MINISTRY OF HEALTH

National Health Sector Standard Operating Procedures on Management of Sexual Violence in Kenya

2014

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List of Acronyms

ABC	Abacavir
ALT	Alanine Aminotransferase
ARV	Anti-Retro Viral
ATV	Atanovir
CDC	Center for Disease Control
Cr	Creatinine
DRH	Division of reproductive Health
D4T	Stavudine
GBV	Gender Based Violence
GIZ	German Technical Cooperation
HIV	Human Immuno-deficiency Virus
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HQ	Headquarters
HR	Human Resources
3TC	Lamivudine
LPV/r	Lopinavir/ritonavir
MOMS	Ministry of Health Services
MOPS	Ministry of Public Health and Sanitation
NVP	Nevirapine
PEP	Post Exposure Prophylaxis
PLHIV	People living with HIV
RMHSU	Reproductive & Maternal Health Services Unit
RTV	Ritanovir
SV	Sexual Violence
SGBV	Sexual Gender Based violence
SOPs	Standard Operating Procedures
TDF	Tenofovir
TFSOA	Taskforce on the Implementation of Sexual Offences Act
TT	Tetanus Toxoid

Definition of Terms

"… **gender-based violence (GBV)** is violence that is directed against a person on the basis of gender or sex. It includes acts that inflict physical, mental or sexual harm or suffering, threats of such acts, coercion and other deprivations of liberty…." While women, men, boys and girls can be victims/survivors of gender-based violence, women and girls are the main victims/survivors.

GBV shall be understood to encompass, but not be limited to the following:

- Physical, sexual and psychological violence occurring in the family, including battering, sexual exploitation, sexual abuse of children in the household, dowry-related violence, marital rape, female genital mutilation and other traditional practices harmful to women, non-spousal violence and violence related to exploitation.
- Physical, sexual and psychological violence occurring within the general community, including rape, sexual abuse, sexual harassment and intimidation at work, in education institutions and elsewhere, trafficking in women and forced prostitution.
- Physical, sexual and psychological violence perpetrated or condoned by the State and institutions, wherever it occurs."

The underlying root cause of GBV is the historically unequal power relations between men and women, which have led to domination over and discrimination against women by men. Poverty, culture and substance abuse are factors which exacerbate these unequal power relations.

Under the Law of Kenya, a minor or parent or any other person cannot give consent to a sexual act on behalf of a child. Thus any sexual act carried out with a minor is considered defilement and is punished in the same manner as sexual violence.

Crime scene: this can refer to either a person, place or an object- capable of yielding physical evidence which has the potential of assisting in apprehending or exonerating the suspect. A survivor is considered a crime scene as a lot of evidence can be collected from him/ her.

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
Defilement: An act which causes penetration of a child's genital organs. (Child is any one below the age of 18 years).

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 the evidence in criminal investigation includes: i) To link/delink the perpetrators to crime; ii) To ascertain that SV occurred; iii) To help in collection of data on perpetrators of SV

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

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.

Indecent Act: Any unlawful act which causes (i) any contact between the genital organs of a person, his or her breasts and buttocks with that of another person (ii) exposure or display of any pornographic material to any person against his or her will, but does not include an act that causes penetration.

Medical practitioners: Medical practitioner means a practitioner registered in accordance with Section 6 of the 'Medical Practitioners and Dentist Act'

Penetration: Means partial or complete insertion of the genital organs of a person or an object into the genital organs of another person.

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 circumstance of the crime or any other fact deemed to be important to the process. Physical evidence can be collected from the survivor as well as the environment.

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.

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.

For the purpose of this SOPs, "sexual violence" refers to all forms of sexual violence such as:Rape, attempted rape, defilement, attempted defilement, sexual assault and attempted sexual assault.

Executive Summary

Preventing and responding to sexual abuse requires the contribution and co-ordination of different professionals and towards this end the Task Force on the Implementation of the Sexual Offences Act (TFSOA) was set up[1] and is currently developing a multispectral national SOP that will facilitate joint action by all actors to prevent and respond to SGBV.

For the health sector, the Reproductive and Maternal Health Services Unit- RMHSU (formerly DRH) in its mandate to steer the provision of quality services to survivors of SGBV in Kenya, through development of key policies, strategies, guidelines and tools, initiated a process to develop National SOPs to guide facility level service providers in the public and private sector .

These SOPs are a product of a harmonization of the existing SOPs in the sector through a desk review and consultations with the various stakeholders. It details the minimum procedures for the management of SGBV in the health sector and outlines referral mechanisms to the other sectors that provide psycho-social care, legal services and other community support mechanisms.

This document recognizes that the service providers are trained health professionals and there is in existence a National Guidelines on Management of Sexual Violence that comprehensively describes the various services offered by the health sector. The document therefore focuses on the 'how' and offers specific steps on how the health services are offered. SGBV and SV will be used interchangeably within the document.

The document is structured as follows:
Part 1 – The general package offered by the health sector – this is as briefly described by the General SOPs developed by the Sexual Offences Task Force and comprehensively elaborated on by the Guidelines produced by the RMHSU (formerly DRH). The minimum post rape services that should be provided at the various levels of health facilities, gives information on the quality of standards expected.

Part 2 – The step by step instructions on how to deliver the services from entry to exit. This section is guided by the client flow pathway for the treatment of patients of SGBV and categorizes the types of services as medical, forensic and psycho-social support.

For completeness, each SOP is given a title that describes the function, the objective, the person responsible and the specific steps that describes how the function is performed. (the what? the who? the why?, the when? and the how?)

At the exit, the document gives the specific considerations for humanitarian conditions.

Part 3 – Annexes
Contains all the documentation forms for SGBV management as described within the National Guidelines for Management of Sexual Violence (consent, PRC, P3, psycho-social assessment, registers, etc); Treatment regimens and schedules; Flow diagrams and algorithms and referral pathways

1 Gazette Notice 2155 of March 26, 2007

Introduction

Background information

In recognition of the prevalence of sexual gender based violence (SGBV) and its devastating impact on women and children in particular, as well as families and communities, the Sexual Offences Act [2] 006 was enacted in order to "make provision about sexual offences, their definition, prevention and the protection of all persons from harm and from unlawful sexual acts". The Act provides in Section 47 that the Attorney General should, in consultation with the Ministers responsible for internal security, prisons, social services, education and health, make regulations regarding the inter-sectoral implementation of the Act and on any other matter in order to achieve or promote the objectives of this Act. This was in recognition that preventing and responding to sexual abuse requires the contribution and co-ordination of different professionals. Towards this end the Task Force on the Implementation of the Sexual Offences Act (TFSOA) was set up[3] and is currently developing multispectral national SOPs that will facilitate joint action by all actors to prevent and respond to SGBV.

