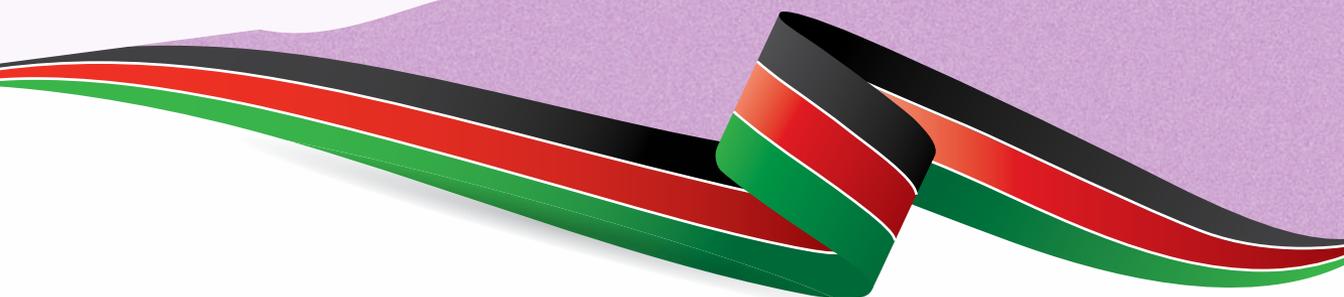
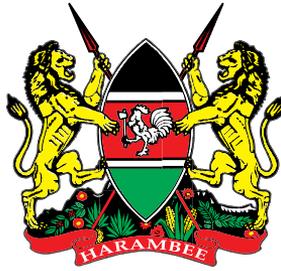


MINISTRY OF HEALTH

**NATIONAL STANDARD OPERATING
PROCEDURES
FOR THE MANAGEMENT OF
SEXUAL VIOLENCE AGAINST
Children**





MINISTRY OF HEALTH

NATIONAL STANDARD OPERATING PROCEDURES FOR THE MANAGEMENT OF SEXUAL VIOLENCE AGAINST Children

2018



Table of Contents

Acknowledgements	5
Foreword	6
Abbreviations and Acronyms	7
Definition of Terms	8
CHAPTER 1: INTRODUCTION	11
1.1. Background	11
1.2. Purpose	12
1.3. Outline	13
1.4. Target Audience	13
1.5. Guiding principles and rights for working with survivors of child sexual violence	13
CHAPTER 2: KEY CONSIDERATIONS FOR ESTABLISHING SERVICES FOR CHILD SURVIVORS OF SEXUAL VIOLENCE IN KENYA	15
2.1 The Child Centered Approach	16
2.2 Strong leadership and governance	17
2.3 Public Awareness and Advocacy	17
2.4 Setting standards	18
2.5 Capacity building and training	19
2.6 Child Protection, Referral and Response Mechanism	20
2.7 Monitoring and Evaluation	21
CHAPTER 3: COMPREHENSIVE CLINICAL SERVICES FOR THE MANAGEMENT CHILD SEXUAL VIOLENCE	24
3.1. Core components of comprehensive clinical services for child sexual violence	24
3.2. Guiding principles for the health care provider	25
3.3. Process Flow for the management of a CSV survivor within the clinical setting	26

CHAPTER 4: HEALTH FACILITY STANDARDS FOR THE MANAGEMENT OF SEXUAL VIOLENCE AGAINST CHILDREN	27
4.1 Minimum Standards for Medical Management of CSV survivors	27
4.2 Personnel	29
4.3. Infrastructure	29
4.4. Equipment and Supplies	30
4.5. Medication	31
4.6. Tools and Documentation	32
CHAPTER 5: STANDARD OPERATING PROCEDURES FOR THE MANAGEMENT OF SURVIVORS OF CHILD SEXUAL VIOLENCE	33
5.1. SOP 1: Taking consent/assent from a child survivor of sexual violence	35
5.2. SOP 2: Medical-Forensic history taking and examination for a child survivor of sexual violence	38
5.3. SOP 3: Clinical Management of Child Survivors of Sexual Violence	45
5.4. SOP 4: Collecting forensic evidence and maintaining a credible chain of custody of evidence	51
5.5. SOP 5: Provision of psychosocial support	57
5.6. SOP 6: Referral and linkages	60
ANNEXES:	62
Annex 1: The Setting for Clinical Services for Child Survivor of Sexual Violence	63
Annex 2: Post Rape Care Consent Form	64
Annex 3: Sexual Violence - Trauma Counseling Data Form	65
Annex 4: Flow Chart for documentation and reporting of child sexual violence services	67
Annex 5: Pictograms / Diagrams for Medico-legal forensic examination	68
Annex 6: Psychosocial support	71
Annex 7: Client referral form	72
Annex 8: Algorithm for management of survivors of sexual Violence	73
REFERENCES	74

Acknowledgements

The development of this National Standard Operating Procedures for Management of Sexual Violence Cases in Children was a result of concerted efforts of several individuals and organisations through a highly consultative process with a wide range of stakeholders including from government both at the National and County levels; the private sector; civil society organisations and development partners. Additionally, literature review, pilot studies and pretesting exercises were conducted to identify best practices and possible solutions to the challenges faced by children survivors of violence

The Ministry of Health feels greatly indebted to the Reproductive and Maternal Health Services Unit for leading the Technical Working group and steering the consultations both the National and County levels to develop this SOPs. Specifically the Ministry would like to thank Dr. Joel Gondi, Head RMHSU who gave valuable inputs and guided the process.

Special thanks to Dr. Jeanne Patrick, Deputy Head, RMHSU, Alice Mwangangi and Damaris Mwanzia for coordinating the review process and working with Dr. Minnie Kibore and Agnes Midi-Keita to collect, collate and analyse inputs from various stakeholders during the process.

We also acknowledge Moi Teaching and Referral Hospital and Kilifi County health teams for sharing their valuable experience and insights during the pretesting exercise that helped enrich this SOPs.

To all individuals and organisations that participated in the development of this SOPs your contributions are highly appreciated.

Finally we thank Population Council and LVCT Health for their technical and financial support to the review process.



Dr. Peter Cherutich, OGW, MBS
Head, Department of Preventive and Promotive Health Services

Foreword

Sexual Violence (SV) is a life threatening crime that has a devastating impact on the health, social wellbeing and human rights of the survivor, and in particular women and children. Sexual violence against children is a gross violation of children's rights with severe immediate and long-term physical, psychological and social consequences. Globally at least 150 million girls and 73 million boys under 18 years have experienced some form of sexual violence. In Kenya at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood. Notable progress has been made in Kenya in establishing laws and policy frameworks to address sexual violence against children. These include The Sexual Offences Act 2006, the National Policy on Gender and Development, National Reproductive Health Policy and the Children's Act 2001. However, there is still limited guidance on the necessary service delivery standards and management protocols for the management of child survivors of sexual violence.

These Standard Operating Procedures (SOPs) seek to enhance the capacity of Health Care Providers and Health Management Teams to respond to and support child survivors of sexual violence. Building on both National and International Sexual and Gender Based Violence SOPs, the document provides a standardized, user-friendly guide on how to apply child-centered approaches for the effective management and support of child survivors of sexual violence; and describes clear procedures, roles and responsibilities for all health care providers. It provides concise detail on the sequence of steps to follow to ensure the appropriate clinical response that a child survivor of sexual violence should receive at each point of the continuum of comprehensive care within the health facility.

The SOPs recognize that effectively addressing child sexual violence requires a comprehensive, multi-sectoral approach that is supported by strong referral and linkages to complimentary interventions and involves actors and actions that address child sexual violence prevention, recovery and response. The SOPs would provide a practical guide to ensuring a comprehensive model of quality care and management that is responsive to the needs of child and adolescent survivors of sexual violence in Kenya.

It is our sincere hope that implementation of this SOPs will comprehensively address the needs of survivors of Sexual Violence in Kenya.



Dr. Kioko Jackson K., OGW, MBS
Director of Medical Services

Abbreviations and Acronyms

ANC	Antenatal care
ART	Antiretroviral Therapy
CCC	Comprehensive Care Clinic
CHMT	County Health Management Team
CHRIO	County Health Records and Information Officer
CSV	Child Sexual Violence
EC	Emergency Contraceptive
HCP	Health Care Provider
HTS	HIV Testing Services
HBV	Hepatitis B Virus
HPV	Human Papillomavirus
HVS	High Vaginal Swab
M&E	Monitoring and Evaluation
MOH	Ministry Of Health
PEP	Post-Exposure Prophylaxis
PFA	Psychological First Aid
PITC	Provider Initiated Testing and Counseling
PRC	Post Rape Care
RH	Reproductive Health
RMHSU	Reproductive Maternal Health Services Unit
SCHRIO	Sub-County Health Records and Information Officer
SGBV	Sexual and Gender Based Violence
SOPs	Standard Operating Procedures
STI	Sexually Transmitted Infection
SV	Sexual Violence
TT	Tetanus Toxoid
TWG	Technical Working Groups
WHO	World Health Organization

Definition of Terms

In order to better respond to child sexual violence and support child survivors, it is important to understand basic concepts and definitions about child sexual violence. The following terms and definitions have been informed by national and international sexual and gender based violence (SGBV) SOPs and child protection frameworks, and are not intended as legal definitions.

Adolescence:

The period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19.

Assent:

Agreement by a minor or any person not competent to give legally valid informed consent—e.g., a child or cognitively impaired person, to participate in a procedure or treatment

Authorized officer:

A police officer, an administrative officer, a children's officer, an approved officer, a chief appointed under the Chiefs' Act (Cap. 128), a labour officer or any other officer authorized by the Director for the purposes of this Act;

Chain of Custody of Evidence:

This refers to the process of obtaining, processing and conveying evidence through accountable tracking mechanisms (paper trail showing movement of evidence) from the first responder, the health facility, the National Police Service and finally to the court. The investigating officer is the custodian of an evidentiary material

Child:

Any person under the age of eighteen (18) years.

Caregiver:

The person who stays and lives with the child, providing all the basic needs of that child.

Informed Consent:

The process by which a person learns about and understands the purpose, benefits, and potential risks of an intervention and then agrees to receive the treatment or procedure.

Defilement:

An offence of defilement is when a person: Intentionally and unlawfully commits an act, which causes penetration with his or her genital organs with a child.

Designated persons:

This includes a nurse registered under section 12(1) of the 'Nurses Act' or clinical officer registered under section 7 of the clinical officers (training, registration and licensing) Act

Evidence:

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

Forensic evidence/ Exhibit:

This is the evidence collected during a medical examination.

Forensic examination:

Is a medical assessment conducted in the knowledge of the possibility of judicial proceedings in the future requiring medical opinion.

Health Care Provider:

These are service providers at facility level, these may include facility managers; general practice clinicians such as medical doctors, registered clinical officers, registered nurses; clinicians with specialized medico-legal or forensic training; medical specialists such as trauma surgeons, obstetric/gynaecologists and paediatricians; mental health professionals such as psychiatrists, psychologists and clinical counselors; pathologists, laboratory scientists, technicians and technologists; pharmacists and pharmaceutical technologists; social workers and child welfare officers; and community health extension workers.

Medical practitioners and designated persons:

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

Menarche:

The beginning of the menstrual function; especially the first menstrual period of an individual.

Penetration:

Partial or complete insertion of the genital organs of a person or an object into the genital organs of another person

Psychological First Aid (PFA):

An evidence-informed approach that aims to reduce stress symptoms and assist in a healthy recovery following a traumatic event, natural disaster, public health emergency, or even a personal crisis.

Puberty:

The stage in life where a boy or girl begins to undergo biological changes that result in sexual maturity. The onset of puberty marks the transition between childhood and adolescence.

Sexual Violence (SV):

This SOP adopts the World Health Organization definition of sexual violence (SV) as any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic [a person'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." This definition is expanded to include the forced sex, sexual coercion and rape of an adult and/or adolescent men and women, and child sexual abuse.

Survivor/victim:

A person who has experienced sexual violence (SV). The terms "victim" and "survivor" can be used interchangeably. "Victim" is a term often used in the legal and medical sectors. "Survivor" is the term generally preferred in the psychological and social support sectors because it implies resiliency.

Reference Sample:

This is a sample used to determine whether or not specimen collected is foreign to the survivor or the alleged perpetrator. Blood and buccal (inner cheek) swabbings should be collected from both the survivor and the alleged perpetrator.



CHAPTER 1: INTRODUCTION

- 1.1. Background
- 1.2. Purpose
- 1.3. Outline
- 1.4. Target Audience
- 1.5. Guiding principles and rights for working with survivors of child sexual violence

1.1. Background

Child sexual violence (CSV) is a critical public health, human rights and a developmental issue that has severe consequences on the immediate and long-term health outcomes and well-being of children. The Violence against children national survey 2010, indicated that violence against children is a serious problem in Kenya, at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood. In addition, anecdotal evidence points to a high number of children reporting for sexual violence management services in Kenyan Health facilities.



In Kenya and at least 32 percent of females and 18 percent of males reported experiencing sexual violence during their childhood – Violence against children national survey (2010)

Sexual violence is often hidden and under-reported among children. Reporting is even less likely as the children are often ashamed, frightened, and incapable of verbalizing their experience. In addition, very few children who experience sexual abuse seek or receive any type of services. For example, the Kenyan violence against children survey showed that only 2.1 % of boys and 6.8% of girls (18-24 years) who had experienced sexual abuse sought services prior to age 18. Moreover, only 0.4% of the boys and 3.4% of girls actually received care. Additionally, 31% of girls who had experienced abuse indicated that they would have wanted some or additional health care services for the sexual violence they had experienced.

Numerous efforts having been made to strengthen the quality of services offered for survivors of sexual violence in the Kenya. The Ministry of Health has developed and disseminated national guidelines, standard operation procedures and a training curriculum on the management of survivors of Sexual Violence. Core components of a comprehensive response to sexual violence and exploitation include clinical evaluation, examination and documentation; HIV testing, HIV prevention through use of Post Exposure Prophylaxis (PEP); Pregnancy prevention through provision of emergency contraception (EC); STI management; Counseling for trauma and referral for on-going well-being of survivors. Despite these efforts, Kenya's guidelines and other national documents for responding to sexual violence are heavily adult-focused thus, overlooking the needs of child and adolescent survivors.

1.2. Purpose

These Standard Operating Procedures (SOPs) have been developed based on current, evidence-based practices to facilitate joint action by all health actors to effectively respond to child sexual violence. The SOPs have been informed by lessons learned from establishing sexual violence (SV) prevention, response and recovery programs in Kenya; and are aligned to the National Guidelines on Management of Sexual Violence in Kenya, National Standard Operating Procedures on Management of Sexual Violence in Kenya, the Training curriculum for management of Sexual Violence and World Health Organization (WHO) and President's Emergency Plan for AIDS Relief (PEPFAR) guidance. They provide a practical guide for health care providers on the appropriate care of children and adolescents who have experienced sexual violence.

1.3. Outline

The SOPs is divided into the following sections:

Chapter 1: Introduction

Chapter 2: Key considerations for establishing services for the management of child sexual violence in Kenya

Chapter 3: Comprehensive clinical services for management of child sexual violence

Chapter 4: Health facility standards for management of child sexual violence

Chapter 5: Standard operating procedures for the management of child survivors of sexual violence

Annexes

1.4. Target Audience

This document is primarily intended for use by health service providers in public and private health care facilities, including medical doctors, clinical officers, nurses, social workers, medical social workers, laboratory technologists, pharmacists, pharmaceutical technologists and, psychiatrists, psychologists and counsellors. In addition, it is a useful guide for national level policy makers and officers, county, sub-county and facility health management teams as they plan for resources and implementation of child sexual and reproductive health programs.

