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NATIONAL GUIDELINES ON PREVENTION AND MANAGEMENT OF GENDER BASED VIOLENCE

2024 Edition

Contents

Contents **2**
Foreword **6**
Acknowledgment **7**
Executive Summary **8**
Introduction 8
Overview of the Guidelines 8
Target Audience 8
Scope of the Guidelines 8
Abbreviations and Acronyms **10**
Key Definitions and Terms **11**
Background **17**
Context Analysis of Gender-Based Violence in Kenya 17
Overview of GBV Legal and Policy Frameworks in Kenya 17
Situational Analysis 18
Guiding Principles When Managing Survivors of Gender Based Violence **20**
Obligations of Health Care Providers 21
Considerations for Vulnerable Groups Affected By GBV 22
Intergration of GBV Services in other Health Services **24**
Benefits of Integrating Gender-Based Violence and Other Health Services 24
Gender Based Violence Prevention **25**
Prevention Programs 27
Prevention to Response Continuum 27
Survivor Identification and Screening **29**
Types of GBV Client Identification and Screening 29
Clinical Management of Gender Based Violence **34**
Obtaining Informed Consent 34
History Taking and Physical Examination of Survivors 36
Adult History Taking and Examination 36
General Psychological Assessment 39
General Guidelines for Conducting a General Physical Examination 41
Children and Adolescent History and Examination 43
History Taking and Physical Examination for Children 43
History Taking for Children 44
Psychological Assessment 46
Systematic Head to Toe Examination for Children 47
Genito-Anal Examination for Girls 48

Examination of Post-Pubescent Female 48
Hymenal Assessment Techniques in Post-Pubertal Females 49
Genito-Anal Examination for Boys 49
Anal Examination of Children and Adolescents 49
Treatment of Survivors 51
Management of Physical and Genital Injuries 51
Management of Sexually Transmitted Infections (STIs) 54
Hepatitis B Vaccination 55
Tetanus Diphtheria (TD) Vaccine 55
Human Papillomavirus (HPV) 55
Management of Children and Adolescents 56
Clinical Management of Children and Adolescent Survivors of GBV 56
Follow-Up of Survivors of Violence 57
Sexual Violence 57
Other Forms of Violence 58
Documentation of Care 59
Forensic Management and Handling of Evidence 60
Preparing for Forensic Examination 61
Forensic Evidence Collection Process 62
Inspection of the body 62
Inspection of the Anus, Perineum and Vulva 63
Examination of the Vagina and Rectum 63
Depending on the site of penetration or attempted penetration, examine the vagina and/ or the rectum 63
Maintaining the Chain of Custody 64
Presenting Medical Evidence In a Court of Law 65
Mandatory Medico-legal Documentation 66
Female Genital Mutilation 67
Forensic Evidence Management in FGM 72
Person-Centred Communication for Female Genital Mutilation Prevention 73
Management of Gender-Based Violence in Humanitarian Settings 75
Mental Health and Psychosocial Support 78
Survivor-Centred Approach to Counselling 78
Core Principles and Skills Essential for Counselling Session 79
The Counselling Environment 80
Obtaining Informed Consent 80
Providing Mental Health Support to Persons with Disabilities: 90

Referral and Coordination 93
Importance of Referral systems 93
Functions of Key Players in the GBV Referral System 93
Child Protection, Referral and Response Mechanism 95
Monitoring, Evaluation Research,and Learning 97
GBV Data Documentation 97
GBV Reporting 97
GBV Quality Management 99
Continuous Quality Improvement (CQI) 100
Methods of Monitoring Quality 100
Data Quality 100
Data used in Quality Assurance (QA) 100
Reference and Recommendations for Further Reading 101
Annex 1: Standard GBV Screening Tool 103
Annex 2: Consent Form 104
Annex 3: Post Rape Care Form (MOH 363 Part A AND B) 105
Annex 4: Post Rape Care Kit Checklist 107
Annex 5: Head to Toe Examination for Adults -Job Aid 108
Annex 6: Genito-Anal Examination for Adults - Job Aid 109
Annex 7: Essential Functions for GBV Service Provider 110
Annex 8: Sexual Maturity Rating - Tanner's Staging 112
Annex 8: Post Exposure Prophylaxis (PEP) Protocols 114
Annex 10: Emergency Contraception 115
Annex 11: STI Management Regimen (Adults) 116
Annex 12: Vaccination Protocols 117
Annex 13: Counselling Data Form 118
Annex 14: Gender Based Violence Clinical Notes Template 119
Annex 15: Evidence Chain of Custody Tracking Form 121
Annex 16: Protocol on Types of Specimens, Preservation Methods, Tests and Reasons for Testing 124
Annex 17: Kenya Medical Examination Form (**P3**) 132
Annex 18: PHQ9 Mental Health Screening Tool 136
Annex 19: Facility Referral Pathway 137
Annex 20: National Health Sector QA Tool for GBV 138
Annex 21: Referral Form 140

List of Figures

Figure. 1 Percentage of women and men who have experienced physical, sexual violence since age 15 in Kenya (KDHS, 2022) 18
Figure 2. Socioecological model for understanding risk drivers for GBV 19
Figure 3. Imaginary clock 47
Figure 4. Examination of prepubescence girl 48
Figure 5. Female genital anatomy 49
Figure 6. Male genital anatomy 49
Figure 7: Normal Female Genitalia 67
Figure 8: Clinical care process map for the management of CSV within the clinical setting 95
Figure 9: Core component of a comprehensive, coordinated response 96
Figure 10: GBV Data flow chart 99

List of Tables

Table 1: Key Definitions and Terms 11
Table 2: Guiding principles 20
Table 3: Obligations of healthcare providers 22
Table 4: GBV prevention levels 25
Table 5: Screening per service delivery points 30
Table 6: First -line support (LIVES) framework. source WHO clinical handbook 2014 32
Table 7: LIVES approach for children 33
Table 8: Informed consent/assent (QA tool guideline,2020) 35
Table 9: Warning signs of possible GBV in a child 46
Table 10: Considerations and recommendations for PEP provision 53
Table 11: Time-bound treatment schedule 55
Table 12: Types of Female Genital Mutilation 67
Table 13: Management of FGM complications 68
Table 14: Person-centred communication for FGM prevention 74
Table 15: Core Principles and Skills for Counselling 79
Table 16: Commonly Used Mental Health Assessment Tools 83
Table 17: GBV Reporting, Roles and Responsibilities 98

Foreword

Gender Based Violence is a serious public health and human rights concern in Kenya. It affects men and women, boys and girls and has adverse physical and psycho-social consequences on the survivor. It impedes the effective functioning of an individual, hence limiting his/her effective participation in society. Sexual violence is also a serious risk factor in HIV transmission. The legal and policy environment in Kenya favors the SGBV response with the Constitution of Kenya 2010 exhorting the right to the highest attainable standard of health.

Comprehensive care for GBV ranges from medical treatment which includes management of physical injuries, provision of emergency medication to reduce chances of contracting sexually transmitted infections including HIV and provision of emergency contraception to reduce chances of unwanted pregnancies. It also entails provision of psychological first aid to help survivor deal with trauma and legal assistance to assist the survivor access justice, as well as includes provision of evidentiary requirements for the criminal justice system.

This National Guideline has been designed to give guidance on the prevention and management of GBV in Kenya and focus on the necessity to avail quality services that address all the medical, psychosocial, legal needs of a survivor of GBV.

The Guideline recognize the fact that children form a significant proportion of survivors of sexual and other forms of violence and make special provisions for them and address their unique aspects, distinct from those of adults. The Guideline also highlight the need to provide quality services to perpetrators.

The Guideline should be available in all health care facilities and it is our sincere hope that its implementation will comprehensively address the needs of survivors of Gender Based Violence in Kenya.

Dr.Patrick Amoth, EBS

Director General for Health

Acknowledgment

This guideline is as a result of collaborative efforts of various government sectors, partner organizations and individuals. I therefore take this opportunity to appreciate the effort of the officers from the Ministry of Health, National AIDS and STI control Program who coordinated and provided leadership to the development of this guideline.

The development and subsequent revisions to these guidelines 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.

I therefore acknowledge the following organizations, government ministries and departments who volunteered technical expertise and resources to facilitate the review process: Ministry of Health, National Police Service, Ministry of Interior – Government Chemist, County Governments, Ministry of Education, Judiciary, Office of the Director of Public Prosecution, Directorate of Children Services, CDC, USAID, WHO, UNICEF, UNFPA,GVRC, MSF France, Kenya Red Cross, CIHEB and LVCT Health.

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Dr. Issak Bashir

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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 health care providers, 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 Guidelines on Prevention and Management of Gender Based Violence.These guidelines are designed to establish a consistent and improved health care approach for survivors, guaranteeing the provision of suitable medical, psychosocial, and legal assistance.

Overview of the Guidelines

These guidelines 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, medical, psychosocial, and legal aspects. The guidelines emphasize a survivor-centred approach, promoting dignity, respect, confidentiality, and empowerment throughout the care process.

Target Audience

These guidelines are primarily designed for health care providers in Kenya who come into contact with survivors of GBV. This includes but is not limited to:

- Doctors, nurses, clinical officers and other health care providers working in emergency departments, primary healthcare centres, and GBVRC units.
- Psychologists, counsellors, and social workers involved in providing psychosocial support and trauma counselling to survivors.
- Police officers, forensic experts, and legal professionals involved in the collection of evidence and legal proceedings related to GBV cases.
- Healthcare administrators and policymakers responsible for developing protocols, allocating resources, and implementing strategies to improve survivor GBV management.
- Community Based Organisations (CBO), Community Health Promoters (CHPs) implemeting prevention programmes.
- Scope of the Guidelines
- The National Guidelines aim to provide comprehensive direction for preventing and managing survivors of GBV across the continuum of care, from the initial re-

sponse to long-term follow-up. It covers a wide range of topics, including but not limited to:

- Strategies for prevention of GBV occurrence and evidence-based interventions
- Immediate response and emergency medical care for survivors
- Documentation and forensic evidence collection
- Comprehensive medical care, including assessment and treatment of physical injuries,prevention of sexually transmitted infections (STIs) and HIV, emergency contraception, and pregnancy options
- Psychosocial support, including crisis counselling, mental health assessment, and referral for appropriate care
- Legal considerations, including survivor rights, reporting procedures, and support through the legal process
- Confidentiality and privacy considerations.
- Coordination and referral mechanisms for comprehensive care and support services
- Follow-up care and rehabilitation services for survivors, including ongoing medical, psychosocial, and legal support
- Strengthening facility and community linkage
- All GBV survivors should be offered first line support - Listen Inquire Validate Enhance Safety and Support (LIVES)

Abbreviations and Acronyms

ANC	Antenatal Clinic
ARV	Anti-Retroviral
APNS	Assisted Partner Notification Services
CBO	Community Based Organisations
CCC	Comprehensive Care Centre
CHP	Community Health Promoters
COK	Constitution of Kenya
DNA	Deoxyribonucleic Acid
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored and Safe
EC	Emergency Contraceptives
FGM	Female Genital Mutilation
FP	Family Planning
GBV	Gender-Based Violence
HIB	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
PEP	Post-Exposure Prophylaxis
PFA	Psychological First Aid
PMTCT	Prevention of Mother to Child Transmission of HIV
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

Key Definitions and Terms

Table 1 below shows the key definitions and terms applicable in this guideline.

Table 1: Key Definitions and Terms

Terms	Definition
Adolescent	Adolescence is a period of transition from childhood to adulthood. During this period, boys and girls undergo physical, behavioural, cognitive, social, intellectual and emotional growth and change. An adolescent is a person between 10 and 19 years of age[1].
Attempted Defilement	A person who commits an act which causes penetration with a child is guilty of an offence termed defilement (SOA, 2006)
Attempted Rape	This is an attempt to unlawfully and intentionally commit an act which causes penetration with his or her genital organs
Chain of Custody of Evidence	This is the chronological documentation or paper trail records of the sequence of safekeeping, control, transfer, analysis, and disposition of physical or electronic evidence
Child	Any person under the age of 18 years, per the 2010 Constitution of Kenya[2].
Child Abuse	According to Children's Act (2022) child abuse includes infliction of harm on children through physical, sexual, psychological and mental injury and include online abuse, harassment or exploitation.
Child Marriage:	This refers to any formal/informal marriage or union between a child under the age of 18 and an adult or another child
Client-Centred Approach or Survivor-Centred Approach	This means establishing a relationship with the survivor that promotes their emotional and physical safety, builds trust, and helps them restore control over their life. The approach prioritizes the rights, needs, and wishes of the survivor[3].
Confidentiality	Confidentiality promotes safety, trust, dignity, and empowerment. Breaching confidentiality inappropriately can put the survivor and others at risk of further harm and may discourage clients from accessing services.
Defilement	This is an act that causes the penetration of a child's genital organs.

Designated Persons	For purposes of the Sexual Offences Medical Regulations (2012), designated persons are Medical Practitioners, Nurses, and Clinical Officers registered under the various acts of parliament.
Domestic Violence	Refers to physical, sexual, economic, or psychological harm, including acts of physical aggression, sexual coercion, economic abuse, psychological abuse, and controlling behaviors (such as controlling finances, movement, and access to other resources) that a person perpetrates against an intimate partner, dating partner, or any member of a household, including a child, parents, other relatives, or a domestic worker.
Emotional or Psychological Violence	This is the intentional use of words and non-physical actions with the purpose of manipulating, intimidate, hurt, weaken, or frighten a person mentally and emotionally; or influencing a person's thoughts and actions within their everyday lives.
First-line Support	This is a practical, survivor-centred, empathetic counselling approach and responds to emotional, physical, safety and support needs without intruding on their privacy. The WHO defines "first-line support" using the acronym "LIVES": Listening, Inquiring, Validating, Ensuring safety, and Support through referrals.
Forensic Evidence	This is the information and materials collected during a medical or crime scene examination that would assist in the dispensation of justice. This includes biological materials such as blood, hair, urine, sperm, seminal fluid, nails, and DNA, which can be used in court to link or de-link the suspect to the crime.
Female Genital Mutilation	This is the ritual cutting or removal of some or all of the external female genitalia. It violates women's bodies and often damages their sexuality, mental health, well-being, and participation in their community.
Forced Marriage	This refers to marriage concluded under force or coercion – either physical pressure to marry or emotional and psychological pressure. It's closely linked to a child or early marriage when children are wed before reaching the minimum age for marriage.