2 Act No 3 of 2006

3 Gazette Notice 2155 of March 26, 2007

The RMHSU (formerly DRH), operating under the Division of Family Health in the Ministry of Health recognizes the need for inter-agency communication, inter-operability, and cooperation in the comprehensive management of sexual violence in Kenya. While the various sectors concerned have established inter-operability capabilities and mutual aid agreements in place which formally extend beyond jurisdictions, they tend to remain intra-discipline in practice. It is for this reason that the RMHSU, in collaboration with its stakeholders, is developing the HealthSector SOPs that are linked with the Multi-sectoral SOPs for Prevention and Response to Sexual Violence.

It is in line with this that the RMHSU initiated a process to develop National SOPs to guide facility level service providers in the public and private sector in provision of comprehensive medico-legal care, linkages and psycho-socio support to survivors of SGBV. Creating and applying SOPs that foster inter-operable communications across all the players in the health sector can be challenging due to the differences in knowledge, attitude and skills and the overall experience of the sensitive nature of SGBV. However, SOPs are essential for successful response and the DRH and her partners hope that this guide will help in the effectiveness and efficiency of the health sector in the management of SGBV in Kenya.

Part 1: General SOPs

- Multi-Sectoral SOPs
- Minimum Package of Post Rape Care services offered at various levels of health facilities

Multi- Sectoral SOPs

General Guiding Principles

The health sector as part of the overall multi-sectoral actors have agreed to extend the fullest cooperation and assistance to each other in preventing and responding to SGBV, as well as adhere to the following set of guiding principles:

- ✓ Ensure the safety of the victim/survivor and his/her family at all times.
- ✓ Respect the confidentiality of the affected person(s) and their families at all times.
- ✓ Respect the wishes, rights, and dignity of the victim(s)/ survivor(s) when making any decision on the most appropriate course of action to prevent or respond to an SGBV incident, while also bearing in mind the safety of the wider community as well as the individual concerned.
- ✓ Ensure non-discrimination in the provision of services.
- ✓ Apply the above principles to children, including their right to participate in decisions that will affect them. If a decision is taken on behalf of the child, the best interests of the child shall be the overriding guide and the appropriate procedures should be followed. Special procedures for working with child survivors and child perpetrators are described in the section on responses.

Health sector mandate, role and flow of services

Specifically for the health sector, the multi-sectoral SOPs identify the mandate, role and flow of services offered as follows:

The mandate of the Ministry of Health is to provide health services, create an enabling environment, regulate and set standards and policy for health service delivery. This is done through an integrated approach in the provision of curative and rehabilitative services.

The role of the health sector in prevention and response to SV is:

- ✓ Developing national policies, guidelines, standards, protocols and training curricula for SV service delivery
- ✓ Capacity building of health service personnel through training and mentorship on clinical management of SV
- ✓ Providing supportive supervision through the provincial and district health providers to ensure quality service delivery on SV
- ✓ Providing services to SV survivors.

The proposed step by step SOPs at the health facility as proposed by the multi-sectoral SOPs:

1. Take the medical history of the survivor and conduct further tests based on the report made (ensure confidentiality in the process)
2. Conduct the relevant medical examinations
3. Treat any physical injuries suffered in the course of violation
4. Provide the survivor with post exposure prophylaxis (PEP) and emergency contraception (EC) where needed
5. Provide prophylaxis for sexually transmitted infections (STIs) and hepatitis B prevention
6. Offer psychosocial support through trauma counseling
7. Ensure referral of survivors for other essential services (including social services, legal aid and economic support).
8. Document medical findings in the PRC form (MOH 363) and by filling out the medical sections of the P3 form.
9. Support survivors with the preservation of evidence.
10. Testify in court about medical findings should the survivor pursue legal action.

Minimum package of post rape care services offered at the different levels of 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 HCT services are available, provide initial counseling	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 counseling 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 counseling for trauma, HIV testing and PEP adherence	Fill in PRC form in triplicate Maintain PRC register Maintain a laboratory PRC register Fill in PRC form to follow up management of survivors	1 medical or clinical officer trained in ARV/ PEP management 1 trained counselor

Part 2:
Detailed Health Sector SOPs

Entry into the Health Facility
- Registration
- Triage

Engagement at the Health Facility
- Availing medical services
- Availing forensic services
- Availing psycho-social support services

Exit from the health facility
- Facilitating entry (or re-entry) into the general multi-sectoral referral pathways
- Special considerations in humanitarian settings

Entry into the Health Facility

General information

Like all other SGBV service providers, the health professional must encourage the SGBV patient to take back control of her /his life and whatever the situation, the team involved in the care must respect the choices and decisions made by the patient.

The objectives of the medical response to rape and sexual abuse are to:

- Attend to the physical injuries;
- Prevent pregnancy
- Prevent sexually transmitted infections including HIV
- Collect specimens for forensic evidence
- Offer basic psycho-social support
- Refer the client for other services

An evaluation of vital needs should be made for each person presenting very soon after an attack. In case of hemorrhage, state of shock, etc., priority must be given to immediate treatment of the medical needs.

When examining a person who has been a victim of violence of any kind, the possibility that rape has occurred needs to always be taken into consideration. The person receiving the patient needs to know how to address this situation and use sex and age appropriate skills.

Registration

The purpose of the registration is to ensure that the patient has their records taken and it is documented in a way that it can be retrieved any time that is needed.

Triage

The purpose of the triage is to identify patients who need to be fast-tracked.Emergency situations, efficacy of medication and/or pscho-social reasons all justify the prioritization of SGBV patients

SOP: Entry into the service facility (Registration and Triage)	
Objective: To effectively and efficiently ease the patient into the health facility	**Responsibility**: Ideally, a trained counselor should be available to do this and she/he would work closely with the registration and triage staff
Procedure: Calm the patient - (Offer a de-briefing pscho-social session if need be.) Do the necessary entry point documentation of the patient Prioritize patient – fast tract for time-dependent services (EC and PEP) and to limit further emotional injury by waiting	

Engagement at the Health Facility

General information

- Ensure a gentle approach in everything you do to the patient.
- Respect the patient's modesty by only uncovering him/her partially as the examination proceeds.
- The clinical work-up should include full head to toe body examination. The precise description of the nature, size and locality of the wounds should be carefully recorded. Establish the extent of the agreement between the clinical signs and what the victim says or recalls: perforated tympanum as the result of blows to the head, part of the scalp torn off, etc.
- Make a meticulous examination of the head, the mouth and the ears, as well as any marks on the forearm (attempt to resist), wrists and ankles (immobilisation).
- Proceed to a genital examination (if agreed by the patient): pubis, interior of the thighs (marks left by forcing them apart), clitoris, urethra, genital lesions (haematomas, scratch marks, etc.) and any signs of STI (vaginal discharge, temperature, etc.). Gloves must always be worn while carrying out the examination.
- For the gynaecological examination, lubricate a speculum with water or a saline solution before insertion to avoid contamination of the sample. Inspect the vaginal walls, the cervix, the posterior fornix and the vaginal mucus.
- Proceed to an examination of the anal region: observe for dilatation of the anus, shape, cracks, presence of faecal matter on the perineum, bleeding, rectal lesions, etc. A retro-vaginal examination may be required, as well as an inspection of the rectal zone in order to detect any lacerations, trauma or fistulas.
- At the end of the clinical examination, the medical file should be completed with all the elements revealed during the examination. Pictograms make it possible to locate and detail the size of the injuries.
- If the clinician observes either signs of sexual or other forms of violence or if the patient him/herself relates such facts, you have a medical and legal obligation to prepare a confidential medical legal certificate (PRC form).
- These certificates are covered by medical confidentiality. To receive this document is a right of the victim, and it is the only documentation that can help the victim to claim her rights before a national court or tribunal in Kenya.