1.5. Guiding Principles and Rights for Working With Survivors of Child Sexual Violence

Clinical care for children who have been sexually abused should be guided by obligations to protect, prevent and respond to all forms of violence against children. These guiding principles specified in the Kenyan children Act and the Sexual offence Act are aligned to the four international guiding principles of the Convention on the Rights of Children: Non-Discrimination; Best Interest of the Child; Survival and Development; and Participation. Health care providers need to be aware of these standards and apply them as guiding principles in providing care to children and adolescents who have been sexually abused.

All Health care providers providing services to child survivors must:

1. **Ensure the safety and protection of the survivor and his/her family at all times** - Remember that s/he may be frightened, and need assurance that s/he is safe. In all types of cases, ensure that s/he is not placed at risk of further harm by the perpetrator.
2. **The best interest of the child should be the primary consideration** – Any action or decision should respect the wishes, rights, and dignity of child survivor.
3. **Address the evolving capacities of the child by providing information that is appropriate to age** - Children must be consulted and using child-friendly techniques that encourage them to express themselves given all the information needed to make an informed decision.
4. **Obtain Informed Consent** – All health care providers must obtaining assent or consent from the child or adolescent and/or caregiver as appropriate, prior to any response service or sharing of information.
5. **Respect the confidentiality of the affected child survivor and their families.**
6. **Do No Harm-** Ensure appropriate confidentiality throughout the reporting, referral process and access of services to ensure no harm is done to the child or the family Ensure non-discrimination in the provision of services – provide services without discrimination based on age, sex, religion, clan, ethnicity, wealth, language, status, political opinion, culture, etc.
7. **Ensure that children are participating in the decision making process of services:** make sure that children are involved in all decision making processes regarding referral and access to services.

2

CHAPTER 2:

KEY CONSIDERATIONS FOR ESTABLISHING SERVICES FOR CHILD SURVIVORS OF SEXUAL VIOLENCE IN KENYA

- 2.1 The Child Centered Approach
- 2.2 Strong leadership and governance
- 2.3 Public Awareness and Advocacy
- 2.4 Setting standards
- 2.5 Capacity building and training
- 2.6 Child Protection, Referral and Response Mechanism
- 2.7 Monitoring and Evaluation

This chapter is intended for use by health management teams at the national, county, sub-county and facility level; implementing partners and other technical support personnel. It will provide programmatic and operational guidance relevant to the establishment, provision and scale up of responsive, child-centered, sexual violence clinical services.



Key considerations for establishing services for child survivors of sexual violence:

- *The child centered approach*
- *Strong leadership and governance*
- *Public awareness and advocacy*
- *Setting standards*
- *Capacity building and training*
- *Child protection, referral and response mechanism*
- *Monitoring and evaluation*

2.1 The Child Centered Approach

A child centered approach aims at providing services that are primarily specific to the needs of the survivor. The child's perspective when establishing and providing services for child survivors of sexual violence should be taken into account.

A child centered approach:

- Takes into account the different developmental stages of children; and tailors interventions to the specific needs.
- Ensures services offered are appropriate to their developmental needs.
- Provides children with appropriate opportunities to participate in decisions that affect them
- Provides age-appropriate information about the care that will be provided, and disclosure to relevant designated authorities.
- Empowers non-offending caregivers with information to understand possible symptoms and behaviours that the child or adolescent may show in the coming days or months and when to seek further help.
- Minimizes the need for the Child Survivor to go to multiple points of care within the health facility
- Promotes a collaborative approach to influencing the child's environment and their interactions in those environments.

2.2 Strong Leadership and Governance

Government leadership and the involvement of civil society, Non-Governmental Organizations (NGOs), private sector service providers and other key stakeholders are critical to achieving a broad understanding of and support for the introduction and scale-up of CSV clinical services. Leadership, cooperation and collaboration are required at the national, county, sub-county and community levels in preventing and responding to CSV to improve service delivery. To ensure inclusivity, ownership, and sustainability of new programs, implementing partners need to consider the following guidance as they engage all key stakeholders:

- Identify and engage all the partners that are involved in SV work within relevant national and the county government ministries and other implementing partners. The involvement of the stakeholders should be done from as early as program inception and continued on a regular basis until termination or transition of the program
- Actively engage in the national, level 6, county and sub-county level sexual violence Technical Working Groups (TWGs) to give feedback on program progress. Where these groups do not exist, partners should work closely with the county governments to establish one in their respective counties. Health management teams should be trained to facilitate their optimal engagement with stakeholders.
- Health management teams should conduct support supervision visits for monitoring SGBV services.
- Regularly track progress through national and county monitoring and evaluation systems to ensure accountability and to strengthen the data management systems.
- Establish or participate in forums that bring together implementing partners that work in the SV field to discuss common activities in order to avoid duplication of efforts and to enhance synergy.

2.3 Public Awareness and Advocacy

- The identification of a strategic champion or leader(s) and a clear focal person at national, level 6, county, sub-county and facility and community level to lead advocacy efforts is vital in promoting accountable and responsive policies, practices, budgets and services to end CSV and foster institutional and social change.

- Advocacy for child sexual violence includes raising public awareness. Key components include
 - What CSV is
 - Root causes and risk factors
 - Who inflicts it; its criminality and other legal consequences?
 - Key signs of CSV
 - Consequences and effects of CSV
 - Stigma and disclosure
 - Typical emotional, social and behavioral responses of abused children
 - Principles of consent, children's rights
 - Obligations of those within the medical, legal and justice system
 - Caring and reassurance by community
- Professionals and institutional leaders must also be aware of their legal and ethical duties to report known and suspected cases.
- Concerted efforts should be made at publicizing the availability of services, through community-based and media campaigns and outreach activities. Key opinion leaders including chiefs, women and ward representatives and others should be actively engaged in these activities.

2.4 Setting Standards

Standards define the desired performance for a health care system or service and provide the basis for measuring quality. The service standards for CSV define the necessary elements of providing high quality care. The following are standards that should be adhered to for the provision of quality services for management of sexual violence in children:

- An effective management system should be established to oversee the provision of child sexual violence services
- Key County and facility managers including providers should be trained, qualified and competent in the provision of child sexual violence services according to the national training curriculum of clinical management of sexual violence.
- The minimum package of child sexual violence services should be adhered to ensure a standardized approach to care is implemented
- Ensure the facility has the necessary medicines, supplies, equipment and environment for providing safe CSV clinical services of good quality

- A system of referral of SGBV cases should be integrated into the overall referral system in the counties
- A system for monitoring, evaluation and knowledge generation should be established
- Joint supportive supervision for SGBV services should be carried out regularly to ensure quality of services.

2.5 Capacity Building and Training

In order to establish a baseline standard of care, Health Care Provider (HCPs) providing medico-legal services to children who have experienced sexual violence and exploitation should be given specialized training that addresses the medico-legal aspects of service provision. Module 6 of the national training curriculum for management of SGBV outlines the clinical management of CSV survivors

The following steps should be considered while building capacity for provision of services for the management of sexual violence in children:

- Assess the human resource situation and constraints and identify opportunities and actions for effective task-shifting in order to achieve results efficiently
- Clearly define the target of training for all the requisite skills and components of the agreed minimum package of services, and determine the specific needs of targeted trainees
- Training and updates across all tiers of service provision for relevant Health Care Providers (HCP) should be continuous. Post training supervision and mentorship follow up should be offered. MOH (RHMSU) is the certifying authority for capacity building.
- Trainee selection criterion should be based on; first line responders of Gender Based Violence in the OPD, ED, GBVRCs and CCCs
- Establish the competencies required of trainees before they can be certified as competent
- Ensure proper trainee selection by developing training standards and a process for the selection of trainees. Since the sex of the health worker may be a critical issue, where possible ensure that both male and female nurses and physicians are trained
- Establish systems and capacities to ensure the transfer of learning from the training site to the service delivery site (follow-up by trainers, on-site mentoring, etc.)

- Involve local law enforcement, legal and forensic experts to facilitate in the training as investigating and prosecuting child sexual violence and exploitation is a priority
- Consider including Ministry of Education, local school officials and Community Health Volunteers (CHVs), Children Volunteer Officers (VCO's) to sensitize them on CSV and their role in prevention and response
- Periodically review the human resource situation and needs including ensuring expertise is transferred to incoming HCPs and a succession strategy is outlined

2.6 Child Protection, Referral and Response Mechanism

Access to care, treatment and justice after sexual violence is essential in ensuring the survivor's recovery and reintegration into the community without stigma and discrimination. An effective, well-coordinated and integrated protection and response mechanism ensures that child survivors receive the appropriate support (Figure 1).

Health assistance is the priority for cases involving sexual violence and/or possible bodily injuries. In the case of CSV, assistance must be in accordance with the SOPs that guide the clinical management of CSV including the provision of EC and PEP for HIV. HCP's should inform the child/survivor and legal guardian of available assistance and/or any limitations to services. Service providers in the referral network must be knowledgeable about the services provided by internal and external actors to whom they refer a child survivor.

Children should be accompanied by a health care provider or an identified non-offending escort person to all services within the referral pathway provided the principles of safety and confidentiality are adhered to. For purposes of securing a child survivor, children officers should be involved in order to process a court committal order for the child, to a children's institution.

Health facilities are encouraged to forge good relationships with the children's department, police and other relevant service providers. A strong protection and referral network ensures that the care provided is comprehensive, responsive and addresses both short and long term recovery needs of the child.

Figure 1: Core components of a comprehensive coordinated response to CSV



2.7 Monitoring and Evaluation

Monitoring and evaluation (M & E) plays an important role in the effective and efficient management of health programmes by ensuring that: resources devoted to a programmed are used appropriately; services provided are accessed by the target population; programmed activities happen in a timely manner, and expected results achieved. Monitoring and evaluation must be an ongoing element of any CSV service delivery program.

The Ministry of Health has well defined processes related to how data should flow from facility to national level and has outlined key responsibilities of different teams in the data collection process (Figure 2). In addition, the national SV program has standard data collection and summary tools and that are available for use at the facility level.

Health facilities are mandated to collect and maintain good quality data from child survivors using the PRC forms (MOH 363) and register (MOH 365) and to compile and transmit monthly summaries to the sub county Health Record information officer

(SCHRIOs) using PRC summary forms (MOH 364). The SCHRIOs are then required to review the PRC summary reports from each facility and submit the final reports into the national data health information system (DHIS2).

To ensure that accurate data is collected and used for service delivery improvement, it is critical for facility, Sub County and County program managers to:

- I. Support training of Sub County and county HRIOs to coordinate data management for SV using the appropriate data collection tools and maintain DHIS2.
- II. Make available the national SV data collection tools and registers to all facilities and develop standard operating procedure for data management.
- III. Support training of health facility staff on the accurate use of the national SV data collection tools and registers and reporting procedures.
- IV. Support development/strengthening and implementation of systematic data quality assessment plans
- V. Strengthen capacity for Data Demand for Information and Use (DDIU) through working with the S/CHRIO to regular data review meeting with the health facility teams.

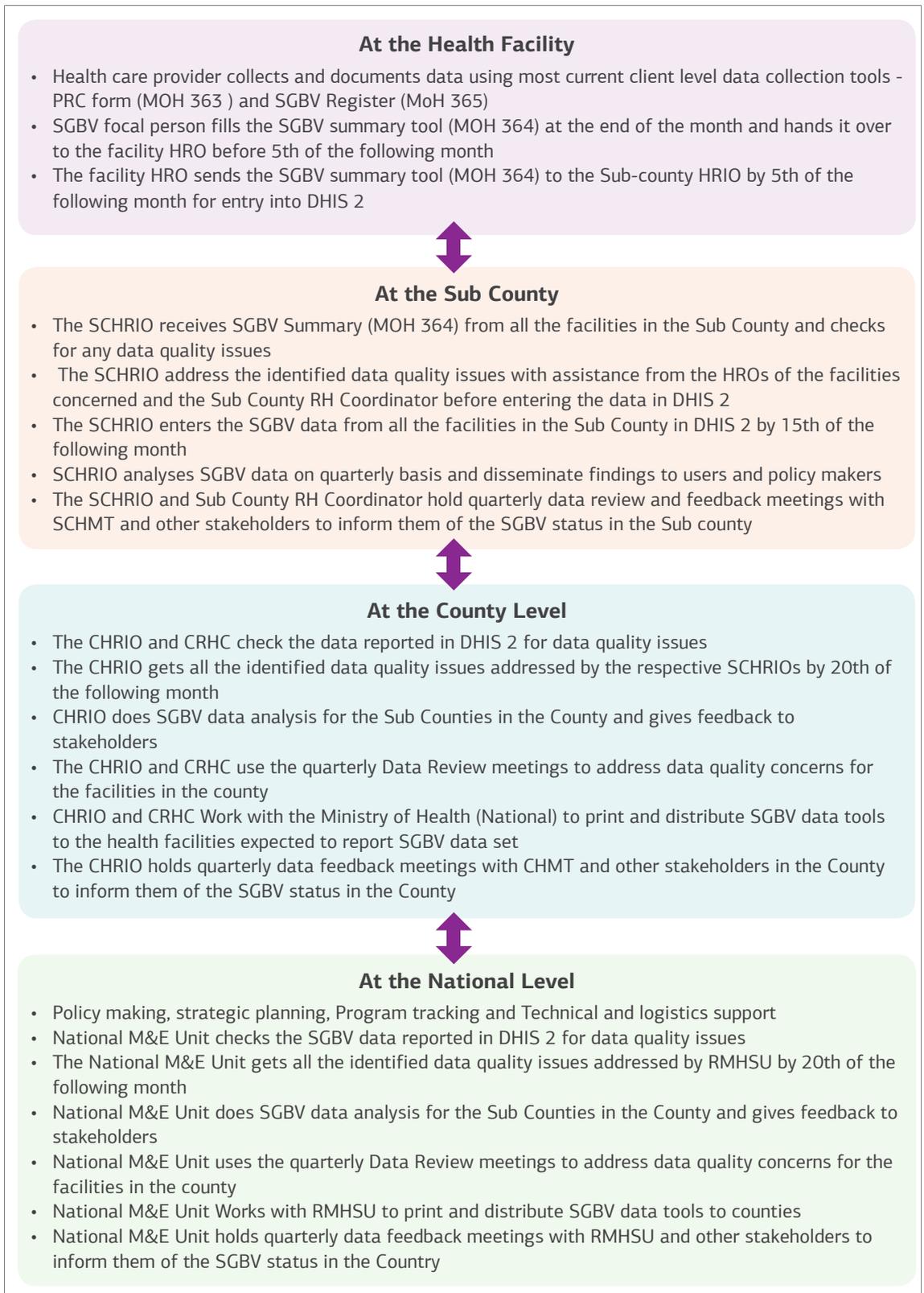
Key Indicators to be tracked in provision of CSV services are:

- Percentage of clients provided with Sexual and Gender Based Violence (SGBV) services
- Sexual and Gender Based Violence prevalence rates
- Proportion of health facilities providing SGBV services as per the national guidelines
- Percentage of Sexual and Gender Based Violence (SGBV) clients/survivors presenting within 72 hours
- Percentage of SGBV survivors lost to follow-up

The health care provider should ensure data collection and reporting using the standardized data tools as listed below:

- Informed consent form
- Post Rape Care (PRC) form (MOH 363)
- SGBV daily activity register (MOH 365)
- PRC monthly form (MOH 364)
- Trauma counselling form
- Kenya Police Medical Form (P3)
- Data upload to DHIS 2