Gender-Based Violence	This refers to any harmful act that is perpetrated against a person's will and that is based on their gender. GBV includes various forms of physical, emotional, sexual, or psychological abuse
GBV Response	This refers to immediate interventions that address survivors' physical safety, health concerns, psychosocial needs, and access to justice, in line with the survivor-centred approach. All survivors of GBV, including survivors of sexual exploitation and abuse (SEA) perpetrated by healthcare providers, have the right to immediate life-saving protection and GBV services.
GBV Prevention	This refers to actions that prevent GBV from occurring by addressing its root causes, namely abuse of human rights, gender inequality, systemic discrimination, and unequal power relations between women and men, as well as people with diverse sexual orientations and gender identities. GBV is preventable.
Genital Organs	This includes the whole or part of the male or female genital organs and the anus according to the 2006 Sexual Offences Act.
Harmful Cultural Practices	These are forms of violence resulting from societal norms / practices that have been reinforced overtime (normalized) e.g. child marriage, FGM, and forced marriage. Violations of human rights that put women's, children's, and adolescents' sexual and reproductive health and rights at great risk.
Indecent Act	An unlawful intentional act that causes any contact between any part of a person's body with the genital organs, breasts or buttocks of another but does not include an act that causes penetration. It also includes exposing or displaying any pornographic material to anyone against their will. It can be compelled or induced.
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. Assent: This is the agreement of someone not being able to give legal consent to participate 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.

Intimate Partner Violence	This involves physical, sexual, and emotional violence by an intimate partner or ex-partner. Among romantically involved but unmarried adolescents it is sometimes called "dating violence". An intimate partner is defined as a current or former spouse, boy/ or girlfriend, husband or wife, lover, cohabiting partner
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)
Medical Practitioners:	Medical practitioner means a practitioner registered by section 6 of the 'Medical Practitioners and Dentists Act'.(SOA medical treatment regulations, 2012)
Offender/Suspect	This is a person alleged to have committed an offence A person who commits an illegal act
Paralegals	These are individuals trained in subsidiary legal matters but not fully qualified as lawyers
Penetration	Partial or complete insertion of the genital organs of a person or an object into the genital organs of another person.
Perpetrator	A perpetrator is defined as a person who directly inflicts or supports violence or other abuse inflicted on another against his/her will. (IRC, 2012). These can include caregivers, peers, romantic partners or boyfriend or girlfriend, neighbours, strangers, authority figures such as teachers, police, employers, religious or community leaders, and healthcare providers. Violence can be perpetrated physically or online.
Post Rape Care Form (MOH 363)	This is a document that is used for recording and presentation of medico-legal evidence on sexual violence.
Psychological or Emotional Trauma	This refers to damage or injury to the psyche after living through an extremely frightening or distressing event and may result in challenges in functioning or coping normally after the event
Rape	This is any act that causes the penetration of one person's genital organs with the genital organs of another without their consent or where the consent is obtained by force, threats, or intimidation.

Quality	This is the standard of something as measured against other things of a similar kind; the degree of excellence of something. "Doing the right thing right, right away" (Deming 1982)
Quality Management (QM)	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 resources
Quality Assurance	This is a systematic and planned approach to monitoring, assessing, and improving the quality of services continuously
Screening	This is a structured process used to detect a disorder or health condition. There are two recommended types of GBV screening/enquiry: • Routine screening/enquiry: This is done for all patients in a particular setting (e.g., asking all ANC or HIV patients). This should only be done in settings meeting minimum standards per WHO guidelines. • Clinical Enquiry/Case Finding: This refers to asking questions about GBV to patients who disclose they have experienced violence or patients/clients who show signs and symptoms of GBV.
Sexual Assault	This is an act of penetration of the genital organs of another person with • any part of the body of another or that person; or • an object manipulated by another to cause penetration of the genital organ into or by any part of the other person's body The exception is where such penetration is carried out for proper and professional hygienic or medical purposes, and consent is sought
Secondary Trauma	This occurs when a service provider relates to someone who has undergone a traumatic event to the extent that they begin to experience similar symptoms of post-traumatic stress disorder that the trauma survivor is experiencing
Sexual Harassment	This is any unwelcomed sexual advances, unwelcomed requests for sexual favours or unwelcomed sexual conduct of sexual nature which makes a person feel offended, humiliated and or intimidated.

Sexual Violence	Any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic women's sexuality, using coercion, threats of harm or physical force, by any person regardless of relationship to the survivor, in any setting, including but not limited to home and work. Examples include rape, attempted rape, defilement, attempted defilement, sexual assault, sexual harassment and indecent act
Survivor/Victim	Any person who has undergone GBV

Background

Context Analysis of Gender-Based Violence in Kenya

Gender-based Violence (GBV) is still widespread in Kenya and is rooted in gender-related power differences and cultural, social, economic, and political inequalities. GBV is any form of violence against an individual based on their biological sex, gender identity or expression, or perceived adherence to socially defined expectations of what it means to be a man or woman, boy or girl.

However, it disproportionately affects women and girls. Individuals from other diverse and marginalized communities face greater risk where gender inequality combines with other forms of oppression.

GBV is inter-related to and impacts many dimensions of an individual's health and is diverse in typology and context. The impact of GBV is often compounded when it intersects with other forms of discrimination, such as race, class, sexual orientation, or disability. It involves physical, sexual, emotional, economic violence and harmful cultural practices.

Other types of violence include cyber-facilitated GBV. This is digital violence which is committed through the use of information and technology, or digital spaces against a person based on gender e.g. image based abuse, online harassment, cyber-stalking, online grooming, hate speech among others.

Overview of GBV Legal and Policy Frameworks in Kenya

Kenya has a robust legal and policy framework that articulates comprehensive legal response to GBV. The Constitution of Kenya in its bill of rights under chapter 4 guarantees for wide range of rights and freedoms that are of importance to gender equality and that have a general bearing on gender-based violence, these include Articles; 26, 27,28, 29,30,31,32,36,40,41 and 43.

Kenya has ratified several international and regional human rights instruments which address the obligations of the State on GBV. Kenya has also enacted various legislations to curb GBV, e.g., the Constitution of Kenya (2010), Penal Code, Sexual Offences Act (2006), Children Act (2022), Protection Against Domestic Violence Act (2015), Prohibition of FGM Act (2011), HIV prevention and control Act (2017) Countertrafficking in Persons Act (2010), Computer Misuse and cyber-crime Act (No. 5 of 2008) Marriage Act (No .4 of 2014) and International Crimes Act (No 16 of 2008).

In addition, Kenya has developed key policy documents that address prevention and response to GBV, such as the National Policy for Prevention and Response to Gender-Based Violence (2014), Kenya National Social Protection Policy (2011), National policy for eradication of FGM (2019), National Prevention and Response plan on VAC 2019-2023.

Situational Analysis

The 2022 Kenya Demographic and Health Survey (KDHS) reported that over 1 in 3 (34%) of women ages 15-49 years had experienced physical violence, and over 1 in 10 (13%) had experienced sexual violence, there is a slight increase of violence reported against men (Figure 1).

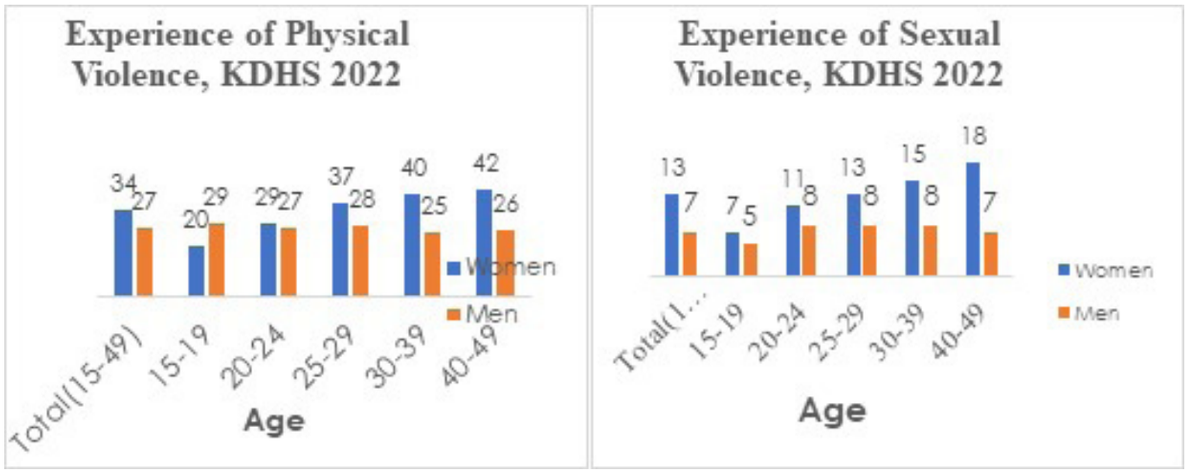


Figure. 1 Percentage of women and men who have experienced physical, sexual violence since age 15 in Kenya (KDHS, 2022)

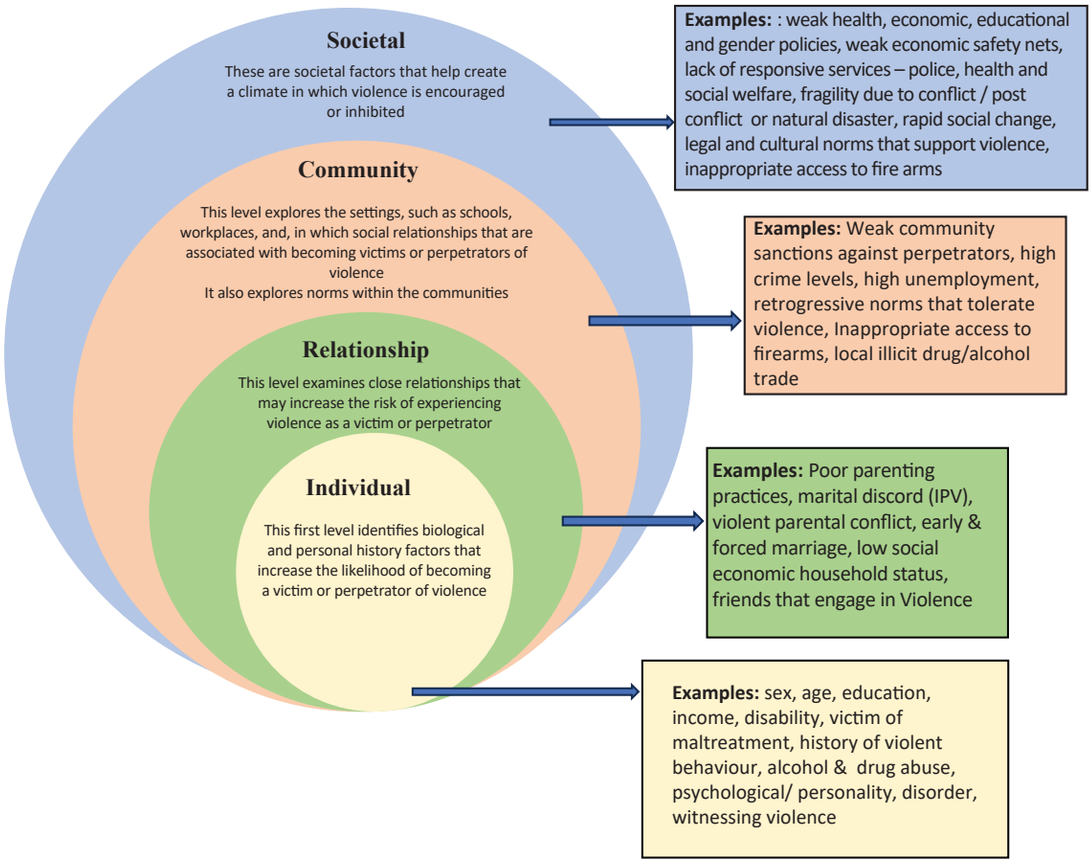
The Kenya Violence against Children Survey (VACS, 2019) reported that nearly half of the females (46%) and more than half of the males (56%) experienced violence (physical, sexual, or emotional) in Kenya. Physical violence is the most common type of violence experienced by children in Kenya. Two out of five (39%) females and one out of two males (52%) experienced childhood physical violence. Females are more than twice as likely (16%) to experience sexual violence in childhood as males (6%). Among 16% of females who experienced childhood sexual violence, nearly two-thirds (62%) experienced multiple incidents before age 18. This was the second VACs Survey which demonstrated reduction of GBV apart from violence exposure to adolescent girls that appear to have stagnated.

The prevalence of Female Genital Mutilation (FGM) declined from 38% in 1998 to 15% in 2022. Since 2014, the percentage of circumcised women who were cut and had flesh removed declined from 87% to 70%, while the percentage of circumcised women sewn closed increased from 9% to 12%. FGM Prevalence generally increases with age; 9% of women age 15–19 have been circumcised according to KDHS 2022.

Socioecological Model for Understanding Risk Drivers for GBV

The contributing factors to GBV and VAC span from individual to societal factors as shown in figure below.

Figure 2. Socioecological model for understanding risk drivers for GBV



Consequences of GBV

GBV has devastating negative consequences on survivors' physical, psychological, and social economic well-being. GBV impacts the cost of health and legal services, loss of earnings, absenteeism, or inability to work for those affected. In addition, there is also multigenerational impact, perpetuating cycles of violence and negative outcomes within families. The survivors may suffer further because of the stigma associated with GBV.

