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MINISTRY OF HEALTH

NATIONAL STANDARD OPERATING PROCEDURES FOR THE MANAGEMENT OF GENDER BASED VIOLENCE

2024 Edition

MINISTRY OF HEALTH

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National Standard Operating Procedures for the Management of Gender Based Violence 2024.

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Foreword

Gender-Based Violence (GBV) remains a critical public health and human rights issue in Kenya, impacting individuals regardless of gender or age, leading to severe physical and psychological consequences for survivors. It significantly hinders an individual's ability to engage fully in society. Additionally, sexual violence poses a significant risk factor in the transmission of HIV. The legal and policy framework in Kenya supports a robust response to SGBV, with the Constitution of Kenya 2010 advocating for the right to the highest possible standard of health.

Amidst the COVID-19 pandemic, there was a surge in reported cases of Gender-Based Violence (GBV), highlighting the severity of this issue in Kenya. The repercussions of GBV pose a threat to achieving both the Sustainable Development Goals, the national objectives outlined in Vision 2030, and the National Health Sector Strategic Plan II. GBV significantly impacts the health and overall well-being of survivors, undermining their welfare.

Holistic care for GBV encompasses various aspects: medical treatment involves managing physical injuries, providing emergency medication to minimize the risk of contracting sexually transmitted infections, including HIV, and offering emergency contraception to prevent unwanted pregnancies. Additionally, it involves delivering psychological first aid to aid survivors in coping with trauma, offering legal aid to facilitate access to justice, and providing the necessary evidence required by the criminal justice system.

This Standard operating procedure (SOP) manual aims to provide comprehensive information on managing GBV in Kenya, emphasizing the crucial importance of delivering high-quality services that cater to the medical, psychosocial, and legal requirements of GBV survivors in both standard and humanitarian settings.

The SOP manual acknowledges that children constitute a substantial portion of survivors of sexual and other violence, thus making specific provisions tailored to their unique needs, which differ from those of adults. Additionally, SOP emphasizes the importance of offering quality services to perpetrators as part of HIV/STI management and the collection of essential forensic evidence when necessary.

The SOP manual is expected to be accessible across all healthcare facilities, aiming for comprehensive implementation to effectively cater to the needs of Gender-Based Violence survivors in Kenya.

Dr. Patrick Amoth, EBS

Director General for Health

Acknowledgment

This SOP manual is the product of collaborative endeavors involving multiple government sectors, partner organizations, and individuals. I would like to extend my gratitude to the Ministry of Health and the National AIDS and STI Control Program officers for their coordination and leadership in developing this guideline.

The development and subsequent revisions to these SOPhs were guided by the Gender based violence prevention and response Technical Working Group whose membership is drawn from various government ministries, partner organizations, Academia and civil society organizations, all of whom contributed considerably to the production of this guideline.

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Executive Summary

Introduction

Gender-Based Violence is a devastating human rights violation affecting individuals of all ages and genders. Survivors of Gender Based Violence often experience significant physical, psychological, and social consequences. As healthcare workers it is recommended that we provide comprehensive and compassionate care to survivors, addressing their immediate and long-term needs.

In order to streamline the provision of excellent care, Kenya has formulated national standard operating procedures (SOP) for the management of gender-based violence for the survivors. These SOPs are designed to establish a consistent and improved healthcare approach for survivors, guaranteeing the provision of suitable medical, psychosocial, and legal assistance.

Overview of the SOPs

These SOPs serve as a comprehensive resource for all individuals involved in providing services for gender-based violence (GBV), whether directly or indirectly involved in the care of survivors of GBV. They outline evidence-based practices and recommendations that address survivor care's medical, psychosocial, and legal aspects.

The SOPs will serve as essential standards, facilitating the effective delivery of post-GBV services with a focus on quality care. Additionally, the standards serve as a framework for healthcare institutions to implement standardized protocols. They guide healthcare providers in offering consistent and quality medical, psychosocial, and legal support to GBV survivors and includes a structured approach to conducting assessments, providing treatment, documentation, and follow-up care.

Abbreviations and Acronyms

ARV	Anti-retroviral
CCC	Comprehensive Care Centre
COK	Constitution of Kenya
DNA	Deoxyribonucleic Acid
EC	Emergency Contraceptives
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-Based Violence
HIV	Human Immunodeficiency Virus
HCP	Health Care Provider
HPV	Human Papilloma Virus
HRIO	Health Records Information Officer
LIVES	Listen Inquire Validate Enhance Support
MCH	Maternal Child Health
OPD	Out-Patient Department
PE	Post-Exposure Prophylaxis
PFA	Psychological First Aid
PRC	Post Rape Care Form
PREP	Pre-Exposure Prophylaxis
SGBV	Sexual and Gender-Based Violence
SCHRIO	Sub-County Health Records Information Officer
SOA	Sexual Offences Act
SOP	Standard Operating Procedures
STI	Sexually Transmitted Infections
Td	Tetanus diphtheria

List of Standard Operating Procedures

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1. Guiding Principles for GBV Survivors

Objective

To provide step-by-step instructions on the application of guiding principles in the management of GBV survivors.

Scope

This SOP will be used as a reference document by health care providers to guide in the provision of GBV care across various departments including Sexual and Gender Based Violence Unit (SGBV), Comprehensive Care Centre (CCC), Maternal Child Health (MCH)/ Family Planning (FP clinics), Maternity units, Inpatient Department (Post Natal Care, Ante-Natal Care, Gynecological), Out Patient Department (OPD).

User

It is intended for policymakers, trainers, program officers, health service managers and all health care providers providing GBV services.

Definition of Terms

Safety and Security: Is a non-threatening atmosphere, free from danger and further harm for the GBV survivor.

Every person has the right to be protected from further violence and harm. This includes physical, psychological, and emotional safety while considering the safety needs of Survivors, family members and supporters and those providing care.

Confidentiality: Confidentiality is not disclosing any information at any time to any party without the informed consent of the person concerned. Confidentiality promotes safety, trust and empowerment.

Exceptions to confidentiality include:

- The threat of ongoing harm to a survivor where the need to protect them overrides confidentiality
- Laws or policies that require mandatory reporting of certain types of violence against children
- Where there is a risk of self-harm, and harming others, including threats of suicide or murder

Respect and dignity: The survivor is the primary actor. The role of Health care providers is to facilitate recovery and provide resources for problem solving.

All actions taken should be guided by respect for the choices, wishes, rights and dignity of the survivor.

Do no harm: Health care providers should undertake actions, procedures, and programs in a way that does not put the survivor at further risk of harm or unintended consequences.

Urgency: Health care providers of GBV services should prioritize survivors' urgent medical needs and immediate response.

Integrity: Consistently and authentically demonstrating a commitment to justice, equality and non-violence while addressing GBV and ensuring that actions align with these principles.

Non-discrimination: This is the provision of equal and fair treatment, regardless of age, sex, race, marital status, nationality or any other characteristic.

Mandatory reporting: Laws or policies that require mandatory reporting of all types of violence against children. In Kenya, Section 145(2) of The Children Act 2022 obligates a medical practitioner to act in the best interest of the child when they encounter a child survivor of violence/ child in need of care and protection. This action includes reporting, retaining for safe custody and placement in a place of shelter. Mandatory reporting may also be applied in cases where a person is a threat to themselves or another person.

Procedures

Safety and Security

- Ensure the safety of the survivors, caregivers and health care providers while conducting conversations, assessments and interviews
- Assess the safety of the survivor and promote security measures e.g. ask for assistance from security, police, elders, community leaders or others who can provide security
- Only take action with the informed consent and assent of the survivor
- Maintain awareness of safety and security of people who are helping the survivor, such as family, friends, counselors, health care providers
- In all types of cases, ensure that s/he is not placed at risk of further harm by the assailant

Confidentiality

- Respect the privacy of the survivor, child and their family at all times
- If the survivor gives his/her informed consent and assent, share only relevant information with others for the purpose of helping the survivor, such as referring for services

- All written information about survivors must be secured under lock and key
- If any reports or statistics are to be made public, only authorized persons are mandated to release or relay such information in adherence to the Data Protection Act and protocols
- All identifying personal information (name, address, etc.) will be withheld in the reporting, compilation and sharing of data

Informed Consent

- Health care providers must receive written informed consent from the survivor, or legal guardian if working with a minor, prior to any response service or sharing of information
- If the survivor cannot read and write, an informed consent statement will be read up to the survivor and a verbal consent will be obtained
- The survivor should have the option to provide limited consent where they can choose which information is released and which is kept confidential
- Children must be involved in their care and decision-making using child-friendly techniques that encourage them to express themselves

Respect and Dignity

- Do not judge the survivor's behaviour or decision
- Be patient; do not press for more information if they are not ready to speak about it
- Show that you believe the survivor, that you don't question or blame the survivor, and that you respect their privacy
- Treat survivors with empathy, compassion, and respect ensuring dignity is upheld at all times
- Respect the strength and capacities of the survivor to cope with what has happened to them
- Allow the survivor to make choices about the care and support they need

Non-Discrimination and Impartiality

- Treat all survivors in a dignified way, ensure equal service provision and support irrespective or their gender, race, ethnicity, religion, disability or any other factor.
- Be aware of your own prejudices and opinions about GBV, and do not let these influence the way you treat a survivor.
- Appraise yourself on the existing laws and policies on human rights.

Do No Harm

- When providing a service to a survivor, ensure that all interventions, procedures and interactions prioritize the safety, dignity and the rights of the survivors refraining from actions that may cause additional harm
- Regularly perform risk assessment to detect potential dangers or re-victimization

Integrity

- While providing services to the GBV survivors, adhere to ethical standards and professional code of conduct
- Avoid conflict of interest, favoritism, discrimination or any behaviors that compromises ethical principles
- Provide accurate and truthful information to survivors regarding available services, procedures and potential outcomes while upholding transparency
- Report any breaches of integrity, ethical violations or safe guarding concerns related to provision of GBV services through designated channels

Urgency

- Provide beneficial treatments that do not aggravate the presenting situations in a timely manner
- Prioritize ALL GBV cases
- Treat all life-threatening injuries first

2. Informed Consent and Assent

Objective

To ensure that all clients' rights, autonomy, and well-being are respected throughout the clinical encounter and that they receive accurate information about their care so that they can make a decision on whether or not to participate.

