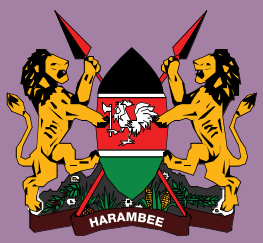

MINISTRY OF PUBLIC HEALTH & SANITATION
MINISTRY OF MEDICAL SERVICES

National Guidelines on Management of Sexual Violence in Kenya

2ND Edition, 2009

National Guidelines on Management of Sexual Violence in Kenya

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Foreword

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

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

These guidelines have been designed to give general information about management of sexual violence in Kenya and focus on the necessity to avail services that address all the needs of a sexual violence survivor, be they medical, psycho-social, humanitarian and/or legal. Although these needs are interrelated, attempt has been made to group the guidelines into chapters that can easily be accessed for easy reference.

The guidelines recognise the fact that children form a significant proportion of survivors of sexual violence and make special provisions for them that address their unique aspects, distinct from those of adults.

The guidelines should be available in all health facilities and it is our sincere hope that their implementation will comprehensively address the needs of survivors of sexual violence in Kenya.

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Acronyms

3TC	Lamivudine
AZT	Zidovudine
CCC	Comprehensive Care Clinic
Cr	Creatinine
D4T	Stavudine
DCT	Diagnostic Counseling and Testing
DNA	Deoxyribonucleic Acid
EC	Emergency Contraception
EFV	Efavirenz
Ex	Examination
Hb	Haemoglobin
HCW	Health Care Worker
HIV/AIDS	Human Immuno-deficiency Virus/Acquired Immune Deficiency Syndrome
HVS	High Vaginal Swab
IDR	Indinavir
LFTs	Liver Function Tests
NVP	Nevirapine
OB	Occurrence Book
OPD	Out Patient Department
PEP	Post Exposure Prophylaxis
U+Es	Urea and Electrolytes
VCT	Voluntary Counseling and Testing
LVCT	Liverpool VCT, Care and Treatment, Kenya
GBV	Gender Based Violence
SGBV	Sexual Gender Based Violence
GBVRC	Gender Based Violence Recovery Center
GVRC	Gender Violence Recovery Center
MOH	Ministry of Health
SV	Sexual Violence
IDPs	Internally Displaced Persons
STIs	Sexually Transmitted Infections
DRH	Division of Reproductive Health
NHSSP II	National Health Sector Strategic Plan
MDGs	Millennium Development Goals
PRC	Post Rape Care
PTSD	Post Traumatic Stress Disorder
QA	Quality Assurance
QI	Quality Improvement
SDP	Service Delivery Point
SGPT	Serum Glutamate Pyruvic Transaminase
ALT	Alanine Aminotransferase

(Sexual Offences Act 2006)

Terms	Definition
Sexual violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work[1].
Genital organs	Includes the whole or part of male or female genital organs and for the purposes of the act of sexual violence includes the anus.
Penetration	Means partial or complete insertion of the genital organs of a person or an object into the genital organs of another person.
Rape	An act done which causes penetration of one persons genital organs with the genital organs of another without their consent or where the consent is obtained by force, threats or intimidation of any kind.
Defilement	An act which causes penetration of a child's genital organs (child is any one below the age of 18 years).
Indecent Act	Any unlawful act which causes (i) any contact between the genital organs of a person, his or her breasts and buttocks with that of another person (ii) exposure or display of any pornographic material to any person against his or her will, but does not include an act that causes penetration.
Survivor	Any person who has been violated sexually and has lived through the experience.
Sexual Assault	One unlawfully penetrating the organs of another person with (i) any part of the body of another person or (ii) an object manipulated by another person or that person except where it is done for professional hygienic or medical purposes, (iii) manipulating any part of one's body or the body of another person so as to cause penetration of the genital organ into or by any part of the other person's body.
Incest	An indecent act or an act which causes penetration, done by a person to a relative such as a brother, a sister, a mother, a father, an uncle, a cousin or a grandparent.
Designated persons	These include all doctors, nurses and clinical practitioners registered under their various laws and acts of parliament.

Executive Summary

Sexual violence is a serious human rights issue and public health problem in Kenya and the world over. It has devastating effects on the lives of the survivors in terms of long-term consequences on their health and mental wellbeing. Survivors deserve to be supported, to be treated with dignity and respect, and to see their offenders brought to justice. This requires a comprehensive set of policies, legislations and programmes to effectively respond to these needs. Although various legislations, policies and service guidelines on sexual violence exist, the changes in the medico-legal environment and the emerging dynamics of sexual violence, as experienced following the post election violence in 2008, coupled with some gaps in the legal provisions and service guidelines have made it necessary to review sexual violence guidelines.

These guidelines have been designed to give general information about management of sexual violence in Kenya and focus on the necessity to avail services that address all the needs of a sexual violence survivor, be they medical, psycho-social and/or legal. The guidelines also cater for the needs of children owing to the fact that in many of the health facilities in Kenya, children comprise a significant percentage of the survivors of sexual violence. The guidelines single out all the aspects of child management that differ from those of adults and, where possible, this has been integrated into the content of the information being given in each section.

The guidelines outline the procedures relating to medical management of sexual violence including providing information about the first steps that are to be taken after meeting a survivor of sexual violence. The ethical issues, how to get a history and what every healthcare provider in every institution needs to know about management of the health related problems of sexual violence are highlighted.

The guidelines further provide information on the main psychological consequences of sexual violence and some counseling procedures including ethical considerations.

Forensic management which is essential in helping survivors access justice by ensuring availability of credible evidence that sexual violence indeed took place and help link the perpetrator to the crime is also elaborately covered in the guidelines. Information on appropriate collection and preservation of specimens has been elaborated upon as well as the need for proper documentation and the maintenance of the chain of evidence.

The guidelines further provide information on the humanitarian issues relating to sexual violence and how best to manage sexual violence in such conditions.

Quality assurance (QA) and Quality Improvement (QAQI) which are a core component of any service delivery are also covered in the guidelines.

Overview of Sexual Violence

Sexual violence is a serious human rights issue and public health problem in Kenya[1] and the health sector bears much of the economic burden of the violence through public financing and/or direct public expenditures. The Kenya Sexual Offences Act No 3 of 2006[2], (Revised Edition 2007), defines a sexual offence as that offence that is prescribed in the act. Sexual violence therefore would include acts such as rape (section 3), and attempted rape (section 4), defilement (section 8), attempted defilement (section 9), gang rape (section 10) indecent act (section 11 and 11A), sexual assault (section 5), incest by both males (section 20) and females (section 21), deliberate transmission of HIV and any other life threatening sexually transmitted diseases (section 26), sexual offences relating to positions of authority and persons in position of trust(section 24). Sexual violence has a profound impact on physical and mental health of the survivors. In addition to causing physical injury, it is associated with an increased risk of a range of sexual and reproductive health problems, with both immediate and long-term consequences.