The documents must include:

- ✓ The name of the clinical officer (or doctor) signing the certificate.
- ✓ The name of the person who is the victim of the sexual violence.
- ✓ The full date and time of the examination.
- ✓ The survivor's statement (in their own words).
- ✓ The observations during the clinical examination.
- ✓ The nature of any samples taken or examinations carried out.
- ✓ A patient summary (including, if possible, an estimate of the length of any incapacity to work as well as an assessment of any permanent incapacity).

- The original copy of the medical certificate is given to the patient. A copy should be kept in the file and may be used at a later date to authenticate the certificate given to the patient. The copies must be kept in the archive for a period as long as the survivor is legally capable of presenting the case in court. For sexual violence considered war crimes or crimes against humanity the period can last up to ten years.

The clinician must:

- Never repeat the words of the patient as if they were his/her own words: do not say, “this person has been raped”, but rather “this person says she has been raped.’
- Never state that a crime has been committed and point out who is responsible; this is the domain of the judiciary authority.
- Never conclude that there has been no sexual aggression because the examination does not reveal the presence of a lesion. The absence of lesions does not exclude rape to have taken place.

Particular needs where children are concerned

In the case of sexual violence against a child, it is important to have somebody present who has legal responsibility for the child, in whom the child can have confidence in order to facilitate the subsequent medical care. However, certainly in case of suspicion of intra-family violence, it is necessary to have an interview alone with the child once a relationship of trust has been established.

Time must be taken to explain what will happen in simple, understandable words. A doll might be used to demonstrate everything that has to be done during the examination in order to de-dramatise the situation. A child could be examined while being held on the knees of the mother or of someone else in whom s/he has trust.During the examination of the genital area, it is preferable to lie the child down on his/her stomach or side. The dorsal position with bended knees on the chest is often the position used by the assailant. If a child refuses examination and there are urgent medical concerns with regard to the child such as danger and/or extensive measures are needed to repair the damage, sedations, anaesthesia is recommended.

If the child cannot be persuaded to calm down (extreme agitation) and when treatment is vital, the following medication may be administered:
Diazepam, by mouth, 0.15mg/kg with 10 mg maximum
or
Promethazine, syrup (5mg/ml), by mouth:
2-5 years: 15-20 mg
5-10 years: 20-25 mg
The effects will show within one to two hours during which time the child should rest in a calm place.

A speculum should never be used when examining girls who have not reached puberty since such an examination is extremely painful and can provoke serious lesions.

Availing medical services

Obtaining consent:

- The survivor should be given adequate information in order to give his/her informed consent. This information should include the implications of sharing information about the case with other actors and the options/services available from the different agencies.
- Children must be consulted and given all the information needed to make an informed decision, through the use of child-friendly techniques that encourage them to express themselves. Their ability to provide consent on the use of information they provide and the credibility of their information, will depend on their age, maturity and ability to express them freely and coherently.

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

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

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).

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

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

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)*

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.

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.

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.

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 for Clinical Management

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
  - Urine 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.

Availing Forensic Services

General information

Objectives of medical-legal evidence are:

- To confirm a recent sexual contact
- To prove the use of force or constraint
- To confirm the facts presented by the person who has been the victim of sexual violence
- To identify the assailant if possible

Medical-legal evidence based on samples of spermatozoa must be collected within a time limit depending on the site of collection:
Vagina: 72 hours
Anus: 72 hours
Mouth: 48 hours
Skin: 24 hours

After this time, it is no longer possible to prove the presence of spermatozoa in samples. For the collection of a sample from the vaginal area a high vaginal swab is needed.

If the patient requests an analysis of the sample, arrangements must be made to take it to the police, who will send it to the National Chemistry Laboratory for further investigation. (See multi-disciplinary SOPs for guidance)

The collection of medical-legal evidence should be done during the clinical examination in order to avoid repeating an examination (at the police station) that is traumatising for the victim.

Laboratory tests done for clinical management of the patient and not necessarily for forensic evidence:

- Hb, renal and liver function tests – mainly to determine clinical state of patient
- HIV (Determine, Unigold: if positive confirm with SD- Bioline, if discordant ask lab for next steps),
- Syphillis,
- Pregnancy test,
- Hep B (It may be cheaper to give every patient the vaccine other than persue a test)

SOP: Collection of forensic evidence
Procedure <u>Documenting the case</u> • Record the interview and your findings at the examination in a clear, complete, objective, non-judgmental way in the PRC form. • Document your findings without stating conclusions about the rape. Note that in many cases of rape there are no clinical findings. • Completely assess and document the physical and emotional state of the survivor. • Document all injuries clearly and systematically, using standard terminology and describing the characteristics of the wounds. Record your findings on pictograms on the PRC form.(see attached PRC form) • Record precisely, in the survivor's own words, important statements made by her, such as reports of threats made by the assailant always use qualifying statements, such as "patient states" or "patient reports". Avoid the use of the term "alleged", as it can be interpreted as meaning that the survivor exaggerated or lied. • Make note of any sample collected as evidence.
<u>Samples that can be collected as evidence</u> • Injury evidence: physical and/or genital trauma can be proof of force and should be documented and recorded on pictograms.(see PRC form attached) • Clothing: torn or stained clothing may be useful to prove that physical force was used. If clothing cannot be collected (e.g. if replacement clothing is not available) describe its condition. • Foreign material: (soil, leaves, grass) on clothes or body or in hair may corroborate the survivor's story. • Hair: Foreign hairs may be found on the survivor's clothes or body. Pubic and head hair from the survivor may be plucked or cut for comparison. • Sperm and seminal fluid: swabs may be taken from the vagina, anus or oral cavity, if penetration took place in these locations, to look for the presence of sperm and for prostatic acid phosphatase analysis. • DNA analysis, where available, can be done on material found on the survivor's body or at the location of the rape, which might be soiled with blood, sperm, saliva or other biological material from the assailant (e.g., clothing, condoms etc.), as well as on swab samples from semen stains, and involved orifices, and on fingernail cuttings and scrapings. In this case blood from the survivor must be drawn to allow her DNA to be distinguished from any foreign DNA found. • Blood or urine may be collected for toxicology testing (e.g. if the survivor was drugged).