Scope

This SOP shall guide healthcare providers interacting with survivors of GBV, in providing survivor-centered quality care and response, empowering them to decide what to do with their lives.

User

Healthcare Providers

Definition of Terms

Informed consent This is the voluntary agreement of an individual, who has been provided with relevant information about the risks, benefits, and alternatives and is legally able to understand make a choice and participate in care. In Kenya, the legal age of consent is 18 years and above.

Informed assent This is the agreement of someone not able to give legal consent to participant in an intervention. This applies to children or adults not capable of giving consent (subject) thus requiring the consent of the parent or legal guardian.

Authorized officer includes a police officer, a chief, a children's officer, prison officer, registered medical practitioner, a labour officer, a teacher, or any other officer approved under any other written law.

Lacking Legal capacity- This is when a person is incapable of consenting because they are; (a) unconscious; (b) in an altered state of consciousness; (c) under the influence of medicine, drug, alcohol or other substance to the extent that the person's consciousness or judgment is adversely affected; (d) mentally impaired; or (e) a child. **SOA 43(4).**

Procedures

- Service providers must do the following to guarantee that the permission given is "informed" as outline in Annex 1.
- Explain the steps involved in providing services to the survivor.
- Ensure that there are measures in place to protect the privacy and confidentiality of the survivor.

Explain the purpose, process and procedure to the survivor in a simple language that the survivor understands; and in a manner that takes into account the survivor's level of literacy.

1. Explain the potential risks, benefits and alternative options in details.
2. Allow the survivor to ask questions about the interventions and provide honest and accurate answers to their queries and clarify any concerns.
3. Remind the survivor that they have the option to reject any services offered to them without facing negative repercussions.
4. Ensure that the survivor has read or understood the content of the form before signing.
5. A healthcare provider must take all reasonable steps to obtain the survivor's informed consent unless the survivor lacks the legal capacity to do so.
6. If a survivor lacks the legal capacity to give informed consent:
    a. For the minor, the HCP will seek consent from parent, guardian or an authorized officer
    b. The consent is given by a person mandated by the patient in writing to grant consent on his or her behalf where applicable
    c. The consent is given by the next of kin where no person is mandated or authorized to give such consent
    d. Services are provided without the consent for instances where the patient is being treated in an emergency situation
    e. Services are provided without the consent for instances where any delay in the provision of the health service to the patient might result in his or her death or irreversible damage to his or her health
    f. Services are provided without the consent where the provision of a health service without informed consent is authorized by a court order
7. Check limitations of consent; the survivor has the right to place limitations on the types of information to be shared and to specify which organizations can and cannot be given the information.
8. Explain to the client that the service provider may need to share the client's data with other parties who can offer supplemental services.
9. Ensure the person giving informed consent appends their signature on the appropriate form.

3. GBV Screening During Service Delivery

Objective

To provide consistent screening for identification of GBV survivors, offer first line support, and facilitate appropriate referrals to access health services based on their needs and willingness, including minimum post violence services.

Scope

This SOP outlines the systematic process for healthcare providers to screen for GBV, provide support (LIVES), and facilitate referrals to specialized services for survivors.

User

ALL healthcare providers who provide first line support at service delivery points.

Definition of Terms

Screening: This is 'the presumptive identification of unrecognized disease in a healthy, asymptomatic population using tests, examinations or other procedures that can be applied rapidly and easily to the target population'[1]

Types of SGBV Client Identification and Screening:

1. **Routine enquiry:** Asking all clients who present for specific services about experiencing violence or fears of violence. Minimum requirements must be in place.
    a. **Service delivery points for routine enquiry screening:** HIV Testing Services (HTS) (during Assisted Partner Notification Services (APNS) and PrEP provision), ANC/MCH/FP/PMTCT, CCC
2. **Clinical enquiry:** Asking only clients you suspect are experiencing violence. Minimum requirements do not need to be in place – the priority is to support the client.
    a. **Service delivery points for clinical enquiry screening:** Outpatient departments, Special clinics (medical, surgical, Gynecological. Etc.)
2. **Universal Screening:** This is asking ALL clients about violence.

NB: Asking **ALL** clients about violence (i.e., Universal screening) is **NOT recommended** in Outpatient departments, Special clinics (Medical, Surgical, Gynecology. Etc.)

Minimum requirements prior to routine enquiry:

- **A protocol or standard operating procedure to guide the intervention.**
- **A standard set of questions to aid enquiry.**

- **Health providers trained on how to ask and respond to clients who disclose a history of experiencing violence.**
- **Ensured safety, with privacy and confidentiality considerations.**
- **A warm functional referral pathway and linkages system.**

Procedures

Create a Safe and Confidential Environment

- Ensure privacy and confidentiality for the survivor during screening.
- Establish a non-judgmental and empathetic atmosphere.
- Use job aid 1 (Annex 2), screening during service delivery.

Introduction and Informed Consent

- Introduce yourself, your role, and the purpose of the screening
- Explain that the survivor has the right to decline or terminate the screening at any point.

Screening for GBV

1. Administer a validated GBV screening tool, Annex 3.
2. When beginning to ask about GBV, start by using an introductory statement, which explains to the client that GBV affects many people and impacts their health
3. Ask questions sensitively, ensuring clarity and understanding. Probe for experience of violence using open-ended questions to allow the survivor to share their experiences.
4. When screening for IPV, do not ask about violence in the presence of a partner, family member, friend or a child above two years.
5. Do not pressure them to disclose, and explain to them that they can come back for further assistance

Offer LIVES Support

- Listen actively and non-judgmentally to the survivor's disclosure.
- Inform the survivor of available support services, including medical, psychosocial, legal and emergency support.
- Be patient with survivors, keeping in mind that they are in a state of crisis and may have contradictory feelings

- Validate the survivor's feelings and experiences.
- Enhance the survivor's safety by discussing safety planning.

Assess immediate safety and risk by conducting a risk assessment to determine the survivor's safety level. Trust the survivor when they tell you they are in severe danger.

Facilitate Referrals

1. Based on the survivor's needs and preferences, offer referrals to specialized services to include;
    a. Sexual violence services as need arises
    b. FGM support and counseling services
    c. Medical care for physical injuries
    d. Psychosocial support and trauma counseling
    e. Legal aid services for survivors pursuing legal action
2. Offer educational materials on GBV, available services, and how to seek help.
3. Schedule follow-up appointments to monitor the survivor's well-being and progress.
4. Offer ongoing support and ensure referrals were accessed.

Document the Screening and Response

1. Document the screening process, survivor's responses, and offered support.
2. Maintain confidentiality and store records securely.

Feedback Mechanism: Ensure there is a feedback mechanism in place

4. Mental Health Screening During Service Delivery

Objective

To outline the process of conducting mental health screening during service delivery to survivors of Gender-Based Violence (GBV) in a humane, ethical, and effective manner.

Scope

This SOP applies to all healthcare providers providing mental health and psychosocial support services.

NB: GBV can trigger anxiety, depression and substance use.

User

Healthcare providers

Definition of Terms

Trauma counselling: A specialized form of counseling aimed at helping survivors cope with and heal from traumatic experiences, such as GBV.

Procedures

Create a Safe and Confidential Environment

1. Welcome the survivor and make them feel at ease
2. Ensure privacy and confidentiality for the survivor during screening
3. Establish a non-judgmental and empathetic atmosphere
4. Introduce yourself, your role, and the purpose of the screening
5. Listen to the survivor and ask only non-intrusive, relevant and non-judgmental questions for clarification only

Intake and Assessment

1. Survivor is referred or self-reports for trauma counseling.
2. Healthcare providers conduct an initial assessment to understand the survivor's needs, history, and trauma symptoms.
3. Assess for immediate safety and security risks of the survivor.

Informed Consent

1. Healthcare providers explain the counseling process, confidentiality, and survivor's rights.
2. Survivor provides written informed consent to receive counseling.

Mental Health Screening

1. Offer psychological first aid (PFA) for stabilization of the survivor.
2. Administer a validated mental health screening tool (Annex 4). Use PHQ 2 to screen for depression and if the survivor responds to any of the two questions, then use PHQ9. To screen for anxiety disorders use GAD-7 tool.

Trauma Counseling Sessions

1. Reassure the survivor that GBV is always the fault of the perpetrator and never the fault of the survivor.
2. Conduct sessions focusing on providing emotional support, psychoeducation, coping strategies, and empowerment.
3. Techniques such as play and art therapy, cognitive-behavioral therapy, mindfulness, and expressive therapies may be used.
4. Empower the survivor by helping them make informed decisions.

Confidentiality

Healthcare provider maintains strict confidentiality, except in cases where there's a risk of harm to the survivor or others. Mandatory reporting laws are followed.

Monitoring Progress and Follow up

Healthcare provider regularly assesses the survivor's progress and adjusts counseling strategies guided by the 5 visits schedule (refer to Job Aid on SGBV follow up care in Annex 5).

Referrals

If needed, healthcare provider refers to medical services, legal aid, and other support services.

Documentation

1. Healthcare providers document each counseling session, including objectives, interventions, and the survivor's progress.
2. Records are kept securely and in accordance with data protection regulations.

Closure

1. Healthcare providers and survivor collaboratively decide on the appropriate timing to end counseling.
2. Survivor is provided with coping strategies and resources for continued support.

5. History Taking

Objective

To obtain a comprehensive and accurate information from the client in order to make a diagnosis and develop a treatment plan.

Scope

This SOP is aimed at providing guidance to healthcare providers on the procedure and content of client's history.

User

Healthcare providers

Definition of Terms

Lacking Legal capacity- This is when a person is incapable of consenting because they are; (a) unconscious; (b) in an altered state of consciousness; (c) under the influence of medicine, drug, alcohol or other substance to the extent that the person's consciousness or judgment is adversely affected; (d) mentally impaired; or (e) a child. **SOA 43(4)**

Procedures

Refer to section one, SOP 01 of this document on the Guiding Principles for the post-violence care to survivors.