Background to Review of Guidelines

The Kenyan government and other stakeholders in acknowledging the consequences of sexual violence have over the years developed responses that are captured in the legal and policy frameworks and programmatic interventions. The Division of Reproductive Health (DRH) of the Kenyan Ministry of Public Health and Sanitation- plans, implements and monitors programmes to promote the reproductive health of the Kenyan people. Her goal is to ensure provision of a comprehensive and integrated system of reproductive health care, through a range of services offered by the government, non-governmental organizations (NGOs), and the private sector. International human rights instruments and standards such as International Conference of Population and Development (ICPD) and the Millennium Development Goals, to which Kenya is a signatory, obligate governments to put in place measures to address sexual violence. Kenya recognises both constitutional and traditional legal systems of law, although Kenya's Constitution makes it clear that traditional laws shall not be applied where they are repugnant to 'justice and morality'[3]. Provisions of the law and the policy documents emanating from the specific sectors have gone a step further to domesticate the relevant international instruments such as the ICPD and MDGs, into usable guidelines that can inform service provision. These include the Sexual Offences Act, and the National Policy on Gender and Development.

Specifically for the health sector, the Reproductive Health Policy, arising from the second National Health Sector Strategic Plan (NHSSP II) has gone further to provide

1 National Reproductive Health Policy; Pg 16, Gender Issues, Sexual and Reproductive Rights

2 The SOA is an act of parliament (2006) whose foundation is the promotion and protection of one's rights. The act makes the provision for the prevention of the sexual offences and the protection of all persons from unlawful sexual acts.

3 Constitution of Kenya, Section 76

the policy framework from which specific guidelines have been developed. Kenya has national guidelines for the medical management of rape and sexual violence[4], a trainer's manual on clinical care for survivors of sexual violence (2007), and a trainer's manual for rape trauma counselors developed in November 2006. However, over the years, there have been new developments in forensic issues and in the medico-legal environment that have necessitated the review of these guidelines. The recent experience of the massive sexual assaults during the 2007/2008 post election violence has also further augmented the need to have appropriate guidelines that can inform the service providers in such circumstances. The gaps that have continued to exist in the legal frameworks as well as the service provision guidelines that govern the operations of the various institutions have also brought to the fore the need to review the guideline. These include the unclear distinction between the medical and the legal aspects of sexual violence as well as the largely ignored need for psycho-social support. Myths surrounding rape have also continued to hamper access to care by survivors of sexual violence. (Some of the more popularly held misconceptions about rape are summarized in the information for survivors in Annex 4). Prevailing myths affect the way in which the society responds to rape and rape survivors. When these myths go unchallenged, sometimes, rape is justified, and even condoned

It is against this background that the Ministry of Public Health and Sanitation and the Ministry of Medical Services collaborated with other stakeholders to develop comprehensive guidelines that can adequately respond to the complex and often diverse needs of sexual violence survivors and bridge the gaps that exist in legal frameworks and service provision guidelines that are in place.

The Guidelines seek to address the medical, psycho-social, legal and humanitarian aspects of sexual violence. The main goal is to ensure that the needs of survivors are addressed as much as possible.

4 National Guidelines for Medical Management of Rape and Sexual Violence (2004)

Medical Management

1 Introduction

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

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

General considerations

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

2 Obtaining Consent

Before a full medical examination of the survivor can be conducted, it is essential that informed consent is obtained by ensuring that the survivor fills the consent form. (See annex 1). In practice, obtaining informed consent means explaining all aspects of the consultation to the survivor. It is crucial that patients understand the options open to them and are given sufficient information to enable them to make informed decisions about their care. Particular emphasis should be placed on the matter of the release of information to other parties, including the police. This is especially important because there is a legal obligation to report an episode of sexual violence to the relevant authorities if the case is going to court. Examining a person without their consent could result in the medical officer in question being charged with offences of assault and trespass of their privacy. The results of an examination conducted without consent cannot be used in legal proceedings.

3 History Taking and Examination

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

Before starting the physical examination, take time to explain all the procedures to the survivor and why they are necessary. Give your survivor a chance to ask any questions. Allow the survivor to have a family member or friend present throughout the examination, if s/he so wishes. Throughout the physical examination, inform the survivor what you plan to do next and ask for permission. Always let the survivor know when and where touching will occur. Show and explain instruments and collection materials. Survivors may refuse all or parts of the physical examination and you must respect the survivor's decision. Allowing the survivor a degree of control over the physical examination is important for her/his recovery.

Both medical and forensic specimens should be collected during the course of the examination. Make sure that the survivor understands that she can stop the procedure at any stage if it is uncomfortable for her/him and give her/him ample opportunity to stop the examination, if necessary. Always address survivors' questions and concerns in a non-judgmental, emphatic manner. Use a calm tone of voice.

The findings of medical history, examination and sample collection should be carefully and precisely documented in the PRC form (annex 6 PRC Form).

3.1 History Taking for Adults

General history:

- Tell me about your general health.
- Have you seen a nurse or a doctor lately?
- Have you been diagnosed with any illnesses?
- Have you had any operations?
- Do you suffer from any infectious diseases?
- Do you have any allergies?
- Are you currently taking any tablets or medicine?

Gynaecological history:

- When was the first day of your last menstrual period?
- Had you had any sexual intercourse prior to this incident?
- Have you had any pregnancies?
- Do you use contraception? What type?
- Do you currently have a sexual partner?
- When did you have the last consented sexual intercourse?

3.1.1 Head to Toe Examination for Adults

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

- First note the survivor's general appearance and demeanour. Take the vital signs, i.e. pulse, blood pressure, respiration and temperature. Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
- Inspect the forearms for defence related injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body. Defensive injuries include bruising, abrasions, lacerations or incised wounds.
- The inner surfaces of the upper arms and the armpit or axilla need to be carefully observed for signs of bruising.
- Inspect the face and the eyes.
- Inspect the ears, not forgetting the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp.
- Gentle palpation of the scalp may reveal tenderness and swelling, suggestive of haematomas.
- The neck area is of great forensic interest. Bruising on the neck can indicate a life-threatening assault.
- The breasts and trunk should be examined with as much dignity and privacy as can be afforded.
- The survivor can then be reclined for an abdominal examination, which includes abdominal palpation to exclude any internal trauma or to detect pregnancy.
- With the survivor still in a reclined position, the legs should be examined in turn, commencing with the front of the legs.
- It is advisable, if possible, to ask the survivor to stand for the inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing. Any biological evidence should be collected with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibres, grass and soil).

3.1.2 The Genito-Anal Examination for Adults

Try to make the survivor feel as comfortable and as relaxed as possible.

- Explain to them each step of the examination. For example say, "I'm going to have a careful look. I'm going to touch you here in order to look a bit more carefully. Please tell me if anything feels tender."
- Examine the external areas of the genital region and anus, as well as any markings on the thighs and buttocks.
- Inspect the mons pubis; examine the vaginal vestibule paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum.