Figure 2. Documentation and use of data at various levels of the healthcare system



3

CHAPTER 3:

COMPREHENSIVE CLINICAL SERVICES FOR THE MANAGEMENT OF CHILD SEXUAL VIOLENCE

- 3.1. Core components of comprehensive clinical services for child sexual violence
- 3.2. Guiding principles for the health care provider
- 3.3. Process Flow for the management of a CSV survivor within the clinical setting

3.1. Core Components of Comprehensive Clinical Services for Child Sexual Violence

Multi-sectoral linkages are key to the management of services for child sexual violence. These linkages allow for the child sexual violence survivors' medical, psychosocial and legal needs to be adequately addressed throughout the continuum of care as illustrated in Figure 4. The individual capacity of each of these sectors to address child sexual violence is enhanced through policies and programs that create avenues for linkages. While the management of child sexual violence requires a comprehensive, cross-sectoral approach, in which services at all levels should be child-centered, a comprehensive clinical service for child sexual violence should meet the range of medical and psychosocial needs of

the child sexual violence survivor from the first point of contact through to the final stages of recovery and reintegration into the community. This document specifically addresses the health sector component of a comprehensive response to child sexual violence with specific emphasis on the clinical setting that includes:

- History taking and examination
- Management of physical injuries
- Prevention of disease and unwanted pregnancy
- Forensic examination and evidence collection
- Short and long term psychosocial support
- Medical documentation and follow up care

3. 2. Guiding Principles for The Health Care Provider

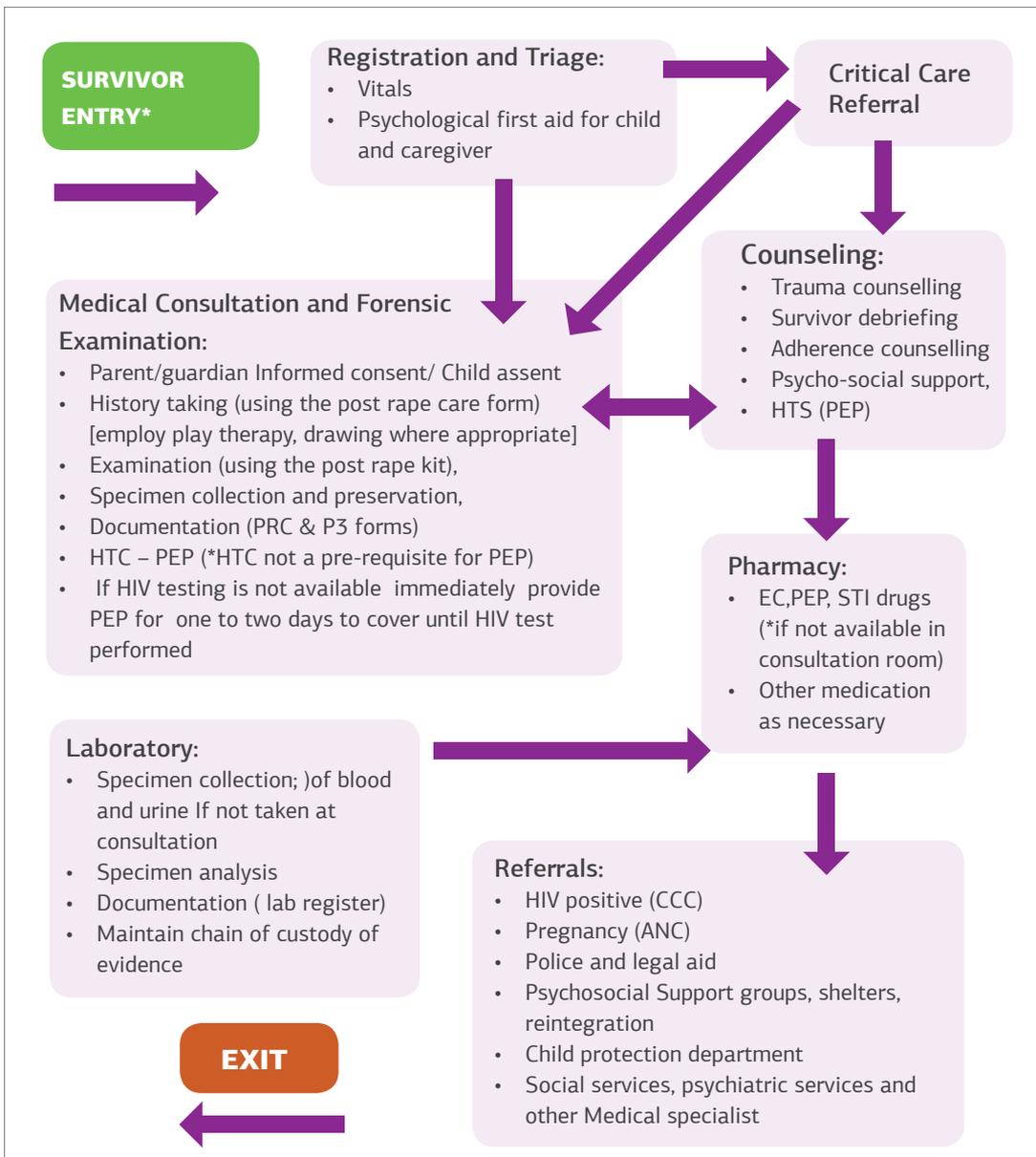
In order to provide comprehensive medical-forensic and psychosocial services, it is critical that HCPs recognize the international guiding principles in sexual violence. These principles ensure that any action taken by a HCP on behalf of the child survivor is supported by standards of care that will enhance the child's health and well-being and avoid re-victimizing the child during the process of care. It is imperative that HCPs apply these principles in their day to day management of child sexual violence. The principles include:

- Promoting the child's best interest
- Ensuring safety
- Ensuring comfort by establishing rapport and giving encouragement to the child
- Ensuring appropriate confidentiality
- Ensuring participatory decision making with the child survivor
- Ensuring fair and equal treatment, with no discrimination
- Strengthening the child's resiliencies
- Ensuring that the health and welfare of the child takes precedence over the collection of evidence
- Using a "child-first" approach to care
- Note that it is crucial to minimize the number of persons who come into contact with the survivor in the course of care. This is to ensure adherence to the principles of GBV
- An adolescent has the right to seek care without the consent of a parent/ guardian

3.3. Process Flow for the Management of a CSV Survivor Within the Clinical Setting

The clinical care process map is intended to guide HCPs in following a sequence of steps to provide the appropriate type of clinical service that a child survivor of sexual violence should receive at each point of care in the continuum of comprehensive care within the health facility. The process map is outlined in Figure 3 with detailed guidance on the services offered at each service delivery point.

Figure 3. Typical process flow map of the CSV services at a health facility



4

CHAPTER 4:

HEALTH FACILITY STANDARDS FOR THE MANAGEMENT OF SEXUAL VIOLENCE AGAINST CHILDREN

- 4.1 Minimum Standards for Medical Management of CSV survivors
- 4.2 Personnel
- 4.3. Infrastructure
- 4.4. Equipment and Supplies
- 4.5. Medication
- 4.6. Tools and Documentation

4.1 Minimum Standards for Medical Management of CSV Survivors

The focus of this chapter is to outline the resources required in order for a facility to provide appropriate and comprehensive services to child survivors. Children who have experienced SV may present at any point and time in the health system. Health facilities should therefore be prepared to receive and recognize any form of child SV and provide all necessary interventions. Where further medical-forensic examination or psychosocial services cannot be provided, a referral service should be

instituted to the nearest medical facility that can offer advanced care. It is advised that referral occurs immediately after the first contact with a child survivor for timely interventions. The national sexual offences medical regulations Act of 2012 stipulates that medical treatment for victims of sexual violence is to be offered free of charge in all public health facilities.

Table 1 outlines the minimum standards for medical management of CSV survivors at different health facility levels, their reporting requirements and minimum personnel requirements. In order to provide comprehensive medical-forensic and psychosocial services, it is essential that health facilities are well equipped and have the right resources and resource persons to provide these services.

Table 1: Minimum Standards for Medical Management of CSV survivors

	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)	<p>Manage injuries as much as possible</p> <p>Detailed history, examination and documentation (refer for HVS, PEP/EC, STI)</p>	<p>Fill in PRC form in triplicate</p> <p>Maintain PRC register</p> <p>Please ensure that the survivor has a copy of the PRC form and takes it to the laboratory</p>	A trained nurse
All health facilities with a functioning laboratory (public and private)	<p>Management injuries as much as possible</p> <p>Detailed history, examination and documentation (including HVS)</p> <p>Ideally, 1st doses of PEP/EC should be provided (even where follow up management is not possible)</p> <p>Where HIV testing services are available, provide initial counseling</p>	<p>Fill in PRC form in triplicate</p> <p>Maintain PRC register</p> <p>Maintain a laboratory register</p> <p>Referral to comprehensive post rape care facility</p>	<p>A trained nurse and/or a clinical officer</p> <p>A trained counselor (where counseling is offered)</p>

	Minimum Standards for Medical Management of Survivors	Reporting/Recording Requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities with HIV, ARV or Comprehensive Care Clinic (CCC) where ARV can be monitored (comprehensive post-rape care facilities can be provided) (Private and Public Health facilities)	Management injuries as much as possible Detailed history, examination and documentation Provide emergency and ongoing management of PEP and EC if applicable Provide STI prophylaxis or management Provide counseling for trauma HIV testing services and PEP adherence	Fill in PRC form in triplicate Maintain PRC register Maintain a laboratory register Fill in PRC form to follow up management of survivors	1 medical or clinical officer trained in ARV/ PEP management 1 trained counselor (trauma, HIV testing and PEP adherence counseling) Laboratory for HIV and HB testing Preservation of sperms from HVS specimen

4.2 Personnel

The ideal approach to managing CSV is that both medical-legal and psychosocial services are provided simultaneously in the same location and as much as possible by the same trained, HCP. HCPs are mandated to provide post violence service in their respective cadres, however the provisions of the law mandate the designated persons (Doctor, Clinical officers and Nurses) to fill the PRC Form. A best practice would be to have an updated directory of specific service providers (clinical and non-clinical) in order to strengthen referral and linkages to child protection services. Consider adopting integrated services across all points of service provision e.g. GBV/HIV integration, forensic providers, etc.

4.3. Infrastructure

Infrastructure that enables a child-friendly service is critical throughout the cascade of care for sexual violence among children in all the sectors. At minimum the infrastructure should offer security, cleanliness, privacy and access to services by all, with the ultimate goal to keep the child safe from SV and harm. Medical-forensic examinations should take place at a health facility where there is access to the full range of services required by the child survivor in accordance with the national guidelines on management of sexual violence in Kenya.

The service delivery point for child SV should:

- Have an aesthetic lay out and is attractive to walk into*
- Allow for both auditory and visual privacy e.g. a room with a door rather than curtains/ screens.*
- Be thermally neutral (neither too hot nor too cold)*
- Be clean, with clean equipment and linen*
- Have proper lighting e.g. fluorescent light that is neither too bright nor too dim*
- Have immediate access to soap and clean water*
- Have immediate access to a clean toilet and shower*
- Have a table, desk, examination couch*
- Have a phone where possible*
- Have access to a separate support room for the caregiver or guardian*
- Have child friendly rooms with assorted items appropriate for psychotherapy*
- Have specific infrastructure to address PWD's including messaging*

4.4. Equipment and Supplies

The facility should be equipped to manage any acute medical conditions or emergencies and to offer a range of laboratory and counselling services. If the health facility does not offer these services there should be ready access to a range of medical-forensic services that may be required through referral to service providers or reverse referral mechanisms where the service provider is called to provide the service at the health facility (Table 2).

Table 2: The essential equipment and supply requirements for providing services for management of sexual violence in children include:

<p>A locally assembled evidence collection kit (post rape care kit) as recommended by the national programmed</p>	<p>Evidence collection kits (syringes, empty sterile bottles, cotton swabs for collection forensic biological specimens)</p>
<p>Essential Supplies: items that need to be replaced on a routine basis</p>	<ul style="list-style-type: none"> • Forensic supplies: paper bags, evidence tape for sealing bags) • Powder-free, non-sterile exam gloves • Sanitary towels • Wound management supplies • Culture supplies • Lubricant • Hospital gowns • Extra clothes for survivors whose clothes may be collected for evidence- Health facilities or persons accompanying the survivors should source for extra clean
<p>Essential Equipment: capital equipment and durable items that last for several years</p>	<ul style="list-style-type: none"> • Examination table/bed/stretchers that allows for positioning in lithotomy • Specula for children preferably for use in post-pubertal girls but where absolutely necessary can be used for examination of pre-pubertal girls • Waste disposal equipment • Handheld magnifying glass • If possible non-Digital camera facility capacity to store intimate images which has been securely obtained

4.5. Medication

Essential medication required for management of child sexual violence include:

- Treatment for STIs
- Post Exposure Prophylaxis for HIV
- Emergency contraceptives (combined oral contraceptives, “morning after pills”, progesterone only pills)
- Tetanus Toxoid
- Analgesics
- Antibiotics
- Hepatitis B Virus vaccine
- Human Papilloma Virus vaccine

4.6. Tools and Documentation

The child who reports to the health facility for care should have a written record of the visit. This record should include a medical and forensic report, diagrams of any findings, and, if available, photographs. All aspects of the care should be documented including consent forms, the medical forensic history, findings from the physical assessment, evidence collected, any testing or treatment rendered, photographic images obtained during the examination, and any follow-up care and referrals given. If the health care provider is called to testify in any criminal justice proceedings, they may use this report to recall the patient encounter.

The ministry of health has developed standard tools for consenting and collecting data for survivors of violence this include:

- Informed consent form
- PRC forms (MOH 365)
- SGBV Register (MOH 364)
- SGBV Summary tool (MOH 364 B)
- Trauma Counseling Form
- Kenya Police Medical Form (P3)

Note: Examples of the above forms are annexed in the National Guidelines on Management of Sexual Violence in Kenya.

Table 3: Documentation Do's and Don'ts

Do's	Don'ts
Write or type legibly	Leave blank sections
Complete all aspects of the chart	Cross out previously documented information
Record the date and time of examination	Use unauthorized abbreviations
Record the history and source	Draw unfounded conclusions
Make sure all duplicate copies are legible	
If you did not examine something, write Not Examined	Draw legal conclusions
Put patient statements in quotation marks	Fill in the form if you are not the person who completed the examination
Sign every page	
Complete all legally required paperwork	

5

CHAPTER 5:

HEALTH FACILITY STANDARDS FOR THE MANAGEMENT OF SEXUAL VIOLENCE AGAINST CHILDREN

- 5.1. SOP 1: Taking consent/assent from a child survivor of sexual violence
- 5.2. SOP 2: Medical-Forensic history taking and examination for a child survivor of sexual violence
- 5.3. SOP 3: Clinical Management of Child Survivors of Sexual Violence
- 5.4. SOP 4: Collecting forensic evidence and maintaining a credible chain of custody of evidence
- 5.5. SOP 5: Provision of psychosocial support
- 5.6. SOP 6: Referral and linkages

Standard operating procedures aid in translating the “what” in policies and guidelines into the “how” in service delivery in a structured format. These set of instructions aim to:

- Define or standardize procedures for clinical management of CSV
- Maintain good clinical practices
- Create a good quality health system for CSV
- Create an avenue for individual performance improvement for health care providers
- Improve institutional results and outcomes for CSV survivors

The SOPs outlined in this section follow the critical steps of:

- Taking consent/assent from a child survivor of sexual violence
- Medical-Forensic history taking and examination for a child survivor
- Clinical management of the child survivor
- Maintaining the chain of custody of evidence
- Provision of Psychosocial support
- Undertaking Referral and Linkage

5.1. SOP 1: Taking Consent/Assent From a Child Survivor of Sexual Violence



Objectives

- To provide information about the processes and procedures that will take place during the course of management of child survivors.
- To seek permission from the child survivor and a non-offending caregiver to carry out health services



Guiding Principles

When a child sexual violence survivor is presented/presents to a health facility, it is important that:

- Safety, privacy and confidentiality remain paramount during the course of all processes of management.
- Informed consent/assent is obtained before conducting a full medical examination or providing psychosocial support
- Consideration for obtaining consent/assent for the history and examination of a child survivor may be determined by the age of the child and/or his/her capacity to understand the procedures that are likely to take place during the continuum of care.
- The HCP should explain all aspects of the consultation and processes that the survivor will undergo during the course of their short-term and long-term recovery management.
- HCPs should recognize consent/assent as a process that continues throughout the examination and treatment and that the child survivor and /or non-offending caregiver may withdraw consent/assent at any time.