Maintain a safe and confidential environment.

During history-taking, the HCP must ensure that in:

General History:

1. Date, time, and location of the incident.
2. Whether the suspect is known or unknown; if unknown, whether there are distinct descriptive characteristics noted on the person.
3. Circumstances of the incident: Any injuries, blows, strangulation, weapons or other objects, verbal assault, threats.
4. Associated events such as loss of consciousness, toxic substances, and drugs
5. Use of weapons and restraints.
6. The name, identity and number of assailants.
7. The nature of the physical contacts and detailed account of violence inflicted.
8. When is the first time you remember this happening?
9. Threats that were made.

Sexual violence history

1. How the incident unfolded (penetration—oral, vaginal, anal, with or without foreign objects; use of a condom).
2. The location and description of the type of surface on which the violence occurred.
3. Subsequent incidences or activities by the survivor that may alter evidence, e.g. having passed urine and stool, bathing, douching, wiping, the use of tampons, and changes of clothing
4. Any symptoms that may have developed since the incident, e.g., blood in undergarments or toilet, genital bleeding, discharge, itching, sores or pain, pain on passing urine or stool.

Gynecological history

1. First day of the last menstrual period.
2. Menarche
3. Pregnancy history.
4. Use (and type) of current contraception methods.
5. Last consensual sexual intercourse.

Male survivors

1. Do not make any assumptions about the sexuality of the survivor.
2. Recognize that they may be in denial about what has happened, and so their story of the experience may not be consistent or accurate.
3. Do not make any judgments about negative coping mechanisms they may have adopted.
4. Reassure them of their strength. Telling them they are strong and brave for disclosing the GBV incident.
5. This can help revalidate their sense of masculinity and be part of their healing.
6. Last consensual sex.

Suspected perpetrators

1. It is the clinician's role to provide medical care and treatment to the suspected perpetrator, with informed consent, and also conduct a forensic medical evaluation.
2. It is **NOT** the clinician's role to conclude whether or not the violence (e.g., rape, defilement) has occurred.

Considerations for Special Populations:

Persons with disabilities

1. Assume an adult survivor with a disability has the capacity to provide informed consent independently. However, make considerations for clients who lack legal capacity to give consent.
2. Always ask the survivor if they would like support to make an informed decision.
3. Use a variety of communication methods to ensure the survivor can communicate well and understand.
4. Ask questions to check if the survivor has understood the information and consequences related to accessing services.
5. Be aware of the power dynamics between the survivor and their caregiver to ensure the survivor is not being coerced into making decisions.
6. If required, ask the survivor if they will agree to involve somebody, they trust to help them, and let the survivor identify who this person is.
7. Ensure any decisions you make with or for the survivor are in the best interests of the survivor and empower them to take control of their healing.

Elderly

1. Use simple language to explain what services are available, including the possible consequences of accessing them.
2. Pay attention to the mental status of the survivor. The ability of a survivor to explain what has happened and to make decisions about services they wish to access can differ greatly depending on their status.
3. If required, ask the survivors if they will agree to involve somebody, they trust to help them, and let the survivor identify who this person is.
4. Sensitize outreach and mobile teams to the inclusion of elderly survivors in information provision and GBV awareness sessions.

6. Physical Examination

Objective

To assess the client's health status, the nature, extent, and severity of physical injuries, and identify any potential emergencies and complications.

Scope

The physical examination includes a thorough head-to-toe assessment with documentation of normal and abnormal findings.

User

Healthcare providers

Definition of Terms

Physical examination: a systematic, "Head-to-toe" evaluation to ascertain and treat possible injuries and preserve evidence.

Procedures

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

1. Obtain written informed consent and assent.
2. Note the survivor's general appearance and demeanor.
3. Take the vital signs, i.e., pulse, blood pressure, respiration, and temperature.
4. Inspect the face and the eyes.
5. Gently palpate the scalp to check for tenderness, swelling, or depression.
6. 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.
7. Carefully examine the neck. The neck area is of great forensic interest; bruising can indicate life-threatening violence.
8. Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
9. Examine the breasts and trunk with as much dignity and privacy as can be afforded.
10. Inspect the forearms for defense-related injuries.
11. Examine the inner surfaces of the upper arms and armpits, or axilla, for bruises.

12. Recline the survivor's position and perform an abdominal examination, which includes abdominal palpation to exclude any internal trauma or to detect pregnancy.

13. While in the reclined position, examine the legs, starting with the front.

14. If possible, ask the survivor to stand for an inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing.

15. Collect any biological evidence with moistened swabs (for semen, saliva, and blood) or tweezers (for hair, fibers, grass, and soil). **Refer to Forensic Management SOP for types, collection, and preservation of evidence.**

The Genito-Anal Examination

1. Prepare or assemble the PRC kit before the survivor comes in.
2. If available, ensure a trained support person of the same sex accompanies the survivor throughout the examination.
3. Try to make the survivor feel as comfortable and relaxed as possible.
4. Explain to them each step of the examination. For example, say, "I'm going to have a careful look."
5. Examine the external areas of the genital region and anus, as well as any markings on the thighs and buttocks.

Examination of female genital and anal areas

1. Examine the survivor systematically, using the physical examination checklist annex 6. Make sure that you have a good light source to view injuries. Specifically, be sure to conduct the following steps:
2. Help the client lie on her back with her legs bent, and knees comfortably apart.
3. Place a sheet over her body and expose only the parts of her body you are examining.
4. Inspect, in the following order: (a) the inner of the thighs, (b) mons pubis, (c) labia majora and minora, (d) clitoris, (e) urethra and introitus. (f) perineum, (g) anus. Note any previous scars from female genital mutilation or childbirth.
5. Look for genital injuries such as bruises, scratches, abrasions, and tears (often located on the posterior fourchette). Note the location of any tears, abrasions, or bruises on the pictogram and the examination form.
6. Look for any sign of infection, such as ulcers, vaginal discharge, or warts.
7. Check for injuries to the vulva, introitus, and vagina by holding the labia at the posterior edge between the index finger and thumb and gently pulling outwards

and downwards. This allows for better visualization of the posterior fourchette area to reveal abrasions that are otherwise difficult to see.

8. When collecting forensic evidence, collect specimens as outlined in the Forensic Management SOP, remembering to collect swabs of the external genitalia before attempting any digital exploration or speculum examination.
9. When collecting specimens for DNA analysis, make sure you collect swabs from around the anus and perineum before the vulva, in order to avoid contamination.
10. For the anal examination, the patient may have to be in a different position than for the genital examination. Document the position used for each examination (supine, prone, knee-chest, or lateral recumbent for anal examination; supine for genital examination).
11. Note the shape and dilatation of the anus; any fissures around the anus; the presence of faecal matter on the perianal skin; and any bleeding from rectal tears
12. When collecting forensic evidence, collect samples from the rectum according to the procedure for collecting specimens as outlined in the Forensic Management SOP.
13. Conduct the Speculum Examination on Females as indicated and 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.

Examination of male genital and anal areas

1. Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus, and anus. **Note** if the survivor has been circumcised.
2. Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele and haematocele, torsion of testes, bruising, anal tears, etc.) Rule out medical emergencies that requires immediate surgical referral.
3. If the urine contains large amounts of blood, check for penile and urethral trauma.
4. If indicated during history taking, do a rectal examination and check the rectum and prostate for trauma and signs of infection. Collect material from the anus for direct examination for spermatozoa under a microscope as outlined in the Forensic Management SOP.

7. Collection and Management of Forensic Evidence

Objectives

1. To efficiently manage forensic evidence from survivors and perpetrators of Gender-Based Violence.
2. To link or de-link a physical connection between individuals, objects or places.

Scope

To implement a standard and comprehensive forensic evidence management to include; collection, preservation, packaging, labelling, transportation, analysis and maintaining the chain of custody.

User

Medical practitioners, Designated persons (nurse and clinical officer) and Registered medical laboratory officers

Definition of Terms

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

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

Forensic evidence: this is the evidence collected during a medical examination. The role of the evidence in criminal investigation includes:

- To link/delink the perpetrators to crime.
- To ascertain that SV occurred.
- To help in collection of data on perpetrators of SV.

DNA analysis: means the process through which deoxyribonucleic acid (DNA) in a human biological specimen is analyzed and compared with DNA from another human biological specimen for identification purposes.

Forensic examination: A head to toe (including genital-anal) examination of a survivor and/or suspect for evidence and collection of samples that maybe used as evidence in a crime investigation and subsequent prosecution.

Offender- A person who commits an illegal act.

Phsical 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 important to the process.

Physical evidence can be collected from the survivor as well as the environment.

Survivor/Victim- Any person who has undergone violence (in this case, sexual violence) and has lived through the experience. A survivor is also known as a 'victim' according to the SOA.

Suspect- A person thought to have committed an offense.

Toxicology- The branch of science concerned with the nature, effects, and detection of poisonous substances.

Procedures

Principles:

1. Avoid contamination; wear non-powdered gloves at all times. Change gloves per procedure and with collection of each sample.
2. Collect forensic specimens as soon as possible to forestall the decrease in value of evidential material.
3. Handle appropriately and ensure that specimens are packed, stored and transported correctly. **Specimen should not be exposed to direct sunlight or heat.**
4. Label all specimens accurately with the survivor's / suspect's name and age/ date of birth; type of specimen; date and time of collection; health care provider's name (use full names, not initials).
5. Packaging biological evidence materials e.g., body fluids should be done in appropriate containers. Infectious specimen should be packaged according to the triple packaging system.
6. Ensure security: Specimens should be packaged to ensure that they are secure and tamper proof and signed across the security seal.
7. To maintain chain of custody, once a specimen has been collected, its subsequent handling should be properly recorded. Details of the transfer of the specimen between individuals should also be documented. An exhibit tracking register should be maintained at each facility.

N.B: Survivor / suspect/ offender SHOULD NOT move their samples from one service delivery point to the other, one facility to another for any analysis.

