.
- High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anaesthesia by a gynaecologist or other qualified personnel and repaired accordingly.
- In cases of confirmed or suspected perforation, laparatomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon
- Provide analgesics to relieve the survivor of physical pain.

Post traumatic vaccination with Tetanus Toxoid

- Where any physical injuries result in breach of the skin and mucous membranes, immunize with 0.5mls of tetanus toxoid according to the schedule table
- Use table 6.1 below to decide whether to administer tetanus toxoid (which gives active protection) and anti -tetanus immunoglobulin (which gives passive protection) if available.
- If the vaccine and immunoglobulin are given at the same time, it is important to use separate needles and syringes and different sites of administration.
- Advise survivors to complete the vaccination schedule (second dose at 4 weeks, third dose at 6 months to 1 year).

Table 6.1 Tetanus toxoid schedule

This table applies to survivors who have not previously been vaccinated with TT.

Dosing Schedule conferred	Administration Schedule	Duration of Immunity
1st TT dose	At first contact	Nil
2nd TT dose	1 month after 1st TT	1-3 years
3rd TT dose	6 months after 2nd TT	5 years
4th TT dose	1 Year after 3rd TT	10 years
5th TT dose	1 Year after 4th TT	20 years

Note: Do not give TT if the survivor has received 3 or more doses previously and the last dose is within 5 years

6 . Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) for HIV is the administration of a combination of anti- retroviral (ARV) drugs for 28 days after the exposure to HIV, and should be started within 72 hours of sexual violence if a survivor tests HIV negative. PEP is given in the event of rape, defilement and some cases of sexual violence; significant risk involves oral, vaginal and/ or anal penetration.

This guideline recommends the use of **Triple therapy** i.e. three ARV drugs as per the National ART guidelines.

In the event that the survivor tests HIV positive, PEP IS NOT RECOMMENDED; the survivor should be referred for HIV care, treatment and follow up.

In the event that the survivor declines to take a HIV test, counselling should be continued and other management provided as per the health care provider's clinical judgment.

6.1 Timing of PEP for HIV

The efficacy of PEP decreases with the length of time from exposure to the first dose, therefore administering the first dose is a priority. **People presenting later than 72 hours after sexual violence should be offered other aspects of post rape care, except PEP.**

6.2 ARV prophylaxis options in sexual violence

All HIV exposures through sexual violence are considered to be high risk and should be treated as indicated. The recommended triple therapy is as follows:

TDF + 3TC +ATV/r

Treatment	Prescription
TDF + 3TC+ ATV/r	
Tenofovir 300mg	Once a day for 28 days
Lamivudine 300mg	Once a day for 28 days
Lopinavir 200 mg/ ritonavir 50mg	Twice a day for 28 days
Atanovir (ATV) 400 mg	Once a day for 28 days
Ritanovir (RTV) 199 mg	Once a day for 28 days

6.3 Recommended PEP Regimens for Children

For children, the drugs slightly differ; the recommended triple therapy is as follows:
ABC + 3TC +LPV/r

Children's doses must be given according to weight as indicated below. Both syrups and tablets can be used.

Paedriatic ARV Drug Dosing Chart

Weight Range (kg)	Fixed dose combination			Single formulation where FDCs are not available						
	Abacavir (ABC) + Lamivudine (3TC)	Zidovudine (ZDV) + Lamivudine (3TC)	Zidovudine (ZDV) + Lamivudine (3TC) + Nevirapine (NVP)	Efavirenz (EFV)	Nevirapine (NVP) (use weight appropriate formulation)		Lopinavir/Ritonavir (LPV/r)		Additional dosing for Ritonavir for TB/HIV co-infection	
	TWICE Daily	TWICE Daily	TWICE Daily	ONCE Daily	ONCE Daily for first 2 weeks then twice daily		TWICE Daily		TWICE Daily	
	60mg ABC +30mg 3TC tablets	60mg ZDV + 30mg 3TC tabs	60mg ZDV + 30mg 3TC tabs + 50mg NVP tabs	200mg EFV tabs	10mg/ml suspension	200mg tabs	LPV/ t80/20mg per ml solution	LPV/r 200/50mg tabs	RTV liquid (80mg/ml as 90ml bottle)	RTV capsule 100mg
3.59	1 tab	1 tab	1 tab	see notes	5ml	-	1.5ml	-	1ml	-
6-9.9	1.5 tab	1.5 tab	1.5 tab	see notes	8ml	-	1.5ml	-	1ml	-
10-13.9	2 tab	2 tab	2 tabs	1 tab	10ml	0.5	2ml	-	1.5ml	-
14-19.9	2.5 tab	2.5 tab	2.5 tabs	1.5 tab	15ml	1 tab in am 0.5 tab in pm	2.5ml	1 tab twice daily	2ml	2 cap
20-24.9	3 tab	3 tab	3 tab	1.5 tab	15ml	1 tab in am 0.5 tab in pm	3ml	1 tab twice daily	2.5ml	2 cap
25-34.9	300 + 150mg	300 +150 mg	300/150/ 200mg	2 tab	-	1 tab	4ml	2 tab in am 1 tab in pm	4ml in am & 2ml in pm	2 cap in am & 3 cap in pm

Source: MoH guidelines on use of ARV drugs for treatment and prevention of HIV infection: Rapid advice, 2014.

6.4 Side Effects of PEP

Patients taking PEP should be forewarned about the possibility of experiencing the side-effects below, and prepared on how to deal with them should they occur. They should for instance be informed that they can reduce the intensity by taking the pills with food. Side-effects usually diminish with time and do not cause any long-term damage.

Extreme side effects are rare due to the short duration of PEP treatment.

Drug	Possible side effects
Tenofovir	Renal toxicity and bone mineral loss.
Zidovudine	Anaemia, gastrointestinal side-effects, and proximal muscle weakness.
Abacavir	Skin rash, cough, fever, headache, asthenia, diarrhoea
Lamivudine	gastrointestinal side-effects, anaemia,
Lopinavir/ ritonavir	gastrointestinal side-effects

7. Pregnancy Prevention

- Emergency Contraception (EC) should be readily available at all times during the day and night, and should be provided free of charge for survivors of sexual violence in all health facilities. EC should be given within 120 hours/ 5 days of sexual violence; ideally as early as possible to maximize effectiveness
- EC should be given to all females who have experienced menarche except those on menses, pregnant or on reliable contraceptive methods.
- EC does not harm an early pregnancy
- EC is not a form of abortion
- There are no known medical conditions for which EC use is contraindicated. Medical conditions that limit the continuous use of oral contraceptive pills do not apply for the use of EC.

Table 7.1 Options for Emergency Contraception

Regime	Pill composition (per dose)	Examples of brand names	1st dose –no of pills	2nd dose no of pills
Levornogestrel only	LNG 750 µg	Postinor-2 Plan B	2	NA
Combined Estrogen-progesterone pills	EE 30 µg + LNG 150 µg	Microgynon 30, Nordette	4	4

Note

Emergency contraception is to prevent pregnancy and is **NOT** a form of abortion. Unless a woman is obviously pregnant, a baseline pregnancy test should be performed. However, this should not delay the first dose of EC as these drugs are not known to be harmful to an early (unknown) pregnancy.

A follow-up pregnancy test at four weeks should be offered to all women who return, regardless of whether they took EC after the sexual violence occurrence or not. If a survivor intends to terminate a pregnancy which resulted from the sexual violence, the health care provider and the survivor should be aware of the Constitutional provision in reference to abortion, thus ``Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other law (Kenya Constitution 2010).''

8. Management of Sexually Transmitted Infections

- STI prophylaxis should be offered to all survivors of sexual violence.
- The HVS performed at initial presentation is done for forensic reasons and not for screening for STIs or to guide antibiotic administration.
- Survivors with a "normal" HVS result should still be offered STI prophylaxis.
- Survivors of sexual violence should be given antibiotics to treat gonorrhoea, chlamydial infection and syphilis.
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP), although the doses should be spread out (and taken with food) to reduce side-effects, such as nausea.

Table 8.1 Options for STI Management

	STI Dosage	Alternative Regimen
Males and non-pregnant adult females	Cefixime 400 mg stat OR Ceftriaxone 250 mg IM stat **PLUS** Azithromycin 1 g stat OR Doxycycline 100 mg B.D for 7 days **PLUS** Tinidazole 2 g stat	Norfloxacin 800mg stat Doxycycline 100mg b.d. for 7 days
Pregnant females	Cefixime 400 mg stat OR Ceftriaxone 250 mg IM stat **PLUS** Azithromycin 1 g stat PLUS Tinidazole 2 g stat	Spectinomycin 2g stat **PLUS** (Amoxil 3g stat + Probenecid 1g stat) **PLUS** Erythromycin 500mg QID for 7 days

Children's prophylactic treatment for STI's					
Children	Product	Presentation	Strength	Dosage	Duration
5-12kg	Cefixime	Powder for suspension	100mg/5ml	8mg/kg	stat
	Azithromycin		200mg/5ml	20mg/kg	
12-25kg	Cefixime	Tablet or capsule	200mg	200mg	
	Azithromycin		250mg	500mg	
25-45kg	Cefixime		200mg	400mg	
	Azithromycin		250mg	2g	

Alternative treatment

Amoxicillin 15mg/ kg TDS for 7 days PLUS Erythromycin 10mg/kg QID for 7 days

Children's prophylactic treatment for trichomoniasis					
Children	Product	Presentation	Strength	Dosage	Duration
<45kg	Tinidazole	Tablet +/-powder for suspension	500mg	50mg/kg (max 2g)	stat
	Metronidazole		250mg or 500mg or 125mg/ml	30mg/kg/day in 3 dosages	7 days

9. Hepatitis B

Hepatitis B vaccination is intended to provide protection from future Hepatitis B virus infection. It is not meant to treat an already existing infection. It is much less costly to vaccinate all survivors of rape/sexual violence, rather than to test everyone for Hepatitis B antibodies to see who might benefit. Ideally, if Hepatitis B Vaccines is available, it should be considered for survivors of sexual violence according to the schedule in the table below.

Dosing schedule	Administration schedule	Duration of immunity conferred
1st dose	At first contact	Nil
2nd dose	1 month after first dose	1-3 years
3rd dose	5 months after second dose	10 years

If a survivor has been vaccinated before and completed the full series of vaccinations as scheduled, there is no need to re-vaccinate. If s/he did not complete the full series, they should complete as scheduled.

Table 11. Treatment summary table

√ Drug should be administered X Drug should not be administered

Interventions/ Time after the sexual violence	<72 hours	>72 hours but < 1 month	1 month to 3 months	> 3 months
PEP	√	X	X	X
Cefixime	√	√	X	X
Ceftriaxone	√	√	X	X
Azithromycin	√	√	√	X
Doxycycline	√	√	√	X
Tinidazole	√	√	X	X
Norfloxacine	√	√	X	X
Spectinomycin	√	√	X	X
Amoxycilline	√	√	X	X
Probenecid	√	√	X	X
Erythromycin	√	√	√	X
Hepatitis B immunization	√	√	√	X
Tetanus immunization	√	√	X	X

10. Medical Management of Perpetrators of Sexual Violence

Survivors of sexual violence should be encouraged to report to the police immediately after medical treatment. It is however an individual's choice and he/she should not be forced. Police should encourage and assist anyone presenting at the police station following rape/sexual violence, to attend the nearest health facility as soon as possible, preferably before legal processes commence as both PEP and EC become less effective with the passing of time.

11. Follow Up of Survivors of Sexual Violence

The follow-up visits for survivors who receive post-exposure prophylaxis for HIV and those who do not, only differ slightly.

2nd visit- 2 weeks

- Provide PEP refill
- Assess adherence to treatments previously given
- Evaluate for STIs and treat if necessary
- Evaluate mental and emotional status; treat or refer as needed
- Provide adherence and trauma counselling

3nd visit- 4 weeks

- Check for PEP completion
- Repeat PDT and refer for care if necessary

- Do follow up vaccinations
- Evaluate for STIs and treat if necessary
- Evaluate mental and emotional status; treat or refer as needed
- Provide trauma counselling

4rd visit- 6 weeks

- Evaluate for STIs and treat if necessary
- Evaluate mental and emotional status; refer or treat as needed.
- Provide trauma counselling

5rd visit- 3months

- Retest for HIV and refer for care if necessary
- Evaluate for STIs and treat if necessary
- Evaluate mental and emotional status; refer or treat as needed.
- Provide trauma counselling

Pyscho Social Support

Pyscho Social Support

1. Introduction

Survivors of sexual violence react differently to the ordeal. Some survivors experience immediate psychological distress, others short-term and/or long-term psychological problems. The amount and length of social support and/or psychological counselling required by survivors of sexual violence varies enormously, depending on the degree of psychological trauma suffered and the survivor's individual coping skills and abilities.

This chapter highlights the procedures of psycho-social care for survivors of sexual violence including ethical consideration. Efforts are made to address the distinct psycho-social needs of adult male and females and children- boys and girls, persons with disabilities and perpetrators of sexual violence.

- It is recommended that all counselors providing trauma counselling to survivors of sexual violence may be trauma counselors and should also have basic professional training (e.g. nurses, clinical officers, doctors, psychological counselors, social workers, psychiatrists).
- They should be members of an accredited counselling association e.g. Kenya Counselling Association (KCA), Kenya Psychologists Association (KPA) or be recognized by Ministry of Public Health and Sanitation or Ministry of Medical Services as rape trauma counselors.

2. Survivor-Centred Approach to Counselling

The counselor should apply the principles of doing "good" and not "doing harm" in counselling a survivor.