Procedure

- Taking actions to enhance the child's safety and to minimize harm, including the likelihood of the abuse continuing; this includes ensuring visual and auditory privacy
- Introduce yourself to the child survivor and caregiver as a helping person if applicable.

- Assure the child survivor and/or caregiver of safety, privacy and confidentiality. If not at the service delivery point, escort the child survivor and caregiver to the designated service delivery point.
- Put up appropriate signage to minimize interruption of the session.
- Establish the socio-demographic details (name, age, etc.) of the child survivor to determine the type of consent that is to be sought.
- Ensure all required medical equipment and tools for documentation are available.
- Explain the processes and procedures that will take place during the course of management, making reference to the process flow map (Figure 3).
- Establish the age of the CSV survivor, obtain and document consent/assent.
- Depending on the child's age, assent/consent shall be taken as follows:
 - 0-5 years: obtain informed **written consent** from the non-offending caregiver
 - 6 – 11 years: obtain **oral assent** from the child **AND written consent** from the non-offending caregiver
 - 12-14 years: obtain **written assent** from the child **AND/OR written consent** from a non-offending caregiver **OR written consent** from an emancipated minor
 - 15 – 18 years - obtain **written consent** from the child

For reasons of confidentiality and safety, interviewing the child on their own (i.e. separately from their caregivers), while offering to have another adult present as support

NOTE: A HCP may have to breach confidentiality (e.g. to a non-offending caregiver) under the following circumstances:

- Where there is a reasonable suspicion that the child may present a danger of violence to others
- Where there is reasonable suspicion that the child may harm him/herself, unless protective measures are taken

Use the nationally approved consent form (Annex 2) to document the consent and assent. File this in the child survivors' medical/case file.

Handling an Offending Caregiver

You can identify a potential offending caregiver by:

- Child's report during interview/ history taking
- Behavior of the child e.g. fear
- Behavior of the caregiver e.g. over protectiveness
- Witness reports
- Repeated trends indicating possible abuse from medical history, or scars observed during examination.

On suspicion of any of the above, the HCP should immediately report the concerns to the children's officer, police and hospital social worker.

Consenting for Children living with Disabilities

If a child living with disability is of sound mind, the above consent/ assent guidelines apply. If the child is of unsound mind, then the caregiver or an authorized officer can consent.

5.2. SOP 2: Medical-Forensic History Taking and Examination for a Child Survivor of Sexual Violence



Objectives

- To obtain routine background of symptoms and behavior resulting from sexual violence
- To assess the nature, extent and severity of physical injuries



Guiding Principles

- Life-threatening injuries and extreme distress should take precedence over other aspects of medical and forensic examination.
- Ensure informed consent and assent has been obtained and documented.
- Psychological First Aid (PFA) should be provided to the child and the caregiver until proper counseling can be conducted.
- If the survivor declines any part of the physical examination, respect her/his wishes. Giving the survivor autonomy over the process is important for the recovery process.

Document the following in the PRC form and survivor's case file. (Remember to ask open ended questions)

- Date and time of incident (If not already given, give the first doses of the time-bound medication like PEP (within 72 hours) and EC (within 120 hours).
- Place of incident and circumstances surrounding it
- Type of sexual violence; if any penetration occurred; if condoms were used
- Perpetrators known or unknown to survivor; number; estimated age; gender
- Repeated incidents of sexual violence
- If any threats were made or incentives given
- Any struggle by the survivor and any related injuries
- Any pain in the bottom or genital area
- Any blood or discharge in the panties
- Any difficulty or pain while voiding or defecating

- If reported to police or any other service provider, and the intervention given
- When was the last time you had sexual intercourse? Last consensual intercourse (*explain why you need to ask about this*)
- Obstetric and gynecological history should be taken from female pubertal survivors. This includes: LMP, parity, contraception, known pregnant or lactating
- Other prior medical or surgical history

Any additional information. Take your time while taking history from the child survivor; use play therapy where necessary

- Document the history in the survivor's own words (verbatim), if the survivor is old enough to talk
- Use neutral non-leading language, while remaining empathetic to the client
- Consider special circumstances, such as disabilities, as you take the history
- Take age specific history as follows:
 - 0 to 4yrs: From a non-offending guardian
 - 5 to 9yrs: Child survivor + supplement with non-offending guardian
 - 10 to 18yrs: Survivor only (non-offending guardian may be interviewed separately)

Examples of Open ended questions to use during history taking

- How are you feeling?
- What happened?



Procedure

Setting (Annex 1)

- Ensure privacy and safety for the child survivor
- Build trust and rapport by attempting general non-threatening conversation first, before moving on to questions specific to the sexual violence.
- Interview the child separately from the caregiver, while offering to have another adult present as support
- Ask the survivor if he or she wishes to have the caregiver or family member present at the examination.

- Listen attentively, without interpreting or judging the child's account, even when it might differ from that of the accompanying caregivers.
- Always have another HCP as a chaperone, while offering choice in the sex of the examiner.
- Explain to the survivor and caregiver all the steps and procedures you will be undertaking in this examination and the reasons why.
- Show survivor and caregiver the equipment that will be used; reassure the child that the equipment will do no harm to them.
- Give them an opportunity to ask questions.
- Inform them that they are allowed to stop the procedure at any time.

History taking

- Start by documenting the necessary demographic and administrative information **AS PER THE POST-RAPE CARE FORM (MOH 363 PARTS A & B)**. Document additional notes in the survivor's clinical file.
- Elicit the history on the incident and the circumstances surrounding the incident.

Forensic history

Ask and document the following:

- Have you changed clothes after the incident? If yes, were they handed over to the police?
- If the clothes were handed to the police, what was the nature of the carrier bag?
- Have you passed urine or defecated after the incident?
- Have you taken a bath/cleaned after the incident?
- Did you leave any mark(s) on the perpetrator?

Note:

Ensure to note down any discrepancies between the child's and the caregivers' account, if any, without giving your own interpretation

Medical and Forensic Examination

- Reassure the survivor at every step of the examination, while explaining what will be done, prior to each step
- Record the state of the clothes, if the survivor is wearing the same clothes that were worn during the sexual violence e.g. stains, tears, colour; collect and put all items in separate paper bags and label
- Examine the survivor on a drop sheet (or white sheet of paper) either standing or on a couch (see annex 5c)
- Use examination instruments and positions that minimize physical discomfort and psychological distress.
- Examine small children on caregiver's lap and consider sedation or general anaesthesia for small children especially if the injuries are expected to be severe.
- **NEVER** force the child survivor to be examined

Head to toe examination

- Record vital signs if i.e. height (cm) and weight (kg), temperature, respiratory rate, heart rate,
- Examine and record general appearance, hygiene and nutritional status
- Examine mouth/ pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Document any bruises, cuts, inflammation and marks on the body outside the genitalia. Also look for healing injuries and scars that may indicate prolonged abuse (See annex 5e)
- Check for ligation marks on wrists and ankles and record findings on the PRC form
- Determine the child's sexual development stage (tanner staging) to determine treatments e.g. EC
- **Age assessment:** never guess the age. A dental odontologist will conduct x rays and give an age range)
- Head to toe examination should be done in a systematic way (See annex 5d).

Positioning girls for genito-anal examination

- Use examination positions that minimize physical discomfort and psychological distress (Diagram 1); avoid examining the girl in the position they were violated in.
- Frog leg or knee chest position gives satisfactory view and often causes less distress than lying supine (both positions should be used for maximum visualization)
- Examine infants or very young girls (under 5 years of age) either on an examining table or while on a caregiver's lap.
- An assisting HCP can help to position the child and separate the child's thighs.

Genito-anal examination for Girls

- Examine any vulvar inflammation, eruptions, open lesions, tears, pain, discharge and bruises to inner thighs.
- Examine the patency of the hymenal orifice, size of the introital opening and the form and thickness of the hymen and document (Annex 5a)
- Describe the hymenal tissues focusing on the margins, color, shape (annular, crescent in pre-pubescent or irregular margins, thickened, in adolescents). Descriptions should be documented using the "imaginary clock" as illustrated in diagram 2.
- If there is discharge, determine the character, consistency, color and the presence of any odour. Make a point to collect the specimen for laboratory investigation.
- Record the patency of anal sphincter bearing in mind that repeated anal penetration over a long period may cause a loose and an enlarged opening.
- Document in the PRC form and in the survivor's case/medical file

Note:

- Do not routinely use speculums, anoscopes and digital or bimanual examinations of the vagina or rectum of pre-pubertal children, unless medically indicated. If they are used, sedation or general anaesthesia should be considered.
- A speculum may be used in post-pubertal and sexually active girls. If the survivor declines a speculum exam, the positions and techniques described for pre-pubertal children should apply.
- Do not conduct 'virginity testing' (two-finger test or per-vaginal examination) as it increases distress and does not indicate whether or not abuse took place. Virginity testing is not a medical procedure and has no scientific basis

Positioning boys for genito-anal examination

- Use examination positions that minimize physical discomfort and psychological distress; avoid examining the boy in the position he was violated in.
- The examination of external genitalia may be performed with the patient in the sitting, supine or standing position.
- Evaluation of the anus may be performed with the patient in the supine, lateral recumbent or prone position with gentle retraction of the gluteal folds (Diagram 3)

Genito-anal examination for boys

- Examine for injuries on the penis, testicles and perineum e.g. bite marks, abrasions, bruising and lacerations
- 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 to avoid trauma.
- Examine the anus for sphincter laxity, swelling, and mucosal tears, bleeding, sphincter spasm, discharge
- Check for skin tags that can form when tears heal
- Record the patency of anal sphincter - repeated anal penetration over a long period may cause a loose and an enlarged opening
- Avoid digital rectal examination, unless medically indicated.
- Document in the PRC form and in the clinical file

Proceed to carrying out forensic investigations and interventions as guided by the history and examination findings

NOTE:

- Where no physical evidence is found, note that the absence of physical evidence does not mean that abuse did not occur
- Document the child's or adolescents emotional state, while noting that no particular state is indicative of sexual abuse

Diagram 1: Positions for genital-anal examination in girls

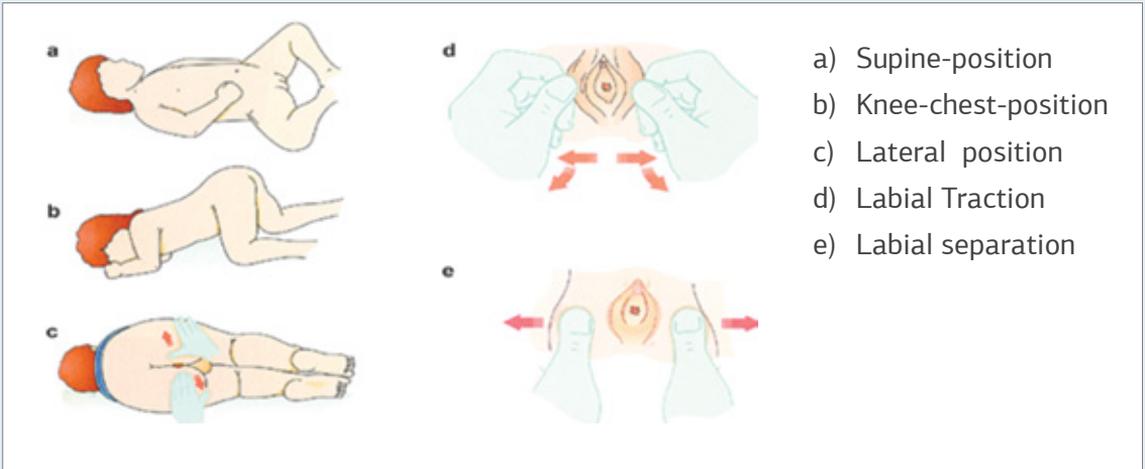


Diagram 2: Imaginary clock – for describing genital injuries and hymenal tissues

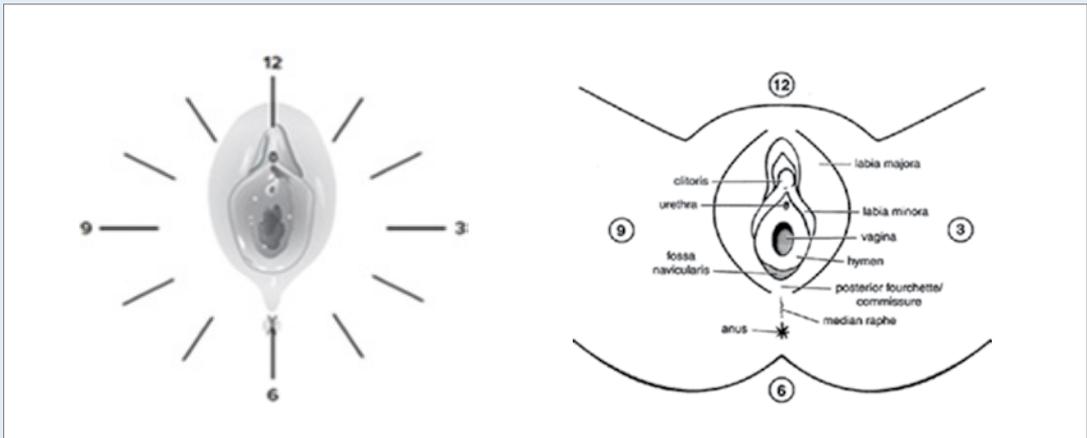
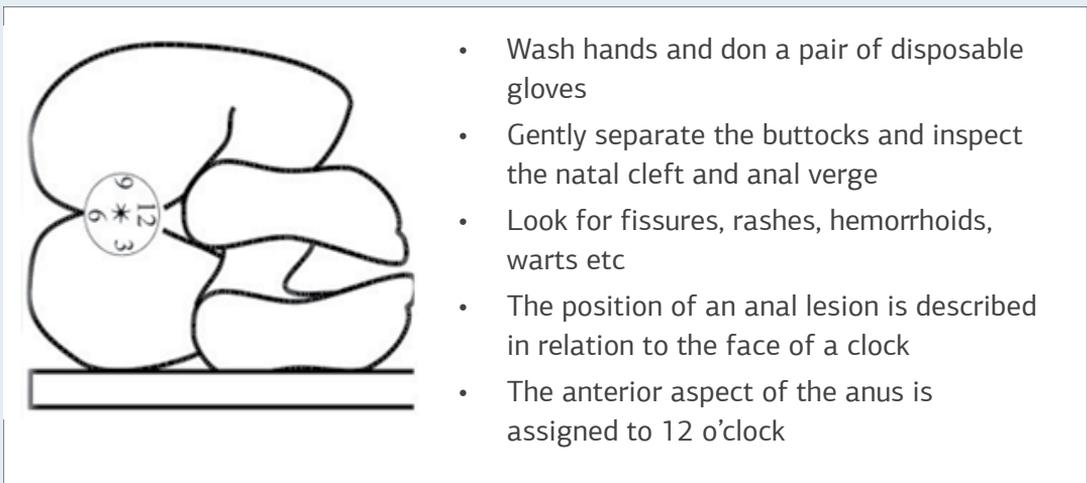


Diagram 3: Inspection of the Anus



5.3. SOP 3: Clinical Management of Child Survivors of Sexual Violence



Objectives

To provide comprehensive medical services to the survivor of sexual violence based on the findings of the history and examination



Guiding Principles

Medical providers should ensure private, confidential, accessible, compassionate, and appropriate medical care for child survivors of SV. Health care services provided should include :

1. Treatment of physical injuries
2. Prevention of disease, including STIs/HIV , Hepatitis B and Human Papilloma virus (HPV)
3. Prevention of unwanted pregnancy
4. Psychosocial support
5. Collection of forensic evidence
6. Medical documentation
7. Follow up care
8. Referral linkages
9. Documentation – Filling of P3 and PRC forms



Procedure

Treatment of physical injuries

- Clean abrasions and superficial lacerations with antiseptic or normal saline , including minor injuries to the vulva and perineum
- If stitching is required, stitch under local anesthesia. If the child is too young or level of anxiety does not permit, consider sedation or general anesthesia.
- High vaginal vault, anal and oral tears and 3rd/4th degree perineal injuries should be assessed under general anaesthesia by a gynaecologist or other qualified personnel and repaired accordingly.