Availing Forensic Services

Investigations for clinical laboratory Management of various specimens (urine, blood and swabs) will include:

- Urine
- Urinalysis- microscopy
- Pregnancy test
- Spermatozoa
- Urine Blood
- HIV Test
- Hemoglobin (Hb) level
- Liver Function Tests (where possible)
- Hepatitis B
- Anal Swab
- High Vaginal Swab (To be collected)
- Oral Swab for evidence of spermatozoa
- Swabs from dried fluids (semen, saliva, blood)

Medical-legal evidence based on samples of spermatozoa must be collected within a time limit depending on the site of collection:

Site	**Maximum length of time spermatozoa remains intact after sex**
Vaginal swabs	120 hours
Endocervical swabs	144 hours
Rectal swabs	65 hours
Types of Specimens, Preservation Methods, Tests and Reasons for Testing	

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Oral swab	Oral swabbing is essential, to collect seminal fluid in the oral cavity where there is suspected oral- genital contact. Using sterile swabs collect the oral swabs, air dry and store in a clean dry standard tube with screw top or a paper envelope	Wet preparation for microscopy DNA Analysis	Detection of spermatozoa DNA comparative analysis Corroborate oro-genital contact by the suspect and the victim	Facility Lab Government Chemist
Anal and Rectal Swabs	In cases of anorectal assault external anal rectal swabs should be collected The swab should be slightly moistened with sterile water and the anus carefully swabbed, slightly extending into the anal canal -Sterile cotton swabs should be used -Swabs for DNA extraction should be air dried before packaging -Swabs for microbiological analysis should be inserted in appropriate transport media e.g. Amies transport media. Collect at least three swabs for analysis: **One** for the facility laboratory and **two** for the Government Chemist's.	Wet preparation for microscopy Culture and sensitivity DNA Analysis Prostate Specific Antigens (PSA) Acid Phosphatase Test	Detection of spermatozoa Pathological organisms DNA comparative analysis Identification of victim /assailant by DNA profiling Corroborate anal-genital contact between the suspect and the victim detection of semen	Facility Lab Government Chemists

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Penile/ Urethral swab	Moisten the tip of the swab with sterile water and roll it around the tip (glans) of the penis including the sulcus and urethral meatus. The inside of the foreskin (if present) should be swabbed.	Wet preparation for microscopy Culture and sensitivity	Detection of epithelial cells of the survivor Pathological Organisms	Facility Lab
		DNA Analysis	DNA Analysis Identification of victim / suspect by DNA profiling Corroborate penile- genital contact between the suspect and the victim	Government Chemists

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Vulval / Vaginal/ cervical swabs	Vulval swab should be taken prior to the collection of the vaginal and cervical swab To collect vulval swab, the labia majora should be separated carefully using the left hand (non- dominant hand). Swabbing should be done around the inner surface of the labia minora and fossa navicularis. Swabs of the vaginal fornices are essentially used to collect any saliva or semen that may be present in the vaginal area. Swabs of the anterior and posterior vaginal fornices (walls) should be taken using a vaginal speculum for the cervical area, swabs should be taken from the cervical orifice by collecting as much of the mucus plug as possible. Collect at least three swabs for analysis: **One** for the facility laboratory and **two** for the Government Chemist's.	Wet preparation for microscopy Culture and sensitivity DNA Analysis	Detection of spermatozoa Pathological organisms DNA comparative analysis Identification of victim /assailant by DNA profiling to corroborate vulval-genital contact between the suspect and the victim	Facility Lab Government Chemist's

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Urine (of both the victim and the suspect)	Clean dry urine bottle with screw top Collect up to 100 ml Do not use preservatives. Refrigerate between 2° C to 8° C (if to be stored for longer period of time, the urine should be frozen a -20 ° C) The first urine following the sexual violence is the most ideal i.e. up to 48 hours for spermatozoa detection, and up to 120 hours for toxicology. Urine for culture and sensitivity should be collected in a sterile container	Microscopy Microscopy, Culture and sensitivity Pregnancy testing Toxicology	Detection of spermatozoa Pathological organisms Pregnancy Drugs and alcohol	Facility Lab (where available) Government Chemists

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Hair from the pubic area, armpit, / head hair, chest, beard etc,	• Pick loose hairs using non-powdered gloves and store in a paper envelope, or using clear cello tape and fold the tape for transportation. An acetate sheet may be used where available. • Matted hair (hair mixed with semen, blood, saliva or other body fluids) may be collected using sterilized scissors and forceps and packed in another sheet of paper, which should be folded inwards and labeled. • Evidence of semen or other matted material on hair may be collected with the help of a moistened swab and air dried, or cut out using scissors and packed.	DNA Analysis	DNA Transfer evidence analysis Corroborative evidence of contact between the suspect and the victim	Government Chemists
Foreign fibers/ grass/ soil	Hand pick the foreign fiber/grass / soil using non- powdered gloves and store in a paper envelope or lift using clear cello tape.	Transfer evidence analysis	Corroborative evidence of contact between the suspect and the victim	Government chemists

Blood	• Collect 10 ml of blood into two purple top vacutainers. • Collect 10 ml of blood into two red top vacutainers. • In the absence of vacutainers, universal blood collection bottles may be used. • Blood for toxicology should be collected within 24 hours of the sexual violence. • Store the blood at 2-8 degrees Celsius • If not for immediate use, blood should be stored at -20 degrees Celsius • Dried blood spot cards or filter papers may be used for DNA Analysis as reference samples	Toxicology DNA Analysis	Drugs and alcohol Ability of the survivor to consent Corroborative evidence of contact between the suspect and the victim	Government Chemists
Dried Blood and blood stains	• Moisten a sterile cotton gauze or cotton wool with sterile water or normal saline. • Rub the moistened swab on the dried blood spot until the stain has been transferred onto the moistened swab. Air dry and pack in an envelope.	DNA Analysis	• For comparative DNA analysis • Corroborative evidence of contact between the suspect and the victim • Identify assailant and survivor	Government Chemists

Specimen or samples	Method of collection and preservation	Test	Reasons for testing	Where
Semen and semen stain	• Air dry semen-stained clothes. Avoid direct sunlight. • If semen has dried on a surface, moisten a sterile cotton gauze or cotton wool with sterile water or normal saline. Rub the moistened swab on the semen stain until the stain has been transferred onto the moistened swab. • Air dry and pack in a paper envelope. • Do not dry in front of fire or artificial means or directly under sun. • Avoid packing in plastic bags	Acid Phosphatase Test DNA Analysis	• Detection of semen and spermatozoa • Identify assailant • Corroborative evidence of contact between the suspect and the victim • Suspect • DNA and proteins • in semen • (PSA2 or P3)	Government Chemists

8. Clinical Management

Objective

To provide comprehensive treatment to the clients of Gender-based violence based on the findings of the history and examination.

Scope

To provide clear and concise instructions to healthcare providers on how to clinically manage clients with specific conditions as a result of GBV, to improve their health outcomes and quality of life.

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User

Healthcare providers

Definition of Terms

HIV Post-Exposure Prophylaxis: Post-Exposure Prophylaxis (PEP) for HIV is the administration of a combination of anti-retroviral (ARV) drugs for 28 days after exposure to HIV and should be started within 72 hours of sexual violence if a survivor tests HIV negative.

Emergency Contraception (EC): EC should be given within 120 hours/ 5 days of sexual violence; ideally as early as possible to maximize effectiveness.

Human Papilloma Virus (HPV): HPV vaccination should be given to girls between the ages of 10-14 as per the current MOH HPV guidelines, who are abused and haven't been vaccinated during the initial evaluation. HPV vaccine may be administered concomitantly with hepatitis B vaccine.

Procedures

Availing Treatment Services

The management of any life-threatening injuries takes precedence over all other aspects of post-rape care.

1. Refer patients with life-threatening or severe conditions such as extensive injury, neurological deficits, respiratory distress fever, and sepsis for emergency treatment.
2. Minor cuts and abrasions should not delay the delivery of other more time-dependent treatments.

3. Clean tears, cuts, abrasions, and superficial lacerations
4. If stitching is required, stitch under local or general anesthesia within 24 hours. Manage wounds appropriately. Give antibiotics and pain relief especially for major contaminated wounds.
5. High vaginal vaults, anal and oral tears, and 3rd and 4th-degree perineal injuries should be assessed under general anesthesia and repaired accordingly.
6. In cases of confirmed or suspected perforation, laparotomy should be performed and any intra-abdominal injuries repaired in consultation with a general surgeon
7. Provide analgesics to relieve the survivor's physical pain.
8. Where any physical injuries result in the breach of the skin and mucous membranes, immunize with 0.5 ml of tetanus-diphtheria.
9. Advise survivors to complete the vaccination as per schedule (Refer to the annexures 7B).

Medical Management

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

Post-exposure prophylaxis:

1. Give PEP in the event of rape, defilement, and some cases of sexual violence; significant risk involves oral, vaginal, and/ or anal penetration.
2. If the survivor tests HIV positive, PEP IS NOT RECOMMENDED; the survivor should be referred for HIV care, treatment, and follow-up.
3. If the survivor declines to take a HIV test, counseling should be continued and other management provided as per the health care provider's clinical judgment.
4. PEP should be started within 72 hours of sexual violence if a survivor tests HIV negative.
5. People presenting later than 72 hours after sexual violence should be offered other aspects of post-rape care, except PEP.

Refer to the latest version of the National ART Guidelines for the most recent recommendations regarding PEP for both adults and children.

Pregnancy Prevention

1. Emergency Contraception (EC) should be given within 120 hours of sexual violence; ideally as early as possible to maximize effectiveness.
2. EC should be given to all females who have attained menarche (i.e., post menarche), as well as those who are in the beginning stages of puberty (i.e., have

reached Tanner stage 2 or 3) without any restrictions; as long as they reported within 120 hours of the incident.

Women of reproductive age on menses, pregnant, or on reliable contraceptive methods should not be given EC. The currently recommended EC options are included as Annex 7C to this SOP.

Please refer to the current version of the appropriate National SRH Guidelines for the most up-to-date recommendations for Emergency Contraception.