When providing services to survivor of sexual violence, counselors should adhere to the following fundamental principles of counselling:

- *Autonomy :* The right of patients to make decisions on their own behalf (or in the case of patients under 18 years of age, individuals acting for the child, i.e. parents or guardians). All steps taken in providing services are based on the informed consent of the survivor.
- *Beneficence :* The duty or obligation to act in the best interests of the survivor
- *Non-maleficience :* The duty or obligation to avoid harm to the survivor. *Justice or fairness* **:** Doing and giving what is rightfully due to the survivor.

These principles have practical implications on the manner in which services are provided, namely:

- Awareness of the needs and wishes of the survivor;
- Displaying sensitivity and compassion;
- Maintaining objectivity (WHO 2003).

3. Counselling Different Groups Affected by Sexual Violence

Male Survivors of Sexual Violence

When counselling male survivors of sexual violence, counselors need to be aware that men have the same physical and psychological responses to sexual violence as women. Men experience Rape Trauma Syndrome (RTS) in much the same way as women. However,men are likely to be particularly concerned about their masculinity; their sexuality; opinions of other people (i.e. afraid that others will think they are homosexual); the fact that they were unable to prevent the rape.

Children Survivors of Sexual Violence

The dynamics of child sexual abuse differ from those of adult sexual abuse. In particular, children rarely disclose sexual abuse immediately after the event. Moreover, disclosure tends to be a process rather than a single episode and is often initiated following a physical complaint or a change in behaviour (WHO 2003). The counselor should make an effort to believe in and trust the child, create rapport, let the child go at her/his own pace and listen carefully with understanding. The counselor needs to be familiar with the protocol on counselling children.

Persons with Disabilities - Survivors of Sexual Violence

Counselors need to be aware that people with developmental disabilities who have been sexually violated have challenges to “work through” or talk about their traumatic experiences in a treatment or therapeutic setting. Guardians may also need assistance as caretakers of the abused. Counselors should not have prejudices about people with disabilities. For example, the benefit of psychotherapy for people with mental retardation as well as the impact of the abuse should not be questioned. Counselors should debrief the guardian and/or family members and make appropriate referrals.

Perpetrators of Sexual Violence

Counselors need to be aware of their own fears about how they would counsel a suspected perpetrator. When a perpetrator enters the clinic escorted by police or a relative, the counselor should let them know that everything discussed between them (counselor and the perpetrator) is confidential and the counselor is not under obligation to disclose any test results to these parties, except when required by law. However, for purposes of clinical management of the perpetrator, shared confidentiality will still apply.

4. Core Conditions Essential to a Productive Counselling Session

- **Unconditional Positive Regard**: Counselors should perceive and deal with the survivor as s/he is while maintaining a sense of their innate dignity and personal worth.
- **Non-judgmental attitude**: Counselors should not assign guilt or innocence or a degree of survivor responsibility for causation of the problem, and they should not make evaluative judgments about the attitudes, standards or actions of the survivor/perpetrator.
- **Genuineness or Congruence:** Counselors should freely and deeply be able to relate to survivors/perpetrators in a sincere and non-defensive way.
- **Empathy:** The counselor should be able to understand the survivor's reactions from the inside, with a sensitive awareness of the emotions and the situation of the survivor. (Rogers 1967 304-311)

5. Obtaining Informed Consent

The counselor should obtain written consent from the survivor before starting any sessions. If the survivor is below the age of 18, refer to Table 2.1

6. The Counselling Environment

The room should have privacy; unauthorized people should not be able to view or hear any aspects of the consultation. Hence, the ideal examination room should be a private area with walls and doors, not just curtains, to ensure privacy. It should be clear when counselling is in process, indicated on the door with a sign such as: **"Counselling in Process: Please do not Disturb!"**

Make the room friendly, comfortable and clean. There should be a small cabinet that can be locked and secured for confidentiality where files are stored. The room should be child-friendly with toys and other relevant play material. Ensure that all forms (consent and case notes) are readily available. Tissues should be made available if possible. When the survivors/perpetrators are leaving the counselling room, please ensure to provide them with additional material to read as further reference.

7. Trauma Counselling

Trauma counselling entails:

- Contracting with the survivor and initial de-briefing
- HIV pre-test counselling
- HIV post-test counselling
- Adherence counselling for PEP, STI prophylaxis and treatment, and other management

- Counselling on Emergency Contraception and unwanted pregnancies
- Psycho-education
- Adherence to follow-up sessions
- Psychosocial support e.g. support groups for survivors, family and relatives
- Information giving on survivors' rights, legal redress and referral linkages

The recommended minimum period of trauma counselling is five sessions.
The first session should include psycho-education and information on the nature and symptoms of post traumatic stress disorder (PTSD).
The stabilization of the survivor is an important step at the beginning of the counselling process.

Stabilization means that the person gets a sense of "being grounded" back on their feet again, emotionally and socially. Emotional stabilisation means mending the identity of the traumatised person.

Note: The counselor should assess the safety of the environment to which the survivor is returning in case of domestic sexual violence and make referrals as appropriate.

Table 7.1 Rape-Trauma Counselling Protocol

There is need for counselors to be aware of the need for flexibility with the protocol and adapt to fit individual survivors who present to them. All issues must however be covered.

PROTOCOL	CONTENT
Contracting with the survivor and initial de-briefing	• Ensure there's a conducive environment • Introduce yourself and your role as a counselor • Assure the survivor of shared confidentiality • Establish the survivor's reason(s) for coming • Contract time with the survivor; mention that several sessions may be required • Obtain informed consent • Explain the survivor's freedom to terminate the session at any time • Respect the survivor's preference to be attended to alone or accompanied. • Assess whether the survivor qualifies for PEP, ECP and STI management • Establish whether the survivor has received any health services, including examination, PEP, ECP and STI management and PRC form filled elsewhere • (If these have not been done, refer survivor to the clinician for PRC before proceeding with counselling)

PROTOCOL	CONTENT
HIV Pre-test counselling.	• Provide basic HIV-information. • Explain the benefits of HIV testing • Discuss the possible implications of the HIV test results i.e. if positive or negative • Explain the HIV testing process • Risk assessment and risk reduction- consider: • Survivor's age and implications for him/her • Survivor's parents' HIV status (for under 5 year olds) • Perpetrators' HIV status if known • Discuss the window period (up to 6 weeks) • Address survivor's concerns on HIV testing • Review survivor's understanding and readiness for HIV test and subsequent management • Conduct HIV test (can be done on site or at the lab based on facility set up) A survivor who tests HIV negative at the first visit should be retested after six weeks.
Post HIV test counselling.	**For HIV negative results & HIV positive results:** • Re-contract, assess survivor's readiness for the results, Give results. • Discuss result's implications; risk reduction. • Disclosure of SV and of HIV results. • On-going counselling. **For HIV Negative Results include:** • Prevention counselling, continue trauma counselling, referral to additional supportive services , PEP advised for repeat testing after six weeks. • Adherence, legal issues and referrals. **For HIV Positive results include;** • Positive living, continued trauma counselling and referral for comprehensive HIV care. • Plan of action.
Adherence counselling	Adherence counselling for PEP and STI prophylaxis. Counsel on: • Keeping appointments, • Treatment regime and dosage • Side effects of HIV drugs and their management without causing unnecessary alarm. • Potential barriers to adherence • Positive living (e.g. good nutrition, safer sex practices, exercises etc) • Health consequences of STIs. • Other management e.g. Tetanus Toxoid ,Hepatitis B vaccine, Psychotherapy etc

PROTOCOL	CONTENT
Counselling on Adherence to follow-up sessions	Emphasize on importance of follow up care and the options for follow up should be discussed.
Counselling on Emergency Contraception and pregnancy	• Explain the importance of taking EC within 120 hours. However, emphasize that there is still a risk of pregncy. The later EC is taken, the higher the risk of a preg nancy. • Explain the short and long term consequences in case of pregnancy after rape. The survivor should be given information on child adoption or any other available options. Heath care-providers and the survivor should be aware of the Constitutional provision about abortion
Psycho-education	• Explore survivor's issues, concerns, fears. • Identify and normalize feelings of guilt, embarrassment, low self esteem and hopelessness. • Empower the survivor with information on coping mechanisms, tips on how to avoid situations which make them vulnerable to sexual violence in future.
Psychosocial support	• Offer group counselling as an ongoing support for survivors. • It helps to process trauma in a collective way and creates supportive coping mechanisms. • Families need to be counseled and given relevant information to enable them help the survivor cope and heal. • The counselor should refer the survivor to an appropriate professional or agency that is skilled in this area if need be. • Mobilize community support to address the causes and consequences of violence, what to do if raped or violated (including preservation of evidence), what to expect in the health facility and prevention measures of sexual violence. • Raising awareness around children's and women's rights is important while decreasing the stigma associated with sexual violence.
Information on survivors' rights, legal redress and referral linkages	• Give information on health, police, legal services, other linkages and their purposes. • Emerging legal issues for the survivor (reproductive health issues, litigation, reporting, rights and responsibilities).

8. Rights of a Survivor of Sexual Violence

A survivor has a right to Sexual and Reproductive Health Rights (SRHR) which are recognized by the law. These include the right to:

- Attain the highest standard of SRH
- Life and survival
- Liberty and security
- Freedom from torture, cruel, inhuman or degrading treatment
- Freedom from violence against women.
- Freedom from discrimination (on the basis of sex, gender, marital status, age, race and ethnicity, health status, disability)
- Marry with free and full consent
- Enjoy the benefits of scientific progress and to consent to experimentation
- Decide freely and responsibly the number and spacing of one's children
- Access information
- Education

A survivor also has a right to:

- Willingly press a charge of rape with the police
- Be treated with as much credibility as victims of other crimes are
- Information on medical, community and legal services
- Legal representation
- Be notified of any scheduled court proceedings.
- Be represented in court by a relative, guardian or professional if physically unable to in person
- Recover from the violation at their own pace

9. What the survivor should expect at the police station

At the police station, a report is entered into the Occurrence Book (OB) and the survivor is issued with a P3 form. The P3 form should be provided free of charge. An OB number should be availed to the survivor. If the survivor has not been to the hospital, it is important that s/he goes there immediately after reporting. Other procedures such as writing a statement can be undertaken after initial treatment has been received. The police should record the statement of the survivor and any witnesses, and the survivor should sign it only when s/he is satisfied with what the police have written. The P3 form should be completed by an authorized health care provider based on the clinical notes found in PRC Form.

10. Referrals

After acute counselling is done, the counselor should refer the survivor to other qualified professionals as appropriate to the needs of the survivor. The referral network for survivors is wide and includes social services, psychiatrists and other medical specialists, legal services, the criminal justice system and shelters etc

11. Support supervision, debriefing and care of the health care provider

Supportive supervision is important for preventing 'burn out' of the health care privider and counselors and for maintaining high quality communication between the counselors and the survivors. It provides an opportunity for counselors to come together with other professional counselling providers and at least one trained supervisor, to discuss and process issues that arise during counselling of survivors of sexual violence and to monitor the quality of their own service provision over time.

Regular **personal therapy** is also recommended to all practicing trauma counselors in order to cope with secondary traumatization.

Forensic Management of Sexual Violence

Forensic Management

Introduction

Forensic management is essential in helping survivors of sexual violence access justice through judicial processes. Proper management of evidence helps in presenting credible evidence to Court to prove that sexual violence indeed occurred and link the perpetrator to the crime.

This chapter elaborates on the procedures of forensic management while highlighting the processes of collecting, handling and preserving evidence.

1. Definitions

Forensic Examination is a medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion.

Medical practitioners: Medical practitioner means a practitioner registered in accordance with section 6 of the *'Medical Practitioners and Dentists Act'*.

Designated persons: This includes a nurse registered under section 12(1) of the *'Nurses Act'* or clinical officer registered under section 7 of the *'Clinical Officers (training, registration and licensing) Act'*.

Evidence: This is the means by which disputed facts are proved to be true or untrue in any trial in a court of law or an agency that functions like a court.

Forensic evidence: This is the evidence collected during a medical examination. The role of forensic evidence in criminal investigation includes the following: (i) To link or delink the perpetrator to the crime. (Aside from SV, including deliberate HIV/AIDS infection, which constitutes another crime on its own); (ii) To ascertain that SV occurred; (iii) To help in collection of data on perpetrators of SV.

In most cases, forensic evidence is the only thing that can link the perpetrator to the crime. E.g. where the incident is reported a long time after it has happened or where the survivor was pregnant.

Physical evidence: This refers to any object, material or substance found in connection with an investigation that helps establish the identity of the offender, the circumstances of the crime or any other fact deemed to be important to the process. Physical evidence may include: used condoms, cigarette butts, ropes, masking tape etc. Physical evidence can be collected from the survivor as well as the environment (crime scene location).

Crime scene: This constitutes either a person, place or an object - capable of yielding physical evidence which has the potential of assisting in apprehending or exonerating the suspect. No one should interfere with a crime scene by changing or tampering with any of the objects. One should leave everything as it was. A survivor is considered a crime scene as a lot of evidence can be collected from him/her. For example suspects hair found on the survivor. There are 5 stages in crime scene management: (i) Identification; (ii) Protection; (iii) Search; (iv) Record; (v) Retrieval

2. Types of Evidence

There are two types of evidence that need to be collected:

- Evidence to confirm that sexual violence has occurred e.g. evidence of penetration (torn hymen), if obtained by force there might be bruises, tears and cuts around the vaginal area and the clothing may be stained.

Locard's exchange principle
States that, every contact leaves a trace.....