- In cases of confirmed or suspected perforation, laparotomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon.
- Provide analgesics to relieve the survivor of physical pain
- Where any physical injuries result in breach of the skin and mucous membranes, immunize with 0.5mls of tetanus toxoid according to the schedule below:

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

Prevention of HIV

HIV testing and provision of PEP

HIV testing should be offered to the child before initiation of PEP. However in a rare situation where the HIV test is unavailable and PEP should not be withheld.

1. HIV Pre-test counseling

- Provide basic HIV information
- Explain benefits of HIV testing, the possible implications and the HIV testing process
- Conduct a risk assessment and ensure risk reduction while considering the survivor's age, the HIV parental status for children under 5 years, the perpetrators' HIV status if status is known
- Discuss the 72 hour window period, concerns around HIV testing, review the caregiver's/survivor's understanding and readiness for the test
- Conduct a HIV test, preferably as PITC as stipulated by the national HTS guidelines

2. HIV Testing Services (HTS)

- Provide counseling and baseline HIV testing to the child survivor
- Regardless of the outcome, assess the survivor's/caregiver's readiness for the results, provide results and discuss implications and risk reduction. Continue ongoing counseling
- For HIV negative results provide prevention counseling, and, refer for additional support as required. Repeat HIV testing at 4 weeks and at 12 weeks after which annual testing applies

- For those with HIV positive results, initiate adherence counseling while linking them to HIV care for ART initiation; continue trauma counseling

3. Provision of Post exposure prophylaxis

- Post Exposure Prophylaxis (PEP) for HIV is the administration of a combination of antiretroviral drugs (ARVs) for 28 days after the exposure to HIV.
- Follow up client on PEP is at on day 7, 14, and 28 .
- Provide continuous adherence counseling
- Offer Post-exposure prophylaxis (PEP) to all HIV negative children who have gone through sexual violence and present within 72 hours of the incident. Children who have been defiled and who present later than 72 hours post-exposure would normally not be considered as eligible for HIV PEP. However, in the case of ongoing sexual abuse that occurs over a number of days, the 72-hour time limit should be applied to the most recent exposure to oral, vaginal or anal penetrative intercourse.
- Those presenting more than 72 hours after exposure may still require other treatments and interventions, including referrals, which should be offered.
- As soon as decision to give PEP has been made, treatment should be initiated as soon as after the exposure as possible and administered for 4 weeks. The first doses should not be delayed by baseline HIV testing.
- Recommended drug regimens for PEP in children should be given as per the national ART guideline. A regimen for HIV PEP with Triple therapy ARV drugs is advised.
- Provide a 28-day prescription of antiretroviral drugs for HIV PEP following initial risk assessment. Given the stigma associated with sexual abuse, the first visit to the health-care provider may be the only visit and thus the only opportunity to provide treatment and counseling. Therefore, the full drug regimen required for completing HIV PEP should be provided at first contact rather than only a starter pack that would require the patient to return to the health service.

Note: The patient and caregiver need to be informed on the following:

- The need to begin treatment immediately for maximal effects of medications;
- The need for strict compliance when taking the medications;
- Length of treatment;
- Possible side effects of the medication;
- Importance of follow up.

Prevention of STI

- Children who experience sexual abuse may get infected with a sexually transmitted infection (STI).
- STI prophylaxis should be offered to all survivors of sexual violence. STI prophylaxis treatment can be prescribed for the survivor within 24 hours.
- Note that even people with a 'normal' HVS should be offered STI prophylaxis. (The HVS performed at presentation is done for forensic reasons and not to screen for STIs and/or guide antibiotic administration. Drugs used for STI Prophylaxis in children :
 - Amoxicillin 15mg/kg TDS one week
 - Erythromycin 10mg/kg QDS one week

Hepatitis B Vaccination

- Offer hepatitis B to children who have been sexually abused and who have not been previously vaccinated.
- Emphasize the importance of completing the 3 doses to the patient.
- The vaccine should be administered intramuscularly in the deltoid region.

Schedule for Hepatitis B vaccination (for patients who have never been vaccinated for hepatitis B)

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

- For patients who previously started but have not completed a series of vaccination. Complete the series from last dose given.
- For patients who have previously received all the three doses of vaccination, there is no need to revaccinate.

Human Papilloma Virus Vaccination

- HPV vaccination should be offered to girls in the age group 9–14 years, as per the national guidance.
- It is not necessary to screen prior to HPV vaccination. If two or three doses have been received, depending on age and national schedule, no further course of vaccination is required.

- Girls receiving the first dose of HPV before the age of 15 years can use a two-dose schedule. The interval between doses should be at least 6 months. While there is no maximum interval, an interval of 12–15 months is suggested. For girls aged 15 years and older, a three-dose schedule (0, 1–2, 6 months) should be given.
- HPV vaccine may be administered concomitantly with hepatitis B vaccine. If HPV vaccine is given at the same time as another injectable vaccine, the vaccines should always be administered at different injection sites using separate syringes

Prevention of unwanted pregnancy

Emergency contraceptive pills (ECPs) can be offered to girls who have attained menarche (i.e. post-menarche), as well as those who are in the beginning stages of puberty (i.e. have reached Tanner stage 2 or 3) without any restrictions.

- Give Emergency contraception to girls who have been sexually assaulted/raped and who present within 120 hours (5 days) of the incident. If a patient presents more than 5 days after incident she should be advised to return for pregnancy testing if she misses her next menstrual period.
- A follow up pregnancy test at six weeks should be offered to all women who return for follow up, regardless of whether they took EC after the rape or not.

NB: 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.

Facts about EC:

- EC can be used by all females with secondary sexual characteristics or who have started menstruation.
- EC should be available 24 hours a day.
- EC does not harm an early pregnancy.
- EC does not prevent or affect implantation
- EC does not cause abortion.
- EC does not delay return of fertility
- EC is not dangerous to a woman's health

Examples of EC Regime

Regime	Pill Composition	Examples of Brand	1st Dose (no of pills)	2nd dose(no of pills)
Levonogestrel only	LNG- 750 ug	Postinor 2 Plan B	2	NA
Combined Estrogen progesterone	EE 30 ug + 150 ug LNG	Microgynon	4	4
Progestin-only pills	30ug LNG	Nordette	50 tablets	0

Adherence Counseling and Treatment Literacy

- Discuss the treatment regimens and dosages for PEP/STI prophylaxis/ART
- Advise on side effects and their management and potential barriers to adherence
- Provide guidance on positive living, health consequences of STIs and other management e.g. TT vaccination, Hepatitis B vaccination, psychotherapy
- Emphasize on adherence to follow up care and appointment keeping
- Explain the importance of taking EC within 120 hours for female, pubertal child survivors

5.4. SOP 4: Collecting Forensic Evidence and Maintaining a Credible Chain of Custody Of Evidence



Objective

To correctly preserve and/or collect evidentiary material that may help prove or disprove links between individuals and/or between individuals and objects or places identified following an act of sexual violence. Evidentiary material if well managed can be used to access justice during the judicial process.



Guiding Principles

- Ensure essential supplies and commodities for forensic evidence collection are available (See Post rape Care Kit Table 5).
- **Collect evidence as soon as possible after the incident** to retain the value of the evidentiary material as much as possible. Ideally specimen should be collected within **24 hours** in pre-pubertal children and up to **72 hours** in post pubertal of sexual violence. Generally yields are significantly reduced in specimens collected after **72 hours**.
- Specimen should be collected before the survivor takes a bath, defecates, urinates and changes clothes. However, if any of these have happened, it should not deter the HCP from collecting specimens.
- 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 **non-powdered** gloves and protective gear at all times. Store each exhibit separately in a place that guarantees safety and confidentiality.
- **Ensure that specimens are labeled, packed, stored and transported safely and securely;** Biological evidentiary material (e.g. body fluid swabs, soiled clothes) should be packaged in khaki paper envelopes or bags after drying, **avoid polythene / plastic bags.**
- For specimens that require transportation ensure that this is done within two hours of collection. Where this is not possible, as a general rule, fluids should refrigerated between 4-80C and anything else should be air dried in room temperature.
- Exhibits should not be exposed to direct light and sunshine. If wet, exhibits should be dried under shade or dark rooms.

- **Ensure that specimen are accurately labeled.** Label all specimens clearly with the survivor's name and date of birth, the health care providers name, the type of specimen, and the date and time of collection.
- **Ensure that all Specimen are appropriately packaged to ensure that they are secure and tamper proof.** Only authorized people should be entrusted with specimens
- **Ensure that documentation of all collection and handling procedures is accurate as opportunities for follow-up examinations may not arise;** it is thus vital to make full use of this single patient contact. Information so recorded may be used in criminal proceedings.
- **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 at each facility
- Call on an expert if you lack adequate training to handle a particular type of exhibit.

Evidence that should be collected: (Table 4)

- **Injury documentation:** physical and/or genital trauma can be proof of force and should be adequately documented and recorded on pictograms in the PRC forms and other medical documentation.
- **Clothing:** torn or stained clothing may be useful to prove that physical force was used and can be analyzed for foreign DNA.
- **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. Matted hair can be shaved for analysis of foreign DNA.
- **Sperm and seminal fluid:** swabs may be taken from the vagina, anus or oral cavity or other body parts, if penetration or ejaculation took place. These samples are used to look for the presence of sperm and for prostatic acid phosphatase analysis.
- **DNA analysis** can be done on material found at the crime scene- the survivor's / perpetrator's body, location and object which might be soiled with blood, sperm, saliva or other biological material from the assailant (e.g. clothing, condoms etc.).

- Swab samples from semen stains, involved orifices, and on fingernail cuttings and scrapings are also examined for comparative analysis of DNA.
- Reference samples **MUST** be collected from the survivor and the perpetrator.
- **Blood or urine** may be collected for toxicology testing (e.g. if the survivor was drugged)



Procedure

Procedure for Collecting and storing Forensic samples /exhibits

- Take at least 3 swabs **from each relevant site:** One for microscopy, culture and sensitivity testing at facility level and two for DNA Analysis at Government Chemist's Laboratory. These sites include; oral, external genital/labial, low and high vaginal and anal.
- In teens who are sexually active, a swab of the external os should be considered (endo cervical swab). The specimen can be collected using a speculum with their consent.
- Ensure that each of the swabs are air dried and are **protected from contamination** at room temperature before packing .
- Collect urine specimen for microscopy to analyze for: spermatozoa, culture and sensitivity, drugs and alcohol and conduct pregnancy testing
- Collect blood to determine the haemoglobin level, HIV serology for child survivors older than 18 months, (for child survivors < 18 months a dried blood sample (DBS) for DNA PCR should be collected), Syphilis and Hepatitis B infection
- Collect pubic hair for comparison of hair strands and foreign DNA. However, this is not frequently conducted.
- Collect nail clippings and foreign material as forensic specimens that can be used as evidence.
- Certain areas of the body (e.g. the axilla, behind the ears, in the mouth, the soles of feet) not usually examined as part of a routine medical examination that are of forensic interest and must be inspected.
- Specimens such as clothing should be collected as part of a forensic examination. Wet clothes **MUST** be dried under a shade or in a room before labeling and packaging in a **Khaki bag**.
- Preserve used condoms in the freezer (below 4oC)

Chain of Custody of Evidence

- Ensure all specimens are clearly labeled and packed appropriately away from environmental harm e.g. excessive heat
- Each item of clothing should be packed on its own bag and sealed in a tamper proof manner. Failure to do this can lead compromised integrity.
- Make a record of all specimens collected and results in the laboratory register that should be kept locked away
- Sign and date the PRC form
- Contact the receiving police officer
- The receiving police officer should sign and date confirming that the forensic specimens have been received

Table 4: Collecting forensic evidence and maintaining a chain of custody of evidence

Site	Material being analyzed	Equipment	Sampling Instructions	Preservation	Reason for testing
Anus / Rectum	Semen	Cotton swabs	Use swab to collect; lubricate instruments with water, not lubricant	Air dry and store in a clean	NA
Blood	• Drugs • Alcohol	Appropriate tube	Collect 10 ml of venous whole blood	A clean sterile dry bottle with screw top or transfer liquid blood onto sterile cotton gauze and air dry	Toxicology
	• DNA (Survivor/ perpetrator)	Nordette	50 tablets		Comparative DNA Analysis
Clothing	Adherent foreign materials (e.g. semen, blood, hair, fibers)	Khaki bags and drop sheets	Clothing should be placed in a khaki paper bag(s). Collect drop paper sheet or drop cloth (see annex 5c). Wet items should be bagged separately	Dry blood stained clothes in open air. Do not dry in front of fire or artificial means or directly under the sun. Preserve in a khaki paper. Avoid polythene bags	DNA Analysis and trace element analysis
Genitalia and body parts	Semen, blood, saliva from bite marks, foreign material	Cotton swabs	Use separate swabs to collect from the external genitalia, vaginal vault and cervix; lubricate speculum with water not lubricant or collect a blind vaginal swab	Dry swabs in open air and store in Khaki envelopes	Comparative DNA Analysis
Hair	Comparison to hair found on the victim	Sterile container	Pick approximately 20 hairs and place in a sterile container	Pick the hair using non-powdered gloves and store in an envelope or lift using tape store on acetate sheet	Comparative DNA analysis

Table 4: Collecting forensic evidence and maintaining a chain of custody of evidence cont'