- Take a swab of the external genitalia before attempting any digital exploration or speculum examination Gently stretch the posterior fourchette area to reveal abrasions that are otherwise difficult to see.
- If any bright blood is present, gently swab in order to establish its origin, i.e. whether it is vulval or vaginal.
- Warm the speculum prior to use by immersing it in warm water.
- Insert the speculum along the longitudinal plane of the vulval tissues and then rotate it into its final position once the initial muscle resistance has relaxed.
- Inspect the vaginal walls for signs of injury, including abrasions, lacerations and bruising. Collect any trace evidence, such as foreign bodies and hairs if found.
- Suture any tears if indicated.
- Before removing the speculum, do a warm saline vaginal wash.

3.2 History Taking and Examination for Children

General approach:

- Always ensure patients privacy;
- Approach all children with extreme sensitivity and recognize their vulnerability;
- Try to establish a neutral environment and rapport with the child before beginning the interview;
- Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions. It is important to realize that young children have little or no concept of numbers or time and that they may use terminology differently from adults making interpretation of questions and answers a sensitive matter;
- Stop the examination if the child indicates discomfort or withdraws permission to continue;
- Always prepare the child by explaining the examination and showing equipment; this has been shown to diminish fears and anxiety;
- Encourage the child to ask questions about the examination;
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination. Some older children may choose a trusted adult to be present;
- Always identify yourself as a helping person;
- Ask the child if s/he knows why s/he has come to see you;

- Establish ground rules for the interview, including permission for the child to say s/he doesn't know, permission to correct the interviewer, and the difference between truths and lies;
- Ask the child to describe what happened, or is happening, to them in their own words (where applicable);
- Always begin with open-ended questions. Avoid the use of leading questions and use direct questioning only when open-ended questioning/free narrative has been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity;
- Consider interviewing the caretaker of the child without the child presence.

Before proceeding, ensure that consent has been obtained from the child and/or the caregiver. If the child refuses the examination, it would be appropriate to explore the reasons for the refusal. Consider examining very small children while on their mother's (or carer's) lap or lying with her on a couch. If the child still refuses, the examination may need to be deferred or even abandoned. **Never force the examination**, especially if there are no reported symptoms or injuries, because findings will be minimal and this coercion may represent yet another assault to the child. Consider sedation or a general anaesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.

3.2.1 History Taking for Children

History-taking is distinct from interviewing the child about allegations of sexual abuse. Ideally, history should be obtained from a caregiver, or someone who is acquainted with the child, rather than from the child directly; however, this may not always be possible. Nonetheless, it is important to gather as much medical information as possible. Older children, especially adolescents are often shy or embarrassed when asked to talk about matters of a sexual nature. It is a good idea to make a point of asking whether they want an adult or parent present or not; adolescents tend to talk more freely when alone.

When gathering history directly from the child, start with a number of general, non-threatening questions before moving on to cover the potentially more distressing issues.

- "What grade are you in at school?"
- How many brothers and sisters do you have?"

The following pieces of information are essential for medical history:

- When do you say this happened?
- When is the first time you remember this happening?
- Threats that were made?
- What area of your body did you say was touched or hurt?
- Do you have any pain in your bottom or genital area?
- Is there any blood in your panties or in the toilet?
- Any difficulty or pain with voiding or defecating?
- First menstrual period and date of last menstrual period (girls only)?
- Details of prior sexual activity (explain why you need to ask about this).
- History of washing/bathing since assault.

3.2.2 Head to Toe Examination for Children

The physical examination of children can be conducted according to the procedures outlined for adults in section 3.1.1 (Head to toe examination for adults). When performing the head-to-toe examination of children, the following points are important:

- Record the height and weight of the child;
- In the mouth/pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum;
- Record the child's sexual development and check the breasts for signs of injury.

3.2.3 The Genito-Anal Examination for Girls

Remember that in most cases, a speculum exam is not indicated. It is only indicated when the child may have internal bleeding arising from a vaginal injury as a result of penetration.

- In this case, a speculum examination should be done under general anaesthesia;
- Examine the anus. Look for bruises, tears or discharge. Help the child lie on her back or on her side;
- The child may need to be referred to a higher level health facility for this procedure;
- For small girls, a paediatric speculum is recommended.

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

3.2.4 The Genito-Anal Examination for Boys

- Check for injuries to the skin that connects the foreskin to the penis;
- Check for discharge at the urethral meatus (tip of penis);
- In an older child, the foreskin should be gently pulled back to examine the penis. Do not force it since doing so can cause trauma, especially in a young child;

- Examine the anus. Look for bruises, tears, or discharge. Help the boy to lie on his back or on his side. The boy should not be placed on his knees as this may be the position in which he was violated;
- Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

The comments made about the collection of medical and forensic specimens in adults apply equally to children.

4. Investigations

4.1 Investigations for Clinical Management of the Survivor

Basic investigations to know the general condition of the survivor will include urine specimens and blood tests as indicated below.

- Urine
  - Urinalysis – microscopy
  - Pregnancy test

- Blood
  - HIV Test
  - Haemoglobin level
  - Liver Function Tests
  - VDRL

4.2 Investigations Carried Out for Evidence Purposes

- Urine analysis for epithelial cells;
- High vaginal swab for evidence of spermatozoa.

The health worker should collect the specimen, preserve it for appropriate storage and hand it over to the police for further investigations and processing in the courts. Relevant information on the investigations for providing evidence is available in Chapter Four.

5. Management of Physical Injuries

Post traumatic vaccination with tetanus toxoid

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

Where any physical injuries result in breach of the skin and mucous membranes, immunize with 0.5mls of tetanus toxoid according to the revised schedule demonstrated in the table below.

Table 2: Tetanus toxoid schedule

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 TT dose	6 months after 2nd TT	5 years
4th TT dose	1 Year after 3RD TT	10 years
5th TT dose	1 Year after 4th TT	20 years

Tetanus toxoid should be given to all survivors of sexual violence (all sexes and all ages) if there are any physical injuries of the skin and/or mucous membranes.

6. Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) for HIV is the administration of a combination of anti-retroviral drugs (ARV's) for 28 days after the exposure to HIV that has to be started within 72 hours after the assault.

Drugs for PEP for HIV: These guidelines make recommendations for the use of duo therapy (i.e. two ARV drugs) for 28 days. PEP is recommended for men, women, girls and boys at risk of HIV infection. Significant risk involves oral, vaginal and/or anal penetration.

The 2004 National ARV guidelines suggest offering 2 ARV's for PEP. The WHO/ILO PEP guidelines also recommend duo therapy (WHO, 2007).[5]

6.1 Timing of PEP for HIV

The efficacy of PEP decreases with the length of time from exposure to the first dose, therefore administering the first dose is a priority. **People presenting later than 72 hours after assault should be offered all other aspects of post rape care, but not PEP.**

6.2 Blood Monitoring for PEP

Baseline Haemaglobin should be taken within 3 days of starting PEP, and ideally be repeated at 2 weeks, because of the potential for ARV induced bone marrow suppression.