1. Unless a woman is obviously pregnant, a baseline pregnancy test should be performed.
2. A follow-up pregnancy test at four weeks should be offered to all women who return, regardless of whether they took EC after the sexual violence occurrence or not.
3. If a survivor intends to terminate a pregnancy that resulted from the sexual violence, the healthcare provider and the survivor should be aware of the Constitutional provision in reference to abortion

Management of Sexually Transmitted Infections

1. STI prophylaxis should be offered to all survivors of sexual violence.
2. Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP), although the doses should be spread out (and taken with food) to reduce side- effects, such as nausea.

The currently recommended STI prevention regimen is included as Annexure 7D to this SOP. Please refer to the current version of the appropriate National Guidelines for the most up-to-date recommendations for STI management.

Hepatitis B prevention

1. If a survivor has been vaccinated before and completed the whole series of vaccinations as scheduled, the vaccination is unnecessary. If they did not complete the entire series, they should complete it as scheduled.
2. If the client had not been vaccine, ensure that you administer within 24 hours.

Availing Psycho-social Support Services

Psychosocial support starts the moment the client accesses the facility until the client completes the 5th follow-up visit.

1. Ensure the security of the patient
2. Guarantee confidentiality
3. No time limits, be available for the patient

For psycho-social management of the client, refer to SOP on Psychosocial support.

Information on survivors' rights, legal redress and referral linkages

1. Give information on health, police, legal services, and other linkages as well as their purposes.
2. Inform the survivor of emerging legal issues for (reproductive health issues, litigation, reporting, rights and responsibilities).

For further details on referral and consent, refer to SOPs on Guiding Principles, Consent, and Referral.

9. Management of Children and Adolescents

Objective

To actively identify, provide clinical and uniform procedures for management of children presenting with GBV cases.

Scope

This SOP aims at providing healthcare providers with information on assessment and examination as well as documentation of findings.

User

Healthcare providers

Procedures

The healthcare provider will:

1. Ensure privacy and a child-friendly environment.
2. Approach the child with extreme sensitivity and recognize their vulnerability
3. Identify themselves as a helping person and their role in care.
4. Establish a neutral environment with the child before beginning the interview.
5. Ask the child if they know why they have been brought to the facility.
6. Use neutral, non-leading language, while remaining empathetic to the client.
7. Try to establish the child's developmental level in order to understand any limitations as well as appropriate interactions.
8. Take age-specific history as follows according to the developmental stages noting children with special needs, disabilities and developmental delays.
9. Consider interviewing the child and the child's caregiver separately.
10. Document the history in the survivor's own words (verbatim), if the survivor is old enough to talk

History taking

1. Start by documenting the necessary demographic and administrative information as per the post-rape care form (MOH 363 Parts A & B). Document additional notes in the clinical notes (Refer to SOP on documentation).
2. A history should be obtained from a caregiver, someone who is acquainted with the child, or the child her/ himself. It is important to gather as much medical information as possible.

3. Allow older children to be seen alone, as this may encourage them to talk more freely.
4. Elicit the history of the incident and the circumstances surrounding it. Ask the child to describe what happened or is happening to them in their own words (where applicable). Play therapy can be used where necessary.
5. Always ask open-ended questions and avoid leading questions. Only use direct questioning when open-ended questions have been exhausted. Structured interviewing protocols can reduce interviewer bias and preserve objectivity
6. When gathering history directly from a child, start with a number of general, non-threatening questions to create rapport, then move on to questions specific to the incident.

Forensic history

Ask and document the following:

1. If the survivor changed clothes and document their status.
2. If the clothes were handed over to the police, and if so, the form of packaging used.
3. Bowel movement since the incident.
4. If they left any marks on the perpetrator.

Refer to the SOP on Forensic management for more details.

Medical and Forensic Examination

1. Prepare the child for examination by explaining the procedure and showing equipment; this helps to diminish fears and anxiety.
2. Encourage the child to ask questions about the examination.
3. If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination.
4. Stop the examination if the child indicates discomfort or withdraws permission to continue.
5. Reassure the survivor at every step of the examination, while explaining what will be done, prior to each step.
6. Record the state of the clothes, if the survivor is wearing the same clothes that were worn during the sexual violence, e.g., stains, tears, color; collect and put all items in separate paper bags and label.

7. Examine the survivor on a drop sheet (or white sheet of paper), either standing or on a couch.
8. Use examination instruments and positions that minimize physical discomfort and psychological distress.
9. Examine infants and toddlers on the caregiver's lap and consider sedation or general anesthesia, especially if the injuries are expected to be severe.

NEVER force the child survivor to be examined

Mental assessment

- Conduct the psychological assessment and document it in Part B of the PRC form. Refer to Annex 8 for details.

Systemic examination

Document details of the:

1. Central nervous system- level of consciousness, affect
2. Musculoskeletal system- physical disabilities, posture control and gait, swellings, bruises, lacerations, dislocations, bite marks, scratches on the body of survivor from head to toe.
3. The review of system:

Ears, nose, and throat (ENT):

1. Assess the patient's hearing, smell, taste, and voice.
2. Inquire about symptoms such as ear pain, hearing loss, tinnitus, nasal congestion, runny nose, nosebleeds, sore throat, and hoarseness.

Head and neck:

1. Assess the patient's neurological health and function.
2. Inquire about symptoms such as headache, dizziness, vertigo, neck pain, and facial weakness.

Respiratory:

1. Assess the patient's breathing and lung health.
2. Inquire about symptoms such as cough, shortness of breath, wheezing, chest pain, and hemoptysis (coughing up blood).

Cardiovascular:

1. Assess the patient's heart and vascular health.
2. Inquire about symptoms such as chest pain, shortness of breath, palpitations, edema (swelling), and syncope (fainting).

Gastrointestinal:

1. Assess the patient's digestive health.
2. Inquire about symptoms such as abdominal pain, nausea, vomiting, diarrhea, constipation, heartburn, and rectal bleeding.

Genitourinary:

1. Assess the patient's urinary and reproductive health.
2. Inquire about symptoms such as urinary frequency, urgency, dysuria (painful urination), hematuria (blood in the urine), nocturia (urination at night), incontinence, vaginal discharge, and penile discharge.

Musculoskeletal:

1. Assess the patient's bones, joints, muscles, and connective tissues.
2. Inquire about symptoms such as pain, swelling, stiffness, limited range of motion, and weakness.

Skin:

1. Assess the patient's skin health.
2. Inquire about symptoms such as rashes, changes in skin color, pruritus (itching), and hair loss.

Psychiatric:

- Assess the patient's mental health.
- Inquire about symptoms such as mood changes, anxiety, depression, psychosis, and thoughts of suicide or self-harm.

Neurological:

- Assess the patient's nervous system function.
- Inquire about symptoms such as: headache, dizziness, vertigo, seizures, numbness, weakness and vision changes

Head-to-toe examination:

- Record vital signs if i.e., height (cm) and weight (kg), temperature, respiratory rate, heart rate.
- Examine and record general appearance, hygiene and nutritional status

- Examine mouth/ pharynx, note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum.
- Document any bruises, cuts, inflammation and marks on the body outside the genitalia. Also look for healing injuries and scars that may indicate repeated abuse.
- Check for ligation marks on wrists and ankles and record findings on the PRC form
- Determine the child's sexual development stage (tanner staging) to determine treatments e.g., EC
- Conduct age assessment, guided by a dentist or dental odontologist, or radiologist report on age range.
- Head to toe examination should be done in a systematic way.
- Perineum - The perineum consists of the clitoris, labia majora and minora, vagina, mons pubis, introitus, fossa navicularis, vestibule, hymen, penis, prepuce, scrotum, urethra, anus, gluteal region, inner medial thighs.

In the above areas, document details of:

- Any tenderness, bruises, abrasions, cuts, teeth -marks, scratch marks bleeding, discharge, old scars (question their source if any)
- Anus- shape, dilatation (sphincter muscle tone), fissures, faecal matter on perianal skin, bleeding from rectal tears.
- Hymen- shape, position, colour, and type e.g., Cribriform, septal, crescent shaped, carunculae.
- Position and size of tears e.g. At 3 o'clock 1 cm etc.

The Genito-Anal Examination for Female Children

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

- A speculum may only be indicated when the child has internal bleeding arising from a vaginal injury as a result of penetration. In this case:
- Help the child to lie on her back or side.
- Use a paediatric speculum if indicated and conduct the examination under general anaesthesia.
- Check for blood spots or trauma to the urethra.

- Examine the anus for bruises, tears or discharge.
- Refer the child to a higher-level health facility for specialized examination as dictated by their condition.

The Genito-Anal Examination for male children

- Check for injuries to the skin that connects the foreskin to the penis.
- Check for discharge at the urethral meatus (tip of penis).
- Check the scrotal area to rule out testicular torsion and other conditions.
- In older boys, pull back the foreskin to examine the penis. Do not force it since doing so can cause trauma, especially in younger boys.
- Help the boy to lie on his back or on his side and examine the anus for bruises, tears, or discharge.

Special considerations

- Avoid examining the boy in a position in which he was violated as this may mimic the position of abuse
- Consider digital rectal examination only if medically indicated
- The information provided on collection of medical and forensic specimens in adults equally applies to children
- Summary of findings should be documented after examination of a survivor of sexual violence

10. Referral of GBV Survivors

Objective

To assess and prioritize the GBV survivors' immediate referral need for care, prevention, and supportive services.

Scope

This SOP will be used to guide health service providers in providing referral services for survivors of GBV within and beyond the health facility.

User

Healthcare providers

Definition of Terms

Referral: is the process by which a client's immediate needs for care, prevention, and supportive services are assessed and prioritized, and the client is provided with assistance in accessing the necessary services.

Referral Form: This is a dully filled document which should be given to the survivor to present to the referring sector e.g., police, children etc.

Internal referral: This is done between health service provider who are connected within the same facility e.g., OPD to Laboratory

External Referral: This is done for access further management/ unavailable services or to other collaborative sectors such as children services, police etc.

Warm referral: This involves contacting the referral point for availability of service with consent from the survivor.

Referral network: This involves partners include different government departments, women's organizations, community organizations, medical institutions and others (UNFPA 2010).

GBV referral directory: It refers to a document with list of GBV service providers within and without the health facilities. It's a resource that contains information about support services, organizations, and helplines available to a survivor of GBV.