Site	Material being analyzed	Equipment	Sampling Instructions	Preservation	Reason for testing
Mouth	Semen	Cotton swabs, sterile container (for oral washings) or dental flossing	Swab multiple sites -teeth, tongue and oropharynx (Annex 5b) -To obtain a sample of oral washings, rinse mouth with 10 ml water and collect in sterile container	Air dry and store in a clean dry bottle with screw top Store in a clean sterile bottle and refrigerate	Comparative DNA Analysis
	Reference Sample from the survivor/ alleged perpetrator	Cotton swabs	Sample the inner cheeks for up to 20 strokes on each side with separate swabs.	Air dry and store in a clean dry bottle with screw top	Comparative DNA Analysis
Nails	Skin, blood, fibres, etc.	Sterile toothpick or nail scissors/ clippers	Use the toothpick to collect material from under the nails or the nails can be cut and the clippings collected in a sterile envelope	Store in an envelope	Comparative DNA analysis
Sanitary pads/ tampons	Foreign material (e.g. semen, blood, hair)	Sterile container	Collect if used during or after vaginal penetration	Store in a refrigerator between 4-80C	Comparative DNA analysis
Condom	Semen, blood, vaginal fluids, epithelial cells, foreign material	Sterile container	Collect if used by the perpetrator	Store in a freezer below 40C	Comparative DNA analysis
Skin	Semen Saliva (e.g. at sites of kissing, biting or licking), blood	Cotton swabs	Swab sites where semen may be present- sample at least 3 swabs	Air dry and store in a clean dry bottle with screw top	Comparative DNA analysis
	Foreign Material (e.g. vegetation, matted hair or foreign hairs)	Swab or tweezers	Place material in sterile container	Air dry and store in a clean dry bottle with screw top	Trace element analysis to corroborate
Urine	Drugs, alcohol, spermatozoa and pregnancy	Sterile container	Collect 100 ml of urine	Clean dry bottle with screw up, refrigerated	Toxicology and pregnancy

Table 5: Post Rape Care Kit

Description of Item	Use of Item	Number
Powder free gloves (Clean gloves)	To avoid contamination.	1
Sterile gloves	For the sterile procedures such as collecting HVS	1
Six stick swabs	For taking the HVS and/or anal swabs from the survivor.	12
Masking tape	For sealing the brown envelopes in which the specimens have been stored.	1
Brown envelopes for collecting samples	For proper storage of collected specimens.	20
Tape Measure	Tape Measure	1
Needles & syringes	For collection of blood samples	3
Urine bottles	For collection of urine samples	2
Speculum	For collection of specimens from the vaginal cavity	1
Labels	For labelling the brown envelopes with the details of the specimens stored inside.	20
Green towels	One for wiping hands during the sterile procedure One for placing beneath the patient's buttocks	2
Seal lock bags	For proper storage of collected specimens	-
Pregnancy testing kit	To test for pregnancy	2
6 doses of PEP, EC,STI Prevention drugs, Anti-emetic	For prophylaxis	-
Vacutainers tubes	For collection of blood samples.	2

5.5. SOP 5: Provision of Psychosocial Support



Objective

To identify the level of psychological trauma and provide psychosocial support and counseling for mental well-being of the survivor and caregiver



Guiding Principles

- Psychosocial support forms an integral part of the survivor's immediate care, recovery and follow up; and can additionally provide more forensic information
- Create a safe and trusting environment for the interview and eventual examination
- It is recommended that age appropriate psychosocial support be instituted
- Psychosocial support requires time and engagement of both the child survivor and their caregiver
- Ensure safety, privacy and confidentiality when providing psycho-social support
- Treat children and adolescents with respect and dignity
- Explain confidentiality and shared confidentiality to the care giver and the older children
- Remember to document consent and/or assent by the survivor and caregiver as per the consent taking SOP
- Approach to psychosocial support may vary depending on the age and/or developmental stage or special needs of the survivor
- It is essential to explain all aspects of the procedures that the survivor is going to go through during the course of their management
- It is recommended that an empathetic and non-judgmental approach to care is instituted



Procedure

- Introduce yourself, lead to a child friendly room/space and create rapport with the child survivor and caregiver
- Establish whether the survivor has received any other services elsewhere (PEP, ECP, STI management and PRC), if not establish the priorities and refer appropriately
- Allow the child to familiarize themselves with the environment, giving them access to play or art material
- Explain the process of counseling to the caregiver and/or older child survivor:
 - Aim of counseling and a debrief of expected processes and outcomes including approximate number of sessions the caregiver and survivor will require (minimum of 5 sessions)
 - Issues to be covered (trauma counseling, HTS, adherence counseling, ECP, psycho-education, psycho-social support) (Annex 6).
 - Provide information on child survivors' rights, legal redress and referral linkages
 - Children require action oriented approaches to facilitate the counseling process.
 - Some children may have no experience of an adult listening to them and therefore may react with suspicion or resistance to the counselor. Thus, there is need for the helper to use different psychosocial approaches which includes one on one counseling, group counseling and Art & Play (Drawing ,Story-telling, Drama, Play therapy).
- Once you acquired relevant information related to the abuse from the caregiver, politely request the caregiver to step out of the room to a designated area, so as to engage with the child survivor.

Play & Art therapy

Play & Art therapy is an effective child therapy mostly used by trained Psychologist. However, trained Health care providers can use basic approach to play and Art therapy.

- NB/ Drawing and painting are symbolic representation of the child's view of the world as he /she sees it
- Pictures drawn by the children have the power to tell, what the child is feeling and thinking but is unable or unwilling to tell
- Choice of subject- such as draw yourself, draw a family, friend, a person etc.

- Be specific with children and what they draw
- Pay attention to use of space, what they decide to shade and not- children who are depressed draw themselves as tiny and at the far most of the corner. – They feel little, restricted, tiny, small or depleted.
- Pay attention to image how they are placed and positioned in the page – because it means those could be the people that matter according to child.
- Play is a child’s natural form of communication. Children do not need to be talking to be communicating with adult
- They are excellent at communicating through play
- Carry out a social and/or risk assessment so as to determine the risk level or need for rescue services and a mental status examination

Psycho-education

- Explore the survivor’s/caregiver’s issues, concerns and fears
- Identify and normalize feelings of guilt, embarrassment, low self-esteem and hopelessness
- Empower the survivor with information on coping mechanisms and tips on how to avoid situations which make them vulnerable to sexual violence in future
- Educate the caregiver on looking out for possible behavioral changes

Psycho-social support

- Offer group counseling as ongoing support for survivors (if appropriate for age) and/or caregivers
- Family counseling should be offered where possible
- Refer for specialized psychological/psychiatric care
- Provide information on police, legal services, child welfare and other linkages and their purpose

Documentation

- Document as appropriate in the relevant tools. These include; trauma counseling forms (Annex 3), PRC Forms (MOH 363 Part B), SGBV register (MOH 365) and child survivors clinical notes

5.6. SOP 6: Referral and Linkages



Objective

To effectively utilize / develop referral mechanism for successful follow up care, legal intervention, rehabilitation and re-integration of the CSV survivor to the community.



Guiding Principles

- Management of CSV requires a multi-disciplinary, as well as a cross-sectoral approach
- Continuum of care of CSV survivor should include referral and linkage as necessary. Referral and linkage tools should be available and up to date for complete documentation at every service delivery point



Procedure

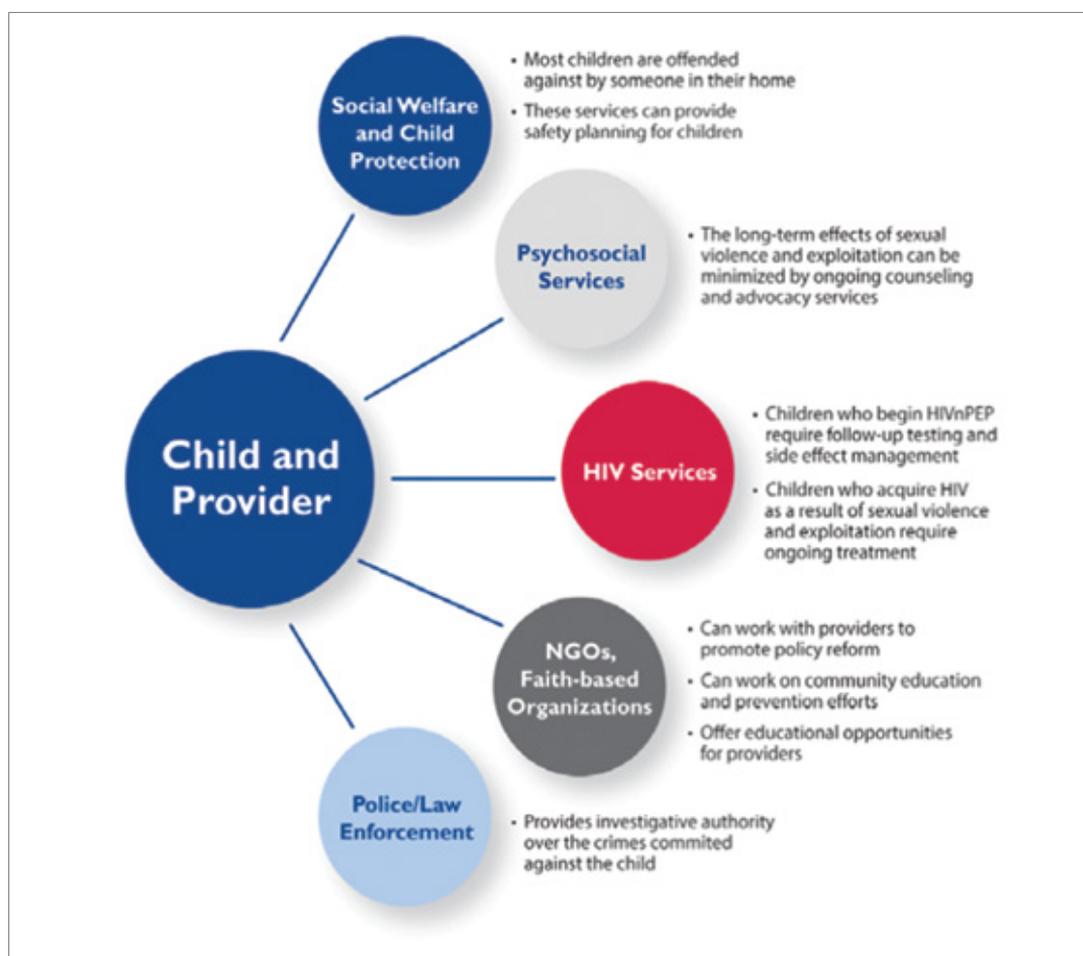
Upon completion of the psychosocial session:

- Counselors should document the session's findings and provide feedback to the clinician
- Schedule joint follow up sessions for the child survivor and for the caregiver
- Plan for home visits for further social assessment and re-integration
- Conduct a post – psychological session assessment after at least 5 sessions to evaluate the acute phase recovery progress and make recommendations for continuous psychosocial support to mitigate/address post-traumatic stress disorder (PTSD)
- Upon reasonable medical and psychosocial improvement, prepare the child survivor and caregiver for termination from care with an open appointment
- Plan for transition from care and re-integration to community
- Make recommendations for future follow up after transition from care
- Refer to police, for legal aid, or to safe spaces based on comprehensive individualized assessments.
- The MOH Client referral form should be used when referring clients from one facility or department to another (Annex 7).

Cross-sectoral Referral and Linkage

- If the child survivor has been referred to the health facility by the police, ensure that the P3 form is filled
- If referring to the police, ensure that correct documentation is available for follow up by the police and for completion of the P3 form.
- Its recommended that a child survivor should be accompanied to the police station by a non-offending care giver or an identified escort provided principles of safety and confidentiality are adhered to. a telephone contact may hasten the referral process.
- Ensure that all evidential material is labeled and preserved as recommended
- It is the role of the assigned police officer to ensure all evidential material is transported to the relevant laboratory for forensic examination.

Figure 4: Referral and linkages between Health care and Community Resources



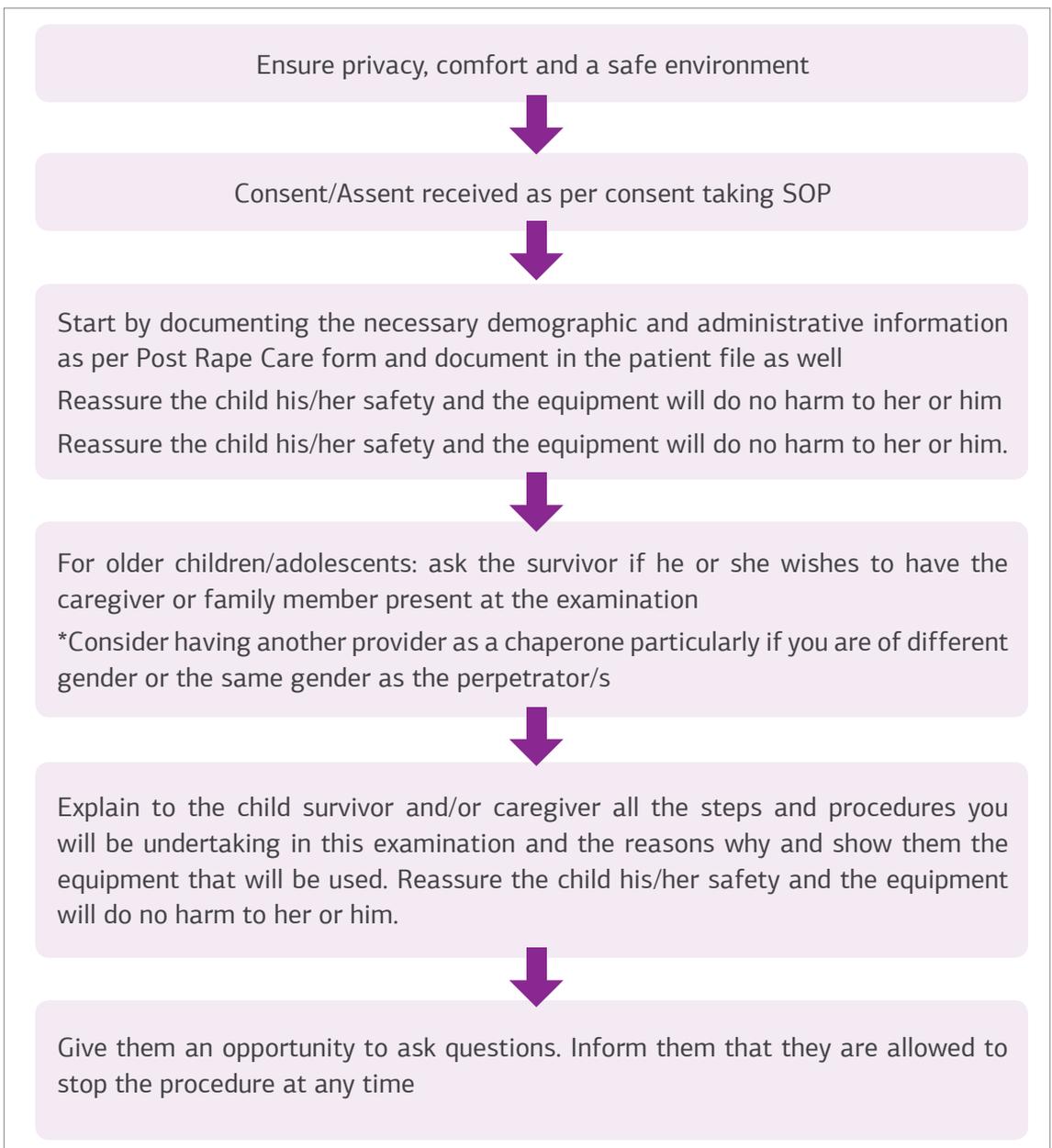


ANNEXES

- Annex 1: The Setting for Clinical Services for Child Survivor of Sexual Violence**
- Annex 2: Post Rape Care Consent Form**
- Annex 3: Sexual Violence - Trauma Counseling Data Form**
- Annex 4: Flow Chart for documentation and reporting of child sexual violence services**
- Annex 5: Pictograms / Diagrams for Medico-legal forensic examination**
- Annex 6: Psychosocial support**
- Annex 7: Client referral form**
- Annex 8: Algorithm for management of survivors of sexual Violence**

Annex 1: The Setting for Clinical Services for Child Survivor of Sexual Violence

Please note that life threatening injuries and extreme distress should take precedence over other aspects of the medical and forensic examination. Psychological first aid should be provided to the child and the caregiver at every step of the process until proper counseling can be conducted. If the child declines any part of the physical examination, you must respect her/his wishes. Giving the survivor autonomy over the process is important for the recovery process.