Guiding Principles When Managing Survivors of Gender Based Violence

These guidelines offer a survivor- centered approach that prioritizes the survivor's rights, needs and wishes. The following fundamental principles in table 2 below, must be adhered to when working with survivors of GBV[5];

Table 2: Guiding principles

Principle	Explanation
Do no harm	Conduct actions, procedures, and programs in a way that does not put the survivor at further risk of harm or unintended consequences this must be applied at all times Ensure that all steps taken in providing services are based on the informed consent of the survivor, without judgment or negative repercussions for the client.
Survivor-Centered Approach	1. Create a supportive environment, that ensures safety and dignity to promote recovery, and reinforces survivors' capacity to make decisions about possible interventions 2. Safety and security: Every person has the right to be protected from further violence and harm 3. Includes physical, psychological, and emotional safety while considering the safety needs of Survivors, their family members, supporters, and those providing care 4. Confidentiality: Respect the confidentiality of survivors (and their families) at all times. There are exceptions to confidentiality that survivors should know. These exceptions include where: • The threat of ongoing harm to a survivor where the need to protect them overrides confidentiality. • Laws or policies require mandatory reporting of certain types of violence against children. • There is a risk of self-harm, and harming others, including threats of suicide or homicide. • There is sexual exploitation or abuse by service providers. 5. Respect and dignity: All action or decision should be guided by respect for the survivor's choices, wishes, and rights 6. Non-discrimination: Survivors should receive equal and fair treatment, regardless of their age, sex, race, marital status, sexual orientation, or any other characteristic

Honesty	Survivors should receive honest and complete information about possible referrals for services. They should be aware of any risks or implications of sharing information about the situation and have the right to limit the types of information shared and whom it is shared with.
Urgency	Prioritization of survivors' urgent medical needs and immediate response.
Non-discrimination	Healthcare providers should offer services to children regardless of sex, race, ethnicity, health status, religion, sexual orientation, gender identity, disability, or socioeconomic status.
Best interests of the child	A child's best interests are of paramount importance in every matter. This means the principles that prime the child's right to survival, protection, participation and development above other considerations. All decisions made by health care providers should be in the child's best interest.
Child participation	Healthcare providers should ensure children exercise their right to participate in decisions that affect them per their evolving capacities. The health care provider should provide information appropriate to the age of the child survivor when seeking assent and respecting the autonomy and wishes of the child survivor.

Survivors Fundamental Rights

Under the Kenyan Laws, the survivor has the following rights:

- Right to life
- Right to highest standard of health
- Right to information
- Right to privacy and confidentiality
- Right to informed consent

A Comprehensive description of these rights is illustrated in the Constitution of Kenya, 2010.

Obligations of Health Care Providers

Healthcare professionals need to recognize their obligations in providing comprehensive and survivor-centered care. Table 3 below, outlines the key obligations that healthcare providers should uphold when responding to GBV:

Table 3: Obligations of healthcare providers

Providers are responsible for:	Providers are NOT responsible for:
• Understanding GBV and prioritizing the client's safety • Creating a safe environment where a survivor can continue accessing services without jeopardizing their safety • Understanding how gender power differences impact access to resources and interactions with the health system • Reinforcing the value of their client through their words, body language, and actions • Respecting dignity by involving the client in decision making. • Explain who they are, their role and responsibilities, and that they are there to support the survivor. • Show the survivor you believe their story, commend them for doing what they needed to do to survive, and recognize their courage and resiliency.	• "Solving" violence for the survivor • Determining the legal aspects of the violence or assault • Determining whether a client is telling the truth about GBV • Mediating relationship problems between a couple • Forcing a survivor to leave an abusive relationship • Knowing all the answers

Considerations for Vulnerable Groups Affected By GBV

In addition to clinical and medical management and care, the following should be considered while handling these different survivors during the provision of psychosocial support:

Children

The dynamics of child sexual abuse differ from those of adult sexual abuse. The needs and capacities of children and the ways of responding to those needs vary. Children rarely disclose sexual abuse immediately. The health providers should make an effort to believe in and trust the child, create rapport, listen carefully with understanding and let them move at their own pace. The providers should be familiar with the Standard Operating Procedure (SOP) for counselling, including LIVES for children.

Persons with Disabilities (PWDs)

Health providers should know that PWDs who have undergone GBV have challenges "working through" or talking about their traumatic experience. Guardians may also need assistance to support survivors. Health providers should not have prejudices about PWDs and should debrief the guardian and/or family members to make appropriate referrals.

Older Persons (Geriatrics)

The guiding principles in counselling older individuals include: Respect, dignity, and honoring their autonomy. Older individuals come from diverse cultural backgrounds; they may have different beliefs, values, and experiences that should be respected. It is important to note that older persons tend not to open up to younger counsellors and psychologists so that a choice of an older person can facilitate better cooperation and security.

Intergration of GBV Services in other Health Services

Clients at risk of or have experienced violence rarely disclose their experience of violence. More commonly, these clients attend the health facility for other health-related issues or present with GBV-related issues.

It is, therefore, important that health workers who routinely offer clinical care to clients have the appropriate skills and knowledge to ask age-appropriate questions whenever they suspect the possibility of GBV.

Benefits of Integrating Gender-Based Violence and Other Health Services

Accessibility: Clients who experience GBV tend to face significant barriers to accessing health services. Purposeful integration of GBV services into other programs and service delivery points (SDPs), such as antenatal care (ANC), sexual and reproductive health services (SRH), and HIV services, is recommended to ensure more GBV survivors access appropriate care.

Utilization of existing services: Of the five essential GBV services – first-line support (LIVES), emergency contraception (EC), post-exposure prophylaxis (PEP), prophylaxis for sexually transmitted infections (STIs) and vaccination against tetanus, Human Papilloma Virus (HPV) and Hepatitis B. Most are already provided by trained staff at HIV/STI clinics or within other departments in health facilities.

Given the training requirements for providers to conduct HIV counselling and testing or to dispense PEP, using existing services and adding missing services (EC and tetanus, HPV and hepatitis B vaccines) where needed makes integrating GBV services cost-effective and logistically easier.

Time-sensitive services delivery: GBV integration improves early identification, provision of time-bound prevention services EC and PEP within the critical time frame, and improves health outcomes for survivors.

Gender Based Violence Prevention

Gender-based violence (GBV) prevention refers to the proactive measures and strategies aimed at stopping or reducing the occurrence of violence against individuals based on their gender. It encompasses a range of interventions and approaches that target the root causes of GBV, challenge harmful gender norms, and promote equitable and respectful relationships.

Violence prevention programs are classified into primary, secondary, and tertiary prevention categories. To better understand these distinctions, refer to Table 4 for clear definitions and examples.

Table 4: GBV prevention levels

Level	Description	Examples of Prevention Interventions
Primary prevention	It aims to prevent GBV from occurring in the first place by addressing the root causes and promoting social change. It focuses on changing societal attitudes, beliefs, and behaviors related to gender and power.	**Social Norms Campaigns:** • These campaigns challenge harmful social norms and stereotypes that perpetuate GBV. • They seek to shift societal attitudes by promoting gender equality, respect, and non-violence through media campaigns, community mobilization, and educational initiatives **Education and Awareness Programs:** • These programs aim to promote knowledge and awareness about GBV, healthy relationships, consent, and gender equality • They may be implemented in schools, communities, workplaces, or online platforms and can include workshops, training, and information campaigns **Gender equality empowerment Programs:** • These programs focus on empowering individuals, particularly women and girls, by enhancing their self-esteem, building skills, and promoting their rights • They aim to address gender inequalities and provide opportunities for economic empowerment, education, and leadership **Bystander Intervention Programs:** • These programs train individuals to recognize signs of potential violence and intervene safely and effectively

		• They teach skills such as bystander activation, de-escalation techniques, and seeking help from authorities or support services **School-Based Prevention Programs:** • These programs operate within educational settings and focus on preventing GBV among students • They often include awareness-raising campaigns, workshops on healthy relationships and consent, and policies that address GBV in schools
Secondary Prevention	Focuses on early detection and intervention to prevent GBV from escalating or recurring. It aims to identify individuals at risk and provide targeted support and interventions	• GBV screening interventions as per WHO guidelines • Alcohol misuse prevention interventions • Managing the underlying mental health problems of Perpetrators • Managing psychological effects on survivors
Tertiary Prevention	It focuses on mitigating the negative consequences of GBV and supporting survivors. It aims to facilitate healing, recovery, and reintegration into society	**Support Services for Survivors:** • These services include medical care, counselling, legal assistance, shelter, and economic support • They aim to address the immediate and long-term needs of survivors and promote their well-being and empowerment **Perpetrator Intervention Programs:** • These programs focus on addressing the behaviour of perpetrators and reducing their likelihood of reoffending • They may involve counselling, therapy, anger management programs, and programs that challenge harmful masculinity norms

Prevention Programs

- In collaboration with stakeholders, the Ministry of Health (MoH) has put in place measures to prevent, coordinate and strengthen GBV referral pathways
- Prevention programs should tackle the underlying causes of GBV, such as harmful gender norms, unequal power dynamics, and social norms that condone violence. By addressing these root causes, prevention efforts will create long-term and sustainable change, leading to a reduction in the occurrence of GBV
- Prevention programs are generally more cost-effective than response interventions and have the potential to reach larger populations, influence social norms, and prevent violence from occurring in the first place, thereby reducing long-term costs
- Prevention programs promotes gender equality, respectful relationships, and non-violent norms, contributing to positive behavioural and attitudinal changes at various levels
- Investing in prevention in societies breaks the cycle of violence and creates a future where GBV is less prevalent, allowing future generations to grow up in safe environments

Prevention to Response Continuum

The Prevention to Response Continuum framework addresses gender-based violence (GBV) to guide efforts from proactive prevention to effective response. It represents a comprehensive approach to addressing GBV throughout its stages, emphasizing the importance of a multi-sectoral and coordinated response. The continuum comprises three categories; universal, selective and response programs.

- Universal prevention programmes are directed at an entire population, community, or group regardless of whether programme participants have experienced or used violence or of their individual or family risk status.
- Selective prevention programmes are directed at specific groups or individuals considered to be at higher risk. This could include, for example, families under stress and/or with mental health and substance abuse problems or individuals or families already experiencing violence.
- Response programmes offer services to address violence survivors' short- or long-term needs. They usually work to strengthen institutional capacities to provide more accessible, relevant, timely, and high-quality services and be responsible and accountable to survivors.

Universal and selective prevention and response initiatives complement one another. For example, as universal prevention targets the whole-of-population level, including social norms and structural inequalities, it inevitably reaches those already experiencing or perpetrating violence or at increased risk. All levels of intervention across the preven-

tion-to-response continuum are important for a comprehensive systems approach adapted to the local context. For example, when prevention work is undertaken in communities, it is common for more survivors to feel confident enough to speak out about the violence they are experiencing and seek help. Therefore, there must be accessible, quality response services that survivors can be referred to for this help.

Survivor Identification and Screening

World Health Organization (WHO) defines screening as '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'.

Health care providers have a primary objective of GBV screening to identify survivors and link them to services based on the needs and willingness of the survivor. Identification alone is NOT the goal.

Typically, survivors of GBV are identified when a survivor self-reports to a service provider at the community or facility level.

Benefits of screening

- Greater willingness to report GBV cases and begin speaking openly about GBV and potentially reduced stigma in the affected communities
- Improve rates of early detection of GBV
- Improved access to comprehensive GBV care
- Higher number of survivors of GBV linked to much needed health, psychosocial, and protection services.
- Increase awareness about services available in the facilities

Types of GBV Client Identification and Screening

Routine Enquiry

Asking all clients who present for specific services e.g., Index Case Testing/Partner Notification Services, PrEP (newly initiated and currently on PrEP), MCH about experiencing violence or fears of violence.

The following minimum requirements must be in place for routine enquiry:

1. protocol or Standard Operating Procedure (SOP) for conducting routine enquiry.
2. A questionnaire with standard screening questions. (See annex 1)
3. Trained providers on the enquiry about GBV and provision of first -line support (LIVES)
4. Ensure privacy and confidentiality.
5. Presence of a system for referral and linkages in place. A referral directory should be routinely updated to ensure an active link for needed services.

If these minimum requirements are missing, GBV services are considered inadequate, and providers should not conduct a routine enquiry.

Clinical Enquiry

The clinical enquiry concerns case finding based on the presenting client's conditions, history and, where appropriate, examination.

- Minimum requirements do not need to be in place – the priority is to support the client.

Universal Screening

This is asking all clients about violence.**THIS IS NOT RECOMMENDED.**

This guide recommends screening in the following service delivery points indicated in table 5 below;

Table 5: Screening per service delivery points

Type of screening	Service delivery points
Routine enquiry	HTS (during Assisted Partner Notification Services (APNS) PrEP provision
	Antenatal Clini (ANC)/Maternal Child Health (MCH)/Family Planning (FP)/Prevention of Mother to Child Transmission of HIV (PMTCT)
	Comprehensive Care Clinic (CCC) DREAMS
Clinical enquiry	Outpatient and inpatient departments
	Special clinics (medical, surgical, gynecological. etc.)

It is recommended that the service delivery point has the minimum requirements in place before conducting a routine enquiry.

NB: You do not need the minimum requirements if you conduct a clinical enquiry; the priority is to provide the client with First line Support and offer or refer them to any additional service they may need.

Signs to look out for in survivors who have not disclosed violence

- Stress, anxiety, or depression
- Repeated or unexplained injuries
- Harmful behaviours such as drug and alcohol abuse
- Thoughts or plans of self-harm or suicide
- Repeated sexually transmitted infections
- Unplanned pregnancies
- Unexplained pain or conditions, e.g., abdominal problems, headaches, sexual problems
- Repeated health consultations with no precise diagnosis. (WHO, 2013)
- The survivor's partner is intrusive during consultations
- Clients miss clinic appointments
- Survivors' children have emotional and/or behavioural problems

First-line Support

The WHO defines "first-line support" using the acronym "LIVES": Listening, Inquiring, Validating, Ensuring safety, and Support through referrals. First-line support is a practical, survivor-centred, empathetic counselling approach and responds to emotional, physical, safety, and support needs. The immediate care given to a survivor of gender-based violence who disclose violence upon fiWrst contact with the health or criminal justice system. The LIVES framework is summarised in the Table 6 below.