Ideally SGPT/ALT and Creatinine should also be checked at baseline and the SGPT repeated at 2 weeks, but the inability to do these tests should not prevent an individual from receiving PEP if otherwise indicated.

At Baseline:

If the Hb < 6.5 mg/dl, SGPT > 175 U/l or Creatinine > 3.0 mg/dl (300) then PEP should not be continued without discussion with a senior clinician experienced in the use of ARV's, as the risks may outweigh the potential benefits in some circumstances.

At 2 weeks:

If there is a significant fall in the Hb or an increase in SGPT compared to the baseline values, then PEP should not be continued without discussion with a senior clinician as above.

5 World Health Organization and International Labour Organization, 2007. Post-exposure prophylaxis to prevent HIV infection: Joint WHO/ ILO Guidelines on Post-exposure Prophylaxis (PEP) to Prevent HIV Infection. WHO Press, Geneva, Switzerland.

6.3 Recommended PEP Regimens for Adults

	Medicine	Application
first line	AZT + 3TC: Zinovudine: 300 mg Lamuvidine 150 mg	Twice a day for 28 days
second line	D4T + 3TC: Stavudine 40 mg (only if a fridge is available) Lamuvudine: 150 mg	Twice a day for 28 days

Fixed Dose Combinations, where the above combinations of drugs are combined into one tablet, should be used if available. This reduces the number of pills taken and so increases compliance to treatment.

6.4 Recommended PEP Regimens for Children

For children, the same drugs are used but the doses must be given according to weight and/or surface area. Both syrups and tablets can be used.

6.4.1 Syrup based regimen for children

	Medicine	**Application**
first line	AZT + 3TC: Zinovudine: 2 mg/kg Lamuvidine 4 mg/kg	Twice a day for 28 days
second line	D4T* + 3TC: Stavudine: 1 mg/kg (only if a fridge is available) Lamuvidine: 4 mg/kg	Twice a day for 28 days

If syrups are available, then more precise dosing is possible. The exact dose can be calculated from the weight and/or surface area, and this should certainly be done for children less then 10kg.

*D4T liquid requires refrigeration so is not appropriate unless the carers have a fridge

6.4.2 Tablet based regimen for children

Syrups are the recommended regimens. However, in situations where syrups may not be available, regimens using tablets have been developed based on weight bands.

Weight Band	Dose AZT	Dose 3ZT
10-20 kg	100 mg 3 times a day	1/2 x 150 mg tab twice a day (75 mg)
20-40 kg	2 x 100mg twice a day	1 x 150 mg tab twice a day (150 mg)
> 40 kg	Adult regime	Adult regime

Weight Band	Dose D4T	Dose 3ZT
10-14 kg	1 x 15 mg cap twice a day	1/2 x 150 mg tab twice a day (75 mg)
15-19 kg	1 x 20 mg cap twice a day	1 x 150 mg tab twice a day (150 mg)
20-60 kg	30 mg cap (or adult FDC)	Adult regime

6.5 Side Effects of PEP

Common Side effects are:

- Nausea;
- Headaches;
- Tiredness;
- General aches and pains.

Patients taking PEP should be forewarned about these side-effects and prepared on how to deal with them. They should for instance be informed that they can reduce the intensity by taking the pills with food. Side-effects usually diminish with time and do not cause any long-term damage. The purpose of the laboratory monitoring is to pick up the more dangerous side-effects, but these are extremely rare in patients taking ARV's for only one month.

7. Pregnancy Prevention

Emergency Contraception (EC) should be readily available at all times including beyond working hours (i.e. in casualty), and free of charge in all Government Health Institutions where women and/or girls are likely to present after being raped or defiled.

- EC can be given up to 120 hours after rape or defilement;
- EC should be given to 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 is not a form of abortion.

Options for Emergency Contraception

Progestin only pills	Postinor 2	1-tabs 12 hours apart (total 2 tabs) or 2-tabs at a go
Combined oral contraceptive pills with high dose of oestrogen (50µg)	Oral	2-tabs 12 hours apart (total 4 tabs)
Combined oral contraceptive pills with low dose of oestrogen (30µg)	Nordette	4-tabs 12 hours apart (total 8 tabs)

Ideally, an anti-emetic should be given about 30 minutes before: Plasil 10mg stat., then as needed.

Note

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

A follow up pregnancy test at six weeks should be offered to all women who return for follow up, regardless of whether they took EC after the rape or not. If they present with a pregnancy, which they feel is as a consequence of the rape, they should be informed that in Kenya, termination of pregnancy may be allowed after rape (Sexual Offences Act, 2006). If the woman decides to opt for termination, she should be treated with compassion, and referred appropriately.

8. Prophylaxis of Sexually Transmitted Infections

STI prophylaxis should be offered to all survivors of sexual violence. It needs not to be given at the same time as the initial doses of PEP and EC as the pill burden can be intolerable. It should preferably be prescribed for the survivor and given for uptake within 24hours.

The HVS performed at presentation is done for forensic reasons and not to screen for STIs and/or guide antibiotic administration. People with a “normal” HVS should still be offered STI prophylaxis.

Drugs used for STI Prophylaxis

Non-pregnant adults male or female	Norfloxacin	800 mg Stat
	Doxycycline	100mg BD one week
Pregnant woman	Spectinomycin	2g Stat
	Amoxycillin + Probenicid	3g Stat 1g Stat
	Erxthromycin	500mg QDS one week
Children	Amoxycillin	15mg/kg TDS one week
	Erythromycin	10mg/kg QDS one week

9. Hepatitis B Prevention

The generally available Hepatitis B Vaccines do not provide any protection from infection if given after an exposure (e.g.: sexual assault), but they do provide protection from future exposures. It is much less costly to vaccinate all survivors of rape/sexual violence, rather than to test everyone for Hepatitis B antibodies to see who might benefit. Ideally, if Hepatitis B Vaccines is available, it should be considered for survivors of sexual violence according to the revised schedule in the table below.

Dosing Schedule	Administration Schedule	Duration of Immunity Conferred
1st Hep B dose	At first contact	Nil
2nd Hep B dose	1 month after 1st Hep B dose	1-3 years
3rd Hep B dose	5 months after 2nd Hep B dose	10 years

10. Medical Management of Adult Male Survivors of Sexual Violence

Men most commonly experience sexual violence in the form of:

- Receptive anal intercourse;
- Forced masturbation of the perpetrator;
- Receptive oral sex;
- Forced masturbation of the victim.

Male survivors of sexual violence should be triaged in the same manner as female victims.

The same procedures for obtaining consent, taking a history, conducting the physical examination (although the genital examination will be different) and ordering diagnostic laboratory tests should be followed, that is:

- Perform a top-to-toe examination looking for any signs of injury;
- Conduct a thorough examination of the genito-anal area;
- Treat any injuries (men also need to be treated for STIs, hepatitis B and tetanus).