'Wherever he steps, whatever he touches, whatever he leaves, even unconsciously, will serve as a silent witness against him. Not only his fingerprints or his footsteps, but his hair, the fibre from his clothes, the glass he breaks, the tool mark he leaves, the paint he scratches, the blood or semen he deposits or collects.'

- Evidence to link the alleged assailant to the violence e.g. perpetrators torn clothes, used condoms, grass and blood stains, scratches and bite marks on the perpetrator, and eyewitness testimony i.e. people last saw the perpetrator walking away with the survivor (this is because circumstantial evidence can help the court adduce the guilt of the accused).

- Forensic materials that can be collected include but not limited to:
  - Suspect's material deposited on an object, e.g. Cigarette butt;
  - Suspect's material deposited at a location;
  - Victim's material deposited on the suspect's body or clothing;
  - Victim's material deposited on an object;
  - Victim's material deposited at a location;
  - Witness' material deposited on a victim or suspect;
  - Witness material deposited on an object or at a location.

3. Exhibit Management

The following practices must be followed when handling an exhibit:

- Protect the exhibit from weather and contamination;
- Use clean instruments and containers;
- Wear protective devices eg gloves when appropriate;
- Package, transport and store exhibit safely and securely;
- Take special care with fragile and perishable exhibits;
- Call on an expert if you lack adequate training to handle a particular type of exhibit.

3.1 Collection and Handling of Specimen

When collecting specimen for forensic analysis, the following principles should strictly be adhered to:

Avoid contamination: Ensure that specimens are not contaminated by other materials. Store each exhibit separately. Wear gloves at all times to ensure that the exhibit is not contaminated and also for your own protection.

Collect early: Try to collect forensic specimens as soon as possible. Specimens should be collected within 24 hours of the violence; after 72 hours, yields are reduced considerably. Collect the same before requiring the victim to bathe.

Handle appropriately: Ensure that specimens are packed, stored and transported correctly. As a general rule, the fluids (e.g. urine) should be refrigerated; anything else should be kept dry. In some instances, blood can be dried on gauze and stored as such. Biological evidence material (e.g. body fluids, soiled clothes) should be packaged in paper envelopes or bags after drying, avoiding plastic bags.

Label accurately: All specimens must be clearly labelled with the survivor's name and date of birth, the health care provider name, the type of specimen, and the date and time of collection.

Ensure security: Specimens should be packed to ensure that they are secure and tamper proof. Only authorised people should be entrusted with specimens.

Maintain continuity: Once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should also be recorded. An exhibit register should be maintained at each facility. It is not a good practice for the survivor to move any samples taken from them from one facility to another for any analysis.

Table 3.2.1: Possible specimens, methods of preservation, tests and purpose of test

Specimen	Method of preservation	Test for	Purpose for testing
Mouth swab	Air dry and store in a clean dry bottle with screw top	Spermatozoa DNA	Identify assailant/ victim
Urine of both the victim and the suspect	Clean dry bottle with screw up, refrigerated	Spermatozoa Alcohol and drugs	To confirm recent sexual intercourse. Whether the assailant/ victim abuses drugs
Pubic hair/ head hair	Pick the hair using non powdered gloves and store in an envelop or lift using tape store on acetate sheet	DNA Transfer evidence analysis	Identify assailant and survivors
Foreign fibres/ grass/ soil(1)	Hand pick the foreign fibre/ grass/soil using non powdered gloves and store in a khaki envelope or lift using tape	Fibres found at the incident for transfer evidence analysis	Verify claim i.e. corroborative evidence
Liquid blood	A clean sterile dry bottle with screw top or transfer liquid blood onto sterile cotton gauze and air dry (only for control samples)	DNA, Alcohol/ drugs	Identify assailant and survivors
	For drug analysis, whole liquid blood should be taken and submitted		Whether the assailant/ victim abuses drugs Ability of the survivor to consent
Semen	HVS, dry semen stained clothes in open air. Do not dry in front of fire or artificial means or directly under the sun. Preserve in khaki paper Avoid using plastic bags	Spermatozoa Secretor, Blood group assailant DNA proteins in semen (PSA2 or P30)	Identify assailant
Fingernail, scrapping or clippings(4)	Pick the finger nail scrapings/ clippings using non powdered gloves and store in an envelope	DNA	Identify assailant and victim

Blood stained clothes (2)	Dry blood stained clothes in open air. Do not dry in front of fire or artificial means or directly under the sun. Preserve in a khaki paper. Avoid polythene bags	DNA, Alcohol/ Drugs	Identify assailant and survivors
Bite marks	Plasticine	Dental impressions	Identify assailant

Note:

- All tests and results should be recorded in a **laboratory register** (date,name, registration number, age, sex, investigations done, results and a place for anyone who takes specimen to sign in order to maintain a chain of custody of evidence). The Laboratory register should be kept well locked away and only accessible to authorized health facility personnel as a measure towards preserving confidentiality and to avoid tampering with the results.
- The above tests can be carried out on the survivor and also on the perpetrator.
- With regard to the perpetrator, the court can under section 26(2) and 36 of the SOA, order that certain specific samples be collected.

Document collection: It is good practice to compile an itemized list in the survivor's medical notes or reports of all specimens collected and details of when, and to whom, they were transferred.

Handling Exhibits

- Exhibits should not be exposed to direct light and sunshine. If wet, exhibits are dried under shade or dark rooms;
- Exhibits should be marked properly and signed for immediately upon receipt and stored;
- All exhibits including documents filled (e.g. PRC, P3) must be kept in places that guarantee safety and confidentiality.i

3.2 Chain of Evidence

This refers to the process of obtaining, preserving and conveying evidence through accountable tracking mechanisms from the community, health facility and finally to the police. Also refers to a paper trail where the movement of evidence is traceable through the different persons in the chain of sample collection, analysis, investigation and litigation)

4. Documentation and Reporting

In general, most effort should be expended on documenting evidence that can corroborate the survivor's evidence in a court of law. Such evidence include:

- Evidence that sexual intercourse (penetration) has taken place – engorgement of the genital and maybe increased epithelial cells in the urine and broken hymen. If the hymen is not broken it does not mean that penetration didn't take place.
- Evidence that ejaculation has taken place – presence of semen around the genitalia. Semen inside the vagina is evidence that ejaculation did take place inside the vagina – hence the importance of a high vaginal swab. It is important to know that ejaculation doesn't always have to take place.
- Evidence that force was used – Torn clothes including undergarments, bruised genitalia. Significant levels of epithelial cells in the urine.
- Evidence linking the suspect with the sexual offence. This will mainly be police work but the Health care provider will collect the various specimens as detailed in the Forensic chapter of these guidelines.

4.1 The Post Rape Care (PRC) Form

The Post Rape Care form is a medical document filled when attending to the survivor. The form allows space for history taking, documentation and examination. It facilitates filling of the P3 form by ensuring that all relevant details are available and were taken at the first contact of the survivor with a health facility. The PRC form strengthens the development of a chain of custody of evidence by having a duplicate that can be used for legal purposes and showing what specimen were collected, where it was sent and who signed for it. The PRC form can be filled by a doctor, a clinical officer or a nurse.

NOTE: When the PRC form is filled and signed completely:

- The Original form is to be given to the police for custody. This is the form that is produced in court as evidence;
- The Duplicate form is given to the survivor;
- The Triplicate form remains with the hospital.

4.2 The Kenya Police Medical Examination P3 Form

This is a Police form that is issued at the police station. It is filled by a health care provider and the police as evidence that an violence has occurred. The P3 form is for all forms of violence and therefore not specific to sexual violence. It is therefore not as detailed as the PRC form. The P3 form is filled and returned to the police for custody. The filling of the P3 form in sexual violence cases is done free of charge. The survivor should get a copy of their PRC form when it is filled and signed and when the P3 form is being filled.

The P3 form is the link between the health and the judiciary systems. The medical officer who fills the P 3 form or their representative will be expected to appear in court as an expert witness and produce the document in court as an exhibit.

5. Role of health care providers in relation to the Sexual Offences Act

5.1 Sexual Offences Act Medical (treatment) regulations 2012

Introduction

Section 35 of the Sexual Offences Act contains progressive provisions on access to free medical treatment for victim/ survivors of sexual offences in any public hospital or institution or other designated/ gazzetted institution. According to Section 35 (3) these provisions are to be operationalized through development of elaborate regulations by the Minister responsible for health, prescribing the circumstances under which a victim/ survivor may access treatment.

Sexual Offences (Medical Treatment) Regulations 2012

Pursuant to the provisions of Section 35 (3), the Sexual Offences (Medical Treatment) Regulations 2012 have been developed. The Regulations generally provide that:

1. Nurses, clinical officers and medical practitioners for purposes of the Sexual Offences Act shall offer medical treatment (which includes counselling) to a victim/ survivor of a sexual offence, a person who is suspected to have committed a sexual offence or a person convicted or a witness of a sexual offence in a public hospital.
2. The medical treatment expenses incurred by a survivor, a person suspected to have committed a sexual offence, a person convicted or witness of a sexual offence in a public hospital shall be borne by the Government.
3. A survivor of a sexual offence is entitled to receive medical treatment regardless of whether they have reported the matter to the police.
4. Public hospital means a Government facility at all levels of health care or such a health facility which the Minister responsible for health may gazette or designate as a public hospital for purposes of offering medical treatment under the Sexual Offences Act.
5. A police officer to whom a report of commission of a sexual offence has been made shall notify a nurse, clinical officer or medical practitioner at any health facility and refer the survivor accordingly for medical treatment.

6. A court may order collection of appropriate samples from any person who has been charged with a sexual offence, specifying the place and conditions for such collection of samples.

7. Once such an order for the collection of samples from an accused is received by a police officer of a rank above the rank of a police constable, the police officer shall request any medical practitioner, nurse or clinical officer to take appropriate samples from the accused.

8. It is the duty of the medical practitioner, nurse or clinical officer to determine the samples to take, part of the body from which the samples shall be taken and the quantity that is reasonably necessary in accordance with the National Guidelines for the Management of Sexual Violence.

5.2 Specific Roles of Health Care Providers

Once a police officer notifies a nurse, clinical officer or medical practitioner of the commission of a sexual offence and refers the victim/ survivor to the health facility, the health care providers shall:

a. Conduct a full medical forensic examination on the survivor and prescribe the appropriate medical treatment;

b. Provide appropriate professional counselling to the survivor of the sexual offence;

c. Complete the prescribed Post Rape Care form and psychological assessment form as set out in the schedule and any other relevant records;

d. Collect and preserve the necessary medical forensic samples in accordance with the National Guidelines on the Management of Sexual Violence;

e. Inform and forward to the investigating police officer or his or her representative the samples collected while maintaining a record of the chain of custody by appending his/her signature for the samples;

f. Initiate appropriate referral to the relevant areas or subsequent areas for the necessary subsequent care;

g. Ensure safe custody of medical records relating to the treatment for use as evidence before any court with regard to any offence under the Sexual Offences Act;

h. Where required produce the completed Post Rape Care form and other relevant medical records in court as evidence in regard to any offence under the Sexual Offences Act;

i. Provide the medical treatment prescribed in paragraph (a), (b), (d), (e) and (f) to a person suspected to have committed a sexual offence;

j. Where they deem appropriate, conduct other examinations and treatment on the victim/ survivor of sexual offence (s), witnesses or a person who is suspected to have committed a sexual offence

5.3 Role of the Expert Witness in Court

Expert witness:
An expert witness, though often called by the prosecution, is really a witness of the court. S/he is therefore primarily to assist the court reach certain conclusions. Their evidence therefore is not to enable the prosecution to win the case, though often this is the effect.

The court recognizes one as an expert witness if s/he has some special knowledge to arrive at judgment. For one to be an expert witness, the expert must:

a. Be qualified in the subject.
b. Have a relevant experience.

Before the report of an expert witness is given, the court has to establish that the witness has indeed some special knowledge which can assist the court. This is done by establishing:

1. The Name: Usually three names are required although on can give more names.
2. Academic/ Educational qualifications
3. Occupation and experience: This is to establish what area one has been specialization in. The length of experience in the field is also very important. A highly qualified expert with little knowledge cannot be taken seriously.
4. Employer: The organization one is working for should be of good reputation.

The prosecution calls witnesses to establish a prima facie case. The evidence adduced is intended to show at first sight (Prima facie) that a law has been broken by the accused. If the case is not established at first sight, then the accused has no case to answer and is discharged.

Conduct of expert witnesses in court

- Be able to give facts the survivor presented - relate to the actual events presented by the survivor, and not interpret them.
- Look professional and dress appropriately.
- Speak clearly, slowly, and loud enough.
- Use simple language- not medical jargon.
- Do not give information beyond what one is asked.
- Treat the legal practitioner (s) with respect.
- Do Not to be afraid to say "I don't know" when you don't know
- Remain objective at all times avoiding bias
- Can refer to books, notes and written information, when presenting evidence.
- Do not draw conclusions unless they are certain.
- If giving evidence on behalf of another health care provider, then restrict yourself to the report made by that provider

Humanitarian Issues

1 Introduction

Understanding gender vulnerabilities in conflict situations

- Age and gender are vulnerabilities that predispose women and girls to exploitation and abuse;
- In early stages of conflict, these vulnerabilities are further increased due to:
- The breakdown of law and order;
- The absence of systems that would respond to distress signals;
- The lack of adequate services that would minimize the effects of sexual
- violence.
- In the stabilized phases of conflict, these vulnerabilities are augmented by:
- The continual reproductive roles of women and girls such as fetching
- firewood and/or water in unsecure areas which predispose them to the dangers of being sexually violated;
- The possible abuse of power by the security and humanitarian workers
- who demand sexual favours in return of goods and services.
- Harmful cultural practices are exacerbated - e.g. – forceful early marriage of the girls in order to meet the lack of resources in the family.