Table 6: First -line support (LIVES) framework. source WHO clinical handbook 2014

L	**LISTEN**	Listen closely with empathy, no judgement. Active listening is demonstrated both verbally and non-verbally. 1. Listening is more than just hearing a survivor's words. It is the most important part of good communication and the basis of first-line support. It gives the survivor a chance to say what they want to a caring person who wants to help. This should be done in a safe and private place.
I	**INQUIRE**	Assess and respond to the client's needs and concerns; emotional, physical, social, and practical. Inquiring about the survivor's needs and concerns in a caring way, putting the survivor at the centre of decisions. Remember to minimise distractions and focus on the client for most effective communication.
V	**VALIDATE**	Show the client you believe and understand them. Validate what the survivor is saying. Demonstrate understanding of what they are saying and that what they say is believed without judgement or conditions.
E	**ENHANCE SAFETY**	Discuss how to protect the client from further harm. When assessing safety after sexual abuse` or partner violence, discuss whether or not it is safe for the survivor to go home. Partner violence is not likely to stop on its own. Safety concerns should be taken seriously, and the survivor should be helped with safety assessment and plans.
S	**SUPPORT THROUGH REFERRALS**	Help connect the client to appropriate services, including social support. Discuss with the survivor what is most important to them, and help them identify and consider their options. Providers should use and update their sites' referral directories as the basis for facilitating access to formal social support based on survivors' needs or survivors may prefer to rely on their informal networks. Healthcare workers play an important role by connecting survivors to needed resources and, through warm referrals, encouraging them to seek support. The support should be appropriate for the population (e.g., child-friendly services, youth-friendly services).

For children survivors who disclose violence, it is recommended that the health provider should apply the children-specific LIVES approach to respond to their needs as described in Table 7 below.

Table 7: LIVES approach for children

- Listen actively and empathically to the child, and believe them when they speak
- Be nurturing, comforting, and supportive
- Reassure the child (validate) that they are not at fault for what has happened to them and that you believe them
- Empower non-offending caregivers with information about the care of the child or adolescent
- Provide age-appropriate information in an age-appropriate manner and environment. Do no harm: be careful not to traumatise the child further
- Do not become angry with the child, force the child to answer a question they are not ready to respond to, force the child to speak about the sexual abuse before they are ready, or have the child repeat their story of abuse multiple times to different people
- Speak in a way that the child understands
- Help the child to feel safe
- Tell the child why you are talking to them
- Choose appropriate people to help. In principle, non-offending caregivers, service providers and interpreters should speak with child survivors about sexual abuse. The best practice is to ask the child (Boy and Girl) which gender they would prefer, where possible
- Pay attention to non-verbal communication. A child may demonstrate feelings of distress by crying, shaking or hiding their face, or changing their body posture
- Be aware of the cues your body language is giving to gain the child's trust
- Respect the child's opinions, beliefs, and thoughts

Adapted LIVES approach for children (WHO)

Clinical Management of Gender Based Violence

The clinical and forensic management of survivors of GBV commences with carrying out a primary survey to identify life-threatening conditions that require appropriate actions for patient stabilization and proper referral.

The primary survey is the first assessment to identify injuries such as airway obstruction, chest injuries, breathing difficulties, severe external or internal hemorrhage, and severe injuries.

General Considerations

- Introduce yourself and the procedure to the survivor
- Conduct a primary survey –ABCDE
- Screen for gender-based violence (GBV)
- Provide first-line support (LIVES)
- Obtain informed consent before examination or treatment
- Maintain confidentiality by following ethical and legal guidelines
- Conduct a thorough history taking
- Examine the survivor systematically from head to toe. In the event of an emergency, address life threatening issues first
- Collect both medical and forensic specimens at the same time
- Provide treatment including PEP, EC, STI prophylaxis etc
- Assess mental health and provide psychosocial support
- Document findings in the PRC form, P3 and the GBV registers
- Provide referral linkage and follow-up care

Obtaining Informed Consent

Definition

This is the voluntary agreement of an individual, who has been provided with relevant information and is legally able to understand, make a choice and participate in care. In examination of survivors the informed consent should be written. See an illustration of informed consent in Annex 2.

Importance of Informed Consent

1. To make an informed decision about the survivor's care
2. To empower the survivors to have control over their medical care
3. For legal purposes.

NB: The results of an examination conducted without consent are not to be used in legal proceedings.

A health care provider must take all reasonable steps to obtain the survivor's informed consent unless the survivor lacks the legal capacity to do so.

When releasing information for legal justice, it is important that consent for medical examination accompany collection and disposition of any forensic samples collected. Consent for the examination should include information on the collection and disposition of any forensic samples collected during the examination. Caregivers should give consent for children, unconscious and survivors with mental illness.

Table 8 below provides guidance on age-specific criteria for identifying the appropriate individuals responsible for provision of informed consent or assent when caring for children survivors of violence, adolescent and their non-offending caregivers.

Table 8: Informed consent/assent (QA tool guideline,2020)

Age Group (Years)	Child	Parent/ Guardian/ Caregiver	If No Parent/ Guardian/ Caregiver (OR if the caregivers are not acting in the best interest of the child)	Means
0-5	-	Informed consent	Authorized Officer informed consent	Written consent from parent / guardian / caregiver
6-17	Informed assent	Informed consent	Authorized Officer informed consent	Oral assent and written consent (from parent / guardian / caregiver)

Confidentiality

Confidentiality is a fundamental ethical principle applied when working with survivors of violence. According to the Health Act 2017, information concerning a user, including that related to their health status, is confidential and can only be disclosed under a court order or informed consent. Breaching confidentiality can put the survivor and others at risk of further harm and may discourage clients from accessing services. However, for purposes of GBV management, shared confidentiality will apply. The recommendation is that interview records be stored safely under lock and key with access to authorized personnel.

Consequences of breach of confidentiality

- Survivors may miss an opportunity to seek help
- Survivors may experience retaliation/victimization

- It may result in violence toward the service provider
- The damaged reputation of the health facility

History Taking and Physical Examination of Survivors

Adult History Taking and Examination

History taking and examination of the survivor should be undertaken immediately by a clinician in a safe and trusting environment. Survivors who cannot be examined immediately because of the trauma experienced should receive first aid and then be provided with first-line support (LIVES).

Before starting and at every step of the physical examination, the healthcare provider should explain the procedures and the rationale to the survivor. A family member or friend can be present throughout the examination if the survivor wishes. If a survivor decline all or part of the physical examination, the health care provider must respect their decision; allowing the survivor a degree of control over the physical examination is important for them to recover. Clinicians respond to survivors' questions and concerns calmly, non-judgmentally, and empathetically. Medical history, examination, and sample collection findings are documented precisely in the clinical notes and PRC form (MOH 363) - Annex 3.

Consideration during history taking and examination

- **Cultural background:** Survivor/suspected perpetrator may be apprehensive about interacting with health providers from ethnic backgrounds or members of the opposite sex
- **Language:** Consider an interpreter/ translator where necessary, e.g., a sign language interpreter for deaf survivors
- **GBV and human trafficking link:** A trafficked person is highly likely to be a GBV survivor
- **Survivors with disabilities:** The service providers should be sensitive to people with disabilities, e.g., physical, sensory, cognitive and developmental
- **Children and adolescent survivors:** The service providers should be sensitive to the needs of adolescents, the role of parents/guardians and the laws governing minors' ability to consent to forensic examination and medical treatment
- **Male survivors:** The service providers should be sensitive to the needs of the male survivors. Male survivors may face significant shame and stigma that prevents them from reporting and accessing health services
- **Key and vulnerable population:** The service provider should be sensitive to the survivor's health needs and not discriminate against them

NB: When patients decline care, respecting their autonomy and rights is important while considering their well-being.

- Engage them openly and empathetically to understand their concerns and reasons for refusing care
- Provide information about the proposed treatment or care, including the potential benefits, risks, and alternatives
- Address any misconceptions or fears the patient may have
- Evaluate the patient's decision-making capacity, and discuss the potential consequences of refusing care, both immediate and long-term

General Tips for History Taking

1. Review any documents the survivor brought, i.e., referral notes and P3 forms
2. Avoid asking questions that have already been asked and documented
3. Let the survivor tell the story how they want to, at their own pace
4. Do not interrupt or pressure them
5. Use a calm tone of voice while maintaining eye contact if culturally appropriate `
6. Do not make stigmatizing or blaming remarks, such as "What were you doing there?"
7. Take time to collect all information needed without rushing
8. Allow the survivor to describe what happened in their own words, avoid interrupting, and avoid signs of disapproval
9. Clarifying certain points should be done after the survivor describes the incident
10. Be aware of sexual orientation and gender identities to avoid stigma and discrimination

In history taking these three parts are included:

1. General medical information
2. Gynecological history
3. Psychological assessment

The health care provider should ask questions that will generate the following information.

General Psychological Assessment

General medical information

- The date, time and location, and surface on which violence occurred
- Whether the suspect is known or unknown
- The name, identity, and number of assailants
- If unknown whether there are distinct, descriptive characteristics noted in the person
- The nature of the physical contact and detailed account of the violence inflicted
- Circumstances of the assault: Any injuries, blows, strangulation, weapons or other objects, verbal abuse, threats, and restraints
- Subsequent activities by the survivor that may alter evidence, e.g., Bathing, douching, wiping, the use of tampons, and changes of clothing
- Symptoms that may have developed since the violence, e.g., Genital bleeding, discharge, itching, sores, or pain
- Current sexual partner/s
- Last consensual sexual intercourse
- How the assault unfolded (penetration – oral, vaginal, anal, with or without foreign objects; use of condom and lubricants)
- Associated events- Loss of consciousness, Use of any medications/drugs/ alcohol/ inhaled substances
- Symptoms associated with pain o passing stool

Male-specific history

- Pain or discomfort experienced in the penis, scrotum, or anus
- Urethral or anal discharge
- Difficulty or pain in passing urine or stool

Past medical history

- In general, medical information, the health care provider should establish whether there are any other general conditions, past medical history, medications, STI, Tetanus, Hepatitis, HIV, recent immunizations

Gynaecological history:

- Last menstrual period
- Number of pregnancies
- Use (and type) of current contraception methods
- Symptoms that may have developed since the incident, e.g., genital bleeding, discharge, itching, sores or pain, pain on passing urine

General psychological assessment is conducted to assess the mental status of a survivor or suspect in order to provide holistic care. It informs the management and follow-up of individuals and is typically performed by designated professionals recognized by the Ministry of Health, such as medical officer, clinical officers, nurses, psychiatrists, psychological counsellors, and medical social workers.

The assessment includes the following key components:

- **General Appearance and Behavior:** Observations regarding the individual's appearance, clothing, grooming, hygiene, tattoos, and scars are recorded. These aspects can provide insights into their mental functioning. Behavioural observations, such as cooperation, agitation, avoidance, or refusal to communicate, are also noted.
- **Affect:** This assesses the patient's observed emotional expression through non-verbal cues. Terms used to describe affect include euthymic, happy, sad, irritated, and anxious. It reflects the physical manifestation of mood.
- **Mood:** Mood is the patient's subjective description of how they are feeling, documented in their own words. Examples include happy, sad, and anxious. The assessment explores the severity and persistence of any reported low mood.
- **Rapport:** This evaluates the patient's comfort level and trust during the interview. It can vary from warm and cooperative to suspicious or hostile, depending on the individual's mental state.
- **Speech:** Passive evaluation of speech during the interview includes noting verbalization, fluency, rate, rhythm, volume, and tone. Deviations in speech patterns can provide valuable diagnostic information.
- **Perceptions:** This assesses abnormal sensory experiences, such as hallucinations, illusions, and depersonalization. It explores disturbances in sensory modalities and their potential causes.
- **Thought Content:** The subject matter of the patient's thoughts is examined, including any preoccupations, suicidal or homicidal ideations, and delusions.
- **Thought Process:** This describes how the patient organises their thoughts. Normal thought processes are linear and goal-directed, while irregular processes can be circumstantial, tangential, or involve a flight of ideas, among others.
- **Cognitive Function:** This includes assessing alertness, orientation, attention/concentration, memory, and abstract reasoning. Impairments in cognitive function can be indicative of various mental and neurological conditions.
- **Judgement:** The patient's ability to make sound decisions is evaluated through hypothetical scenarios. Poor judgement can be demonstrated by repetitive mistakes or refusal to follow recommended treatments.

- **Insight:** Insight refers to the patient's understanding of their illness and its impact on their life. It can range from poor to fair, depending on the patient's ability to recognize their condition and its effects.

For children, alternative assessment methods such as wishes and dreams, art/play therapy, and age-appropriate questioning may be used to evaluate thought processes and content.

NB: *A General Psychological Assessment comprehensively evaluates various aspects of an individual's mental state to guide their care and treatment.*

Management of the suspected perpetrator/accused persons

The SOA medical regulation Act of 2012 states, ' A victim, suspect, a person convicted or witness of a sexual offence has the right to medical treatment in a public hospital, private hospital or any other medical facility.

The expenses incurred by a victim, a person suspected of having committed a sexual offence, or a person convicted or witness of a sexual offence for medical treatment in a public hospital shall be borne by the Government.

The accused person's rights reflect the fundamental principles that a person is innocent until proven guilty and has the right to dignity. Article 43 of the Constitution of Kenya assures every person of the highest attainable standard of health, and Article 50(2) states that "every accused person has the right to a fair trial which includes being presumed innocent until the contrary is proven."