Men should be informed about, and offered, a HIV test and the option of post-exposure prophylaxis, if available. Men should receive follow-up care for wound healing, any prescribed treatments (including those for STIs), completion of medications and counseling.

11. Medical Management of Perpetrators of Sexual Violence

In the event a medical practitioner finds him or herself confronted with a perpetrator in need of medical treatment, the practitioner should accord the perpetrator the necessary treatment as they (perpetrators) too have the right to medical treatment to ensure they access prophylaxis for HIV/AIDS and STIs and management of physical injuries (Sexual Offences Act 2006). The treatment of perpetrators should be the same as for the survivors including collection of forensic specimens and counseling.

Psycho-Social Support

1. Introduction

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

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

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

2. Survivor-Centred Approach to Counseling

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

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

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

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

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

3. Counseling Different Groups Affected by Sexual Violence

Male Survivors of Sexual Violence

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

Children Survivors of Sexual Violence

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

Persons with Disabilities - Survivors of Sexual Violence

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

Perpetrators of Sexual Violence

Counselors need to be aware of their own fears about how they would counsel a suspected perpetrator. When a perpetrator enters the clinic escorted by police or a relative, the counselor will let them know that everything discussed between them (counselor and the perpetrator) is confidential and the counselor is not under obligation to disclose any test results, except when the counselor is required to do so by law.

4. Core Conditions Essential to a Productive Counseling Session

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

5. Obtaining Informed Consent

The counselor should obtain written consent from the survivor before starting any sessions. If the survivor is below the age of 18, parental or guardians consent is required.

6. The Counseling Environment

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

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

7. Types of Counseling

- Trauma counseling and psycho-education;
- EC counseling and unwanted pregnancies;
- Pre-and post-test HIV counseling;
- Adherence counseling for Post exposure prophylaxis (PEP) for HIV and other STIs;
- Follow-up sessions;
- Psychosocial support for groups and the community;
- Information on survivors' rights, including legal care.

7.1 Trauma Counseling and Psycho-Education

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

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

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

7.2 Counseling Related to the Possibility of a Pregnancy

Emergency Contraception

The counselor should explain that after EC is provided, there is still a risk of pregnancy. The later EC is taken, the higher the risk of a pregnancy.

Pregnancy Counseling

The counselor should educate the pregnant survivor on short and long term consequences of unwanted pregnancy after rape. The survivors should be given information on child adoption or termination of pregnancy as available options (Termination of pregnancy is allowed in Kenya after rape. It however requires psychiatric evaluation and recommendation [Sexual Offences Act 2006]). In case the woman decides to terminate the pregnancy, counseling is necessary before and after termination of the pregnancy to prevent long term consequences of the pregnancy termination.

7.3 Counseling Related to Possible STIs Including HIV Infection

HIV Pre- and Post-Test Counseling

Counseling procedures should follow the established National HIV testing Guidelines. While the counselor may provide information to the survivor, the survivor may not be in a position to pay careful attention to the information given to her/him because s/he is highly traumatized. Therefore, it is essential for the counselor to clarify the survivor's understanding of the information provided.

Pre-Test Counseling

The pre-test session introduces basic HIV-information. The benefits of taking HIV-test should be explained. The implications of HIV test results if positive or if negative and the HIV testing process should be explained. Then the survivor should be offered the test on site or taken to the appropriate site for testing.

The window period between the time of exposure to HIV and testing positive for HIV is approximately 6-weeks. It is possible that a person will show a HIV negative result when tested but can transmit the virus during this period. It is therefore important to discuss previous risks and the possibilities of HIV infection prior to the rape.

Post-Test Counseling

It should be remembered that PEP only reduces the risk of infection and does not definitively prevent HIV infection. This needs to be communicated to the survivor at the beginning of counseling. Many survivors cannot understand why if they are HIV negative they are given HIV drugs, whereas if the test is positive these drugs are stopped. Subsequent counseling sessions should be booked to coincide with PEP clinical follow ups. Communicate and show the HIV test results to the survivor and explain appropriate follow up steps. Counselor should be aware of the survivor's reaction and advise appropriately.

- **If positive**: The counselor should refer the survivor to a facility where s/he can access the following information and services: HIV literacy and psychosocial support; Clinical assessment; Management of common opportunistic infections (OIs); Provision of cotrimoxazole prophylaxis; Antiretroviral treatment; Provision of condoms; PMTCT including family planning and infant feeding; TB screening and referral; Malaria prevention and treatment; STI management; Palliative care and symptom management; Safe drinking water interventions.
- **If negative**: The counselor will ensure the following take place: Prevention counseling; Partner testing and disclosure; Emotional support; Referral to additional prevention services as needed e.g. Male circumcision; Needle exchange for injecting drug users (IDUs); Condoms education and distribution; Post-exposure prophylaxis (PEP). Safe sex information and condoms should also be provided appropriately.

Adherence counseling

Effective counseling has been shown to increase adherence. The counselor should explain the side effects of the HIV prophylaxis since it can be very difficult to tolerate. Survivors should be forewarned and counseled about how to manage the side effects and to contact the clinic if required. Survivors should be counseled on the need to complete their treatment and informed of the health consequences of STIs.

7.4 Follow-up Sessions and Other Useful Information for Survivor

Counselors should emphasize on the importance of follow-up care and the options for follow-up should be discussed.

Psycho-social Support for Groups within Families and the Community

Group counseling should be one type of ongoing support for survivors. It helps to process trauma in a collective way and creates supportive coping mechanisms. Families need to be counseled and given relevant information to enable them help the survivor cope and heal. The counselor should refer the case to an appropriate professional or agency that is skilled in this area.

Community support should address the causes and consequences of violence, what to do if raped or violated (including preservation of evidence), what to expect in the health facility and prevention measures of sexual violence. Raising awareness around children's and women's rights is important while decreasing the stigma associated with sexual violence.

Information on Survivor's Rights Including Legal Care

Counselors are in a key position to provide information on survivor's rights and access to legal justice. Referrals should be made as appropriate.

Procedures for Reporting to the Police

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

What the Survivor Should Expect at the Police Station

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

Referrals

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

7.5 Counseling and Support Supervision

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

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

1. Introduction

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

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

Definitions

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

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

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

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

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

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

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

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

2. Types of Evidence

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

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

Locard's exchange principle

States that, every contact leaves a trace.....

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

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

Forensic materials that can be collected include but not limited to:

- Suspect's material deposited on an object, e.g. Cigarette butt;
- Suspect's material deposited at a location;
- Victim's material deposited on the suspect's body or clothing;
- Victim's material deposited on an object;
- Victim's material deposited at a location;
- Witness' material deposited on a victim or suspect;
- Witness material deposited on an object or at a location.