Exhibit management

The following practices must be followed when handling an exhibit:

- Collect evidence as soon as possible after the incident. Ideally specimen should be collected within 24 hours of the assault. After 72 hours, yields are reduced considerably. Specimen should be collected before the survivor takes a bath.
- Whenever possible, forensic evidence should be collected during the medical examination so that the survivor is not required to undergo multiple examinations that are invasive and may be experienced as traumatic.
- Avoid contaminating the specimen. Wear gloves and protective gear at all times. Store each exhibit separately in a place that guarantees safety and confidentiality.
- Ensure that specimens are packed, stored and transported safely and securely; exhibits should not be exposed to direct light and sunshine. If wet, exhibits are dried under shade or dark rooms. Biological evidence material (e.g. body fluids, soiled clothes) should be packaged in paper envelopes or bags after drying, avoid plastic bags.
- Label all specimens clearly with the survivor's name and date of birth, the health workers name, the type of specimen, and the date and time of collection.
- Specimen should be packaged to ensure that they are secure and tamper proof. Only authorized people should be entrusted with specimens
- Call on an expert if you lack adequate training to handle a particular type of exhibit.
- Maintain continuity: once a specimen has been collected, its subsequent handling should be recorded. Details of the transfer of the specimen between individuals should be recorded. An exhibit register should be maintained.

SOP: Filling the PRC form

(The PRC form is filled while attending to the survivor; as the other procedures are going on)

Procedure

- Explain to the survivor why the form is being filled.
- Fill the form in triplicate; explain to the survivor why this is the case.
- (The original copy is attached to police P3 form, duplicate copy is kept by the survivor for legal use and the triplicate copy remains for hospital records)
- Indicate all the names of the survivor as they appear in the national identity card.
- Ensure that all the details are filled in the form; do not leave any blank spaces.
- Explain to the survivor the importance of safe- keeping all the documents and bringing them when re- visiting the hospital.
- Sign the PRC form.
- Ensure that the police officer also signs the form after collecting the forensic exhibits.
- Keep the remaining triplicate copy safely under lock and key to ensure confidentiality and preservation of the evidence.

SOP: Filling the PRC register

(The PRC register is to be filled after all or other procedures- history taking, examination, lab investigations, first counseling session, treatment and referrals- have been done)

Procedure

- Record the province code, district code, year and month in the register
- Fill in the names of the survivor as appears in the national identity card.
- Fill in the residence, contacts, age, sex and marital status of the survivor
- Fill in the serial number
- This is done after all the other services (history taking, examination) have been done.
- Fill in the time and date of the alleged assault
- Indicate whether the PRC form and P3 form has been filled.
- Indicate whether the first doses of PEP and EC drugs have been issued.
- Fill in the referrals done: to police, trauma counselling services, laboratory investigations .
- Sign against your initials
- Indicate the next appointment date in the follow up column
- Fill in any other comments in the remarks section
- Keep the register safely under lock and key to ensure confidentiality.

Availing Treatment Services

The medical treatment consists of post exposure prophylaxix (PEP), prophylactic treatment of STIs, emergency contraception and vaccination.

HIV prophylaxis is of medical urgency. Ideally, PEP and counseling should begin within four hours of exposure. If exposure is more than 72 hours ago, the administration of PEP is not recommended.

First stage: risk evaluation and decision as to whether or not PEP should be proposed. The decision to propose PEP should be based on the risk related to the nature of the exposure. The risk of the rapist being HIV positive is minor consideration.

HIV Post Exposure Prophylaxis

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.

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.**

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

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.

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

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.

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).”

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.

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**
5-12 kg	Cefixime	Powder for suspension	100mg/5ml	8mg/kg (max 2g)	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 10 mg/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

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

Management of Adult Male Survivors of Violence

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.

Treatment summary table

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

√ *Drug should be administered* x *Drug should not be administered*

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.

Availing Psycho-social Support Services

General information

Psychosocial care starts the minute the patient accesses the clinic and it is not over until she/he leaves.

- Ensure the security of the patient
- Guarantee confidentiality
- No time limits, be available for the patient

Rape is a traumatic experience psychologically and physically. The fact that the patient attends a clinic means that she/he understood her/his trauma and the necessity of specific care.

Referral of the patient to psychosocial assistance must be systematically proposed.

Counseling and psychological support

The client will need an element of trauma counseling, pre and post HIV test counseling, and treatment compliance counseling.

Refer to ongoing follow up counseling appropriately

Social support

The social support will be provided within the period that the patient will be medically followed in the clinic. It includes the referral system to other organizations, associations or shelters to whom we will be able to hand over if needed.

The social worker, if available, will write an appropriate letter to the organization being referred to (e.g shelter and/or other social services) and if possible accompany the patient and do a full handing over.

Facilitation for other social support such as transport for follow up visit should be availed if possible.

Legal issues

After availing information about the legal process, the patient should be allowed to make her/his own decision and facilitated to follow through with it appropriately.

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)

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.

PROTOCOL	CONTENT
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
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

PROTOCOL	CONTENT
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).

Exit from the Health Facility

Facilitating Entry (or Re-Entry) into the General Multi-Sectoral Referral Pathways

As the patient leave the health facility, the objective is to make sure that the health care provider has availed all necessary information (both verbal and written) that would help the patient continue with the services of SGBV from the same health facility, other health facilities or from other sectors.

The survivor has the freedom and the right to report an incident to anyone. S/he may report to:

- Anyone whom the survivor perceives that can be of assistance;
- Community or religious leaders;
- School teachers, parents, peers, friends;
- Men, women and girls' support groups;
- NGOs in the vicinity

However, in the case of assault, the survivor will report directly to the police. S/he may be accompanied by a family member or any of the above mentioned individuals.
All actors who become aware of the existence of an SGBV survivor have a responsibility to advise the survivor of the available services.

Incidents of sexual exploitation involving duty bearers and/or service providers must be dealt with through a survivor/victim cantered approach.

Referral system

In cases where SGBV incidents occur, the following steps will be taken to assist the survivor while ensuring that the perpetrator is accorded equal protection of the law and due process.

Survivors of sexual violence may report the incident to the any person of first contact who will then have the obligation to send the person to the police and/or health facility
When the incidence is reported to the police, detailed information on the cases should be documented in the P3 form.

A relative can escort the survivor to the hospital. However, in cases where a minor/mentally challenged individual is involved, the parent/guardian should escort the survivor to the hospital or police. He/she may be required to provide additional information.

Special procedures for child victims/survivors

When an agency becomes aware of a serious incident of abuse or neglect by parents, their first responsibility is to inform County and Sub-county children's officers so that appropriate action can be taken.

Actors engaged in response activities should be trained to handle the psycho-social needs of child survivors.

Interviewers should be aware of the fact that some perpetrators may be family members. The child should therefore be interviewed when no other family member is present. However, the parents/guardians must be informed that an interview is going to be conducted.

Based on the right to participate in decisions that affect their lives, child survivors should be informed of the availability of facilities to ensure their health, psycho-social care, physical safety and legal protection. Child survivors should also be made aware of the limitations of those services.

Special Considerations in Humanitarian Settings

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. In the absence of governmental programmes to mitigate the impacts of sexual violence, humanitarian organizations play a big role in caring for rape survivors

The vulnerabilities of women and girls:

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 favors 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.

What should be included in the minimum set of interventions?