During armed conflict, women and girls are particularly vulnerable to all forms of sexual violence[1]. Vulnerability to exploitation and abuse by virtue of their age and gender is further increased by conflict and the prevailing humanitarian and security conditions. This chapter highlights the vulnerability factors to sexual violence in conflict situations. It further highlights interventions required in addressing the needs of sexual violence survivors in such situations.

2. Multi-Causal Nature of Sexual Violence in Humanitarian Crisis

Today's armed conflicts mostly occur within state borders and typically drag on for years, even decades. Multi-causal in nature, these crises are typically "highly politicized" and "frequently associated with non-conventional warfare". National accountability mechanisms are characteristically absent or severely weakened[2], which consequently gives rise to a climate of impunity for perpetrating all sorts of crimes. These conflicts tend to affect the civilian sphere, regardless of growing international emphasis on the protection of civilians in conflict situations.

1 Derived from the GBV Sub-cluster Strategy and Action Plan developed in March 6, 2008

2 Development Assistance Committee. Guidance for Evaluating Humanitarian Assistance in Complex Emergencies. 1996. http://www.the-ecentre.net/resources/e_library/doc/OECD.pdf#search=%22complex%20emergencies%22

Understanding the nature of today's conflicts

- They occur within state borders;
- They last for a long time;
- They are highly politicized;
- They are frequently associated with unconventional war-fare;
- National accountability mechanisms are characteristically absent.

Civilians are affected accidentally as they are not well distinguishable from combatants. They may be intentionally targeted because "the goal of warfare is not simply the occupation and control of territory – it is about destroying the identity and dignity of the opposition". One of the strategies to achieve this goal is by targeting women's sexuality and reproductive capacity. Sexual violence, therefore, not only causes individual physical and psychological ill health and social exclusion, but uproots families and communities and contributes to the moral and physical destruction of society[3]. In the absence of governmental programmes to mitigate the impacts of sexual violence, humanitarian organizations play a big role in caring for rape survivors.

3. Minimum Set of Interventions in Crisis Situations

Three sets of activities are necessary in combating SV in emergency situations:

- Overview of activities to be undertaken in the preparedness phase;
- Detailed implementation of minimum prevention and response during the early stages of the emergency; and
- Overview of comprehensive action to be taken in more stabilized phases and during recovery and rehabilitation.

These set of activities are applicable in any emergency setting, regardless of whether the "known" prevalence of sexual violence is high or low.

It is important to remember that sexual violence is under-reported even in well-resourced settings worldwide, and it will be difficult, if not impossible, to obtain an accurate measure of the magnitude of the problem in an emergency situation.

All humanitarian personnel should therefore assume and believe that sexual violence is taking place and is a serious and life-threatening protection issue, regardless of the presence or absence of concrete and reliable evidence.

For effective short and long-term protection from sexual violence for women and girls in Kenya, interventions must take place at three levels in order that structural, systemic and individual protections are institutionalized[4].

3 Watts C, Zimmerman C. Violence against women: global scope and magnitude. The Lancet. 2002;359:1232–1237. doi: 10.1016/S0140-6736(02)08221-1

4 Adapted from A. Jamrozic and L. Nocella (1998) The Sociology of Social Problems: Theoretical Perspectives and Methods of Intervention, Cambridge University Press, Melbourne.

Levels of interventions

- **Structural level (primary protection):** preventative measures to ensure rights are recognized and protected (through international, statutory and traditional laws and policies);
- **Systemic level (secondary protection):** systems and strategies to monitor and respond when those rights are breached (statutory and traditional legal/ justice systems, health care systems, social welfare systems and community mechanisms);
- **Operative level (tertiary protection):** direct services to meet the needs of women and girls who have been abused.

Addressing sexual violence among internally displace persons (IDP) communities in Kenya therefore requires: measures to protect women's and girl's rights; intervention when those rights are breached; and services and programs to meet the needs of women and girls who have suffered violence.

4. The Need for Collaboration

Successfully protecting internally displaced women and girls from sexual violence in Kenya is dependent on the active commitment of, and collaboration between, all actors, including male and female community members. Sexual violence is a cross-cutting issue, and no one authority, organization or agency alone possesses the knowledge, skills, resources or mandate to respond to the complex needs of the survivors or to tackle the task of preventing violence against women and girls, yet all have a responsibility to work together to address this serious human rights and public health problem.

To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a co-ordinated manner to prevent and respond to sexual violence from the earliest stages of an emergency.

Minimal services needed

- Survivors of sexual violence need assistance to cope with the harmful consequences of this nature of violence;
- They need health care, psychological and social support, security, and legal redress;
- Prevention activities must be put in place to address causes and contributing factors to sexual violence in the setting;
- Providers of all these services must be knowledgeable, skilled, and compassionate in order to help the survivor, and to establish effective preventive measures;
- Prevention and response to SV requires coordinated action from actors from many sectors.

5. Specific Responsibilities for the Health Sector

The health care provider's responsibility is to provide appropriate care to survivors of sexual violence as documented in these guidelines. This includes collection of any forensic evidence that might be needed in a subsequent investigation either during or post crisis period. It is not the responsibility of the health care provider to determine whether a person has been sexually violated. That is a legal determination. However, all health care providers must be aware of relevant laws and policies governing health care provision in cases of sexual violence.

The health care provider's responsibility

- To provide appropriate care to survivors of sexual violence as is documented in these guidelines;
- To collect forensic evidence that might be needed in a subsequent investigation either during or post crisis period.

Quality Assurance and Quality Improvement

The Quality Assurance and Quality control should be an essential part of all the post rape service. The objectives of quality assurance interventions are:

- To ensure optimal quality of care and support services for survivors;
- To establish the relationships between identified problems and quality of care issues and their impact on the provision of care;
- To recommend corrective action and regularly monitor the effect of the interventions.

Minimum Standards for Providing Comprehensive PRC in Health Facilities

	Minimum Standards for Medical management of survivors	Reporting/recording requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities without a laboratory (public and private)	Manage injuries as much as possible Detailed history, examination and documentation (refer for HVS, PEP/EC, STI)	Fill in PRC form in triplicate Maintain PRC register Please ensure that the survivor has a copy of the PRC form and takes it to the laboratory	A trained nurse
All health facilities with a functioning laboratory (public and private)	Manage injuries as much as possible Detailed history, examination and documentation (including HVS) Ideally, 1st doses of PEP/ EC should be provided (even where follow up management is not possible) Where HTC services are available, provide initial counselling	Fill in PRC form in triplicate Maintain a PRC register Maintain a laboratory register Referral to comprehensive post rape care facility	A trained nurse and/or a clinical officer A trained counselor (where counselling is offered)
All health facilities with HIV, ARV or a com-prehensive care clinic (CCC) where ARV can be monitored (compre-hensive post rape care facilities can be provided) (private and public health facilities)	Manage injuries as much as possible Detailed history, examination and documentation Provide emergency and on-going management of PEP Provide EC Provide STI prophylaxis or management Provide counselling for trauma, HIV testing and PEP adherence	Fill in PRC form in triplicate Maintain PRC register Maintain a laboratory register Fill in PRC form to follow up management of survivors	1 medical or clinical officer trained in ARV/ PEP management 1 trained counselor (trauma, HIV testing and PEP adherence counselling) Laboratory for HIV and HB testing Preservation of sperms from HVS specimen

Annexes

Annex 1: PRC Consent Form

Name of Facility
Consent form

Note to the health care provider: Read the entire form to the survivor, explaining that she can choose any (or none) of the items listed. Obtain a signature, or a thumb print with signature of a witness.

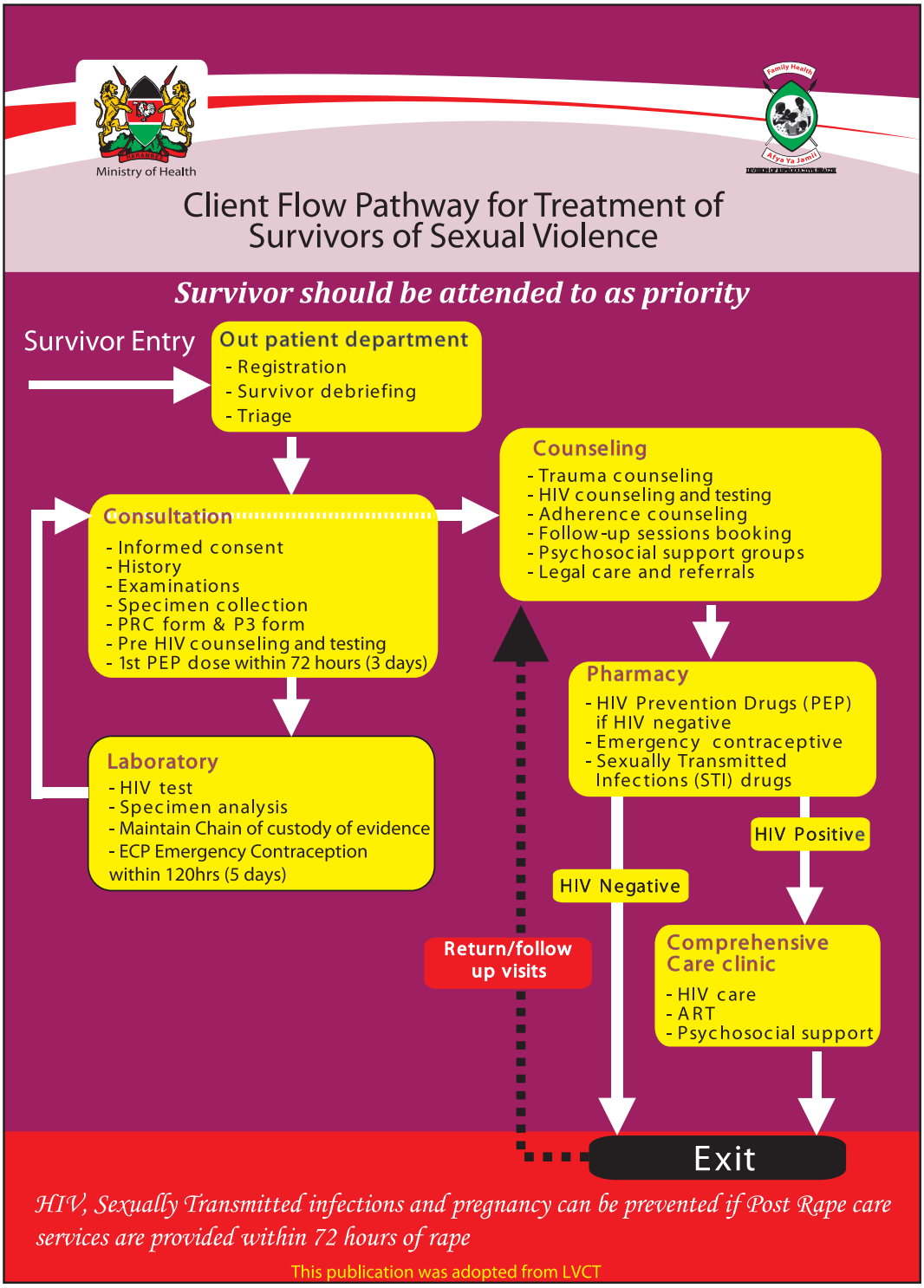
I……..……..(print name of survivor/care giver/guardian) authorize the above-named health facility to perform the following (tick the appropriate boxes):

	Yes	No
Conduct a medical examination, including pelvic examination		
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of finger nails, blood samples, and photographs		
Provide evidence and medical information to the police and law courts concerning my case; this information will be limited to the results of this examination and any relevant follow-up care provided		

Client's Signature……
Date……

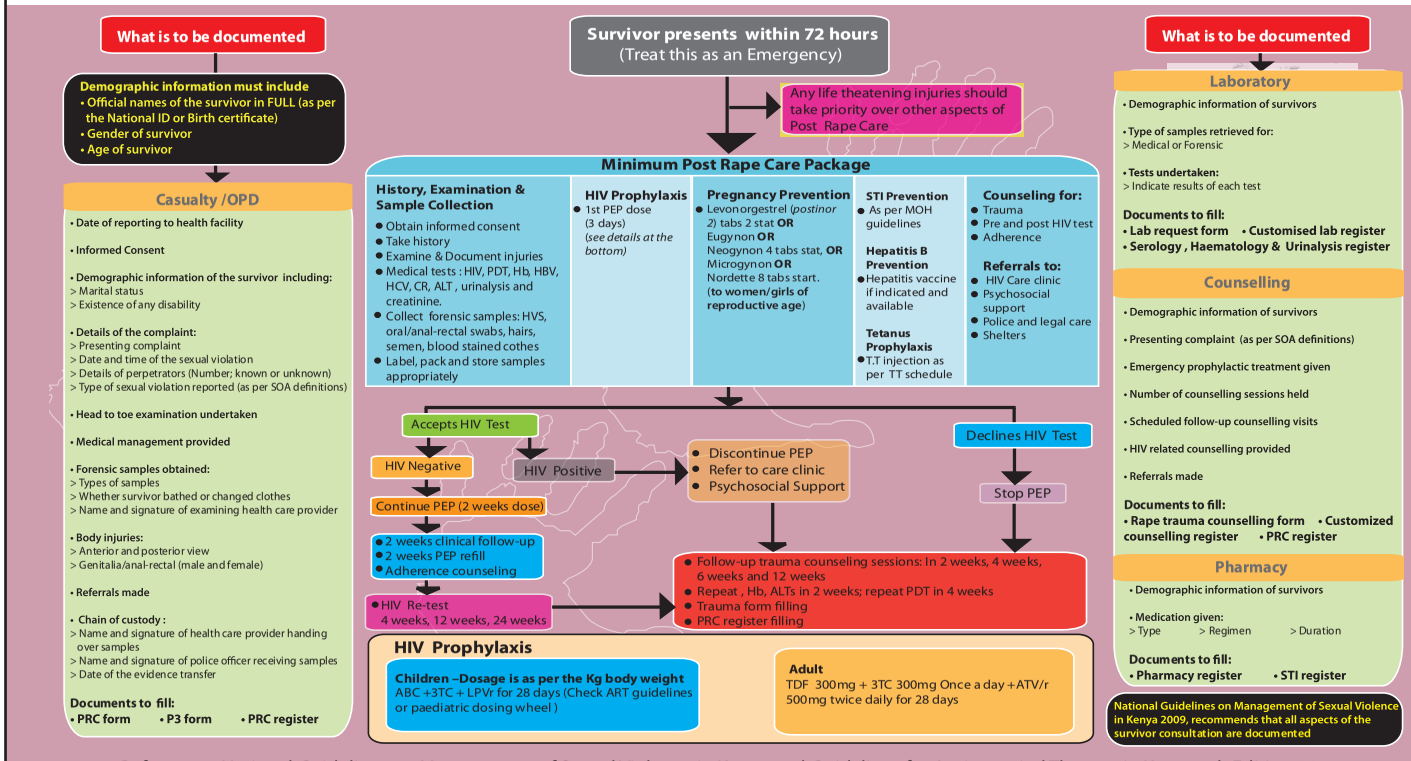
Name of witness…… Signature …….....
Date.....
Initials of HCP ..... Signature …….....
Date.....