The healthcare providers have a role in providing non-judgmental medical care to the accused person, with informed consent and conducting a forensic medical evaluation. It is NOT the healthcare provider's role to use legal terms and their meanings, and they should desist from making conclusions about whether or not the violence (e.g., rape, defilement) occurred. Document perpetrators' medical information in medical reports, clinical notes and P3 forms.

NB: Completion of Post Rape Care and psychological assessment forms is prescribed for Survivors of sexual violence only (Medical Regulation Act, 2012).

Physical Examination

Physical examination of survivors of violence is for both medical and medico-legal purposes.

Significance of conducting a physical examination

- Recognize injuries that may require medical attention.
- Address any concern of the survivor regarding the impact of the violence, e.g., provide reassurance.
- Determine the type of medical care for the survivor.
- Completion of medico-legal documentation.

General Guidelines for Conducting a General Physical Examination

- Have all the needed supplies and equipment. See Annex 4 illustrating Post Rape Care Kit.
- Ensure a trained support person (Chaperone) of same-sex accompanying survivors throughout the examination to protect the survivor and health care provider.
- Explain all the procedures to the survivor, what you plan to do next, and why it is necessary
- Take the survivor's vital signs.
- Take note of the survivor's mental and emotional state.
- Obtain consent at every step and make sure that the survivor understands they can stop the procedure at any stage.
- Respect the person's modesty by uncovering partially during the examination.
- Collect medical and forensic samples concurrently.
- Give the survivor a chance to ask questions.
- Allow the survivor to have a family member or friend present throughout the examination if the client wishes.
- Always address survivors' questions and concerns in a non-judgmental and empathic manner.

Head-to-toe examination for adults

The essential elements considered when conducting a focused, systematic head-to-toe examination include; *(The Genito-anal examination, is described separately).*

- Systematically examine the survivor using Job aid (Annex 5).

- Look in the eyes, nose, and mouth (inner aspects of lips, gums, and palate, in and behind the ears, and on the neck).
- Look for signs that are consistent with the survivor's story, such as bruises, bite, and punch marks, marks of restraints on the wrists, patches of hair missing from the head, or perforated eardrums, which may be a result of being slapped.
- If the survivor reports being choked, look in the eyes for petechial haemorrhages and on the neck for bruises or finger marks.
- Examine the body area that was in contact with the surface on which the sexual violence occurred to see if there are injuries.
- Collect forensic evidence, take samples of any foreign material on the survivor's body or clothes (blood, saliva, and semen), fingernail cuttings or scrapings, swabs of bite marks.
- Take note of the survivor's mental and emotional state.
- Record all your findings and observations clearly and fully on the clinical notes and PRC form

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

Genito-Anal Examination for Adults

- Examine the survivor systematically, using Job aid (Annex 6).
- Have a good source of light for viewing injuries.
- Help the survivor (female) to lie on her back (lithotomy).
- Place a sheet over her body and expose only the parts of her body you are examining.
- Inspect, in the following order; the mons pubis, inside of the thighs, labia majora and minora, clitoris, urethra, introitus, perineum, and anus.
- Look for genital injuries, such as bruises, scratches, abrasions, and tears (often on the posterior fourchette). **NOTE** the location of any tears, abrasions, and bruises on the pictogram and the examination form.
- Look for any sign of infection, such as ulcers, vaginal discharge, or warts.
- 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.

- Check for evidence of FGM wounds and scaring and classify them as appropriate (see FGM section).
- Collect swabs around the anus and perineum before the vulva to avoid contamination.
- Document the position used for each examination (supine, prone, knee-chest or lateral recumbent for anal examination; supine for genital examination).
- 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.
- Collect forensic evidence, and if agreed by the survivor and indicated by the history, collect samples from the rectum.

The Genito-Anal Examination for Adults

A speculum examination is sensitive and should be performed with a history of vaginal penetration and any of the following indications: bleeding, pain and foul-smelling discharge.

NB: Never use a speculum when examining prepubescent girls; examination on prepubescent should be carried out under anesthesia

Special consideration for male genital and anal examination

- Examine the scrotum, testicles, penis, periurethral tissue, urethral meatus, and anus. Note if the survivor is circumcised
- Look for hyperaemia, swelling (distinguish between inguinal hernia, hydrocele, and haematocele), testis torsion, bruising, anal tears, etc. *Torsion of the testis is a medical emergency and requires an immediate surgical referral*
- If the urine contains large amounts of blood, check for penile and/or urethral trauma
- If indicated, do a rectal examination and check the rectum and prostate for trauma and signs of infection
- Collect samples from the anus for sperm microscopy and DNA analysis if indicated.

Children and Adolescent History and Examination

History Taking and Physical Examination for Children

Health care providers should approach child survivors with sensitivity while recognizing

their vulnerability during the history taking and physical examination. The provider should prepare the child for the physical examination, discuss the procedures, and assure the child. Ensure to note any discrepancies between the child´s and the caregivers´ accounts, if any, without giving your interpretation.

General approach:

- Ensure privacy.
- Healthcare providers should identify themselves to the child as a person who is there to assist and not cause harm.
- Establish a neutral environment and rapport with the child before beginning the interview.
- Establish the child's cognitive developmental level to understand limitations and appropriate interactions.
- Note that young children have little or no concept of numbers or time and may use terminology differently from adults interpreting questions and answers to sensitive matters.
- Health care providers should establish if the child knows why they visited the hospital.
- Healthcare providers are encouraged to ask children to describe what happened or is happening to them in their own words where applicable. Play therapy can be adopted where necessary.
- It is always encouraged to ask open-ended questions and avoid leading questions.
- Prepare the child for examination by explaining the procedure and showing equipment to help diminish fears and anxiety.
- Children should be encouraged to ask questions about the examination.
- If the child is old enough, and it is deemed appropriate, ask whom they would like in the room for support during the examination.
- The healthcare provider should stop the examination if the child indicates discomfort or withdraws permission to continue.
- Recommended to Interview the child and the caregiver separately.
- Record the state of the clothes, if the survivor is wearing the same clothes that were worn during the sexual violence, e.g., stains, tears, colour; collect and put all items in separate packaging paper bags according to triple packaging system for infectious specimens and label (Do NOT use polythene bags).
- NEVER force a child survivor to be examined.

History Taking for Children

History should be obtained from a non-offending parent/caregiver/guardian or someone acquainted with the child or the child. It is crucial to gather as much medical information as possible. It is encouraged for older children, especially adoles-

cents, to be allowed to be seen alone as this may encourage them to talk more freely.

History taking should start with general non- threatening questions to create rapport, then move on to questions specific to the incidence.

NB: If an adolescent is hesitant to talk in the presence of a parent/caregiver/guardian, then suggest that they step out so that the adolescent can remain with the provider **DO NOT** ask about GBV in the presence of the parent/caregiver/guardian

History taking according to the developmental stages, children with special needs and circumstances

Developmental stage considerations for history taking

Infants/toddlers/preschool (birth to 4 years old)

- Children in this age group have limited verbal skills and should not provide a history
- Non-offending caregivers or adults presenting with the child for care are the primary sources of information about the child and suspected sexual violence and exploitation

School-going children (5–9 years old)

- Children in this age range should provide a history whenever possible
- Caregivers, parents, and guardians may provide supplemental information but should not be involved in the history-taking unless the child refuses to separate
- Providers should use non-leading language

Early and later adolescents (10–17 years old)

- Children in this age range should provide their history
- Caregivers, parents, and guardians should not be involved in the history- taking to allow the child to express their viewpoint on what has happened to them
- Parents or guardians can inhibit this age group from sharing all information

The child who will not speak

- Some children may not be willing to talk about sexual violence and exploitation—forcing them to talk about this is traumatizing and should not be done
- If a child cannot or will not speak to the provider, the provider should continue to talk and explain the examination process
- It is not unusual for a child who initially will not speak to begin speaking as the examination progresses and they begin to feel more comfortable with the examiner

Children with disabilities

- Children with disabilities should be communicated with in the manner in which they are most comfortable (e.g., sign language, braille, plain language/ pictures, or audio aids)

- Health providers should not assume that because a child has some form of disability, they cannot communicate
- Health providers should note that some disabilities affect the way children and adolescents communicate, which can lead to misunderstandings that further impede comprehension
- Children with disabilities are at greater risk of sexual violence and exploitation
- Health providers should know that children and adolescent survivors with developmental disabilities may struggle to "work through" or talk about their traumatic experiences in a treatment or therapeutic setting
- Health providers should practice patience and believe the client without prejudice about children and adolescents with disabilities
- Health providers should debrief the guardian and/or family members and make appropriate referrals

Psychological Assessment

Psychological assessment of children and adolescents should include the developmental stages and signs of distress they may be experiencing due to GBV. Children who experience GBV need to feel safe, and the provider should ensure that they are not rushed or hurried through the examination. Some of the warning signs of possible GBV in a child are added in Table 9 that follows.

Table 9: Warning signs of possible GBV in a child

Physical	Emotional / Psychological	Behavioral
• Changes in hygiene, such as refusing to bathe or bathing excessively • Self-harms • Shrinks away or seems threatened by physical contact • Diminished energy • Stomach aches / upset • Headaches that don't respond to treatment • Alterations in body image	• Unexplained anger • Withdrawal • Feelings of sadness and hopelessness • Feelings of worthlessness or guilt • Cognitive impairment • Suicidal thoughts, ideations and attempts • Numbing • Hyper arousal	• Insomnia • Verbal outbursts or crying • Nightmares or bed-wetting • Lack of or increased appetite • Runs away from home or school • Returns to regressive behaviors such as thumb sucking • Overly protective and concerned for siblings or assumes a caretaker role • Trouble in school, such as absences or drops in grades • Difficulty interacting with family and friends in school • Avoidance of social interaction • Inappropriate sexual behaviour • Loss of social competence • Substance abuse • Low concentration

Systematic Head to Toe Examination for Children

Physical examination of children should be conducted according to the procedures outlined for adults in the previous section. Before the examination, ensure that consent has been obtained from the caregiver and assent from the child as per the table on informed consent (Table 8). If the child declines the examination, exploring the reasons for refusal would be appropriate.

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

- Record the vital signs, height, and weight of the child
- Make sure that the survivor understands that they can stop the procedure at any stage
- Note petechiae of the palate or posterior pharynx, and look for any tears to the frenulum
- Examine the patency of the hymenal orifice, injury on the introital opening, and the thickness of the hymen and document
- Describe the hymenal tissues focusing on the margins, colour, and shape (annular, crescent in pre-pubescents or irregular margins, thickened in adolescents)
- Descriptions should be documented using the "imaginary clock" as illustrated in Figure 2:

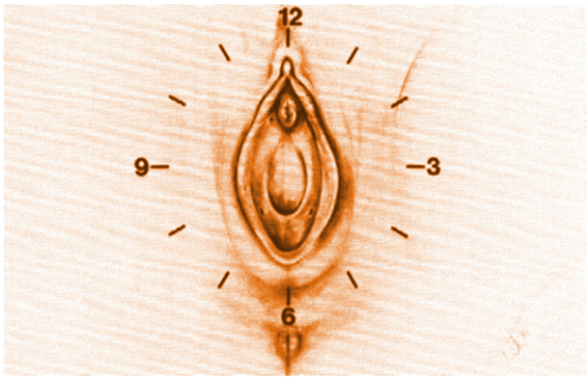


Figure 3. Imaginary clock

- Determine the child's sexual development stage using Tanner Staging (Annex 7) and check for signs of injury to determine treatment
- For age assessment, never guess the child's age. A dental odonatologist may conduct X-rays and give an age range.

Note: Consider examining infant and toddlers on their mother's or caregiver's lap. If the child refuses, defer the examination or even be abandoned. Never force the examination, especially if there are no reported symptoms or injuries, because findings will be minimal, and this coercion may represent yet another violence to the child. Consider sedation or a general anaesthetic only if the child refuses the examination and conditions requiring medical attention, such as bleeding or a foreign body, are suspected.

Genito-Anal Examination for Girls

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

A speculum examination **ONLY** indicated when the child has suspected internal bleeding arising from a vaginal injury due to penetration. In this case, help the child to lie on her back or side, use a paediatric speculum and conduct the examination under general anaesthesia, check for blood spots or trauma to the urethra, and examine the anus for bruises, tears, or discharge. Consider referring the child to a higher-level health facility for this procedure.

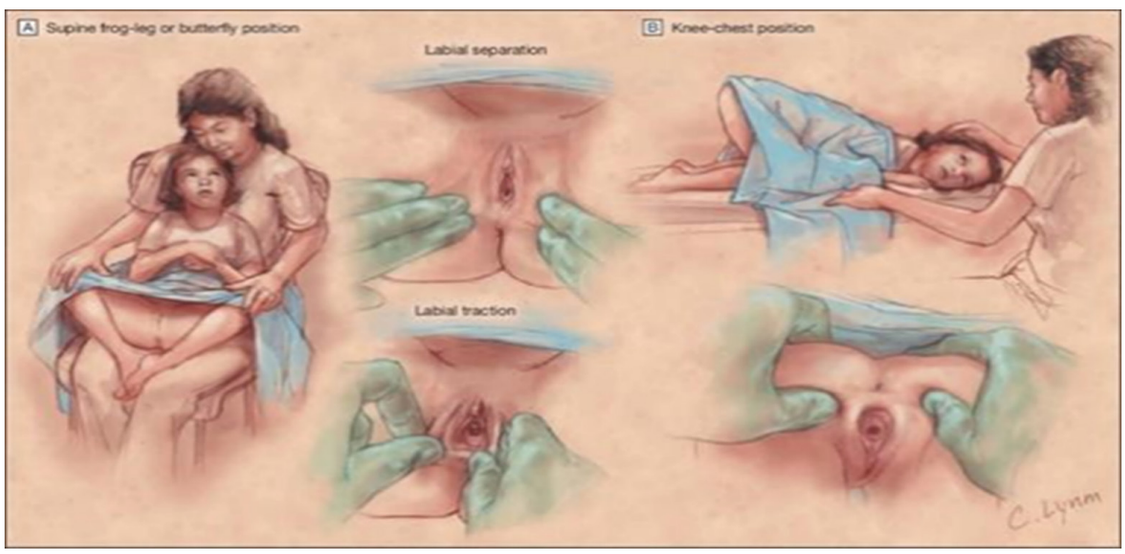
Note:

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

Examination of Post-Pubescent Female

The adolescent girl who has reached puberty should receive a complete pelvic examination and the rest of the history and physical examination. The lithotomy (laying on their back, knees bent, feet in stirrups, and thighs apart) position will also be used as the performance of a speculum examination is standard practice.