- 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

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.

Minimal services needed

- Survivors/victims 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/victim, and to establish effective preventive measures;
- Prevention and response to SV requires coordinated action from actors from many sectors.

Specific responsibility of the health sector

The health care provider's responsibility is to provide appropriate care to survivors of sexual violence as documented in these SOPs. This includes collection of any forensic evidence that might be needed in a subsequent investigation either during or post crisis period.

The need for collaboration and co-ordination

In peaceful times, the prevention and response to SGBV need a certain level of collaboration to ensure that the survivor gets a multispectral package of services.

During humanitarian crisis, successfully protecting all citizens and especially the vulnerable ones, is dependent on the active commitment of, and collaboration between, all actors, including male and female community members. To save lives and maximize protection, a minimum set of activities must be rapidly undertaken in a coordinated manner to prevent and respond to sexual violence from the earliest stages of an emergency.

Part 3: Annexes

Annex 1: Help seeking and referral pathway

Annex 2: Patient flow pathway at the health facility

Annex 3: Essential resources and companion guides

Annexes available in the National Guidelines on Management of Sexual Violence in Kenya

Annex 4: PRC Consent Form

Annex 5: Survivor Flow Chart

Annex 6: Clinical Management Algorithm

Annex 7: Rape Kit

Annex 8: Post Rape Care Form

Annex 9: Counselling Form

Annex 10: Sexual Violence Register MOH 365

Annex 11: P3 Form

Annex 12: PRC Supervision Tool

Annex 13: Sexual Offences Act Medical (Treatment) Regulations, 2012

Annex 14: GBV Community Awareness Info Pack

Annex 15: Useful Resources

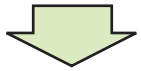
Annex 1: Help seeking and referral pathway

(Establishes the multisectoral nature of the SOPs and offers guidelines on the inter sectoral linkages between the sectors)

TELLING SOMEONE AND SEEKING HELP (REPORTING)	
Survivor tells family, friend, community member; that person accompanies survivor to the health or psychosocial "entry point:	Survivor self-reports to any service provider

IMMEDIATE RESPONSE The service provider must provide a safe, caring environment and respect the confidentiality and wishes of the survivor; learn the immediate needs; give honest and clear information about services available. If agreed and requested by survivor, obtain informed consent and make referrals; accompany the survivor to assist her in accessing services	
Medical/health care entry point	Psychosocial support entry point

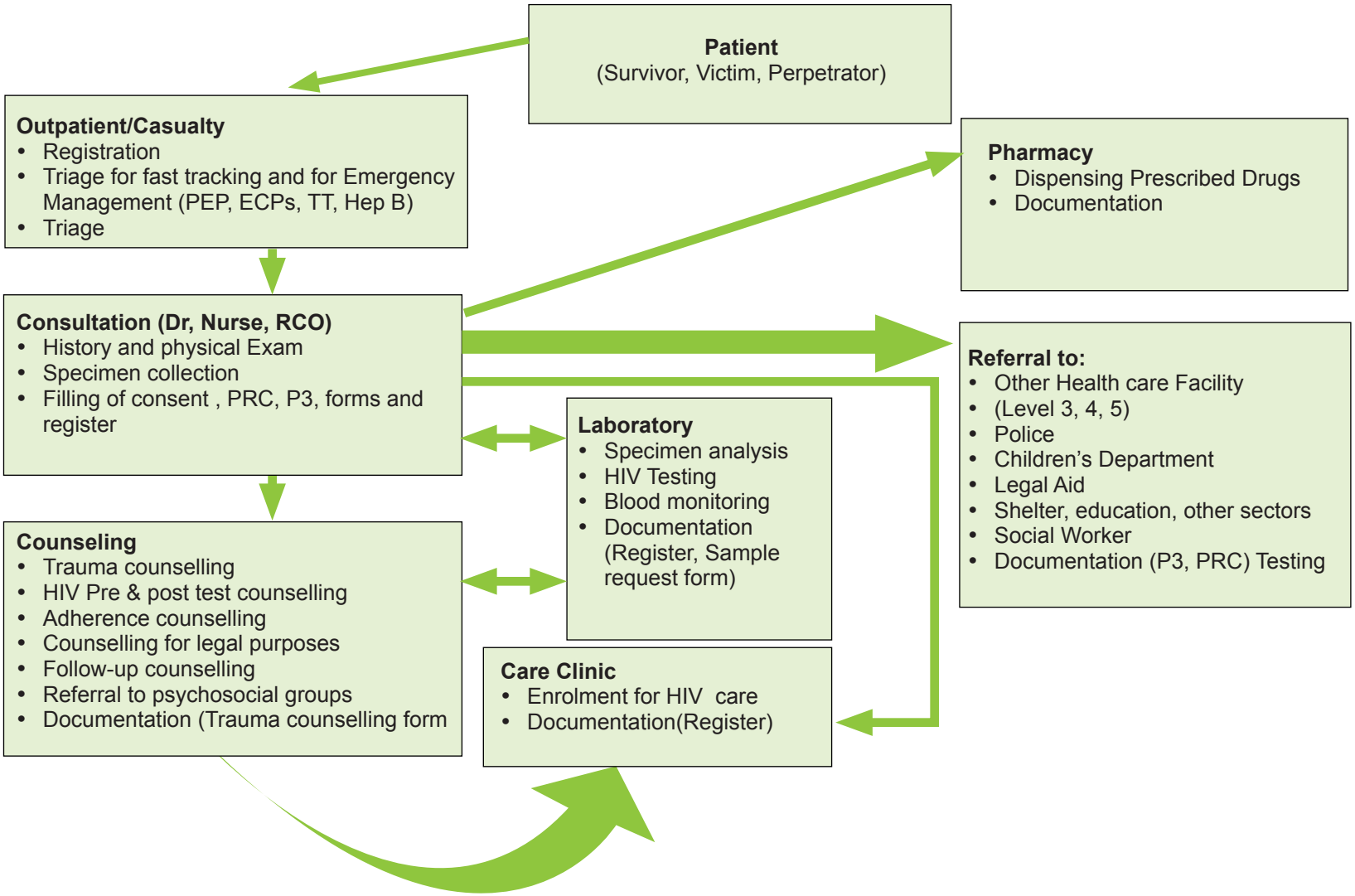
IF THE SURVIVOR WANTS TO PURSUE POLICE/LEGAL ACTION - OR - IF THERE ARE IMMEDIATE SAFETY AND SECURITY RISKS TO OTHERS Refer and accompany survivor to police/security - or - to legal assistance/protection officers for information and assistance with referral to police	
Police/Security	Legal Assistance Counsellors or Protection Officers



AFTER IMMEDIATE RESPONSE, FOLLOW-UP AND OTHER SERVICES Over time and based on survivor's choices can include any of the following			
Health care	Psychosocial services	Protection, security, and justice actors	Basic needs, such as shelter, ration card, children's services, safe shelter, or other

Annex 2: Patient flow Pathway at the Health Facility

(*Establishes the multiple health services to be offered to the SGBV patient and offers guidelines on the inter departmental linkages)*