3. Exhibit Management and Preservation of Evidence

3.1 Exhibit Management

The following practices must be followed when handling an exhibit:

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

3.2 Collection and Handling of Specimen

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

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

Collect early: Try to collect forensic specimens as soon as possible. The likelihood of collecting evidentiary material decreases with the passing of time. Ideally, specimens should be collected within 24 hours of the assault; after 72 hours, yields are reduced considerably. Collect the same before requiring the victim to bathe.

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

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

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

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

Table 3: Possible specimens, methods of preservation, tests and purpose of test

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

Note:

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

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

Handling Exhibits

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

4. Chain of Custody of Evidence

4.1 Chain of Evidence

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

4.2 Documentation and Reporting

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

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

4.3 The Post Rape Care (PRC) Form

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

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

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

4.4 The Kenya Police Medical Examination P3 Form

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

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

1 Introduction

Understanding gender vulnerabilities in conflict situations

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

During armed conflict, women and girls are particularly vulnerable to all forms of sexual violence[6]. Vulnerability to exploitation and abuse by virtue of their age and gender is further increased by conflict and the prevailing humanitarian and security conditions. This chapter highlights the vulnerability factors to sexual violence in conflict situations. The chapter further highlights kinds of interventions to be undertaken during crisis situations including the types of services required in addressing the needs of sexual violence survivors in such situations.

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

Today's armed conflicts mostly occur within state borders and typically drag on for years, even decades. Multi-causal in nature, these crises are typically "highly politicized" and "frequently associated with non-conventional warfare". National accountability mechanisms are characteristically absent or severely weakened[7], which consequently gives rise to a climate of impunity for perpetrating all sorts of crimes. These conflicts tend to affect the civilian sphere, regardless of growing international emphasis on the protection of civilians in conflict situations.

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

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

Understanding the nature of today's conflicts

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

Civilians are affected accidentally as they are not well distinguishable from combatants. They may be intentionally targeted because "the goal of warfare is not simply the occupation and control of territory – it is about destroying the identity and dignity of the opposition". One of the strategies to achieve this goal is by targeting women's sexuality and reproductive capacity. Sexual violence, therefore, not only causes individual physical and psychological ill health and social exclusion, but uproots families and communities and contributes to the moral and physical destruction of society[8]. In the absence of governmental programmes to mitigate the impacts of sexual violence, humanitarian organizations play a big role in caring for rape survivors.

3. Minimum Set of Interventions in Crisis Situations

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

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

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

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

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

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

For effective short and long-term protection from sexual violence for women and girls in Kenya, interventions must take place at three levels in order that structural, systemic and individual protections are institutionalized[9].

Levels of interventions

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

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

4. The Need for Collaboration

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

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

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

Minimal services needed

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

5. Specific Responsibilities for the Health Sector

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

The health care provider's responsibility

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

Quality Assurance and Quality Improvement

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

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

Minimum Standards for Providing Comprehensive PRC in Health Facilities

	Minimum Standards for Medical management of survivors	Reporting/recording requirements for health facilities	Minimum capacity requirements at health facilities
All health facilities without a laboratory (public and private)	Manage injuries as much as possible Detailed history, examination and documentation (refer for HVS, PEP/EC, STI)	Fill in PRC form in triplicate Maintain PRC register Please ensure that the survivor has a copy of the PRC form and takes it to the laboratory	A trained nurse
All health facilities with a functioning laboratory (public and private)	Manage injuries as much as possible Detailed history, examination and documentation (including HVS) Ideally, 1st doses of PEP/EC should be provided (even where follow up management is not possible) Where HCT services are available, provide initial counseling	Fill in PRC form in triplicate Maintain a PRC register Maintain a laboratory register Referral to comprehensive post rape care facility	A trained nurse and/or a clinical officer A trained counselor (where counseling is offered)

	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 a comprehensive care clinic (CCC) where ARV can be monitored (comprehensive post rape care facilities can be provided) (private and public health facilities)	Manage injuries as much as possible Detailed history, examination and documentation Provide emergency and ongoing management of PEP Provide EC Provide STI prophylaxis or management Provide counseling for trauma, HIV testing and PEP adherence	Fill in PRC form in triplicate Maintain PRC register Maintain a laboratory PRC register Fill in PRC form to follow up management of survivors	1 medical or clinical officer trained in ARV/ PEP management 1 trained counselor (trauma, HIV testing and PEP adherence counseling) Laboratory for HIV and HB testing Preservation of sperms from HVS specimen

Annexes

Consent form

Name of Facility

Note to the health worker: 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)

authorize the above-named health facility to perform the following (tick the appropriate boxes):

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

Signature……

Date……

Witness……

Annex 2: Post Rape Care Form (PRC)

Day	Month	Year	Province Code	District Code	OP / IP No.

Last Name	First Name	Date of birth	Date	Month	Year	Male / Female

Contacts (Physical Address and Phone number)

Date and time of Examination	Date and Time of Assault	No. of Assailants

Alleged Assailants (Indicate relation to victim)	Unknown	Known

Place Assault Occurred

Chief complaints / Presenting Symptoms

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

Type pf Assault	Use of condom?	Incident already reported to police?
Oral	Yes	Yes (indicate which station and when)
Vaginal	No	No

Anal	Attended a health facility before this one?	Where you treated?	Were you given any notes?
Other sex	No	Yes	Yes
	Yes (indicate which one and when)	No	No

Comments

Significant medical and/or surgical history

OBS /GYN History	Parity	Contraception type	LMP	Known Pregnancy? Yes	Known Pregnancy? No	Date of last consensual sexual intercourse

General Condition	BP	Pulse Rate	RR	Temp	Demeanor /Level of anxiety (calm or not)

Psychological Assessment (Should be done by: -Psychiatrists, Medical Doctors, Psychologists, Psychiatry-trained nurses, Psychiatry social workers or Counseling psychologists of repute)

PSYCHOLOGICAL ASSESSMENT

PREMORBID HISTORY (state the mental condition of survivor prior to assault)

_____

_____

Mental Status Evaluation *(Tick as appropriate)*

- **Appearance (**kempt, unkempt, other)(specify)_____

- **Behaviour** (appropriate, restless, calm, absent mindedness, other) (specify)_____

_____

- **Mood** (low, excited, depressed, tense, irritable, tearful, anxious, angry, other)_____
- **Speech** (flow, tone, amount)(specify)_____ –
- **Perception** (hallucinations, illusions, derealization, depersonalization, dissociation, other) (specify) (specify)_____
- **Thought** (Preoccupation, Stream of thought, suicidal thoughts, helplessness, hopelessness, worthlessness, odd beliefs, flashbacks, specific fears e.g.. of open places, enclosed spaces, men, women, adults, strangers, other) (specify)_____

Diminished capacity to enjoy life_____

- **Cognitive Disturbance** (Orientation in time, place, person, Level of attention, Concentration (use serial seven subtractions

_____

Memory: short term _____, long term _____

Judgement_____

Insight – does the survivor understand what happened to her/him, possible consequences, any legal implications, any wishes of the survivor?