Procedures

1. Identify the client's health risks and determine their needs.
2. Determine the specialized services that the client needs e.g., CCC, gynecology department, trauma counseling, legal services, and children's department.

3. Engage the client in the process, ensure they are well-informed, and obtain consent to disclose their health information.
4. Provide client with details about the referral services and secure consent to initiate the referral.
5. Call the service provider and inform them of the referral you are making.
6. Provide **ALL** the documentation required for referral.
7. All unstable adult survivors and **ALL** children must be escorted to the recipient service provider by a person designated by the facility.
8. Contact the referral point to confirm if the client has arrived at the service delivery point.
9. Complete the referral form in triplicate (carbon copy/photocopy), ensuring all necessary details are accurately recorded. The original copy is handed over to the recipient service providers, the duplicate is kept by the survivor, and the triplicate is retained at the facility as evidence of the linkage.

11. GBV Documentation and Reporting

Objective

To guide healthcare providers on proper documentation and data management of GBV services.

Scope

This SOP aims to guide the HCP on how to properly collect, report, and analyze GBV data at all service delivery points within the health facility.

User

Healthcare providers

Definition of Terms

Documentation: Collection, analysis, and communication of data in ways appropriate for the context

Indicator: Pre-defined variable that helps to identify (in)direct differences in quality and/or quantity within a defined period of time.

Data quality: This is a measure of the condition of data based on factors such as: accuracy, completeness, reliability, precision, consistency, timeliness and integrity.

Monitoring: Ongoing systematic collection, analysis, and use of information for decision-making. It tracks indicators towards the achievement of specific pre-determined targets.

Evaluation: Assessing the extent to which the program activities have met the expected objectives.

Procedures

Documentation

Documentation **must occur at every service delivery point** of care including outpatient department, inpatient department, maternity, and maternal child health clinic (MCH).

Data tools used for GBV Management

Utilize the following designated data collection and reporting tools:

- MOH 363: Post Rape Care form
- MOH 365: Gender Based Violence register
- MOH 364: GBV monthly summary
- MOH 711: Integrated program summary form

- MOH 333: Maternity register
- MOH 405: ANC Register
- MOH 204 A&B: Outpatient registers
- MOH 705 A&B: Outpatient summary forms
- Consent form
- Clinical Notes
- Referral form

Procedure in filling

The Consent Form

- A copy of an informed consent should be retained at the facility. Refer to SOP 2 on Written Informed Consent

Clinical Notes

- The clinical notes should be completed by healthcare providers interacting and providing service to the survivor i.e., medical service providers, mental health specialists, etc.
- The documentation should be securely kept and availed for reference as required
- Clinical notes should have identifiable organizational documentation or letter-heads

Referral Form

- Maintain a file of duly filled referral forms.

PRC Form (MOH 363)

- This is a primary source tool for SGBV survivors
- The PRC form should be duly filled while observing data quality dimensions
- Fill PRC forms for all sexual violence survivors at any time following the GBV incident

Procedure

1. Obtain a written informed consent
2. Fill the form in triplicate. The original is handed over to the police, duplicate to the survivor and the triplicate remains in the booklet
3. Ensure that all the blank spaces are filled as per instructions in the PRC form including the unique identifiable number

4. Explain to the survivor the need to safely keep all the documents as they will be required in subsequent visits
5. Write your full name, designation and sign the PRC form
6. The police officer should sign the PRC form, and pick the original copy as they collect forensic materials
7. Keep the triplicate under lock and key in the health facility

GBV Register (MOH 365)

This register shall be filled immediately after documenting in the PRC form and any other GBV survivor

All relevant sections of the register should be duly filled

GBV Monthly Summary tool (MOH 364)

- This form shall be populated by the 5th of every month
- The form should be populated by the facility health records officer
- For facilities that do not have health records officers or data clerks, the form shall be populated by the facility GBV focal person and the facility in-charge

Cohort Summary (section B)

- The health records officer shall extract data from the GBV register for three months within which the survivor(s) are expected to have completed their visits

Note that the target group should fall in the bracket of 90 days counted from the first day of enrollment for services. For example, the January cohort will be reported in the April report; the February cohort in the May report, etc.

12. Quality of GBV Data

Objective

To ensure routine generation and reporting of quality GBV data from all service delivery points.

Scope

This SOP aims at guiding health care providers to ensure that GBV data possess all the dimensions of data quality (accuracy, completeness, reliability, timeliness and precision).

User
All healthcare providers.

Definition of Terms

Data quality: Is a measure of the condition of data based on factors such as: accuracy, completeness, reliability, precision, consistency, timeliness and integrity.

Procedures

Healthcare providers should ensure that data quality is upheld at all levels.

- The PRC form (MOH 363) should be duly filled by the designated healthcare provider during the survivor examination process.
- The designated healthcare provider that fills the PRC form to duly fill the MOH 365 in the course of and after examining the survivor.
- The designated HCP to duly fill the MOH 405 during prenatal visits.
- The designated HCP to duly fill The MOH 204 A&B
- The clinician/midwife to duly fill the Maternity register (MOH 333) when seeing the mother at the maternity.
- The facility GBV focal person and the facility in-charge to consolidate data from the following sources (MOH 365, MOH 333, MOH 204 A&B and MOH 405) and summarize it using MOH wW364 at the end of every month.
- The facility GBV focal person and the facility in-charge to verify and validate the report at the health care facility before sending the report to the SCHRIO.
- Send the report to the SCHRIO by 5th of the following month.
- SCHRIO runs validation check of the data before uploading to KHIS.
- Ensure the SCHRIO uploads the data to KHIS by 15th of the following month.
- The SCHRIO ensures the hard copies of the report are kept under lock and key.
- The facility in-charge should ensure that data is periodically analyzed and displayed in charts (talking walls).

13. Quality of GBV Services

Objective

To ensure that all GBV clients receive quality services at all service delivery points up to the end of continuum of care.

Scope

The purpose of this SOP is to direct healthcare providers in delivering high-quality services to GBV clients across all service delivery points.

User

Health care providers

Definition of Terms

Service delivery point: The point where the user receives the service

Quality service: It is the degree with which health services for individuals and populations increase the likelihood of desired health outcomes (WHO, 2020).

Quality management: This is an ongoing effort to provide services that are in line with stipulated service standards and that meet or exceed clients' expectations, equitably and acceptably and within the available resource.

Quality assurance: This is the process of following the standards and practices to deliver quality services to the patient at a health care facility.

Procedures

Quality should be observed at all levels of care.

Input quality:

- Ensure the service delivery point is organized and clean
- The survivor is identified and ushered in without delay
- Ensure room offers privacy to the survivor
- Ensure all the required tools/equipment are available
- Create rapport with the survivor/caretaker
- Show empathy and handle the survivor/care taker with respect

Process quality:

- Explain purpose of all procedures to survivor/caretaker before doing them
- Obtain an informed consent before doing any examination
- Assure survivor of confidentiality and safety
- Involve the survivor/care taker at every step
- Ensure you gain the survivor's confidence
- Offer psychological support to the survivor and family
- Offer all GBV services free of charge
- Counsel the survivor/caretaker on adherence to any drugs given
- Refer the survivor for other services (laboratory, counseling, police)
- Ensure proper documentation on GBV reporting tools
- Ensure you give the survivor/caregiver return date

Feedback mechanism

Encourage the survivor to give feedback through suggestion boxes, exit surveys, GRM Register among others.

14. Female Genital Mutilation (FGM)

Objective

To guide the healthcare providers in the identification of FGM, management and documentation of FGM-related complications.

Scope

This SOP covers the procedures for identification, treatment, documentation, reporting and referral of FGM cases**.**

User

Health care providers.

Definition of Terms

Female Genital Mutilation: Female genital mutilation (FGM) comprises of all procedures that involve the partial or total removal of the external genitalia or other injuries to the female genital organs for non-medical reasons.

Medicalization of FGM: Medicalization refers to situations in which FGM, including re-infibulation (re-closing of external genitalia after childbirth and other procedures), is practiced by any category of health-care providers in a public or a private clinic, at home or elsewhere (World Health Organization, 2010). Re-infibulation is prohibited.

Description of the types of FGM

Type I (Clitoridectomy): Partial or total removal of the clitoral glans (the external and visible part of the clitoris) and/or the prepuce/ clitoral hood (the fold of skin surrounding the clitoral glans)

Type II (Excision): Partial or total removal of the clitoral glans and the labia minora (the inner folds of the vulva), with or without removal of the labia majora (the outer folds of skin of the vulva)

Type III (Infibulation): Narrowing of the vaginal orifice with the creation of a covering seal by cutting and positioning the labia minora and/or the labia majora, with or without excision of the clitoris.

Type IV (Others): All other harmful procedures to the female genitalia for non-medical purposes, for example, nicking, pricking, piercing, incising, scraping, and cauterization

Procedures

Identification

HCPs should be vigilant during routine examinations to identify physical signs or reported symptoms indicating female genital mutilation.

Conduct a thorough genital examination to determine the type and evaluate the extent of FGM complications and manage accordingly.

Treatment

Management of complications of FGM

I. Referred from the community:

Hemorrhage: Apply pressure at the site to stop the bleeding by packing with sterile gauze or pad, or if there is an obvious vessel bleeding, ligate it to arrest the bleeding

Pain: Assess the severity of pain and injury and give analgesia as per the WHO analgesic ladder

Shock: Adopt ABCDE and manage accordingly

Wound infection: Inspect the vulva carefully for signs of an infected wound and manage accordingly

Septicemia: If you are in a primary health facility, refer the patient to a higher level after initial antibiotic and first aid measures.

Urine retention: Assess to determine the cause of retention and encourage the client to pass urine if unable, manage the cause.

Genital tissue swelling; Inspect, clean wound and treat accordingly with anti-inflammatories for inflammation; antibiotics for infection and catheterize for retained urine.

Injury to other tissues, e.g., vaginal fistula: Refer to VVF or RVF for specialist repair.

Ulceration of the genital region: Counsel the client on the need for de-infibulation and the wound left exposed. If chronic, refer for the repair of ulceration and management.