Annex 3: Essential Resources and Companion Guides

A simplified version of the Sexual Offences Act 2006.
Published by the Ministry of Health

National Guidelines on Management of Sexual Violence in Kenya, Published by: the Ministry of Public Health and Sanitation the Ministry of Medical Services.
2nd Edition, 2009 Updated 2012

Multi Sectorial Standard Operating Procedures & Guidelines for Prevention of and Response to Sexual Violence in Kenya (Zero Draft - September 2012)
A comprehensive multi-disciplinary SGBV SOP developed by the Sexual Offences Act Task Force

Guidelines for gender-based violence interventions in humanitarian settings: focusing on prevention of and response to sexual violence in emergencies. Geneva, Inter-Agency Standing Committee, 2005.
http://www.humanitarianinfo.org/iasc/content/subsidi/tf_gender/gbv.asp

Sexual and gender-based violence against refugees, returnees, and internally displaced persons: guidelines for prevention and response. Geneva, United Nations High Commissioner for Refugees, 2003.
http://www.unhcr.org/protect/PROTECTION/3f696bcc4.pdf
WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva, World Health Organization, 2007.
http://www.who.int/gender/documents/EthicsSafety_web.pdf

Additionally, for health/medical providers:
Clinical management of survivors of rape: developing protocols for use with refugees and internally displaced persons, revised ed. Geneva, World Health Organization/United Nations High Commissioner for Refugees, 2004.
http://www.who.int/reproductive-health/publications/clinical_mngt_rapesurvivors/clinical_mngt_rapesurvivors.pdf

Annex 4: 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.

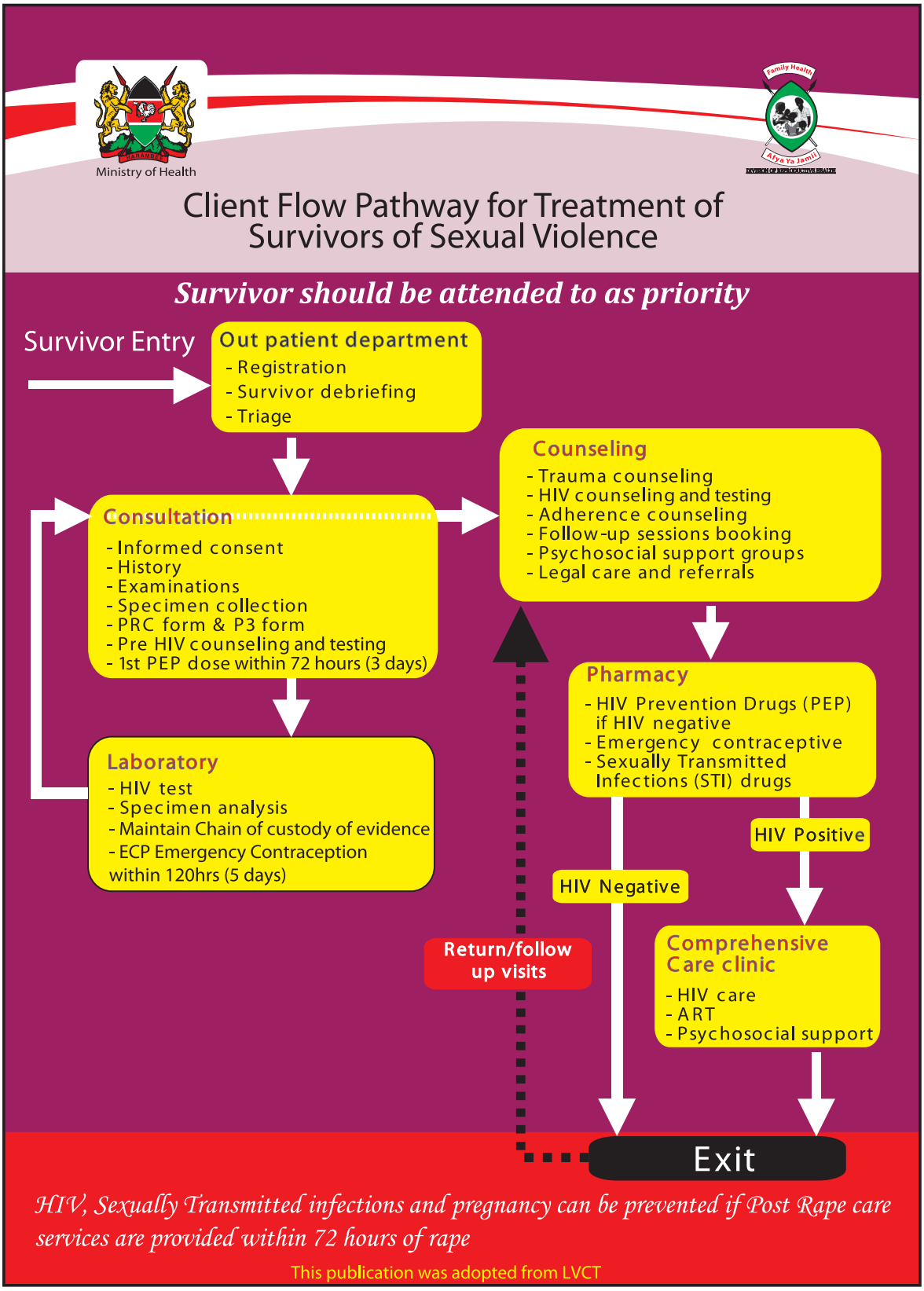
I……..……..(print name of survivor/care giver/guardian) authorize the above-named health facility to perform the following (tick the appropriate boxes):