Diagnosis:

_____

FOR CHILD SURVIVORS:

Evaluate behaviour, mood and speech as above but use the following to evaluate thought:-

- Drawing – allow child to draw (e.g...) family members and let her/him comment on the drawing. report verbatim.

  _____
  _____
  _____

- Play – by use of toys and dolls allow child to give comments on the play and report verbatim.

  _____
  _____
  _____

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

    _____
    _____
  - Wishes (let child state her/his wishes)

    _____
    _____

Diagnosis

_____
_____
_____

Forensic

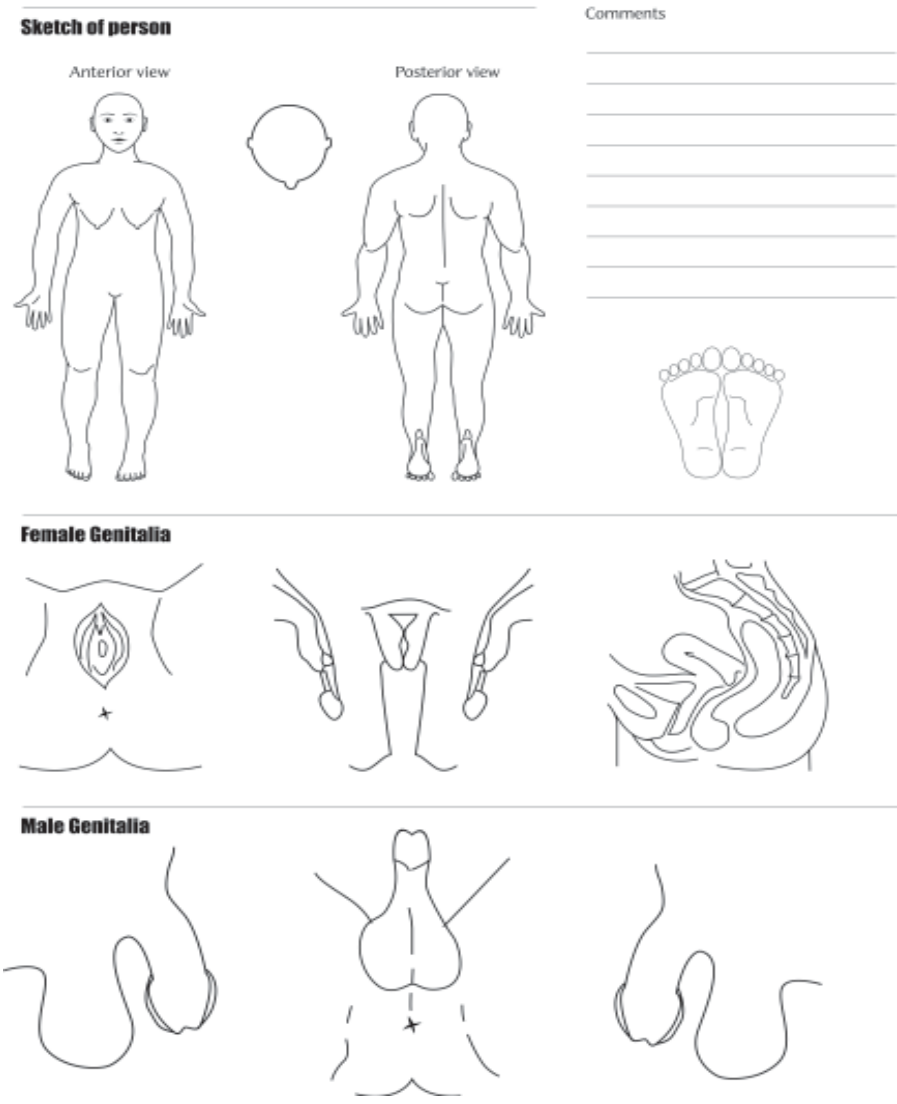
Did the survivor change clothes?		State of clothes (stains, tears, colour, etc)			
Yes	No				
Were the clothes put in a non-plastic paper bag?		Were the clothes given to the police?		Did the police sign the rape register at the health facility?	
Yes	No	Yes	No	Yes	No
Did the survivor have a bath?		Did the survivor go to the toilet?			
Yes	No	Long call?		Short call?	
Comments:					

Does the survivor have any details on the assailant? Is the assailant known, is there	Yes
any relation? Did the survivor leave any marks on the assailant?	No

General Examination	Describe in detail the physical status Physical injuries (sign in the body map) DOuter genitalia Vagina/hymen Anus Other significant orifices

Physical examination [indicates sites and nature of injuries, bruises and marks outside the genitalia]

Please use the sketches below to indicate injuries, inflamations, marks on various body parts of the survivor



Other Comments from the examination								
Diagnosis/impression								
Immediate Management	PEP 1 doses		EC given		Stitching /surgical toilet done		STI treatment given	
	No	Yes	No	Yes	No	Yes	No	Yes
	No. of tablets		which EC		Comment		Comment	
Any other treatment / Medication given /management?								

Referrals to	Police Station
	VCT/DTC
	Laboratory
	OPD/CCC/HIV clinic
	Trauma counselor?
	Other (specify)

Name of Examining Medical/clinical/Nursing Officer	Signature of Examining Medical/clinical/Nursing Officer	Date

Laboratory Samples Lab	Sample Type	Test	Please tick as is applicable		Comments
			National government Lab	Health Facility Lab	
	Genital - Anal - Skin - Oral swabs Specify	Sperm			
		DNA			
		Culture and sensitivity			
	High vaginal swab	Sperm			
	Urine	Pregnancy Test			
		Microscopy			
		Drugs and alcohol			
		Other			

b o r a tory s a m pl es	Blood	Haemoglobin			
		HIV Test			
		SGPT/GOT			
		VDRL			
		DNA			
	Pubic Hair	DNA			
	Nail clippings	DNA			
	Foreign bodies				
	Other (specify)				

Chain of custody

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

To	Police Officer's Name	signature	Date
By	Medical/clinical/Nursing Officer's Name	signature	Date

Annex 3: P3 Form

This P3 Form is free of charge

THE KENYA POLICE P3

MEDICAL EXAMINATION REPORT

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

From_____Ref_____

_____Date_____

To the_____Hospital/Dispensary

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

Name_____Age_____(If known)

Address_____.

Date and time of the alleged offence_____

Sent to you/Hospital on the_____20_____

Under escort of_____

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

Date and time report to police_____

Brief details of the alleged offence

_____

_____

_____

_____

Name of Officer Commanding Station Signature of the Officer Commanding Station

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

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

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

Medical Officer's Ref. No._____

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

_____

_____

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

_____

_____

_____

_____

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

_____

_____

This P3 Form is free of charge

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

COMPLETION OF SECTION "A"

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

a) Head and neck

_____

_____

b) Thorax and Abdomen.