Tetanus: Based on the severity of the disease. For more severe tetanus, patients are likely hospitalized in the intensive care unit (ICU) with sedation and mechanical ventilation.

HIV and Hepatitis B: Manage as per current MOH Guidelines for Antiretroviral Therapy In Kenya.

II. De-infibulation

Wash hands thoroughly with soap and running water.

Put on sterile gloves.

Help the client lie in a lithotomy position and clean the vulva with an antiseptic solution.

Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and on both sides of the scar.

Avoid causing injury to the structures underneath the scar (urethra, labia minora and clitoris). With type III FGM/C, these structures are commonly found intact below the scar.

Place artery forceps in the introitus to delineate the length of scar.

A vertical incision is made anteriorly with scissors from the introitus towards the clitoral location to expose the introitus and urethral meatus.

The raw edges of the labia majora are then re-approximated (sutured) with absorbable 4.0 monocryl sutures. This prevents the two exposed edges from repositioning during healing and bleeding.

Provide analgesics for postoperative pain as per WHO analgesic ladder.

During discharge give oral analgesics.

Make her aware that their voiding stream will change and that they should avoid coital sexual activity until the wound heals (4-6 weeks)

Refer to Annex 9 for FGM Dei-infibulation pictorial procedure.

Documentation

Maintain accurate, confidential and detailed client records.

Document FGM cases in MOH 365 and report monthly to KHIS.

Referral and follow-up

Facilitate timely referral depending on the needs assessment.

15. Special Considerations in Humanitarian Settings

Objective

To guide healthcare providers to identify and comprehensively manage gender-based violence cases in humanitarian setting.

Scope

This SOP outlines the process of delivering applicable services to survivors in humanitarian settings.

User

Healthcare providers and other stakeholders

Definition of Terms

Humanitarian Setting: Refers to "any context where there is a need for humanitarian assistance due to conflict, natural disaster, displacement, or other emergencies that result in increased vulnerabilities and risks for affected population." (WHO, 2019)

MISP: a series of crucial, lifesaving activities required to respond to the SRH needs of affected populations at the onset of a humanitarian crisis.

Minimum -Limited to core SRH services

Initial -To be used in an emergency without the need of prior assessment

Services - Services to be delivered to the affected population

Package- Supplies such as RH kits and other SRH activities, coordination and planning

Age and gender are vulnerabilities that predispose women and children to exploitation and abuse. These women and girls are also at a higher risk of FGM.

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.

Inter-agency collaboration and coordination is crucial during humanitarian crisis to successfully protect all vulnerable population against GBV.

Procedures

1. Assess health facility readiness and service provision, and address gaps.
2. Ensure that GBV survivors have access to high-quality, life-saving healthcare.
3. Ensure survivors have immediate access to GBV and reproductive health services at the onset of an emergency (no needs assessment is necessary in this instance as would be in other cases of setting up facilities).
4. Healthcare providers should be capacitated to deliver quality care to survivors.
5. Establish and maintain safe referral systems within the health sector and between health and other services to ensure follow-up of cases.
6. Work with communities to develop safe access for GBV survivors to obtain health services.
7. Ensure a multi-sectoral and multi-agency approach while addressing GBV in humanitarian setting.
8. Strengthen the capacity of community health promoters and other community-based health actors.
9. Educate and create awareness in the community on GBV, its consequences, and the availability of response services.
10. Re-establish comprehensive healthcare services and strengthen national health systems after the immediate emergency onset and during transition phases.
11. Specific responsibility of the health sector
12. The health care provider's responsibility is to provide appropriate care to survivors of GBV as documented in these SOPs. This includes collection of any forensic evidence that might be needed in a subsequent investigation either during or post crisis period.

Annex 1: Informed Consent and Assent

Name of the facility: .....

Note to the Health Care Provider: After providing the relevant information to the patient, read the entire form to the patient (or their parent/guardian/caregiver), explaining that they can choose to refuse any (or none) of the items listed. Obtain the signature of the patient, or the thumb print of the patient, and the signature of a witness.

I, _____ (Print name of the survivor.) authorize the above-named health-care facility to perform the following (tick the appropriate boxes):

Clinical Interventions	**Yes**	**No**
Conduct medical and physical examination		
Conduct a genital examination		
Collect and analyse evidence, such as body fluid samples, clothing, hair combings, scrapings or cuttings of fingernails, blood samples, and photographs		
Provide evidence and medical information to the police, prosecutor and/or courts concerning my case; this information will be limited to the results of these examinations and any relevant follow-up care provided		
Provide the phone contact number for follow up		

I understand that I can refuse any aspect of the examinations I do not wish to undergo.

Patient Signature: ..... Date: .....

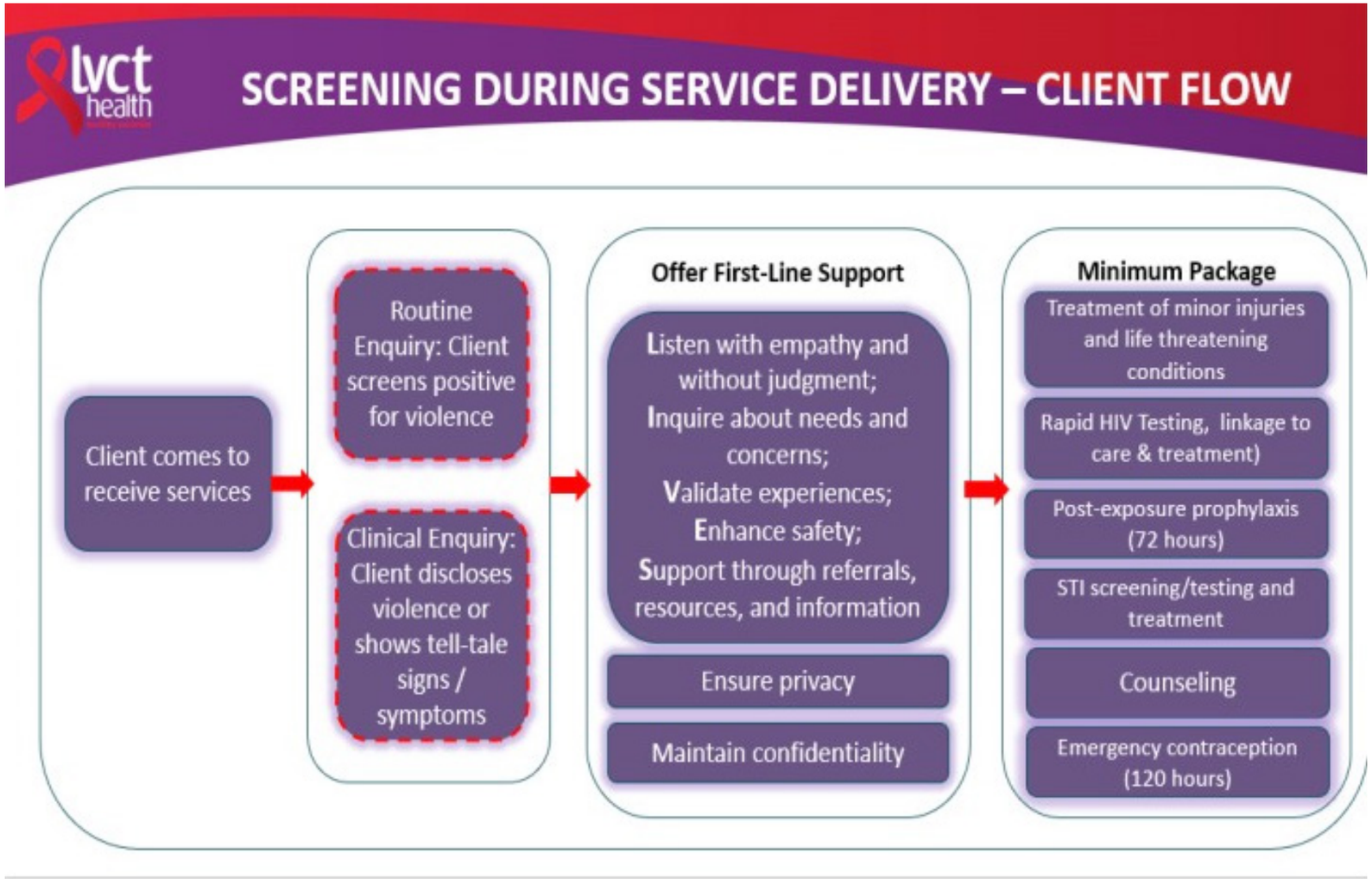
Parent/Guardian/Caregiver Signature..... Date.....

Name of the Witness: ..... Signature.....
Date.....

(If no witness is available, any other health care provider can sign)

Initials of HCP..... Signature..... Date.....

Annex 2: Job Aid 1: Screening During Service Delivery



This Job Aid was produced by the USAID Stawisha Pwani Project supported by the American people through the U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the United States Agency for International Development (USAID).

Annex 3: GBV Screening Tool

County: _____ Sub County: _____ MFL: _____
Facility: _____ Arrival Date (dd/mm/yy): ____/_____/_____

GENERAL INFORMATION		
CLIENT NAME		
REG. NO / UNIQUE NUMBER / CCC. / IPD / OPD		
TELEPHONE NUMBER CLIENT / GUARDIAN		
AGE (YEARS)	**GENDER**	☐ M ☐ F ☐ I

Screening; *Since your last visit, have you undergone any form of violence?* ☐ Yes ☐ No. If yes, type of Violence

SEXUAL VIOLENCE	PHYSICAL VIOLENCE	EMOTIONAL VIOLENCE
Within the last 3 months, has any one forced you to have sexual intercourse with Him /Her even when you did not want to or forced you to perform other sexual acts you did not want to?	Within the last 3 months, has any one ever hit, punched, kicked, tried to strangle, slapped or hit you with something that could hurt you or done anything else that hurt you physically?	Within the last 3 months, has any one threatened, cursed, insulted, done things that made you feel ashamed, kept you in a state of fear or humiliated you in front of others?