Annex 2: Survivor Flow Chart



Ministry of Health

Algorithm for management of survivors of sexual violence



References: National Guidelines on Management of Sexual Violence in Kenya and Guidelines for Antiretroviral Therapy in Kenya 4th Edition 2011

This publication was adopted from LVCT

Annex 4: Rape Kit

Description of Item	Item Use-
Powder free gloves (Clean gloves)	To avoid contamination.
Sterile gloves	For the sterile procedures such as collecting HVS
Six stick swabs	For taking the HVS and/or anal swabs from the survivor.
Masking tape	For sealing the brown envelopes in which the specimens have been stored.
Brown envelopes for collecting samples	For proper storage of collected specimens.
Tape Measure.	For measuring the physical injuries found on the survivor, if any.
Needles & syringes	For collection of blood samples.
Urine bottles	For collection of urine samples.
Vercutainer tubes	For collection of blood samples.
Speculum	For collection of specimens from the vaginal cavity.
Labels	For labelling the brown envelopes with the details of the specimens stored inside.
Pregnancy testing kit	To test for pregnancy
Seal lock bags	For proper storage of collected specimens
Green towels	One for wiping hands during the sterile procedure One for placing beneath the patient's buttocks

Annex 5: Post Rape Care form

MINISTRY OF HEALTH

POST RAPE CARE FORM (PRC)
MOH 363

PART A & B

County: _____

Sub-County: _____

Facility: _____

Start Date: _____ **End Date:**_____

POST RAPE CARE FORM (PRC)

PRC FORM IS **NOT** FOR SALE

PART A

MOH 363

Ministry of Health National Rape Management Guidelines: Examination documentation form for survivors of rape/sexual violence (to be used as clinical notes to guide filling in of the P3 form)

PRC Post Rape Care Form

MOH 363

Date	Day	Month	Year	County Code	Sub-county Code / Facility Name	OP/IP No. / MFL Code

Name(s) (Three Names) | Date of birth: Day Month Year | ☐ Male ☐ Female

Contacts (Residence and Phone number) _____

Disabilities (Specify) _____ | Marital Status (specify) _____

Orphaned vulnerable child (OVC) ☐ Yes ☐ No | Citizenship _____

Date and time of Examination						Date and Time of Incident						No. of perpetrators
Day	Month	Year	Hr	Min	☐AM ☐PM	Day	Month	Year	Hr	Min	☐AM ☐PM	

Alleged perpetrators ☐ Male ☐ Female Estimated Age _____

☐ Unknown ☐ Known (specify the relationship) _____

Where incident occurred

Administrative location: County _____ Sub-county _____ Landmark _____

Chief complaints: Indicate what is observed _____

Indicate what is reported _____

Circumstances surrounding the incident (survivor account) remember to record penetration (how, where, what was used? Indication of struggle?)

Type of Sexual Violence: ☐ Oral ☐ Vaginal ☐ Anal ☐ Other (specify) _____

Use of condom? ☐ Yes ☐ No ☐ Unknown

Incident already reported to police? ☐ No ☐ Yes (indicate name of police station) _____

Date and time of report: Day Month Year Hr Min ☐AM ☐PM

Attended a health facility before this one? ☐ No ☐ Yes (Indicate name of facility) _____

Date: Day Month Year Hr Min ☐AM ☐PM

Were you treated? ☐ Yes ☐ No

Were you given referral notes? ☐ Yes ☐ No

Significant medical and/or surgical history

Comments: Indicate additional information provided by the client or observed by clinician

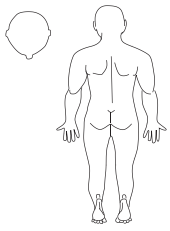
PHYSICAL EXAMINATION [indicates sites and nature of injuries bruises and marks outside the genitalia]

Please use the body map below to indicate injuries, inflammations, marks on various body parts of the survivor

BODY MAP

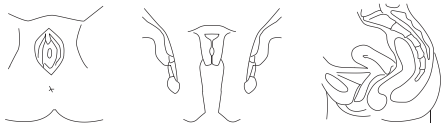
Anterior View

Posterior view

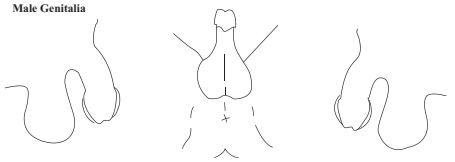


Comments _____

Female Genitalia



Male Genitalia



OB /GYN History	Parity	Contraception type	LMP	Known Pregnancy? ☐ Yes ☐ No	Date of last consensual sexual intercourse
General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm, not calm)

FORENSIC

Did the survivor change clothes? ☐ Yes ☐ No

State of clothes (stains, torn, color, where were the worn clothes taken)?

How were the clothes transported? ☐ a) Plastic Bag ☐ b) Non Plastic Bag ☐ c) Other (Give details) _____

Were the clothes handed to the police? ☐ Yes ☐ No

Did the survivor go to the toilet? ☐ Long call? ☐ Short call?

Did the survivor have a bath or clean themselves? ☐ No ☐ Yes (Give details) _____

Did the survivor leave any marks on the perpetrator? ☐ No ☐ Yes (Give details) _____

GENITAL EXAMINATION OF THE SURVIVOR-indicate discharges, inflammation, bleeding

Describe in detail the physical status

Physical injuries (mark in the body map) _____

Outer genitalia _____

Vagina _____

Hymen _____

Anus _____

Other significant orifices _____

Comments _____

Immediate Management	PEP 1st dose	ECP given	Stitching /surgical toilet done	STI treatment given
	☐ No ☐ Yes (No of tablets)	☐ No ☐ Yes	☐ No ☐ Yes(Comment)	☐ No ☐ Yes(Comment)

Any other treatment / Medication given /management?

Referrals to

☐ Police Station ☐ HIV Test ☐ Laboratory ☐ Legal ☐ Trauma Counseling ☐ Safe Shelter ☐ OPD/CCC/HIV Clinic ☐ Other (specify)

LABORATORY SAMPLES	Sample Type	Test	Please tick as is applicable: National government Lab	Health Facility Lab	Comments
	Outer Genital swab Anal swab Skin swab Oral swab Specify	Wet Prep Microscopy			
		DNA			
		Culture and sensitivity			
	High vaginal swab	Wet Prep Microscopy			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			
	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies	DNA			
	Other (specify)				

CHAIN OF CUSTODY

These /All / Some of the samples packed and issued (please specify)

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year

PSYCHOLOGICAL ASSESSMENT Complete psychological assessment section in Part B

POST RAPE CARE FORM (PRC)

PRC FORM IS **NOT** FOR SALE

PART B

PSYCHOLOGICAL ASSESSMENT

MOH 363

Part B is intended to assess the mental status of a client in order to be able to offer holistic care. This should inform the management and subsequent follow up of the client and hence should be filled in at presentation.

Psychological assessment should be done by trained health care providers including Medical Officers, Nurses, Clinical Officers, Psychiatrists, Psychological Counselors and Medical Social Workers duly recognized by the Ministry of Health.

The Medical Officers and other persons designated by law as expert witnesses in court (Nurses and Clinical Officers) should be the ones to sign off both the Part A and B of the PRC form.

General appearance and behavior
Note appearance (appear older or younger than stated age), gait, dressing, grooming (neat or unkempt) and posture.

Rapport
Easy to establish, initially difficult but easier over time, difficult to establish.

Mood
How he/she feels most days (happy, sad, hopeless, euphoric, elevated, depressed, irritable, anxious, angry, easily upset).

Affect
Physical manifestation of the mood e.g. labile (emotions that are freely expressed and tend to alter quickly and spontaneously like sobbing and laughing at the same time), blunt/ flat, appropriate/ inappropriate to content.

Speech
Rate, volume, speed, pressured (tends to speak rapidly and frenziedly), quality (clear or mumbling), impoverished (monosyllables, hesitant).

Perception
Disturbances e.g. Hallucination, feeling of unreality (corroborative history may be needed to ascertain details)

Thought content
Suicidal and Homicidal Ideation (Ideas but no plan or intent; clear/unclear plan but no intent; ideas coupled with clear plan and intent to carry it out); any preoccupying thoughts.

Thought process
Goal-directed/ logical ideas, loosened associations/ flight of ideas/ illogical, relevant, circumstantial (drifting but often coming back to the point), ability to abstract, perseveration (constant repetition, lacking ability to switch ideas).

(For children use wishes and dreams, and art/ play therapy to assess the thought process and content.
-Through drawing and play (e.g. use of toys). Allow the child to comment on the drawing and report verbatim.

-Assess the unconscious world of the child by asking about feelings e.g. ask the child to report the feeling that he/she commonly experiences and ask what makes him/her feel that way

Cognitive function-

a. Memory: Recent memory, long-term and short term memory (past several days, months, years).

b. Orientation: to time, place, person i.e. ability to recognize time, where they are, people around e.t.c.

c. Concentration: ability to pay attention e.g. counting or spelling backwards, small tasks

d. Intelligence: Use of vocabulary (compare level of education with case presentation; above average, average, below average).

e. Judgment: Ability to understand relations between facts and to draw conclusions; responses in social situations.

Insight level: Realizing that there are physical or mental problems; denial of illness, ascribing blame to outside factors; recognizing need for treatment (Indicate whether insight level is; present, fair, not present)

Recommendation following assessment	Referral point/s

Referral uptake since last visit e.g. other medical services, children's department, police, legal aid, shelter e.t.c.

By	Name of Examining Officer (Doctor/Nurse/Clinical officer)	Signature	Day	Month	Year
To	Police Officer's Name	Signature	Day	Month	Year

Annex 6: Counselling Form

SEXUAL VIOLENCE - TRAUMA COUNSELING DATA FORM

Date: ☐☐☐☐☐☐☐☐

Facility Name: _____

District Code: ☐☐☐ **Site Code:** ☐☐☐☐☐

Survivor Name: _____ **Parents/Guardian Name:** _____

(For children)

Phone Number: _____

Serial No. or OP/IP No.: _____

DATE:

First Visit: ☐☐☐☐☐☐☐☐ **Counselor Name:** _____

Second Visit: ☐☐☐☐☐☐☐☐ **Counselor Name:** _____

Third Visit: ☐☐☐☐☐☐☐☐ **Counselor Name:** _____

Fourth Visit: ☐☐☐☐☐☐☐☐ **Counselor Name:** _____

Fifth Visit: ☐☐☐☐☐☐☐☐ **Counselor Name:** _____

RAPE TRAUMA COUNSELING DATA FORM

Sex		**Has the client reported to the police?**		0 No	1 Yes
1 Male	2 Female			If not, name reason(s)	
Age (years)		0 No	1 Yes		
		If not, name reason(s)		**2nd Visit**	
Education		**a) Is the client willing to report to the police?**		a) Disclosure of SV	
0 None		0 No	1 Yes	0 No	1 Yes
1 Primary		If not, name reason(s)		b) Disclosure HIV results	
2 Secondary		**Client referred from?**		0 No	1 Yes
3 Post Secondary/Technical		1 VCT services	2 Police stations	c) PEP adherence	
Marital Status		3 Health Facilities	9 Other	0 No	1 Yes
0 Never	1 Married	**Was the 1st dose of PEP administered?**		If not, name reason(s)	
2 widowed	3 Separated/Divorced	0 No	1 Yes	d) Still taking PEP	
Type of assault		If not, name reason(s)		0 No	1 Yes
1 Penile anal rape	2 Penile vaginal rape	1 Presented after 72 hours	2 Client declined	**3rd Visit**	
3 Use of objects in vagina		9 Other		Is disclosure done so far ?	
4 Use of objects in anus		**Was EC administered?**		0 No	1 Yes
9 Other		0 No	1 Yes 2 N/A	Comments	
Client seen		If not, name reason(s)		**4th Visit**	
1 Individual	2 With partner	**Did client know HIV status before the assault?**		Comments	
3 With guardian/parent	4 With friend/relative			**5th Visit**	
9 Other		0 No	1 Yes	HIV Test done	
Services required by client		If Yes,		0 Negative	1 Positive
Was the PRC 1 form filled?		0 Negative	1 Positive	Disclosure of SV	
0 No	1 Yes	**1st Visit**		0 No	1 Yes
If not, name reason(s)		a) HIV test done		Disclosure of HIV Results	
		0 No	1 Yes 2 Declined	0 No	1 Yes
		If Yes,	0 Negative 1 Positive	Pregnancy Test done	
Who is the assailant?		b)Pregnancy Test done		0 No	1 Yes 2 N/A
				Results	0 Negative 1 Positive
		0 No	1 Yes 2 N/A	**Comments**	
0 Known	1 Unknown	Results	0 Negative 1 Positive		
If known, specify relationship		c) Disclosed SV			
		0 No	1 Yes		

Annex 7: SV Register

REPUBLIC OF KENYA

MINISTRY OF HEALTH

SEXUAL VIOLENCE REGISTER
MOH 365

Specific Service Delivery Point (SDP)			
Facility Name	:		
Master Facility List (MFL) Code	:		
Sub-county Name	:		
County Name	:		
Start Date:		**End Date:**	

Ver. July 2014

The SGBV register is used to record services provided to of survivors of sexual violence at the health facility. These include rape, defilement, incest, attempted rape, gang rape and sexual assault. The register is also used to capture data on alleged perpetrators of sexual violence attended to at the health facility.
For this register to be comprehensively filled in, information is required from various PRC service delivery points including i.e. OPD, IPD, Lab, Pharmacy and counseling units.