_____

_____

c) Upper limbs

_____

_____

d) Lower limbs

_____

_____

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

3. Probable type of weapon(s) causing injury

4. Treatment, if any, received prior to examination

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

DEFINITIONS:-

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

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

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

Name & Signature of Medical Officer/Practitioner_____

Date_____

This P3 Form is free of charge

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

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

1. Nature of offence_____Estimated age of person examined_____

2. FEMALE COMPLAINANT

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

_____

_____

_____

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

_____

_____

3. MALE COMPLAINANT

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

_____

_____

c) Describe in detail injuries to anus

_____

_____

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

_____

_____

This P3 Form is free of charge

SECTION "D"

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

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

_____

_____

_____

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

_____

_____

_____

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

_____

_____

_____

6. Any additional remarks by the doctor

_____

_____

_____

Name & Signature of Medical Officer/Practitioner_____

Date_____

Annex 4. SV Community Awareness Info Pack

What is rape?

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

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

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

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

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

What should I do if I am raped?

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

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

At the hospital you will get:

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

What should I NOT do if I am raped?

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

Do not destroy or wash your clothing. Wrap them in a newspaper or brown paper bag

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

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

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

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

What happens at the hospital?

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

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

What treatment do I need if I have been raped?

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

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

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

Drugs to prevent pregnancy (emergency contraception).

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

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

You will also be referred:

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

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

Tests to be done right away include;

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

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

Tests to be done later include:

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

HIV test

Why do I need a HIV test?

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

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

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

Do not stop PEP without consultation with your clinician/doctor

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

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

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

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

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

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

What if I tested HIV positive?

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

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

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

What if I choose to report to the police?

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

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

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

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

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

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

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

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

What are my likely reactions to rape?

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

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

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

Some people may also experience:

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

What are my rights as a survivor of sexual violence?

You have a right to:

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

Myths and facts about rape

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

Annex 5. SV Counseling Form

SEXUAL VIOLENCE - TRAUMA COUNSELING DATA FORM

Date: ☐☐☐☐☐☐☐☐

Facility Name: _____

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

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

(For children)

Phone Number: _____

Serial No. or OP/IP No.: _____

DATE:

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

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

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

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

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

RAPE TRAUMA COUNSELING DATA FORM

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

Annex 6. PRC Register

		Name	Age	Sex	Date and Time of alleged assault		Seen by (CO)	P3 filled	Police officer	Forensic Examination	Given 1st dose of		Referred to				Signature of person filling the form	Comments
Date	Time				Date	Time			Signature	Assault type (Insert card no.)	ECP	PEP	VCT / DCT	PEP Follow up	STI	LAB		

Annex 7. Information on Mental Assessment Examination

- **General appearance**: Note appearance, gait, dress, grooming (neat or unkempt), posture, appear older or younger than stated age?
- **Motoric behavior**: Level of activity: Psychomotor agitation or psychomotor retardation, emotional appearance – anxious, tense, panicky, bewildered, sad, unhappy; voice – faint, loud, hoarse; eye contact.
- **Attitude during interview**: How survivor relates to examiner – irritable, aggressive, seductive, guarded, defensive, indifferent, apathetic, cooperative, sarcastic.
- **Mood:** Steady or sustained emotional state – gloomy, tense, hopeless, ecstatic, resentful, happy, bashful, sad, exultant, elated, euphoric, depressed, apathetic, anhedonic, fearful, suicidal, grandiose, nihilistic.
- **Affect**: Feeling tone associated with idea – labile, blunt, appropriate to content, inappropriate, flat.
- **Speech**: Slow, fast, pressured, garrulous, spontaneous, taciturn, stammering, stuttering, slurring, staccato. Pitch, articulation, aphasia, coprolalia, echolalia, incoherent, logorrhea, mute, paucity, stilted.
- **Perceptual disorders:** Hallucinations - olfactory, auditory, haptic (tactile), gustatory, visual; illusions; hypnopompic or hypnagogic experiences; feeling of unreality, déjà vu deja entendu, macropsia.
- **Thought content:** Delusions – persecutory (paranoid), grandiose, infidelity, sensory, thought broadcasting, thought insertion, ideas of reference, ideas of unreality, phobias, obsessions, compulsions, ambivalence, autism, dereism, blocking suicidal or homicidal preoccupation, conflicts, nihilistic ideas, hypochondriasis, depersonalization, derealization, flight of ideas, idée fixe, magical thinking, neologisms.
- **Thought process**: Goal-directed ideas, loosened associations, illogical, tangential, relevant, circumstantial, rambling, ability to abstract, flight of ideas, clang associations, perseveration.
- **Sensorium**: level of consciousness – alert, clear, confused, clouded, comatose, stuporous; orientation to time, place, person, cognition.
- **Memory:** Remote memory (long-term memory); past several days, months, years.
- **Recent memory** (short term): recall of events in past day or two.
- **Immediate memory** (very short-term memory): Laying down of immediate information with ability to quickly recall data.

- **Concentration and calculation**: ability to pay attention; distractibility; ability to do simple math.
- **Information and intelligence**: use of vocabulary; level of education; fund of knowledge.
- **Judgment:** Ability to understand relations between facts and to draw conclusions; responses in social situations.
- **Insight level**: realizing that there are physical or mental problems; denial of illness, ascribing blame to outside factors; recognizing need for treatment.

Annex 8. Useful Resources

General information

- Guidelines for medico-legal care for victims of sexual violence, World Health Organization 2003, (http://www.who.int/violence_injury_prevention/publications/violence/med_leg_guidelines/en/inde)
- Clinical Management of Survivors of Rape. A Guide to the Development of Protocols for Use in Refugee and Internally Displaced Person Situations, World Health Organization 2005, (http://www.unhcr.org/refworld/docid/403b79a07.html)
- Download guidelines for management of sexual violence of Kenya (2003) (http://www.liverpoolvct.org/index.php?PID=172&showsubmenu=172)
- Family planning Guidelines for service providers 2005(http://www.maqweb.org/iudtoolkit/policies_guidelines/kenyafpguidelines.pdf)
- Community Practices post sexual Violence Implications on the uptake of services and the implementation of care (http://www.aidsportal.org/repos/COMMUNITY%20RESPONSES%20TO%20SEXUAL%20VIOLENCE.pdf)

Information on sexually transmitted diseases

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

Information on post-exposure prophylaxis (PEP) of HIVinfection

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

Information on psychosocial issues

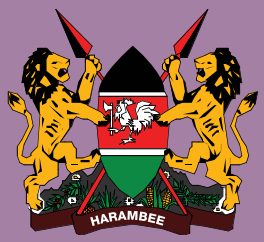
- Campbell R. Mental health services for rape survivors: issues in therapeutic practice. Violence Against Women Online Resources, 2001:1–9 (http://www.vaw.umn.edu/documents/commissioned/campbell/campbell.html).

Information on humanitarian issues

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

Information on legal and forensic issues

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



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