Sexual	☐ Rape ☐ Attempted rape ☐ Defilement ☐ Attempted defilement ☐ Sexual harassment
Physical	☐ Physical Abuse
Emotional	☐ Verbal abuse ☐ Harassment ☐ Discrimination ☐ Illegal arrest ☐ Humiliation
Date Violence occurred	____ /_____ /_____

Perpetrator

☐ Partner ☐ Peer ☐ Family ☐ Client ☐ Teacher ☐ Police ☐ Health Provider ☐ Neighbor ☐ Others Specify _____

Post Violence services offered

☐ First Line Support (LIVES/PSS) ☐ Treatment of Minor Injuries ☐ HIV Testing ☐ PEP ☐ STI Screening ☐ STI Treatment ☐ ECP ☐ Trauma Counselling ☐ Others (Specify) _____ ☐ N/A

Referral

YES	☐ Health Facility ☐ Children's Dept. ☐ Police ☐ Legal Aid ☐ Support group ☐ Economic Support ☐ Advocacy Network ☐ Safe Space Shelter ☐ Forensic interviews ☐ Others (Specify) _____ ☐ N/A
NO	☐ Reasons for not referring ☐ Not ready ☐ Got all required services ☐ N/A

Comments/Notes:

HTS Counsellor / Clinician / Nurse / Adherence Counselor

Name: _____ **Signature:** _____ **Date:** _____

Annex 4 PHQ2 AND PHQ9 Job Aids

a) Job Aid 1: Patient Health Questionnaire-2 (PHQ-2)

Instructions: Print out the short form below and ask patients to complete it while sitting in the waiting or examroom.

Use: The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather toscreen for depression as a "first-step" approach.

Scoring: A PHQ-2 score ranges from 0 to 6; patients with scores of 3 or more should be further evaluated with thePHQ-9, other diagnostic instrument(s), or a direct interview to determine whether they meet criteria for a depressive disorder.

Patient Name: _____ Date of Visit: _____				
Over the past 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than one-half of the days**	**Nearly every day**
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

b) Job Aid 2: Patient Health Questionnaire-2 (PHQ-2)

Instructions: To further evaluate patients with PHQ-2 scores of 3 or more, administer or have them complete thequestionnaire on the next page.

USE OFTHE PHQ-9 TO MAKE ATENTATIVE DEPRESSION DIAGNOSIS

The clinician should rule out physical causes of depression, normal bereavement, and a history of a manic/hypomanic epi-sode.

Step 1: Questions 1 and 2

Need one or both of the first two questions endorsed as a "2" or "3"

Step 2: Questions 1 through 9

Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count

Step 3: Question 10

This question must be endorsed as "Somewhat difficult," "Very difficult," or "Extremely difficult"

PHQ-9 scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe, and severe depression, respectively.

USE OF THE PHQ-9 FOR TREATMENT SELECTION AND MONITORING

Step 1: A depression diagnosis that warrants initiating or changing treatment requires that at least one of the first two questions was endorsed as positive ("more than one-half of the days" or "nearly every day") in the past 2 weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

Step 2: Add the total points for each of the columns 2-4 separately. Add the totals for each of the three columns; this is the total score or the severity score.

Step 3: Review the severity score using the following table

PHQ-9 SCORE	PROVISIONAL DIAGNOSIS	TREATMENT RECOMMENDATION (Patient preference should be considered)
0-4	None – minimal	None
5-9	Minimal symptoms[a]	Support, educate to call if worse, return in 1 month
10-14	• Minor depression[b]	Support, watchful waiting
	• Dysthmia[a]	Antidepressant or psychotherapy
	• Major depression, mild	Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
> 20	Major depression, severe	Antidepressant AND psychotherapy (especially if not improved on monotherapy)

[a]If symptoms are present for at least 2 years, then chronic depression is probable, which warrants antidepressants or psychotherapy

[b]If symptoms are present for at least 1 month or patient is experiencing severe functional impairment, consider active treatment

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. *J Gen Intern Med*. 2001;16:606-613.

c) Job Aid 3: PHQ9 Instructions

Patient Name:_____ **Date of Visit:** _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than one-half of the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling asleep, staying asleep, or sleepingtoo much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you're a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as readingthe newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other peoplecould have noticed; or the opposite—being sofidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or ofhurting yourself in some way	0	1	2	3
10. If you checked off any problems listed above, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people? ❒ Not difficult at all ❒ Somewhat difficult ❒ Very difficult ❒ Extremely difficult				

Kroenke K, Spitzer RL, Williams JB. The PHQ-9: validity of a brief depression severity measure. J Gen Intern Med. 2001;16:606-613. ©CQAIMH. All rights reserved. Used with permisison.

Use of the PHQ-9 to make a tentative depression diagnosis

The clinician should rule out physical causes of depression, normal bereavement, and a history of a manic/hypomanic episode.

Step 1: Questions 1 and 2

Need one or both of the first two questions endorsed as a "2" or "3"

Step 2: Questions 1 through 9

Need a total of five or more boxes endorsed within the shaded area of the form to arrive at the total symptom count

Step 3: Question 10

This question must be endorsed as "Somewhat difficult," "Very difficult," or "Extremely difficult"

PHQ-9 scores of 5, 10, 15, and 20 represent mild, moderate, moderately severe, and severe depression, respectively.

USE OF THE PHQ-9 FOR TREATMENT SELECTION AND MONITORING

Step 1: A depression diagnosis that warrants initiating or changing treatment requires that at least one of the first two questions was endorsed as positive ("more than one-half of the days" or "nearly every day") in the past 2 weeks.

In addition, the tenth question about difficulty at work or home or getting along with others should be answered at least "somewhat difficult."

Step 2: Add the total points for each of the columns 2-4 separately. Add the totals for each of the three columns; this is the total score or the severity score.

Step 3: Review the severity score using the following table

PHQ-9 SCORE	PROVISIONAL DIAGNOSIS	TREATMENT RECOMMENDATION (Patient preference should be considered)
0-4	None – minimal	None
5-9	Minimal symptoms[a]	Support, educate to call if worse, return in 1 month
10-14	Minor depression[b]	Support, watchful waiting
	Dysthmia[a]	Antidepressant or psychotherapy
	Major depression, mild	Antidepressant or psychotherapy
15-19	Major depression, moderately severe	Antidepressant or psychotherapy
> 20	Major depression, severe	Antidepressant AND psychotherapy (especially if not improvedon monotherapy)

Annex 5: Job Aid on SGBV Follow Up Care

2nd visit	3rd visit	4th visit	5th visit
2 weeks	**4 weeks**	**6 weeks**	**3 months**
❑ Assess adherence to treatments previously given (PEP, STI, EC) ❑ Evaluate for STIs and treat if necessary ❑ Evaluate mental and emotional status; treat or refer as needed ❑ Provide adherence and trauma counseling	❑ Check for PEP completion ❑ Repeat pregnancy test and refer for care if necessary ❑ Do follow-up vaccinations ❑ Evaluate for STIs and treat ❑ Evaluate mental and emotional status; treat or refer as needed ❑ Provide trauma counseling ❑ Provide Hep B Vaccine and HPV	❑ Evaluate for STIs and treat if necessary ❑ Evaluate mental and emotional status; refer or treat as needed ❑ Provide trauma counseling	❑ Retest for HIV and refer for care if necessary ❑ Evaluate for STIs and treat if necessary ❑ Evaluate mental and emotional status; refer or treat as needed ❑ Provide trauma counseling

Annex 6: Physical Examination Checklist

Physical Exam Checklist	
Look at all the following	**Look for and record**
• General appearance • Hands and wrists, forearms, inner surface of upper arms armpits • Face, including inside of mouth • Ears, including inside and behind ears • Head • Neck • Chest, including breast • Abdomen • Buttocks, thighs, including inner thighs, legs and feet	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Evidence that hair has been pulled out and recent evidence of missing teeth • Injuries such as bite marks or gunshots wounds • Evidence of internal traumatic injuries in the abdomen • Rupture ear drum
Genito-anal Examination	
• Genitals (External • Genitals (Internal) examination, using a speculum • Anal region (external)	• Active bleeding • Bruising • Redness or swelling • Cuts or abrasions • Foreign body presence

Annex 7: Treatment Schedules

A). STI management regimen (adults and children)

Category	First Line Preferred	Alternative
Males and non-pregnant adult females	CEFIXIME 400 mg stat OR CEFTRIAXONE 250 mg IM stat PLUS AZITHROMYCIN 1 g stat OR DOXYCYCLINE 100 mg B.D for 7 days PLUS TINIDAZOLE 2 g stat OR SECNIDAZOLE	NORFLOXACIN 800 mg stat DOXYCYCLINE 100mg b.d. for 7 days
Pregnant females	CEFIXIME 400 mg stat OR CEFTRIAXONE 250 mg IM stat PLUS Azithromycin 1 g stat PLUS TINIDAZOLE 2 g stat SECNIDAZOLE	SPECTINOMYCIN 2g stat PLUS (AMOXIL 3g stat + Probenecid 1g stat) PLUS ERYTHROMYCIN 500mg QID for 7 days

B) Vaccination protocols

Hepatitis B vaccine schedule

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

Human Papilloma Vaccine schedule

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

Tetanus vaccine 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

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

C): Emergency Contraception Options[1]

Drug	Dosage	Frequency
Progestin-only pills (Levonorgestrel)	750 µcg	One at once and repeat after 12hrs (total 2 tablets within 120hrs)
Levonorgestrel	Or 750 µcg	Two tablets to be taken at once within 120 hrs
Levonorgestrel	30mcg (normal POPS ,40 tablets)	20 tablets given at once then repeat after 12 hrs but within 120hrs
Combined oral contraceptives (COC) i.e. oestrogen and progestin	Low dose 30 mcg (e.g Microgynon)	4 tablets at once and repeat 4 tablets after 12 hrs within 120 hrs (8tablets total)
COC	High dose 50 mcg (e.g Eugynon)	2 tablets at once and repeat 2 tablets after 12 hrs within 120 hrs (4 tablets total)
Ulipristal Acetate (UPA)	30 mg	Single dose within 120 hrs
Copper IUCD		Inserted within 120 hrs

D): STI Treatment Summary Table

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

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