	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		

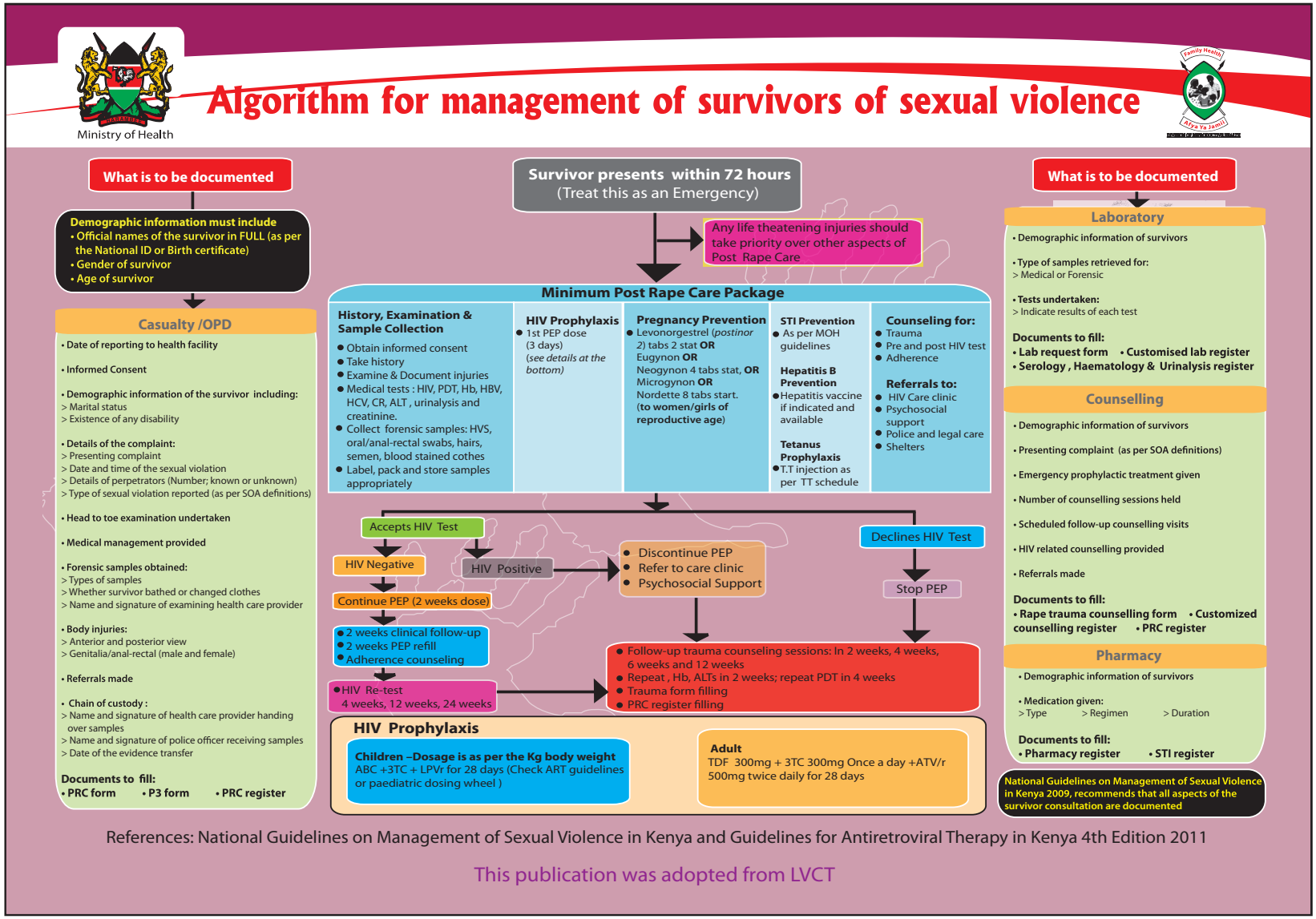
Client's Signature……Date……

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

Annex 5: Survivor Flow Chart



Annex 6: Clinical Management Algorithm



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 7: 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

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)

MOH 363

PRC FORM IS **NOT** FOR SALE

PART A

PRC Post Rape Care Form

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)

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

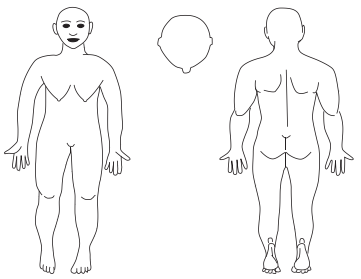
Comments: Indicate additional information provided by the client or observed by clinician

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

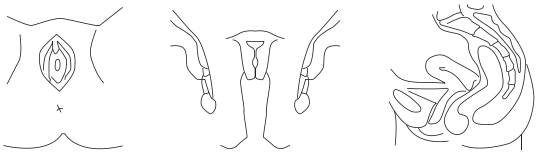
BODY MAP

Anterior View | Posterior view

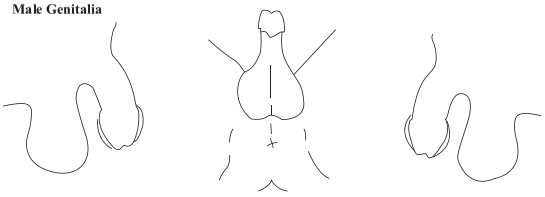


Comments _____

Female Genitalia



Male Genitalia



MOH 363

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	Please tick as is applicable: 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

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 9: 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				

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

Sexual Violence Register MOH 365

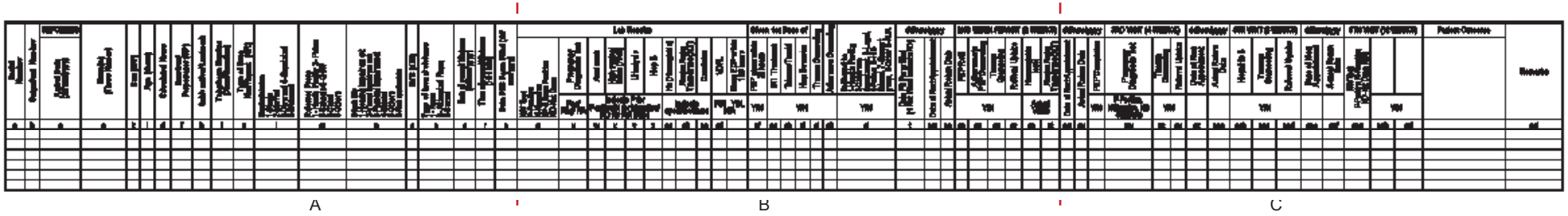
Column	DATA DEFINITIONS / EXPLANATIONS	
a	Serial No.	This is the identification number given to the client on the first attendance and is facility specific. Usually written serially. 1, 2, 3, …..
b	Out patient Number	“This is a unique identification number given to a survivor on first attendance at the 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
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'