Column	DATA DEFINITIONS / EXPLANATIONS	
a	Serial No.	This is the identification number given to the client on the first attendance and is facility specific. Usually written serially. 1, 2, 3, …..
b	Out patient Number	“This is a unique identification number given to a survivor on first attendance at the out patient (Out patient number)
c	Arrival Date	Record the day the client visits your health facility as a new client, or revisit (recorded as DD:MM:YYYY)
d	Calculated hours	Hours taken from the time the incident occurred to the time the client reported to the health facility.
e	Name (S) (Three Names)	Record at least THREE names of the client as appears in the National Identification documents (e.g. ID, birth certificate, pass port)
k	Sex	Record M for Male and F for Female
j	Age	Record the actual stated age of the client expressed in years, If client is below one, Indicate Age in Months. Age here must be indicated in years and NOT ‘A’ or “C”(A for adult and C for child)
f	Survivor/ Perpetrator (S/P)	Record S for Survivor and P for perpetrator
h	Sub Location and landmark	Record the client’s residential location and/ or landmark to enable tracing or follow-ups
i	Telephone Number	Record the client’s telephone number or guardian’s in the case of children
g	Type of Case: New / Repeat	Record the type of case, If a New Case indicate N, If it is Repeat Case indicate R
l	Marital Status	Record 1-Single, 2-Married, 3-Divorced, 4-Separated, 5-Widowed
m	Referred from	Record 1= Health Facility , 2= Police, 3= Schools, 4= Community health worker, 5= Chief , 6= Other
n	Disability	Record 1-Hearing impairement,2-Visual impairement,3-Physical impairment, 4- Mental, 5- Others, 6- Not applicable
o	OVC-Orphan or vulnerable child	Record Y = Survivor is an orphan or vulnerable child (OVC), N = survivor is not an OVC
p	Type of sexual violence	Record type of reported sexual violence 1- Rape, 2- Attempted Rape, 3- Sexual assault, 4-Defilement, 5-Attempted defilement
q	Date of sexual violence	Record date when the sexual violence occurred (recorded as DD:MM:YYYY)
r	Time of sexual violence	Record time when the sexual violence occurred (recorded as HH:MM)
s	Date Post rape care form(PRC) form filled	Record date when Post rape care form(PRC) form was filled (recorded as DD:MM:YYYY)
u	HIV test	Record the HIV test results for those tested during the visit, as negative (-ve) or positive (+ve).(Record N for negative and P for positive tests, KP for Known Postive, ND for Not done)
v	Pregnancy Diagnostic Test (PDT)	Record the Pregnancy diagnostic test test results for those tested during the visit, as negative (-ve) or positive (+ve), N/A , Not applicable, ND Not done. Record N for negative and P for positive tests, ND, N/A
w	Anal Swab	Record the anal swab test results for those tested during the visit, as negative (-ve) if results show absence of spermatozoa or positive (+ve) if results show presence of spermatozoa -Record N for negative and P for positive tests) and NA for tests not done
x	High vaginal swab (HVS)	Record the HVS test results for those tested during the visit, as negative (-ve) if results show absence of spermatozoa or positive (+ve) if results show presence of spermatozoa-Record N for negative and P for positive tests) NA for test not done

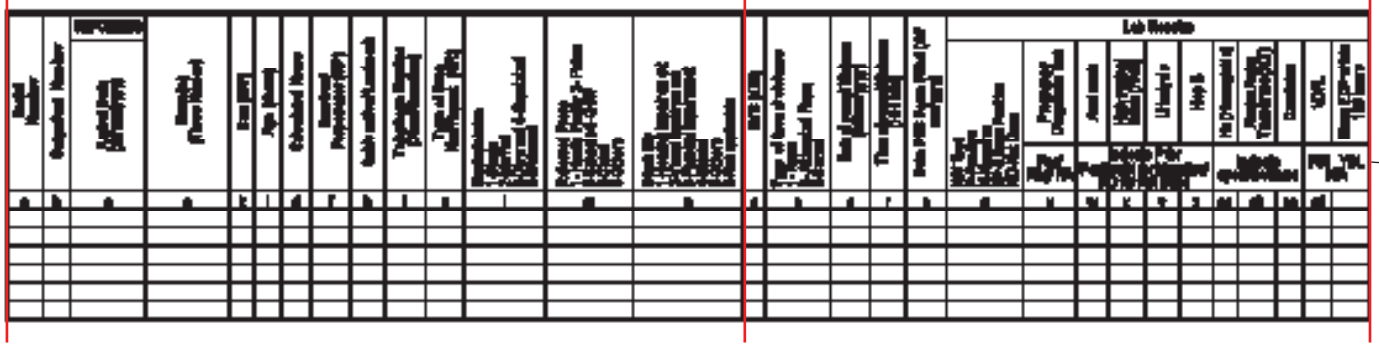
Column	DATA DEFINITIONS / EXPLANATIONS	
y	Urinalysis	Record the urinalysis test results for those tested during the visit, as negative (-ve) if results show absence of spermatozoa or positive (+ve) if results show presence of spermatozoa- Record N for negative and P for positive tests)NA for test done
z	Hepatitis- B	Record the Hepatitis B test results for those tested during the visit, as negative (-ve) or positive (+ve).Record N for negative and P for positive tests), NA for test not done
aa	Hb(Hemoglobin)	Indicate the specific value for Hb (Haemoglobin)
ab	Alanine Amino Transferase (ALT)	Indicate the specific value for ALT
ac	Creatinine	Indicate specific value for Creatinine
ad	Venerial disease research Laboratory (VDRL)	Indicate P if Positive or N for negative
ae	Emergency contraceptive prevention given within 120 hours	Record Y if client was given dose of ECP (Emergency Contraceptives) within 120 hours, Only applicable to Females, N if not given.ECP SHOULD only be given to eligible clients presenting within 120 hours. N/A where not applicable ie Not to Women reproductive age or a Male Survivor.
af	Post Exposure Prophylaxis given within 72 hours	Record Y- if the client was given dose of PEP within 72 hours. N if not given. PEP SHOULD only be given to clients presenting within 72 hours.
ag	Sexual transmitted infections Treatment (STI)	Indicate in this column whether STI (Sexual transmitted infections) Treatment were given ('Y' if given or 'N' if not given).
ah	Tetanus Toxoid (TT)	Indicate in this column whether TT (Tetanus Toxoid) was given ('Y' if given or 'N' if not given).
ai	Hepatitis-B vaccine	Indicate in this column whether Hepatitis B vaccine was given ('Y' if given or 'N' if not given).
aj	Trauma counseling	Indicate in this column 'Y' if the client was given Trauma counseling or 'N' if not given.
ak	Adherence Counseling	Indicate in this column 'Y' if the client was given Adherence counseling or 'N' if not given.
al	Referred to	Record 1- Health Facility ,2- Children's Department, 3- Legal Aid, 4- Police, 5- HIV care, 6-Shelter, 7-Support group, O8-Other,9- Not Applicable
t	Date P3 Form filled	Record date in full (if not filled indicate NOT Done when P3 form was filled (recorded as DD:MM:YYYY)
am	Date of next appointment	Record the next appointment give to the client (dd/mm/yy)
an	Actual return date	Record the actual date the client came for the next appointment (dd/mm/yy)
ao	Post Exposure Prophylaxis Refill	Indicate if client is given Post Exposure Prophylaxis at 2nd visit: Record 'Y' or 'N' , N/A-Not applicable for who seroconvert.
ap	Adherence to PEP Counseling (Post Exposure Prophylaxis)	Indicate if client is adhering to Post Exposure Prophylaxis at 2nd visit: Record 'Y' or 'N'
ar	Adherence Counseling	Indicate in this column 'Y' if the client was given Adherence counseling or 'N' if not given.
aq	Trauma counseling	Indicate in this column 'Y' if the client was given Trauma counseling or 'N' if not given.
as	Referral uptake at 2nd visit	Indicate whether the client took up any of the refferal services : Record 'Y' or 'N'
at	Hb (Hemoglobin)	Indicate the specific value for Hb (Hemoglobin) for test results at 2nd visit
au	Alanine Amino Transferase (ALT)	Indicate the specific value for ALT for test results at 2nd visit
av	Date of next appointment	Record the next appointment give to the client (dd/mm/yy)

Column	DATA DEFINITIONS / EXPLANATIONS	
aw	Actual return date	Record the actual date the client came for the next appointment (dd/mm/yy)
ax	Pregnancy Diagnostic Test (PDT)	Record the Pregnancy diagnostic test test results for those tested during the visit, as negative (-ve) or positive (+ve), N/A , Not applicable, ND Not done. Record N for negative and P for positive tests, ND, N/A
ay	Trauma counseling	Indicate in this column 'Y' if the client was given Trauma counseling or 'N' if not given.
az	Referral uptake at 3rd visit	Indicate whether the client took up any of the refferal services : Record 'Y' or 'N'
aaa	Date of next appointment	Record the next appointment give to the client (dd/mm/yy)
aab	Actual return date	Record the actual date the client came for the next appointment (dd/mm/yy)
aac	Hepatitis-B vaccine	Indicate in this column whether Hepatitis B vaccine was given ('Y' if given or 'N' if not given).
aad	Trauma Counseling 4th visit	Indicate in this column 'Y' if the client is given Trauma and Adherence counseling in the 4th visit or 'N' if not given.
aae	Referral uptake at 4th visit	Indicate whether the client took up any of the refferal services : Record 'Y' or 'N'
aaf	Date of next appointment	Record the next appointment give to the client (dd/mm/yy)
aag	Actual return date	Record the actual date the client came for the next appointment (dd/mm/yy)
aah	HIV test- 5th visit	Record the HIV test results for those tested during the visit, as negative (-ve) or positive (+ve).(Record N for negative and P for positive tests, KP for Known Postive, ND for Not done)
aai	Trauma Counseling 5th visit	Indicate if client is given Trauma counseling at 3rd visit: Record 'Y' or 'N'
aaj	Referral uptake at 5th visit	Indicate whether the client took up any of the refferal services : Record 'Y' or 'N'
	Patient outcome	Indicate the patient health outcome.Indicate 1-Alive, 2-Dead
aak	Remarks	Any relevant comment about the client or management should be documented here.

Sexual Violence Register MOH 365

A

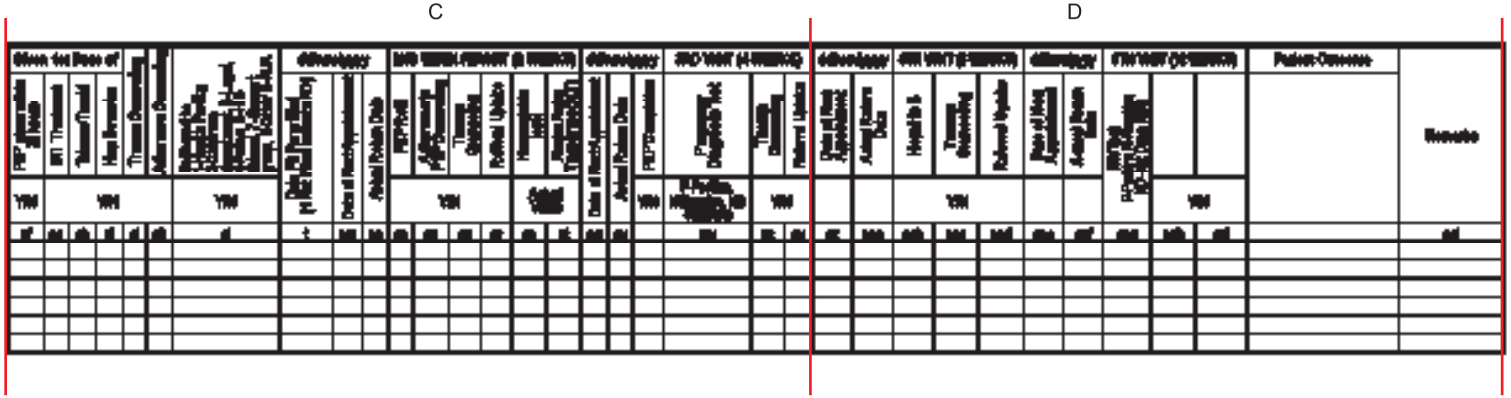
B



SV Register depicted is longitudinal (the sections: A, B, C and D are continuous).