Annex 2: Post Rape Care 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	<input type="checkbox"/>	<input type="checkbox"/>
Collect evidence, such as body fluid samples, collection of clothing, hair combings, scrapings or cuttings of finger nails, blood samples, and photographs	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>

Client's Signature

Date

Name of witness

Date

Signature

Names of HCP

Date

Signature

Annex 3: Sexual Violence - Trauma Counseling Data Form

Date	<input type="text"/>		
Facility Name:	<input type="text"/>		
Sub-County Code:	<input type="text"/>	Site/ Facility Code	<input type="text"/>
Survivor Name	<input type="text"/>		
Parents/Guardian Name:	<input type="text"/>		
	<i>(For children)</i>		
Phone Number:	<input type="text"/>		
Serial No. or OP/IP No.:	<input type="text"/>		
DATES			
First Visit:	<input type="text"/>		
	Counselor Name:	<input type="text"/>	
Second Visit:	<input type="text"/>		
	Counselor Name:	<input type="text"/>	
Third Visit:	<input type="text"/>		
	Counselor Name:	<input type="text"/>	
Fourth Visit:	<input type="text"/>		
	Counselor Name:	<input type="text"/>	
Fifth Visit:	<input type="text"/>		
	Counselor Name:	<input type="text"/>	

RAPE TRAUMA COUNSELING DATA FORM

SEX

Sex

1 Male 2 Female

AGE (YEARS)

EDUCATION

0 None

1 Primary

2 Secondary

3 Post-Secondary/Technical

MARITAL STATUS

0 Never 1 Married

2 widowed 3 Separated/Divorced

TYPE OF ASSAULT

1 Penile anal rape 2 Penile vaginal rape

3 Use of objects in vagina

4 Use of objects in anus

9 Other

CLIENT SEEN

1 Individual 2 With partner

3 With guardian/parent

4 With friend/relative

9 Other

Services required by client

Was the PRC 1 form filled?

0 No 1 Yes

If not, name reason(s)

Who is the assailant?

0 Known 1 Unknown

If known, specify relationship

Has the client reported to the police?

0 No 1 Yes

If not, name reason(s)

a) Is the client willing to report to the police?

0 No 1 Yes

If not, name reason(s)

Client referred from?

1 VCT services 2 Police stations

3 Health Facilities 9 Other

Was the 1st dose of PEP administered?

0 No 1 Yes

If not, name reason(s)

1 Presented after 72 hours

2 Client declined

9 Other

Was EC administered?

0 No 1 Yes

2 N/A

If not, name reason(s)

Did client know HIV status before the assault?

0 No 1 Yes

If Yes,

0 Negative 1 Positive

1st Visit

a) HIV test done

0 No 1 Yes 2 Declined

If Yes, 0 Negative 1 Positive

b) Pregnancy Test done

0 No 1 Yes 2 N/A

Results 0 Negative 1 Positive

c) Disclosed SV

0 No 1 Yes

If not, name reason(s)

2nd Visit

a) Disclosure of SV

0 No 1 Yes

b) Disclosure HIV results

0 No 1 Yes

c) PEP adherence

0 No 1 Yes

If not, name reason(s)

d) Still taking PEP

0 No 1 Yes

3rd Visit

Is disclosure done so far?

0 No 1 Yes

Comments

5th Visit

HIV Test done

0 No 1 Yes

Disclosure of SV

0 No 1 Yes

Disclosure of HIV Results

0 No 1 Yes

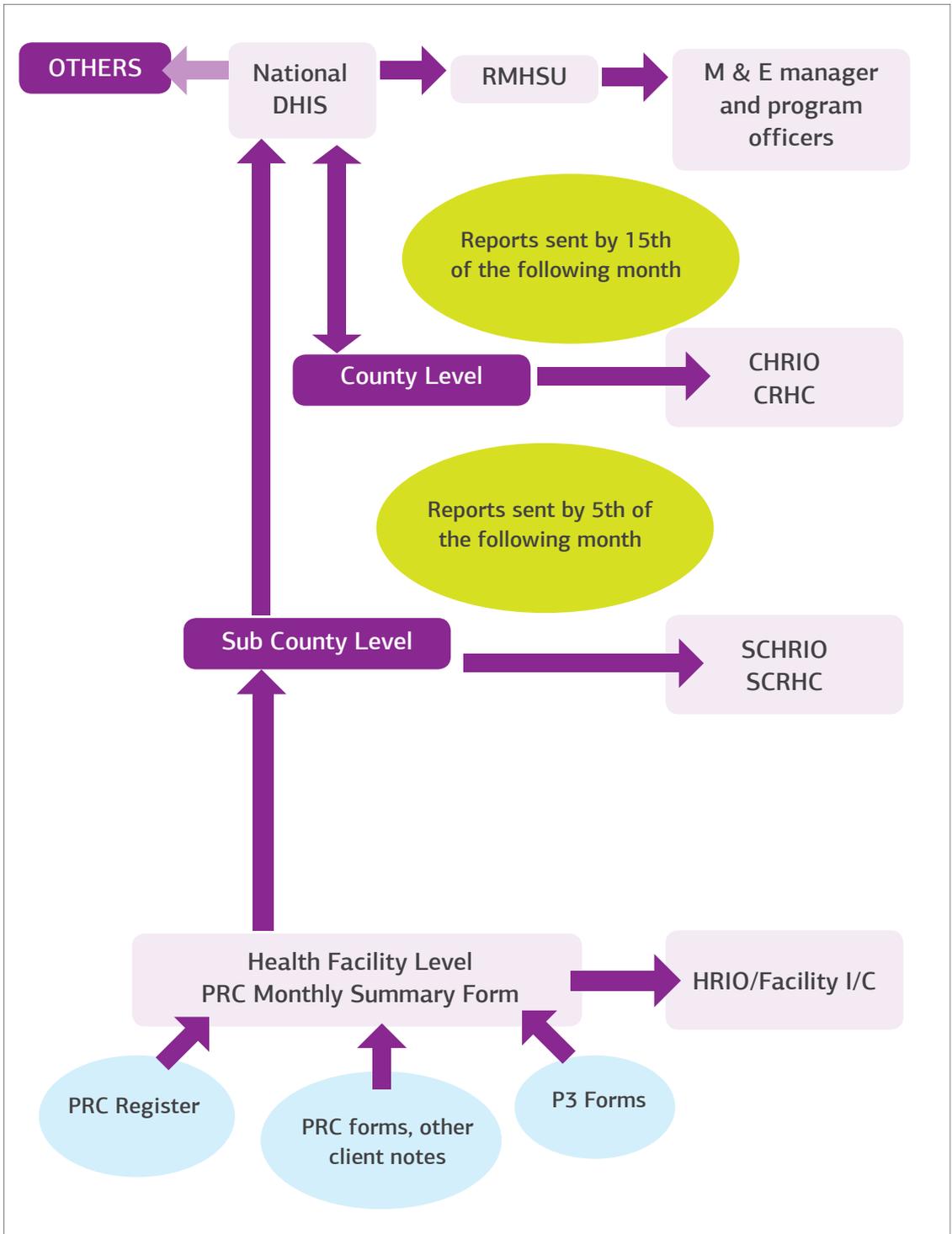
Pregnancy Test done

0 No 1 Yes 2 N/A

Results 0 Negative 1 Positive

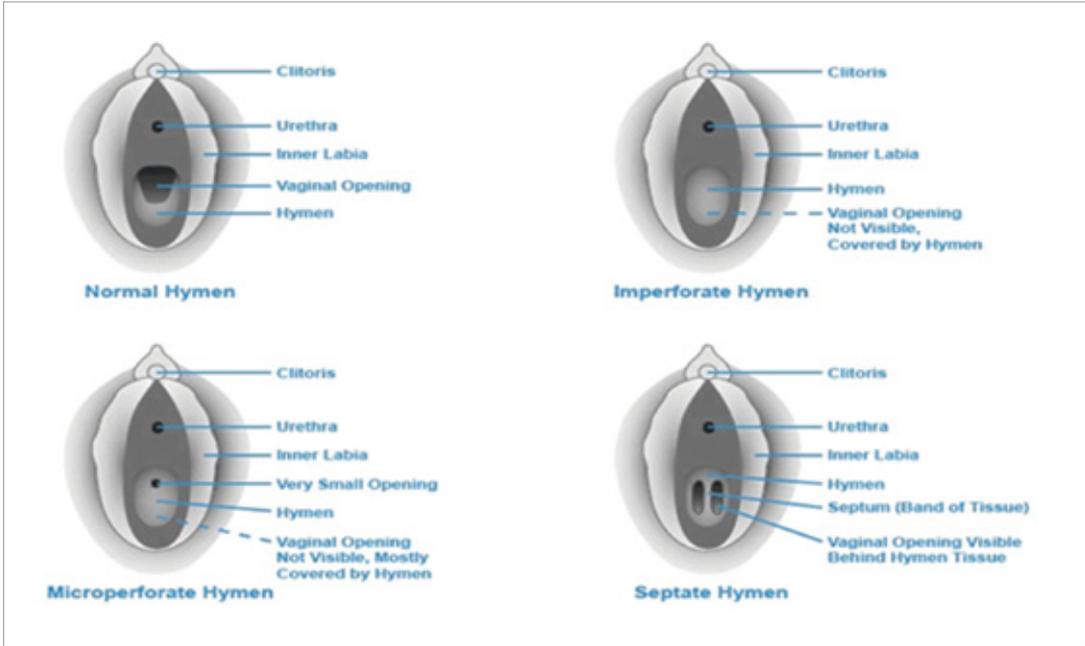
Comments

Annex 4: Flow Chart For Documentation and Reporting of Child Sexual Violence Services