Figure 4. Examination of prepubescence girl



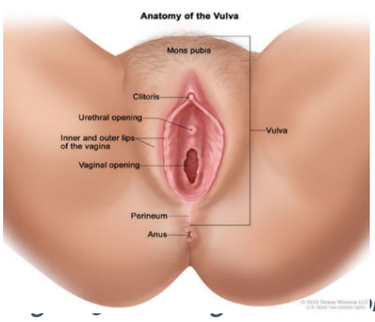
Hymenal Assessment Techniques in Post-Pubertal Females

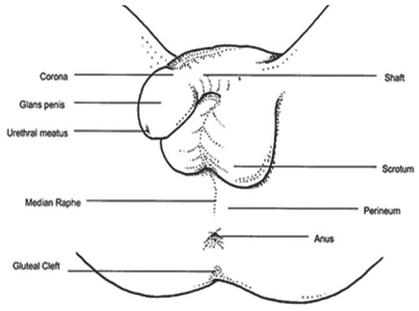
Hymenal assessment should start with an inspection. If the hymen is intact without any abnormality, document your findings without further exploration. If there is an abnormality, then you may explore further. The absence of hymenal injury does not rule out sexual violence.

Genito-Anal Examination for Boys

The health provider should check for the following;

- Injuries to the skin that connects the foreskin to the penis
- Discharge at the urethral meatus (tip of the penis)
- Bruises, tears, or discharge in the anus
- Skin tags that can form when tears heal





Anal Examination of Children and Adolescents

Examination of the anus in children is best approached utilizing either the supine or prone knee-chest positions. In either position, apply gentle traction to part the buttock cheeks.

During an anal examination, the following tissues and structures should be inspected, again looking specifically for signs of injury or disease process:

- Perianal area, paying particular attention to the perianal folds
- Anal verge/margin
- Anorectal canal
- Anus
- Gluteal cleft

Consider a digital rectal examination only if medically indicated, as the invasive examination may mimic the abuse.

Anoscopy should be **NOT** be routinely utilized unless there is bleeding, obvious trauma, or a question of lodged foreign body.

Considerations for Genito-Anal Examination for Boys

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

The information provided on collecting medical and forensic specimens in adults equally applies to children.

Treatment of Survivors

Management of Physical and Genital Injuries

Management of life-threatening injuries takes precedence over all other aspects of post-violence care. The survivors presenting with life-threatening injuries or severe conditions should *immediately be referred for emergency treatment.*

The rationale for the management of injuries in GBV is to;

- Determine whether the survivor needs medical care
- Prevent the risk of tetanus
- Manage pain
- To complete any legal documentation

Complications that may require urgent hospitalization include;

- Extensive injury (to the genital region, head, chest, or abdomen)
- Neurological deficits (for example, cannot speak, problems walking)
- Respiratory distress
- Fever and sepsis
- Fractures

Considerations for Management of physical injuries

- Minor cuts and abrasions should not delay the delivery of other more time-dependent treatments
- Clean abrasions and superficial lacerations with antiseptic and either dress or paint with tincture of iodine, including minor injuries to the vulva and perineum
- If stitching is required, stitch under local anesthesia. If the survivor 's level of anxiety does not permit, consider Examination Under Anesthesia (EUA)
- Clean tears, cuts, and abrasions, and remove dirt, dead or damaged tissue
- Clean wounds should be sutured within 24 hours, as indicated. NB: After this time, the wounds will heal by second intention or delayed primary suture. Do not suture dirty wounds. If there are major contaminated wounds, consider giving appropriate antibiotics and pain relief
- High vaginal vault, anal and oral tears, and 3rd / 4th degree perineal injuries should be assessed and repaired under general anesthesia by gynaecologist or other qualified personnel
- In cases of confirmed or suspected perforation, laparotomy should be performed, and any intra-abdominal injuries repaired in consultation with a general surgeon Provide analgesics to relieve pain

- Where any physical injuries result in the breach of the skin and mucous membranes, immunize with 0.5 mls of Tetanus-Diphtheria. Advise survivors to complete the vaccination schedule

Post Exposure Prophylaxis (PEP)

Post Exposure Prophylaxis (PEP) for HIV is administering 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. Post-exposure prophylaxis (PEP) is the short-term use of antiretroviral treatment to reduce the likelihood of HIV infection after potential exposure.

Give PEP in the event of penetrative sexual violence (anal/oral/vaginal/human bites)

Eligibility for PEP

- The exposed individual is HIV-negative at baseline
- Exposure must have occurred within the past 72 hours
- Exposure to bodily fluids poses a significant risk:
    (i) Type of exposure: mucous membrane (i.e., sexual exposure; splashes to eye, nose, or oral cavity), non-intact skin, percutaneous injury, or parenteral exposures
    (ii) Material: blood, blood-stained body fluids, breast milk, semen, vaginal secretions;

Recommended ARVs for PEP

PEP should be offered immediately (< 72 hours) after high-risk exposure. The recommended ARV agents for PEP are as indicated in Annex 8.
Always refer to the current version of the Kenya HIV Prevention and Treatment Guidelines for dosing and recommendations for PEP Management and Follow-up.

For survivors testing HIV positive, PEP is **NOT RECOMMENDED**; refer them for HIV care, treatment, and follow-up.

If the survivor declines to take an HIV test, offer **PEP** continue with counselling services and offer other management as per the guidelines.

Table 10: Considerations and recommendations for PEP provision

Considerations	Recommendation
Management at Initial contact	• Counsel on risks and benefits of PEP and obtain verbal consent for HIV testing • Voluntary testing for both exposed and source individuals • Offer PEP as soon as high-risk exposure is established and the exposed individuals tests HIV- negative at baseline (if HIV testing not feasable, offer 1-2 days of PEP to cover until HIV test performed) • Provide first aid in case of broken skin or other type of wound
Time of initiation	As soon as possible after exposure, but no later than after 72 hours
Duration of PEP	28 days (dispense all 28 days of treatment at the first visit if tested HIV Negative)
Dose of PEP	Same as indicated for treatment; use weight -based dosing for children
Laboratory investigation at baseline	• Conduct creatine testing (if TDF containing regimen) and Hb (if AZT containing regimen, however PEP should be offered even when lab tests are not available. Do not delay administration of PEP while waiting for lab results • HBsAg testing is recommended. Do not delay administration of PEP while waiting for lab results. If negative provide HBV vaccination • Pregnancy testing for women of childbearing potential in case of sexual assault
Follow-up	• Follow up client at 7days, 14 days, 28 days, and 12 weeks after starting PEP • Assess for and manage side effects due to PEP Follow-up HIV testing should be done at the completion of PEP and if negatively, test again at 12 weeks • Link to HIV treatment if positive
Counselling	• Counselling at basline should include: • Adherence counselling • Information on side effects • Risk reduction counselling • Trauma and mental health counselling • Specific support for sexual assault

Emergency Contraception (EC)

Emergency Contraception should be:

- Given within 120 hours/five days of sexual violence, ideally as early as possible to maximize effectiveness
- Readily available at all times, day and night and should be provided at no cost to survivors of sexual violence in all health facilities.
- Provided to all females who have experienced menarche except those on menses, pregnant, or on reliable contraceptive methods, e.g., Long-term methods
- Use combined contraceptives (CoCs) in the event Postinor 2 (P2) is out of stock

Refer to Annex 9 for types and dosages of emergency contraception.

NB:

- There are no known medical conditions for which EC use is contraindicated. Medical conditions that limit the continuous use of oral contraceptive pills do not apply to using EC
- EC does not harm an early pregnancy and is not a form of abortion. Unless a woman is pregnant, a baseline pregnancy test should be performed

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 occurred or not.

NOTE:
If a survivor intends to terminate a pregnancy that resulted from sexual violence, the health care provider and the survivor should be aware of the Constitutional provision about abortion, thus "Abortion is not permitted unless, in the opinion of a trained health professional, there is need for emergency treatment, or the life or health of the mother is in danger, or if permitted by any other law (Kenya Constitution 2010)."

Management of Sexually Transmitted Infections (STIs)

- All survivors of sexual violence should receive STI prophylaxis to treat gonorrhoea, chlamydial infection, and syphilis (Annex 10)
- The High Vaginal Swab (HVS) performed at the initial presentation is for forensic reasons, not for screening for STIs or guiding antibiotic administration.
- Survivors with a "normal" HVS result should receive STI prophylaxis (empirical treatment)
- Preventive STI regimens can start on the same day as emergency contraception and post-exposure prophylaxis for HIV (PEP). However, the doses should be spread out (and taken with food) to reduce side effects, such as nausea.

Hepatitis B Vaccination

Hepatitis B vaccination is intended to protect from future Hepatitis B virus infection. It is not meant to treat an existing infection (Annex 11a). Refer to the National vaccines and immunisation guidelines for further guidance.
NB: If a survivor has been vaccinated before and completed the whole series of vaccinations as scheduled, re-vaccination is unnecessary. If they did not complete the entire series, they should complete it as scheduled.

Tetanus Diphtheria (TD) Vaccine

- Provision of dual immunity/protection
- Td doses during pregnancy, Immunization programmes, trauma, and women of reproductive age are similar to the dosing schedule for TD.
- Do not give TD if the survivor has received three or more doses previously and the last dose is within five years

Refer to Annex 11c for the Tetanus vaccination schedule.

Human Papillomavirus (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. If the HPV vaccine is given simultaneously as another injectable vaccine, the vaccines should always be administered at different injection sites using separate syringes.
Refer to Annex 11b for HPV dosing Schedule.
NB: If a survivor has been vaccinated before and completed the full series of vaccinations as scheduled, re-vaccination is unnecessary. If they did not complete the full series, they should complete it as scheduled.

The health workers should refer to Table 11 below as guidance for time-bound treatment intervention schedule.

Table 11: Time-bound treatment schedule

Interventions/ Time after the sexual violence	<72 hours	>72 hours but < 1 month	One month to 3 months	> 3 months
PEP	✓	X	X	X
Cefixime	✓	✓	X	X
Ceftriaxone	✓	✓	X	X
Azithromycin	✓	✓	✓	X

Doxycycline	✓	✓	✓	X
Tinidazole	✓	✓	X	X
Norfloxacin	✓	✓	X	X
Spectinomycin	✓	✓	X	X
Amoxicillin	✓	✓	X	X
Probenecid	✓	✓	X	X
Erythromycin	✓	✓	✓	X
Hepatitis B immunization	✓	✓	✓	X
Tetanus immunization	✓	✓	X	X

✓ Administer the drug X. Do not administer the Drug

Management of Children and Adolescents

The fundamental role of the health provider is the same for child survivors of violence as it is for adults; however, the needs and capacities of children and the ways of responding to their needs differ. Health providers should provide first-line support and follow-up care that is gender-sensitive and child or adolescent centred in response to the disclosure of sexual abuse.

Clinical Management of Children and Adolescent Survivors of GBV

The health provider should recognise the life-threatening injuries and provide immediate management.

In pre-pubertal children and adolescents, a "dirty urine (or random voided urine specimen) is collected for nucleic acid amplification test (NAAT) since it is superior to genital swabs. In the absence of NAAT, genital swabs in prepubescent children should be taken from the vulva and beside the vaginal orifice. Cervical specimens are **ONLY** required in adolescents (i.e., those at Tanner stage II of puberty or later), as adolescents may have asymptomatic infections.

Diagnostic tests necessary to complete in children:

1. NAAT urine test for Chlamydia trachomatis and Neisseria gonorrhoeae
1. Trichomoniasis testing of a portion of the "dirty" urine specimen
1. Human papillomavirus (HPV) testing using swabs of the vulva, perineum, and surrounding genital tissues
1. Herpes simplex virus (HSV) cultures to distinguish between type 1 and type Baseline HIV testing

Adherence Counselling and Treatment Literacy

- The health care provider should discuss the treatment regimens and dosages for PEP/STI prophylaxis/ART and EC within 120 hours for female, pubertal child survivors
- Advise on side effects and their management and potential barriers to adherence
- Guide on positive living, health consequences of STIs and other management, e.g., TT vaccination, Hepatitis B vaccination, psychotherapy
- Emphasise adherence to follow-up care and appointment-keeping

Psychosocial Support for Children and Adolescents Counselling
Children require action-oriented approaches to facilitate the counselling process because some children may have no experience of an adult listening to them and, therefore, may react with suspicion or resistance to the counsellor.
Follow-up schedule remains similar to that of the adult

Follow-Up of Survivors of Violence

Sexual Violence

Follow-up care 2nd visit- 2 weeks

- Assess adherence to treatments previously given (PEP, EC, STI)
- Evaluate for STIs and treat them if necessary
- Evaluate mental and emotional status; treat or refer as needed
- Provide adherence and trauma counselling
- Lab evaluation (LFTs and HB)
- Assess referral uptake

3rd visit- 4 weeks

Check for PEP completion

- Repeat PDT and refer for care if necessary
- Do follow-up vaccinations (Tetanus-Diphtheria)
- Evaluate for STIs and treat them if necessary
- Evaluate mental and emotional status; treat or refer as needed
- Provide trauma counselling
- Assess referral uptake

4th visit- 6 weeks

- Evaluate for STIs and treat them if necessary
- Evaluate mental and emotional status; refer or treat as needed.
- Provide trauma counselling and psychosocial support
- Provide Hep B Vaccine and HPV
- Assess referral uptake

5th visit- 3 months

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

Other Forms of Violence

Follow-up care 2nd visit- 2 weeks

- Assess adherence to treatments previously given (PEP)
- Evaluate mental and emotional status; treat or refer as needed
- Provide adherence and trauma counselling
- Assess referral uptake

3rd visit- 4 weeks

- Check for PEP completion
- Do follow-up vaccinations (Tetanus-Diphtheria)
- Evaluate mental and emotional status; treat or refer as needed
- Provide trauma counselling
- Assess referral uptake

4th visit- 3 months

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

NB: For persons who are at high risk of repeated sexual violence consider linking them for PrEP services.