C

D



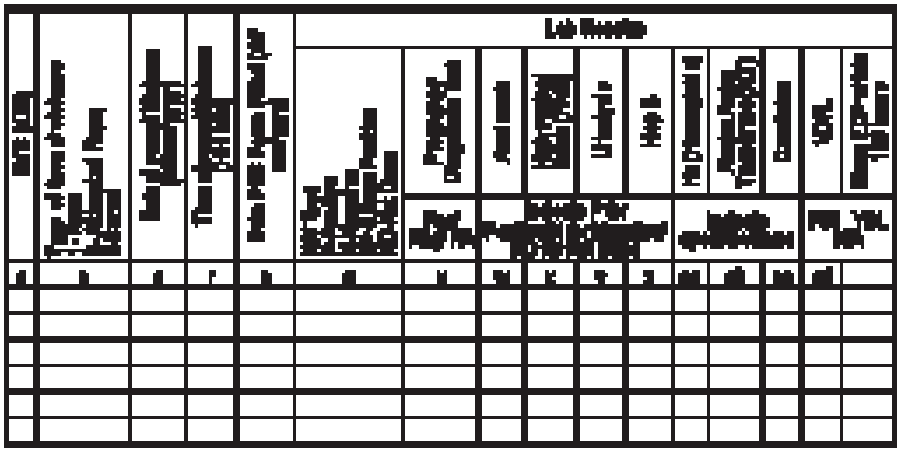
Sexual Violence Register MOH 365

A

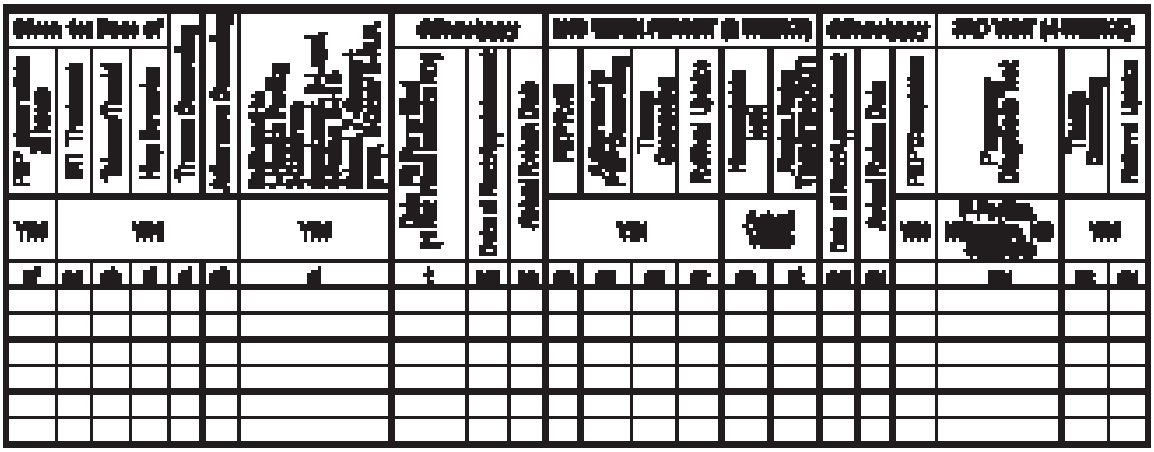
SV Register depicted is longitudinal
(the sections: A, B, C and D are continuous).

Sexual Violence Register MOH 365

B

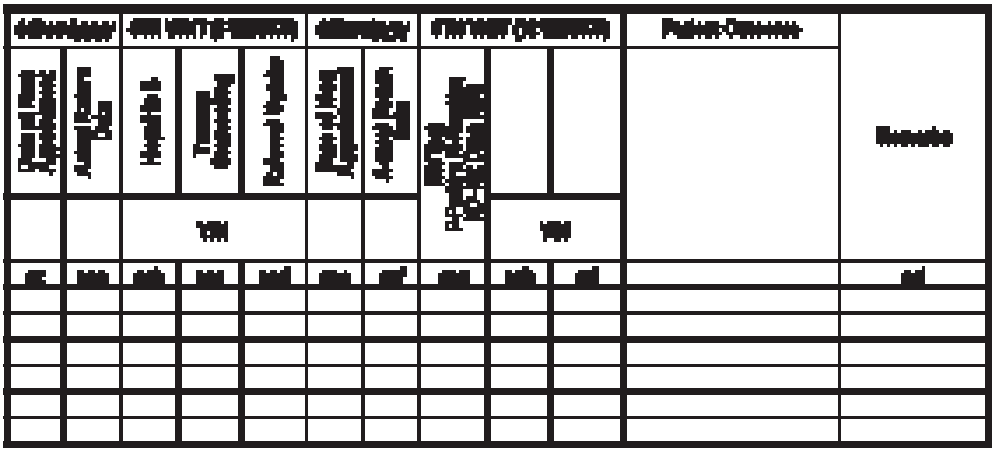


Sexual Violence Register MOH 365



SV Register depicted is longitudinal
(the sections: A, B, C and D are continuous).

Sexual Violence Register MOH 365



MOH 364
Revised July 2014

REPUBLIC OF KENYA

MINISTRY OF HEALTH

SEXUAL VIOLENCE MONTHLY SUMMARY

Facility Name:_____ **MFL Code:**_____ **County:**_____ **Sub-county:**_____

Reporting Month:_____ **Reporting Year:**_____

INDICATOR	0-11 Yrs		12-17Yrs		18-49 Yrs		50 yrs+		Total		Grand Total
	M	F	M	F	M	F	M	F	M	F	
Section A											
Number of rape survivors											
Number presenting within 72 hours											
Number initiated PEP											
Number given STI treatment											
Number eligible for Emergency Contraceptive Pill											
Number given Emergency Contraceptive Pill											
Number tested for HIV											
Number HIV positive at 1st visit											
Total survivors with disability											
Number of perpetrators											

Section B

COHORT SUMMARY

The purpose of section B is to assess programme success by capturing data on treatment outcomes and retention of rape/ defilemnt survivors. Extract data from the SGBV register for three months within which the survivor(s) are expected to have completed their visits. Note that the target group should fall in the bracket of 90 days counted from the first day of enrollment for services. E.g. the January cohort will be reported in the April report; the February cohort in the May report etc.

	0-11 Yrs		12-17Yrs		18-49 Yrs		50 yrs+		Total		Grand Total
	M	F	M	F	M	F	M	F	M	F	
1st visit											
2nd visit											
3rd visit											
4th visit											
5th visit											
Number completed PEP											
Number seroconverted											
Number pregnant											
Number completed trauma counseling											

Report Complied by:		**Date:**	
Designation:		**Signature:**	

Report Checked by:		**Date:**	
Designation:		**Signature:**	

This from should be completed at facility in duplicate; Original copy sent to the Sub-County level by 5th of every month for entry into DHIS and duplicate copy remains at the facilty record

Annex 8: P3 Form

This P3 Form is free of charge

THE KENYA POLICE P3

MEDICAL EXAMINATION REPORT

PART 1-*(To be completed by the Police Officer Requesting Examination)*

From_____Ref_____

_____Date_____

To the_____Hospital/Dispensary

I have to request the favour of your examination of:-

Name_____Age_____(If known)

Address_____.

Date and time of the alleged offence_____

Sent to you/Hospital on the_____20_____

Under escort of_____

and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.

Date and time report to police_____

Brief details of the alleged offence

_____

_____

_____

_____

Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS - ***(To be completed by Medical Officer or Practitioner carrying out examination)***

*(Please type **four** copies from the original manuscript)*

SECTION "A"-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref. No._____

1. State of clothing including presence of tears, stains (wet or dry) blood, etc.

_____

_____

2. General medical history (including details relevant to offence)

_____

_____

_____

_____

3. General physical examination (including general appearance, use of drugs or Alcohol and demeanour)

_____

_____

This P3 Form is free of charge

SECTION "B"- TO BE COMPLETED IN ALL CASES OF ASSAULT INCLUDING SEXUAL ASSAULTS

COMPLETION OF SECTION "A"

1. Details of site, situation, shape and depth of injures sustained:-

a) Head and neck

_____

_____

b) Thorax and Abdomen.

_____

_____

c) Upper limbs

_____

_____

d) Lower limbs

_____

_____

2. Approximate age of injuries (hours, days, weeks)

3. Probable type of weapon(s) causing injury

4. Treatment, if any, received prior to examination

5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e.' harm", or' grievous harm".*

DEFINITIONS:-

"Harm" Means any bodily hurt, disease or disorder whether permanent or temporary.

"Maim' means the destruction or permanent disabling of any external or organ, member or sense

"Grievous Harm" Means any harm which amounts to maim, or endangers life, or seriously or permanently injures health, or which is likely so to injure health, or which extends to permanent disfigurement, or to any permanent, or serious injury to external or organ.

Name & Signature of Medical Officer/Practitioner_____

Date_____

This P3 Form is free of charge

SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES

AFTER THE COMPLETION OF SECTIONS "A" AND "B"

1. Nature of offence_____Estimated age of person examined_____

2. FEMALE COMPLAINANT

a) Describe in detail the physical state of and any injuries to genitalia with special reference to labia majora, labia minora, vagina, cervix and conclusion

_____

_____

_____

b) Note presence of discharge**,** blood or venereal infection, from genitalia or on body externally

_____

_____

3. MALE COMPLAINANT

b) Describe in detail the physical state of and any injuries to genitalia

_____

_____

c) Describe in detail injuries to anus

_____

_____

d) Note presence of discharge around anus, or/ on thighs, etc.; whether recent or of long standing.

_____

_____

This P3 Form is free of charge

SECTION "D"

4. **MALE ACCUSED OF ANY SEXUAL OFFENCE**

a) Describe in detail the physical state of and any injuries to genitalia especially penis

_____

_____

_____

b) Describe in detail any injuries around anus and whether recent or of long standing

_____

_____

_____

5. Details of specimens or smears collected in examinations 2 ,3 or 4 of section "C" including pubic hairs and vaginal hairs

_____

_____

_____

6. Any additional remarks by the doctor

_____

_____

_____

Name & Signature of Medical Officer/Practitioner_____

Date_____

Annex 9: PRC Supervision Tool

POST RAPE CARE SUPPORT SUPERVISION TOOL

NAME OF HEALTH FACILITY: ..... DATE OF VISIT.....
PRC SERVICE POINTS VISITED.....
Names of service providers present.....

Aspect	What is working well	Gaps identified	Comments
1. Visibility Materials			
PRC IECs and signage strategically displayed/ available			
PRC services in service charter			
Client flow charts displayed at OPD and other waiting bays/ strategic points at the facility			
2. PRC Service Delivery			
• OPD/ Consultation rooms			
Private, quiet accessible examination room			
Examination table, lighting			
Access to autoclave/ sterilized equipment			
Displayed IECs, SOP flow charts, forensic charts			
Consent forms			
Local anaesthesia, suture packs			
Assembled PRC kit			
Cloth, or sheet to cover the survivor during examination; Sanitary supplies			
PRC form available, accurately and completely filled; Copies issued out correctly			
PRC drug kit in place- 1st PEP dose, ECP			
Lockable cabinets- for storage of data tools, commodities and evidence			
Referral to next service delivery point			
Laboratory			
Displayed IECs, SOP flow charts, forensic charts			
Lab tests done: HIV, PDT, Hb, Hep B and C, HVS			
STI tests for late presenting survivors			
Functional refrigerator			
HTC lab register completely and accurately filled			
Lab registers in place and filled			
Referral to next SDP			
Counselling			
Private, quiet accessible, well lit room			
Displayed IECs, Counseling SOPs			
Trauma forms			
PRC register: completely & accurately filled;			

1

'Adopted from LVCT'

agrees with PRC form			
PRC drug kit- 1st PEP dose, ECP			
Lockable cabinets- for storage of data tools and commodities			
Referral directory			
Pharmacy			
Displayed IECs, SOP flow charts			
Drugs: PEP, STI drugs, ECP, analgesics and antibiotics			
PEP registers			
3. Quality management			
QM teams address PRC issues			
Availability and adherence to PRC guidelines, SOPs, protocols			
Client satisfaction surveys done and analyzed			
Supervision and provider mentorship given by QM team			
Data flow from SDP to records; timely reporting			
4. Capacity building for PRC providers			
All PRC service delivery cadres trained			
Trauma counselors			
CME for PRC providers			
5. Management involvement and support			
Recognized PRC coordinating team in place			
PRC issues discussed and addressed by HMT			
Management supervision of PRC services			
Utilization of PRC data in planning			

Action Points	Responsible Person	By when

Site support supervision done by:

.....Signed……

……Signed……..

Annex 10: Sexual Offences Act Medical (Treatment) Regulations, 2012

IN THE EXERCISE of the powers conferred by section 35(3) of the Sexual Offences Act, 2006, the Minister for Public Health, makes the following Regulations:

Citation:

1. These Regulations may be cited as the Sexual offences (MedicalTreatment) Regulations, 2012

Interpretation:

2. In these Regulations, unless the context otherwise requires- "Act" means the Sexual Offences Act, 2006; and

"Designated Person" includes-

i. A nurse enrolled or registered under section 12(1) and 14(1) of the Nurses Act;or

ii. A clinical of cer registered under section 7 of the Clinical Officers (Training, Registration and Licensing); Act and "Medical Practitioner" means a medical practitioner registered in accordance with section 6 of the Medical Practitioners and Dentist Act.