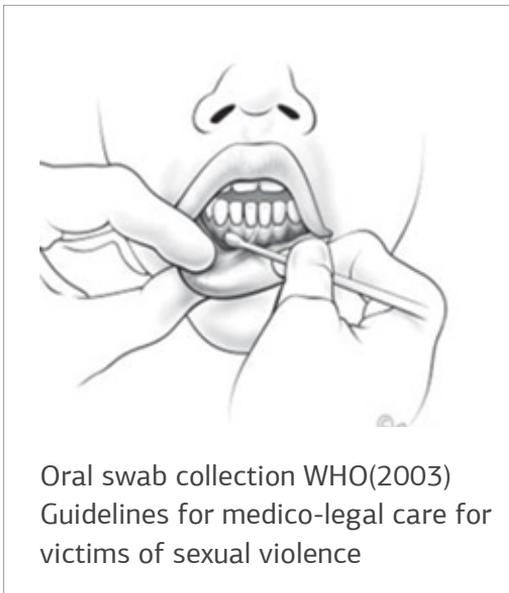


Annex 5: Pictograms / Diagrams for Medico-Legal Forensic Examination

Annex 5a: Patency of the hymenal orifice



Annex 5b: Oral Swab collection



Courtesy of Google images, 2018

Annex 5c: Drop Sheet and evidence bag



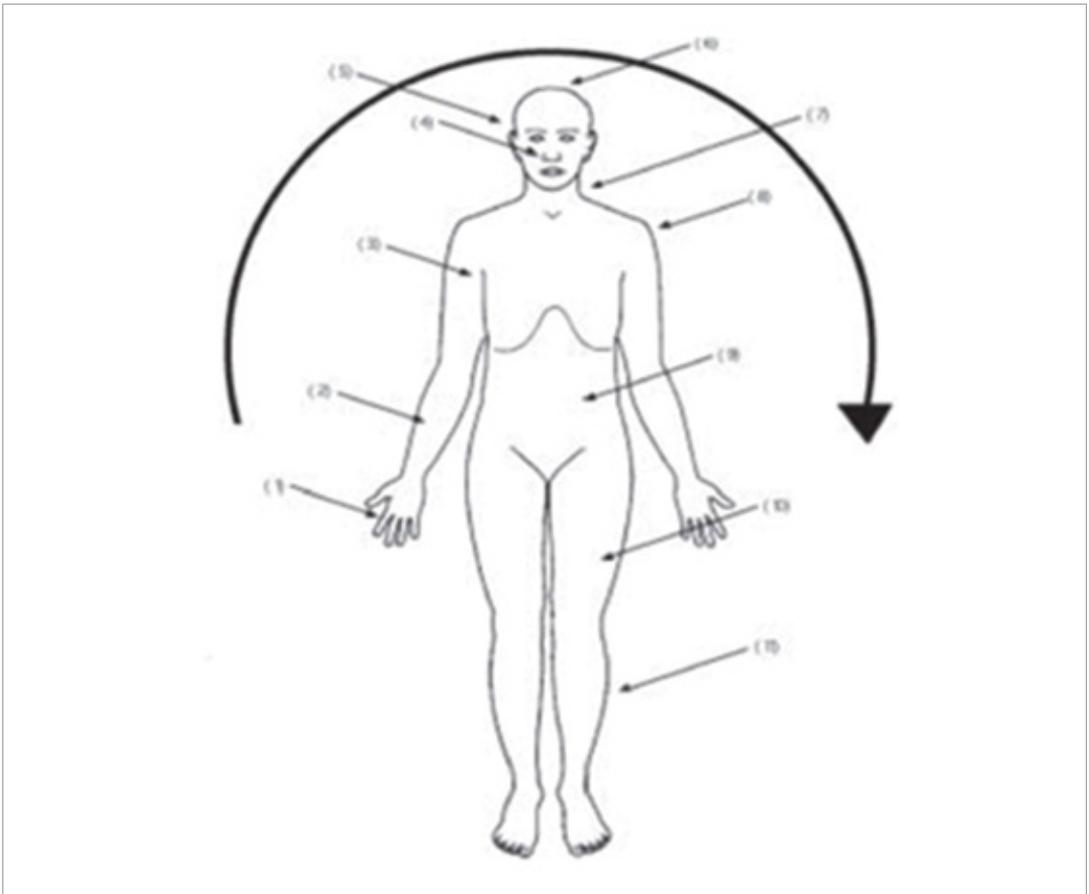
Drop Sheet



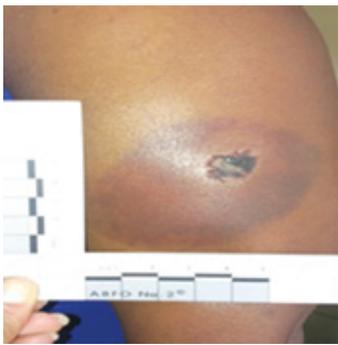
Evidence collection bag

Images courtesy of Dr. Kizzie Shako, Forensic Medical Practitioner

Annex 5d: Flow of Physical examination



Annex 5e: Examples of Physical Injuries on Medico-Legal Forensic Examination



Bite Mark



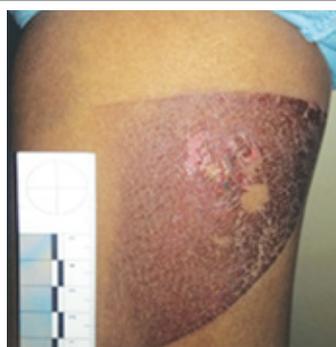
Incised wound



Imprint Bruise



Tramline Bruises



Thermal Injury



Friction abrasions



Periorbital oedema and bruising and laceration of the right brow

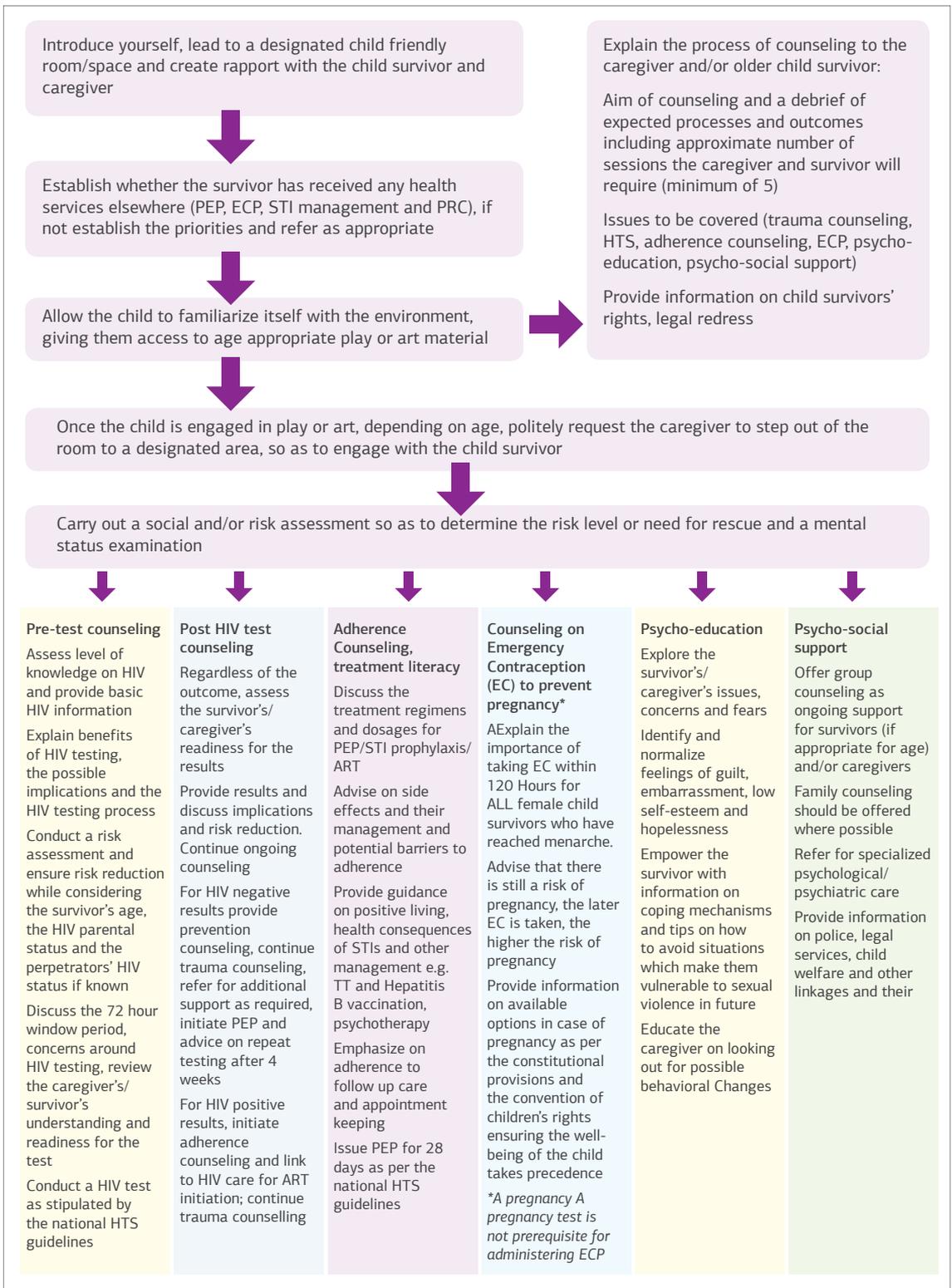


Tramline Bruise



Incised wound (defense injury) with multiple bruises

Annex 6: Psychosocial Support



Annex 7: Client Referral Form

MINISTRY OF HEALTH: CLIENT REFERRAL FORM

Emergency Urgent Routine
(*Tick as appropriate)

Local/ Inter -county Overseas
(*Tick as appropriate)

Date Time Facility code

Client Details:

Name:

Age Sex: (Male/Female)

IP/OP number: ID number:

NHIF Number: Telephone Number(s)

Physical Address: County:

Sub County: Sub Location:

Assistant Chief: Telephone Number(s)

Next of Kin Details

Name:

Telephone Number Relationship to client

Referring from Facility/Department

Referral to Facility/Department

History/Investigations

Diagnosis:

Reasons for Referral:

Referring Officer Details:

Name:

Telephone Number Designation

Signature

Referral Back Details (Tracking Slip):

Name of the Facility or Department

Date Client Reported

Referred from Facility/Department

Clinician Name Telephone Number(s)

Designation Signature

Date

Annex 8: Algorithm for Management of Survivors of Sexual Violence

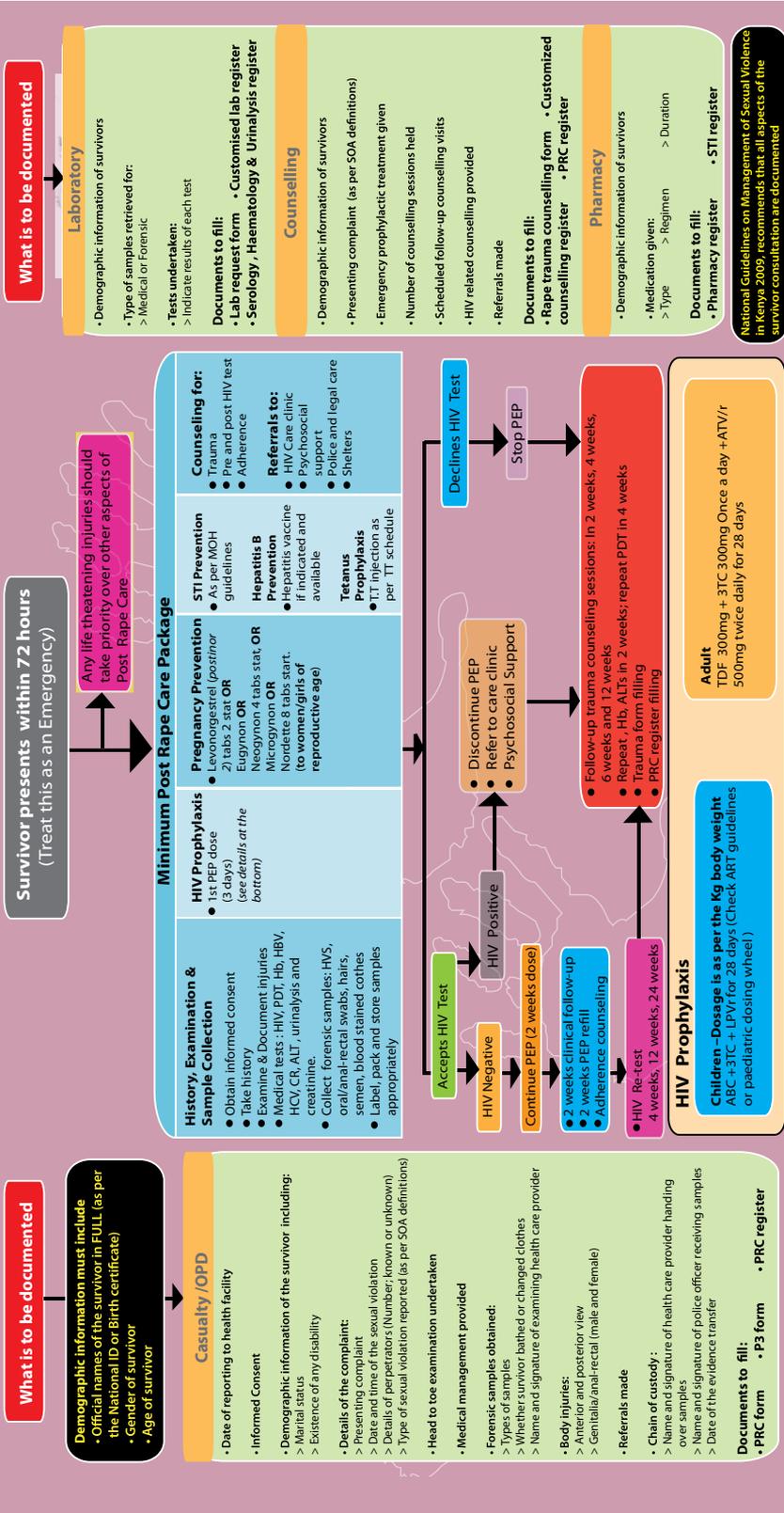
Algorithm for management of survivors of sexual violence



Ministry of Health



Kenya Health Services



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

REFERENCES

1. World Health Organisation. Sexual and reproductive health Sexual violence. 2017:2-4. http://www.who.int/reproductivehealth/topics/violence/sexual_violence/en/.
2. Ministry of Health K. National Guidelines on Management of Sexual Violence in Kenya.; 2014.
3. Ministry of Health K. Standard Operating Procedures on Management of Sexual Violence in Kenya.; 2014.
4. Ministry of Health K. A Training Course for Management of Sexual Violence.; 2015.
5. World Health Organisation. Responding to Children and Adolescents Who Have Been Sexually Abused. WHO Clinical Guidelines.; 2017.
6. PEPFAR. THE CLINICAL MANAGEMENT OF CHILDREN AND ADOLESCENTS WHO HAVE EXPERIENCED SEXUAL VIOLENCE Technical Considerations for PEPFAR Programs.; 2013.
7. UNICEF, CDC. Violence against Children in Kenya. Findings from a 2010 National Survey.; 2010.
8. Mathews B, Collin-vézina D. Child sexual abuse : Raising awareness and empathy is essential to promote new public health responses. *J Public Health Policy.* 37(3):304-314. doi:10.1057/jphp.2016.21.
9. World Health Organisation. WHO guidelines on child sexual abuse. :75-93.
10. Government of the Republic of Kenya. Sexual Offences (Medical Treatment) Regulations 2012.; 2012.
11. National AIDs and STIs Control Programme, Ministry of Health, Kenya. Guidselines for HIV Testing Services in Kenya, Nairobi; NASCOP 2015
12. Ministry of Health Reproductive Health and Maternal Services Unit Second Edition, September , 2015
13. LVCT Health, Population council. Health Facility Responsiveness to the Needs of Child Survivors of Sexual Violence
14. Kenya Health Sector Referral Iplementaton Guideliness 2014
15. Children ACT No. 8 of 2001 (Revised in 2016)
16. World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (CCP), Knowledge for Health Project. Family Planning: A Global Handbook for Providers (2018 update). Baltimore and Geneva: CCP and WHO, 2018.

TASK FORCE MEMBERS

Dr. Gondi Joel	MOH-RMHSU
Dr. Jeanne Patrick	MOH-RMHSU
Aisha Mohamed	MOH-RMHSU
Alice N. Mwangangi	MOH-RMHSU
Damaris Mwanzia	MOHRMHSU
Wilkister Were	Egerton University
Teresa Njore (late)	KNH Hospital
Juliet Njuguna	LVCT Health
Rose Mwongera	MPSYG
Claire Nyambati	IOM
Suhayla Aboud	UNFPA
Nancy Ngetha	KNH
Mercy Githara	MSF – F
Donna Nyamunga	MOH – FPS
Karen Aura	MOH-RMHSU
Clarice Okumu	MOH-RMHSU
Ruth Muia	NCK
Rebecca Gitau	GVRC-Nairobi
Michael Gaitho	LVCT Health
Hellen Sidha	MOH-RMHSU
Ronald Kotut	LVCT Health
Anne Nderitu	Government Chemist
Anne Njeru	MOH-RMHSU
Maureen Obbayi	Gender health Africa
John wanyungu	MOH
Suhayla Aboud	UNFPA
Esther Muketo	FHOK
Merina Lekorere	MOH-RMHSU
Tecla Kogo	MOH-RMHSU
John Mungai	Government Chemist
Jotham Kamau	DCS
Dr. Kizzie Shako	MOH-FPS
Mary Magubo	MOH-RMHSU
Christine Matindi	Government Chemist
Dr. Lina Digolo	LVCT Health

Stephanie Mutindi	NGEC
Caroline Ajema	LVCT Health
Michael Gaitho	LVCT Health
Magdalene Mwanzia (late)	LVCT Health
Chi-Chi Undie	Population Council
Teresa Alwar	UNICEF

CONSULTANCY TEAM

Dr. Minnie Kibore
Agnes Midi-Keita

PRETESTING SITES TEAMS:

Moi Teaching and Referral Hospital

Adelaide Jerono Kiplagat
Marylyne C. Lukoye
Violah Kemboi
Bertilla B. Mose
Dr. Edwin Gudu
Judith Bite
Dr. Temet Eunice
Eunice S. Magoi
Jane Jemutai Biwott
Grace Rutto

Kilifi County Referral Hospital:

Nasoro Leonard
Anderson Kangu
Zuma Bimba
Nelly Ndumbu
Raymond Katana
Juliana Nyevu
Daisy Njeru
Veronica Fulano
Phelomena Munga Mwaidza
Holice Mae

Reviewers

Dr. Jeanne Patrick	MOH-RMHSU
Dr. Lina Digolo	LVCT Health
Michael Gaitho	LVCT Health
Caroline Ajema	LVCT Health

Secretariat

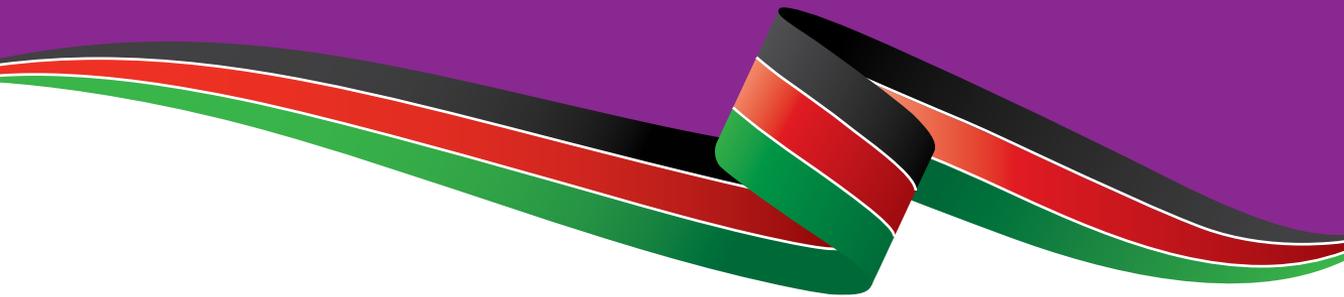
Florence Ileri	MOH-RMHSU
----------------	-----------

Pretesting Team

Alice Mwangangi
Damaris Mwanzia
Maureen Obbayi



MINISTRY OF HEALTH



REPRODUCTIVE AND MATERNAL HEALTH
SERVICE UNIT



Norad