Documentation of Care

Appropriate and safe documentation of service provision information throughout the case management process is necessary to ensure the quality of GBV case management services.

Clinical management documentation should be on identifiable organizational documentation or letterheads and comprehensive notes should be prepared for each patient seen using Post Rape care forms, Counselling data form (Annex 12), P3 form and GBV register.

For inpatients, perpetrators and survivors who present at period where forensic evidential material cannot be collected e.g., after carrying clinical notes (Annex 13) should be filled while observing ethical principles and guidelines. This documentation should be securely kept and availed for reference as required.

Other medico-legal documentation e.g., PRC, P3, etc. should be completed for each survivor as necessary.

Forensic Management and Handling of Evidence

Management of forensic evidential material from survivors of Gender-Based Violence act as the link between health facilities and the criminal justice system. It is essential in helping the survivors of Gender-Based Violence access justice.

Properly managing evidential materials is vital in demonstrating that the crime occurred and linking or delinking the suspect to the crime scene. Health Care Providers can collect basic forensic evidence and document it in a comprehensive and detailed manner that can be useful for criminal prosecution.

Key Definitions in Medical and Forensic Examination

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

Evidence: Anything submitted before a court of law to ascertain the issues under investigation.

Forensic evidence: This is the evidence collected during a medical or crime scene examination that would assist in the dispensation of justice

Physical evidence/ Evidential Material: This refers to any object, material or substance found in connection with an investigation that helps establish the offender's identity, the crime's circumstances or any other fact deemed critical to the process. It may include used condoms, biological fluids, cigarette butts, ropes, masking tape, clothes etc.; these can be collected from the survivor and the environment (crime scene).

Crime scene: This is either a person, place or object capable of yielding physical evidence to potentially assist in a crime investigation.

Forensic Crime Scene Examination: An examination of a person, an area or an object that has the potential of yielding evidence that would assist with the investigation.

Key Considerations During Medical and Forensic Examination

Before medical and forensic examination and handling of evidence, health care providers are required to take note of the following important considerations;

- The health care provider should have undergone training based on the national curriculum on clinical management of sexual violence; and/or any formal specialized training on the management of GBV, e.g., forensic.
- The facility should have a functional supervision system for providers that includes hands-on preceptorship/mentorship.
- There is an established system to maintain the chain of custody for evidence according to the Evidence Act, 2012
- Health care providers should familiarize themselves with National Guidelines on the management of GBV survivors.

- The survivor should be informed that some injuries might become more visible after some days and that, if this happens, they should return for examination and documentation.
- It is encouraged that specialized health care providers be trained in child-friendly communication, specialized examination techniques, and evidence collection for the effective provision of medico-legal services to children.
- All health care providers working with survivors of GBV should be aware of the relevant laws and policies in place in the setting, including those related to consent.
- All health care providers working with GBV survivors should be trained to present medico-legal evidence in court.
- Health care providers should not collect evidence that cannot be processed

Survivors should be provided with information about the examination process, the purpose of evidence collection, and their rights to empower them to make informed decisions about their healthcare and legal options. To promote their autonomy and help restore a sense of control over their lives.

Preparing for Forensic Examination

Health care providers should ensure that;

- A careful explanation is provided to the survivor. This should include the reasons for, and the extent of, the proposed examination, procedures that might be conducted, the collection of specimens and possible standardized photography
- Sensitive and specific explanation of genital or anal examination if required
- Consent to undertake the examination should be obtained from the individual or their guardian. The consent should be specific to each procedure (particularly the genital examination), to the release of findings and specimens, and to any photography.

The survivor may consent to some aspects and not others and may withdraw consent. The Issues of consent, access (respecting privacy and confidentiality) and sensitivities (particularly if genital /anal photographs are taken) need to be addressed and agreed with the survivor since photographs are a useful adjunct to injury documentation.

Consent for the collection and release of the specimens (to investigators) should be obtained from the survivor. Assess the impact on the survivor (both physically and psychologically) of the collection of specimens.

Medical and forensic specimens should be collected at the same time during physical examination of the survivor. By collecting medical and forensic evidence together, survivors receive comprehensive care that addresses both their medical needs and the legal aspects of the crime committed against them. It ensures a holistic approach to their well-being.

Collecting forensic evidence as soon as possible after the incident is crucial for preserving evidence that can be used in the investigation and prosecution of the perpetrator. Biological evidence such as body fluids, or hair that contain DNA can degrade or be lost over time, so prompt collection is vital.

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

Collecting medical evidence at the same time as forensic evidence allows health care providers to document and correlate any physical injuries or findings with the survivor's account of the GBV incidence. This documentation can strengthen the survivor's credibility and provide crucial evidence in court proceedings.

Further, conducting both medical and forensic examinations together can minimize the trauma experienced by survivors and allows them to undergo the necessary procedures and interviews only once, reducing the need for multiple visits, which can be emotionally distressing.

Simultaneous collection of medical and forensic evidence streamlines the process and ensures survivors have timely access to support services, such as counselling, legal assistance, and referrals to other necessary resources; this facilitates a coordinated response to meet their immediate and long-term needs.

Timely and accurate collection of forensic evidence improves the chances of identifying and prosecuting perpetrators, leading to increased conviction rates. This, in turn, can deter future acts of GBV and contribute to a safer society.

Forensic Evidence Collection Process

Inspection of the body

The health care provider should:

- Examine the survivor's clothing under good light before they undress
- Collect any foreign debris on clothes and skin or in the hair (soil, leaves, grass, and foreign hairs)
- Ask the survivor to undress while standing on a white sheet of paper to collect any materials that falls. Do not ask them to undress fully
- Examine the upper half of their body first, then the lower half, or provide a gown for them to cover themselves

- Collect torn and stained items of clothing including shoes if you can provide replacements or offer dignity pack
- When the survivor declines to surrender clothing, DO NOT force them
- Clothes will need to be air dried before storage
- Document all injuries in as much detail as possible
- Collect samples for DNA analysis from all places where there could be blood, saliva, (where the attacker licked or kissed or bit the survivor) semen on the skin, with the aid of a sterile cotton-tipped swab, lightly moistened with sterile water if the skin is dry
- Comb the survivor's pubic hair for foreign hairs. Cut matted pubic hair for analysis
- Should take samples and swab the oral cavity for direct examination for sperm and for DNA and acid phosphatase analysis if ejaculation took place in the mouth. Place a dry swab in the spaces between the teeth and between the teeth and gums of the lower jaw, as semen tends to collect there
- Collect and preserve blood and/or urine for toxicology testing if indicated (e.g., if the survivor was drugged)

Inspection of the Anus, Perineum and Vulva

Inspect and collect biological samples for DNA analysis from the skin around the anus, perineum and vulva/penis using separate cotton-tipped swabs moistened with sterile water. For children, always examine both the anus and the vulva/ penis.

Examination of the Vagina and Rectum

Depending on the site of penetration or attempted penetration, examine the vagina and/ or the rectum.

- Lubricate a speculum with normal saline or clean water (other lubricants may interfere with forensic analysis). use a speculum to examine prepubertal girls **ONLY** if there is indication and this should be done under anaesthesia (Examination Under Anaesthesia). Follow the guideline on indication of speculum use in children as discussed.
- Using a cotton-tipped swab, collect fluid from the posterior fornix for examination of sperm. Put a drop of the fluid collected on a slide, if necessary, with a drop of normal saline (wet- mount), and examine it for sperm under a microscope. Note the sperm motility. Smear the leftover fluid on a second slide and air-dry both slides for further examination at a later stage
- Take specimens from the posterior fornix and the endocervical canal for DNA analysis, using separate cotton-tipped swabs. Let them dry at room temperature

- Collect separate specimens from the cervix and the vagina for acid phosphatase analysis
- Obtain samples from the rectum, if there is indication, for examination of sperm, acid phosphatase and DNA analysis

Take precautions against contamination:
- Restrict access to examination room, ensure facilities are cleaned between cases and change gloves frequently
- Wear sterile powder-free gloves and other relevant protective gear throughout the sample collection process

Maintaining the Chain of Custody

It is important to maintain the chain of evidence at all times, to ensure admissibility in court.

The evidence must be collected, labelled, stored and transported correctly. Documentation must include the signature of everyone who has had possession of the evidence at any time, from the individual who collects it to the one who takes it to the courtroom, to keep track of the location of the evidence since collection.

Health facilities must have a system to minimize the number of people handling the evidence to maintain the chain of custody. The evidence chain of custody tracking form (Annex 14) must be filled as a paper trail movement of evidence.

In the criminal justice system, the most effective approach to secure evidence authenticity is for every individual in the chain to be identifiable.

N.B: If it is not possible to take the samples immediately to a laboratory, precautions must be taken;

- All clothing, swabs, gauze, and other objects to be analysed must be well dried at room temperature and packed in paper (NOT PLASTIC) bags. Samples can be tested for DNA years after the incident, provided the material is well-dried.
- Blood and urine samples can be stored in the refrigerator for five days. To keep the samples longer, they need to be stored in a freezer.

Follow the instructions and laboratory protocols on types of specimens, collection, preservation methods and reasons for testing (*adapted from the National Forensic module management in SGBV care, 2020 pg. 30-39*) Annex 15.

1. All samples should be clearly labelled with a confidential identifying code (not the name or initials of the survivor), date, time and type of sample (what it is, from where it was taken), and put in a container

- Seal the bag or container with paper tape across the closure. Write the identifying code and the date, and sign your initials across the seal
- Evidence should be released to the police or court only if the survivor proceeds with a legal case. The survivor may consent to have evidence collected but not to have it released to the authorities at the time of the examination. In this case, advise them of the laws and procedures around maintaining evidence and the time frame for the storage of evidence before it is destroyed. If the survivors change their minds during this period, they should advise the authorities on their wish to progress with the case.

Presenting Medical Evidence In a Court of Law

If the survivor wishes to pursue legal redress and the case comes to trial, the healthcare provider who examined them after the incident may be asked to present the evidence in court. Providing such evidence in court as an expert witness is an extension of the health worker's role in caring for the survivor.

The healthcare provider is recommended to attend a pre-trial conference with the prosecutor before the court session to prepare their testimony and obtain information about the significant issues involved in the case.

Accurate, complete, legible and sufficient details must be documented by the health care provider during history taking and examination as they are helpful in the criminal prosecution process.

When giving evidence in court, the health worker should;

- Conduct themselves professionally and confidently in the courtroom
- Dress formally
- Speak clearly and slowly and, if culturally appropriate, make eye contact with whoever you are speaking to
- Use precise medical terminology and explain where necessary
- Answer questions professionally
- If you do not know the answer to a question, say so
- Do not make an answer up, and do not testify about matters that are outside your area of expertise
- Ask for clarification of questions that you do not understand. Do not try to guess the meaning of questions.

Mandatory Medico-legal Documentation

The health care providers are legally mandated to accurately and completely document survivors' details in preparation for the criminal prosecution process. These documents include;

Post Rape Care form (MOH 363) should be filled in triplicate;

- The **Original form** is issued to the police for custody. This is the form that is produced in court as evidence
- The **Duplicate form** is issued to the survivor (only when the investigator has signed the three copies)
- The **Triplicate form** remains in the facility PRC booklet

The Kenya Police Medical Examination P3 Form (Annex 17)

- This is a Police form that is issued at the police station. The P3 form is for all assaults and, therefore, not specific to sexual violence. It is, therefore, not as detailed as the PRC form. The police officer requesting the examination completes part 1 of the P3 form, and the escorting police officer delivers it to the attending health facility for completion of part 2. A medical officer or practitioner conducting the examination should document part 2 of the P3 form.
- The filling of the P3 form in sexual violence cases should NOT be charged in health facilities. The survivor should get a signed copy of their PRC form and the P3 form duly filled. The P3 form is corroborative evidence produced by the medical practitioner in court. The medical practitioner who examined the survivor will be expected to appear in court as an expert witness during the trial.