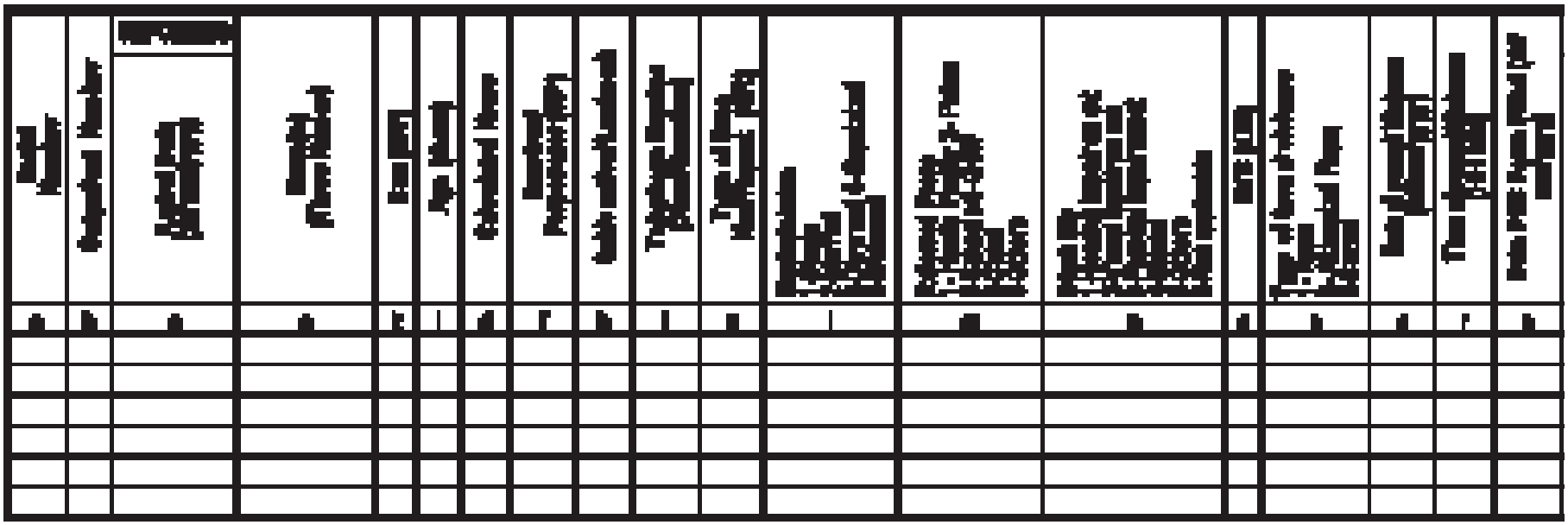
Sexual Violence Register MOH 365

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)
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

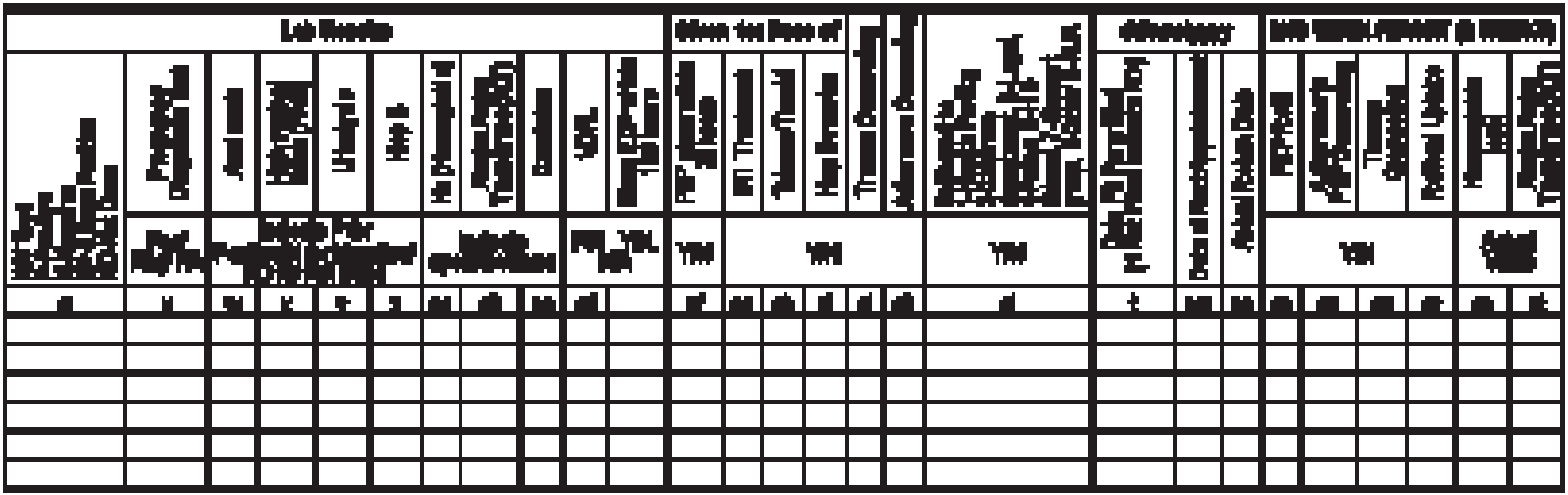


Key: SV Register depicted is longitudinal (the sections: A, B and C are continuous).



Sexual Violence Register MOH 365

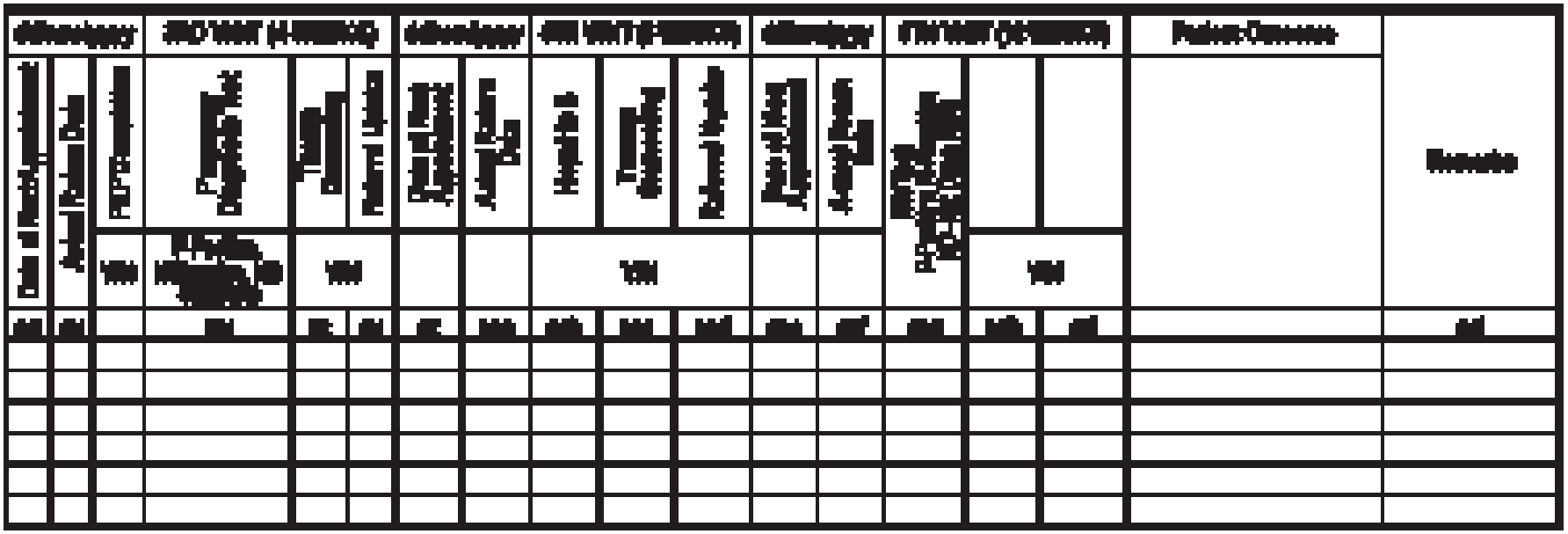
B



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

Sexual Violence Register MOH 365

C



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

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 11: 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_____

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

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 13: 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) and14 (1) of the Nurses Act;or
ii. (ii) A clinical of cer registered under section 7 of the Clinical Of cers (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 appro- priate 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 14: 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 15: Useful Resources

General information

Ajema C, Mukoma W, Mugyenyi C, Meme M, Kotut R, and Mulwa 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

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