"Medical Treatment" includes professional counselling

"Public hospital or institution" means a government health facility at all levels of healthcare, or such other institution that may be designated by notice in the Gazette as a public health facility for the purposes of this Act.

Access to Health:

3. (1) (i) every victim of sexual violence is guaranteed the right to medical treatment in a public or private hospital or any other institution

(ii) every witness is guaranteed the right to medical treatment in a public or private hospital or any other institution

(iii) every suspect or convicted person to a sexual offence is guaranteed the right to medical treatment in a public or private hospital or any other institution

(2) Any expenses incurred by the victim, witness, suspect or convicted person under medical treatment in a public hospital shall be borne by the state

(3) A victim of sexual violence shall receive medical treatment at any health facility whether or not they have reported the matter to the police

(4) The minister may at any time enter into arrangements with private hospitals or other health facility as public hospitals for purposes of implementation of section 35(3) of the Act Notification: a police officer of the rank of inspector and above, shall where an allegation of sexual violence having been committed against anyone, notify and refer the victim of sexual violence to a medical practitioner or a designated person at any health facility

Specimen Collection: 5

(1) a court may make an order for the collection of appropriate samples from a person charged with committing an offence under the act at such place and subject to such conditions that the court may direct

(2) upon receiving the order made, a police officer above the rank of a constable shall request any medical practitioner or designated person to take appropriate sample or samples from the accused person concerned

(3) the medical practitioner or designated person shall determine what sample or samples to take, from what body part and in such quantity as is reasonably necessary for analysis, as per the national guidelines on management of sexual violence

Treatment: 6

(1) medical practitioner or designated person shall-

(a) Conduct a full medical-forensic examination on the victim of sexual violence and prescribe the appropriate medical treatment.

(b) Provide professional counselling to the victim of sexual violence

(c) Complete a prescribed Post Rape Care Form , and any other relevant records.

(d) Collect and preserve the necessary medical forensic samples as per the national guidelines on management of sexual violence.

(e) Inform and forward to the Investigation Officer or his/her representative the collected forensic samples while maintaining chain of custody by signing for them.

(f) Initiate appropriate referral to relevant areas for subsequent care.

(2) a medical practitioner or designated person shall provide medical treatment prescribed in 6(1) (a), (b), (d), (e) and (f) to a suspect of sexual violence

(3) the medical practitioner or designated person may, where they deem appropriate, conduct other examinations and treatment on the victim of sexual violence, witnesses or the alleged perpetrator of sexual violence.

Dated the ……June, 2012

Signed for gazettement by Minister of Health

Annex 11: SGBV Community Awareness Info Pack

What is rape?

Rape is sex (sexual intercourse) that is obtained by use of force, coercion, intimidation of any kind or threats. It includes penetration in the vagina, the anus or any other body orifice. Rape happens to persons when they do not give consent to have sex

Rape happens to women and girls as well as men and boys

In Kenya, sex with children below 18 years is called defilement and is a criminal offence

Rape is often done by people we know and may at times be close to us.

Rape is about violence and the abuse of power by a person. It is not about love.

What should I do if I am raped?

Get to a safe place and go the nearest health facility within 72 hours.

Note: The national, Provincial and District Hospitals provide Post Rape Care Services.

At the hospital you will get:

1. medical evaluation and attention for your injuries
2. counseling support for yourself and your family
3. treatments to prevent infection with HIV, pregnancy and other sexually transmitted infections
4. referral for other services you may require

What should I NOT do if I am raped?

Do not wash yourself no matter how much you want to before you visit a hospital and are examined by a medical officer

Do not destroy or wash your clothing. Wrap them in a non polythene bag or in plain cotton clothes.

Do not put them in a plastic bag. This may destroy the evidence

Take them to the hospital with you and let the doctor examine them.

After rape you may experience feelings of shame, guilt and blame.

Remember: It is the person that raped you who is wrong. What has happened is NOT your fault

What happens at the hospital?

- A health care provider will examine your whole body for marks, bruises and wounds.
  The examination may be uncomfortable, embarrassing and sometimes painful, but it is necessary
- The health care provider will ask questions about the rape experience. You will need to answer all questions asked frankly
- The health care provider will record this information in detail in a book (that you may be required to buy) or in a form already available at the hospital. The health care provider will need to sign this
- if possible take a family member or a friend with you to support you

Remember: keep the medical notes and any documents that the doctor writes in a safe place. You may require them at a later date.

What treatment do I need if I have been raped?

Treatment of your physical injuries (if there are any) is most important

Drugs that could reduce chances of infection with HIV after rape are available

- These anti-retroviral (ARV) drugs are referred to as PEP (Post Exposure Prophylaxis)
- PEP must be started soonest possible after rape and certainly with 72 hours
- PEP is taken for a period of 28 days
- PEP is prescribed and managed by a qualified medical officer
- PEP will benefit you ONLY if you were HIV negative before being raped
- Taking PEP when you are HIV positive is not useful and increases your body resistance to any future ARV treatment
- A HIV test is therefore necessary to determine whether or not you can take PEP

Drugs to prevent pregnancy (emergency contraception).

- These drugs are also available in pharmacies. The most commonly used drug is called postinor 2.
- If this is not affordable or available, ask your pharmacist to give you a combination for emergency contraception from normal oral contraceptive pills

Drugs to reduce the possibility of infection with sexually transmitted diseases (STIs)

You will also be referred:

- For counseling at the VCT site for support and preparation to undertake a HIV test
- To the laboratory for necessary blood tests

What tests do I need to take if I am raped?

Tests to be done right away include;

A vaginal swab or an anal swab in case of sodomy– will attempt to show sperm in your vagina/anus. This can be used as evidence. However, the absence of sperms does not mean you were not raped

A pregnancy test – to make sure you are not already pregnant. If a pregnancy test cannot be done, you should get emergency contraception (Pregnancy prevention). If you suspect that you may already be pregnant it is alright to take emergency contraception since it does not interfere with established pregnancies.

Tests to be done later include:

Test for Sexually Transmitted infections. (these tests are not very necessary if drugs to reduce the possibility of STI infections are provided)

HIV test

Why do I need a HIV test?

PEP drugs reduce the chances of HIV transmission. PEP drugs **do not** cure HIV. PEP is only useful to someone who is HIV negative. It is important to establish HIV status for PEP to be provided.

You can get PEP for 3 days before taking a HIV test as you decide whether you wish to proceed with it. It is important to remember that:

- You will get counseling to support you through your trauma and in making your decision to take a HIV test.
- PEP may have some uncomfortable side effects. You may need to discuss these with your clinician/doctor.

Do not stop PEP without consultation with your Clinician/ Health Care Provider

It is very important to take all the drugs as prescribed throughout the 28 day period.

The HIV test and necessary blood test will be undertaken in a laboratory

Remember: it is entirely an individual's choice to be tested for HIV and is only necessary in hospitals and clinics where PEP is available

If I was raped and did not take PEP does it mean I have HIV?

Many people who have been raped do not get HIV. It is hard to say exactly what the risk is but it is dependent on a number of things:

- There is a chance that the person who raped was not infected or was not infectious (has a low load of HIV virus in his blood)
- If the person who raped did not ejaculate the risk is also less
- The risk is more if there were many people penetrating and there were injuries

What if I tested HIV positive?

If you are in hospitals mentioned above, you will be referred to the HIV care clinic. You will be offered:

- Counseling support that is on-going
- Information about available treatment for management of HIV related illness
- Preventive treatment
- Treatment for other infections
- Referral to other support infections

Many other places also have HIV care clinics or can provide some of the services mentioned above.

What if I choose to report to the police?

At the police station, you will report and a record will be made in the occurrence book (OB). You will get an OB number.

You will be asked questions about the incident. The police will cross-examine what you say in detail and may sometimes ask questions that are difficult for you. It may be uncomfortable or even painful, but necessary. **You may speak the absolute truth of the situation.**

If you have not been to the hospital, it is important that you go there immediately after reporting. Other procedures such as writing a statement or obtaining a P3 form can be undertaken after you have received initial treatment.

You will also be asked to recorded a statement and sign it. Do not sign this statement until you are happy and comfortable with what has been written in it.

You will be provided with a P3 form. This is a legal document that the will be provided for you to sign. If you have already been to the hospital, take it back with you to the health care provider to fill in. You may be accompanied by a police officer. Remember to carry the notes written by the medical officer as they will be used to fill in the P3 form

Remember: you have the right to ask for a female or male police officer to go with you.

The P3 form should be completed and signed only when you have fully recovered from all your injuries

Remember: the P3 form is an important document that provides a link between your statement and prosecution, where the perpetrator is arrested. The P3 form is a free document and this **should not be paid for**

What are my likely reactions to rape?

There are reactions commonly referred to as rape trauma syndrome (RTS):

- Shock can make you cry, laugh, shake or stay very calm
- Guilt and shame – you may feel and think that you could have done things differently to avoid or stop the rape. You may feel that others are faulting you
- Fear – this may immobilize and dysfunction you and can be triggered by different things – a word, a film, a book, a smell etc. Counseling support can help your fear go away
- Silence – you may feel like you want to keep quiet and may be afraid of disclosing rape

Remember: you have done nothing wrong. It is not your fault. It is **OK** to be angry and feel what you are feeling.

Some people may also experience:

- Nightmares, hallucinations and depression
- Anger and sense of loss – you may have lost your sense of safety, being in control and certainly the right to your bodily integrity. It is important to speak to someone to begin to heal. Your counselor will maintain confidentially. Breaking the silence will help you and others to conquer the fear and regain strength.

What are my rights as a survivor of sexual violence?

You have a right to:

- Choose when, where, how and with whom to have sex
- Engage in consensual sex in all situations at all times
- Have your choice respected and protected by society and the law
- Willingly decide to lay a charge of rape with the police
- Access termination of pregnancy and post abortion care in the event of pregnancy from rape
- Legal representation

Myths and facts about rape

Myth:	**Fact**
Rapists are strangers in the dark streets	Rapists are more often than not people known to the survivors. They include husbands, boyfriends, relatives, neighbours, friends or dates
When a woman says "NO" to sex, she means "YES	This belief is based on some cultures where women are expected to be shy and resist when approached by a man. A "NO" means "NO" and it has to be firm
Men cannot be raped	Men and particularly young boys are vulnerable to rape and require as much care and support as women who have been raped
Men cannot control themselves when they get proved and excited	All men and women can control themselves and their sexual activity. Rapists CHOOSE to use sex as a weapon of power It does not matter how women are dressed whether they are children in nappies and women in long robes. Women have the right to dress as they so wish
Husbands cannot rape their wives	Both women and men have a right to bodily integrity and choose when to have sex. Whether they are married or not

Annex 12: Useful Resources

General information

- Ajema C, Mukoma W, Mugyenyi C, Meme M, Kotut R, and aMulwa R (2012) Improving the collection, documentation and utilisation of medico-legal evidence in Kenya; LVCT Kenya.
- Guidelines for medico-legal care for victims of sexual violence, World Health Organization 2003, (http://www.who.int/violence_injury_ prevention/publications/violence/med_leg_guidelines/en/inde)
- Clinical Management of Survivors of Rape. A Guide to the Development
- of Protocols for Use in Refugee and Internally Displaced Person Situations, World Health Organization 2005, (http://www.unhcr.org/refworld/ docid/403b79a07.html)
- Download guidelines for management of sexual violence of Kenya (2003) (http://www.liverpoolvct.org/index.php?PID=172&showsubmenu=172)
- Family planning Guidelines for service providers 2005(http://www. maqweb.org/iudtoolkit/policies_guidelines/kenyafpguidelines.pdf)
- Community Practices post sexual Violence Implications on the uptake of services and the implementation of care (http://www.aidsportal.org/repos/
- Community Responses To Sexual Violence.pdf

Information on sexually transmitted diseases

- Guidelines for the management of sexually transmitted diseases. Geneva, World Health Organization, 2001 (document numberWHO/RHR/01.10) (http://www.who.int/reproductive-health/publications).
- Information on emergency contraception: a guide for service delivery. Geneva, World Health Organization, 1998 (document no. WHO/FRH/ FPP/98.19). (http://www.who.int/reproductive-health/publications).
- Practice Guidance on the supply of Emergency Hormonal Contraception as a pharmacy medicine, Royal Pharmaceutical Society of Great Britain,
- 9/2004 (http://www.rpsgb.org.uk/pdfs/pr040922.pdf)

Information on post-exposure prophylaxis (PEP) of HIV infection

- Post-exposure prophylaxis to prevent HIV infection: joint WHO/ILO guidelines on post-exposure prophylaxis (PEP) to prevent HIV infection, World Health Organization 2007 (http://www.who.int/hiv/pub/guidelines/en/)

Information on psychosocial issues

- Campbell R. Mental health services for rape survivors: issues in therapeutic practice. Violence Against Women Online Resources, 2001:1–9 (http:// www.vaw.umn.edu/ documents/commissioned/campbell/campbell.html).

Information on humanitarian issues

- Inter Agency Standing Committee (IASC) Guidelines on Mental Health and Psychosocial Support in Emergency Settings (http://www.humanitarianinfo.org/iasc/content/products)

Information on legal and forensic issues

- The Sexual Offences Act. No 3 of 2006. Revised Edition 2007 (2006) (http://
- www.kenyalaw.org/.../download.php?...Sexual%20Offences%20Act)
- Community Practices Post Sexual Violence. Implications on the uptake of services and the implementation of care (http://www.aidsportal.org/repos/
- COMMUNITY%20RESPONSES%20TO%20SEXUAL%20VIOLENCE.pf
- The Constitution of Kenya, 2010.

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