Female Genital Mutilation

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

Structure of the Normal Female Genitalia

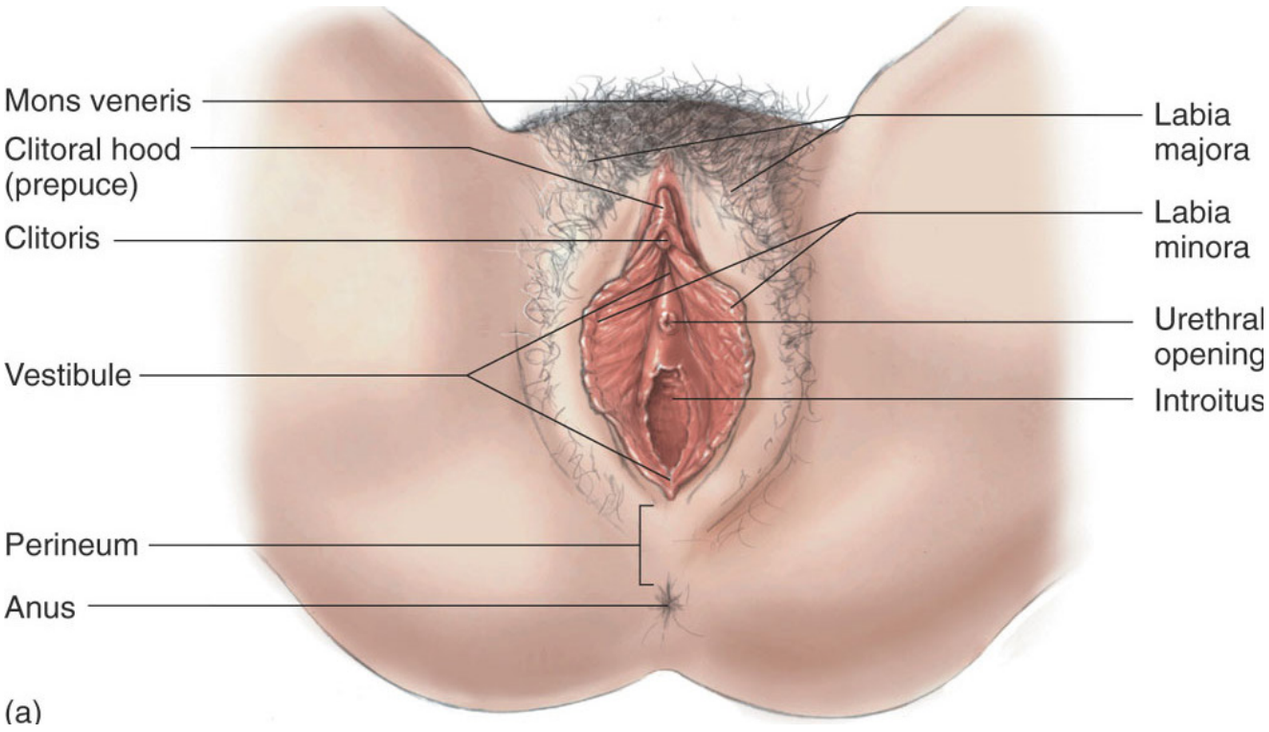


Figure 7: Normal Female Genitalia

Description of the Types of FGM

Female Genital Mutilation (FGM) encompasses various procedures that involve the partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons. The World Health Organization (WHO) categorizes FGM into four major types.

Table 12: Types of Female Genital Mutilation

Category	Description
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 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 include nicking, pricking, piercing, incising, scraping and cauterization.

Medicalization of FGM

Medicalization refers to situations in which FGM, including re-infibulation (re-closing of external genitalia after childbirth and other procedures), is practised by any category of healthcare providers in a public or a private clinic, at home or elsewhere. Section 19 of the Prohibition of FGM Act makes it an offence for any health care provider, qualified or undergoing training, to perform medicalization of FGM on any person.

Management of FGM Complications

The health care provider should recognize the signs and symptoms of FGM which include physical and psychological signs, e.g., pain, bleeding, infections, urinary problems, menstrual complications, sexual difficulties, and psychological distress.

The table below describes the FGM complications and their management.

Table 13: Management of FGM complications

Complication	Management
Haemorrhage	• Conduct a quick assessment through history and examination for signs of acute blood loss and recording her vital signs • If the bleeding is serious and an intravenous line is available secure venous access • Inspect the site of the bleeding • Clean the area • 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 • If active bleeder clamp with small artery forceps, ligate, or cauterize • If client is in shock (Manage as per SOP for shock)

	• If bleeding is due to tears/lacerations that cause excessive bleeding repair or refer for further management • If you are managing the client at a primary level facility, give I.V. fluids, monitor and transfer her immediately to a higher-level facility for blood transfusion if necessary
Haemorrhage	• Administer Vitamin K as per policy • Provide health education to promote biotic compliance, perineal wound care, effective management and monitoring of own recovery • Personal health education includes changing pads regularly, washing hands before and after changing the pads, bathing/showering regularly
Pain	• Assess the severity of pain and injury • Give analgesia as per the WHO analgesic ladder • Clean the site with antiseptic and advise the client or her attendant to keep it dry
Shock	• Shout for help • Adopt ABCDE and manage accordingly • Assess the severity of shock by checking level of consciousness, • Replace lost fluid and perform blood transfusion if necessary • Treat shock according to cause, e.g., septicaemia, hemorrhage, pain • If at a lower-level facility where intravenous fluid infusion or blood transfusion facilities are not available refer
Wound Infection	• Inspect the vulva carefully for signs of an infected wound, and probable causes of infection, such as obstruction of urine, foreign body • If urine obstruction is present, catheterize, treat with antibiotics and analgesics. • If the wound is infected, clean with antiseptic and leave open

	• Take a swab from infection site and a urine sample for culture and sensitivity or microscopy and treat as per causative organism • Administer Tetanus diphtheria as per TT schedule
Septicaemia	• If you are in a primary health facility, refer the patient to higher level after initial antibiotic and first aid measures. • Take blood for culture and sensitivity and treat with antibiotics according to culture and sensitivity results
Urine Retention	• Assess to determine the cause of retention • Encourage the client to pass urine • If unable to pass urine because of pain and fear, give her strong analgesics • If due to infibulation, perform de-infibulation after counselling the client • If retention is due to injury of the opening of the urethra or urethral stricture, refer for specialized care
Injury to other Tissues e.g., Vaginal Fistulae	• Assess the child or woman to identify the cause and type • If client has an infection, given antibiotics as appropriate • If stress incontinence, counsel the client and advice on exercises to strengthen the pelvic floor muscles, or refer the client to a urologist for treatment • Refer VVF or RVF for specialist repair
HIV, HEP B	• Manage as per current MOH Guidelines on use of ARVs for treatment and Prevention of HIV in Kenya

Obstetrics Complications

Many women who have undergone FGM experience a healthy pregnancy and childbirth. However, evidence shows that FGM is associated with a number of obstetric complications, and that greater risk is associated with the most severe forms of FGM (Type III /Infibulation).

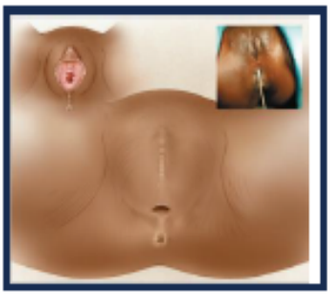
De-infibulation

De-infibulation refers to the practice of cutting open the narrowed vaginal opening in a woman who has been infibulated (Type III FGM/C).

Steps in De-infibulation procedure

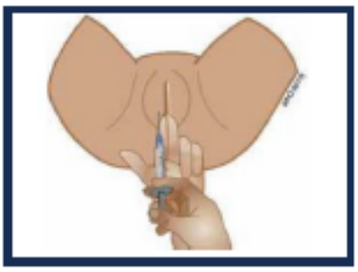
- Observe an aseptic technique through washing hands thoroughly and wearing sterile gloves
- In lithotomy position, clean vulva with antiseptic solution. Often it is not possible to clean inside the vagina due to the narrowness of the vaginal opening
- Infiltrate 2–3 mls of local anaesthetic into the area where the cut will be made, along the scar and in 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. Do not incise beyond the urethra. Extending the incision forward may cause hemorrhage, which is difficult to control. Take great care not to incise a buried clitoris
- The raw edges of the labia majora are then re-approximated (sutured) with absorbable 4.0 monocryl sutures (Figure 20). 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
- The wound usually takes between (4- 6 weeks)

Annex 1: Steps in the De-infibulation procedure

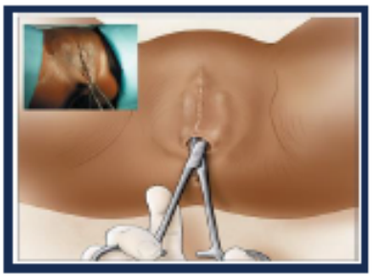


Step 1:Assess the perineum.

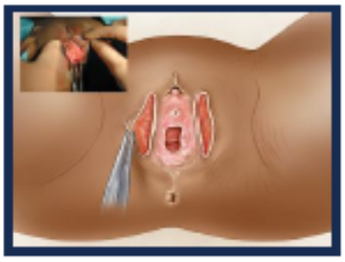
Step 1:Assess the perineum.



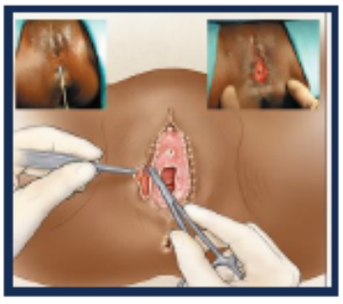
Step 2: *Infiltrating the scar area with local anaesthesia*



Step 3: *Delineating the infibulated scar artery forceps is inserted under the infibulations scar to delianate its length. A vertical incision along the anterior surface of the infibulated scar from the neo-introitus towards the clitoris is made.*



Step 4: *Vertical incision over the artery forceps through the midline of the scar releases the infibulated tissue. Intact clirotis and urethral meatus are visualised upon release of the infibulated scar tissue.*



Step 5: *suture raw edges with absorbable 4-0 monocryl sutures*

Forensic Evidence Management in FGM

Tools and materials recovered from an FGM incident can be collected, preserved and handed over to investigative officers. The evidential material collected may then be submitted for DNA analysis. Refer to the National Training Module on Forensic Management.

Prevention of FGM

Support prevention of FGM by providing correct information on the consequences of FGM and on the benefits of abandoning the practice in the community.

Health care providers should:

- Create awareness on the immediate dangers and long-term consequences of FGM to girls, women, communities, religious leaders, policy makers and other stakeholders
- Educate fellow health professionals, community health care providers and teachers about this harmful traditional practice.
- Provide care for the women and girls affected by FGM
- Support those who want to end the practice in their families or communities.
- Assist in the documentation of the practice and its harmful consequences.
- Oppose any attempt to medicalize the procedure or allow its performance, under any circumstances, in health establishments or any other setting.

Person-Centred Communication for Female Genital Mutilation Prevention

Person-centred Communication is a counselling technique that focuses on the needs of an individual while ensuring that personal preferences, needs and values guide decisions on health issues that concern them in a respectful and responsive manner (WHO, 2022).

Person-centred communication for FGM prevention is designed to empower individuals and communities to abandon the practice of FGM. Using PCC means trying to understand not only the patient's medical concerns but also;

- Who they are as a person
- What their personal beliefs and values are
- What their expectations, needs and feelings are about their health and well-being
- Providing psychosocial support/counselling to survivors of FGM using LIVES approach

Five Steps in the Person-centred Communication for FGM Prevention

Table 14: Person-centred communication for FGM prevention

A	**A**ddress and **a**sses	Step 1 and 2	Address FGM - Confirm the woman's FGM status and health conditions potentially to FGM. Assess the woman's views - If she supports FGM, what are her reason?
B	**B**eliefs	Step 3	Discuss and challenge beliefs about FGM - What are the woman's beliefs about FGM?
C	**C**hange	Step 4	Explore the possibility of change.
D	**D**iscuss and **d**ecide	Step 5	Discuss with the woman about, and support in talking to other members of her community about FGM

Documentation and Reporting of FGM Cases

All cases of FGM should be documented, including physical examination findings, medical treatments provided, and any relevant psychosocial support given. Report suspected cases of FGM to the appropriate authorities, following national guidelines and legal requirements.

Strengthening FGM Prevention

Engage in community outreach and educational programs to prevent FGM. Collaborate with schools, religious leaders, community elders, and other influencers to promote alternative rites of passage and empower communities to abandon the practice.

Continuous Professional Development

- Stay updated with the latest research, guidelines, and best practices related to FGM
- Participate in relevant training programs and workshops to enhance your knowledge and skills in managing FGM cases
- Participate in training on management of specific immediate complications associated with FGM

Management of Gender-Based Violence in Humanitarian Settings

Gender-based violence is an alarming concern during acute emergencies with sexual violence being the most immediate and dangerous type, while other forms of violence happen later in more stabilized phase and recovery in increasing frequency. However, these other forms of violence should not be ignored if they do occur at the onset of a crisis.

Gender Vulnerabilities in Conflict Situations

Different factors predispose individuals to GBV in emergency situations. These factors include increased militarization, lack of community and State protections, displacement, scarcity of essential resources, disruption of community services, changing cultural and gender norms, disrupted relationships, and weakened infrastructure. Age and gender predispose women and girls to exploitation and abuse.

In early stages of conflict, these vulnerabilities are increased due to;

- The breakdown of law and order
- The absence of systems that would respond to distress signals
- The lack of adequate services that would minimize the effects of sexual violence

In the stabilized phases of conflict, these vulnerabilities are augmented by;

- The continual gender roles of women and girls e.g., fetching water in insecure areas which predispose them to dangers of sexual violence
- The possible abuse of power by the security and humanitarian workers
- Harmful cultural practices are exacerbated - e.g., forceful early marriage of children by parents and FGM

The various approaches to GBV response in humanitarian settings should be;

- Survivor-centred which is anchored in the principles of safety, confidentiality, respect and non-discrimination
- Rights-based approach
- Community- based approach
- Do no harm approach
- Principles of partnership and collaboration
- Best interest of the child which involves
- Promoting the child's best interest
- Ensuring the safety of the child

- Comforting the child
- Ensuring appropriate confidentiality
- Involving the child in decision-making
- Treating every child fairly and equally
- Strengthening children's resiliencies

Community-based programmes using awareness-raising techniques have succeeded in reducing the incidence and mitigating the impact of GBV and changing attitudes, perceptions, knowledge and (some) behaviour.

It is crucial to improve monitoring and evaluation mechanisms, build robust systems and independent evaluations into programme plans and budgets to generate findings on the impact of interventions for best practice learnings and reporting during a crisis.

For increased access to GBV service, the interventions employed need to;

- Avail integrated or multi-sectoral services combined with increased capacity and knowledge of staff
- Address stigma associated with certain forms of GBV and overcome socio-cultural norms through integration of victims and survivors of sexual violence into existing activities
- Increase local knowledge through either the engagement of local service providers on GBV issues, or increasing community knowledge about the types and location of services available for GBV response

Multi-Causal Nature of Sexual Violence in Humanitarian Crisis

The risk of sexual gender-based violence in humanitarian settings is exacerbated by several factors including the presence of armed forces, abuse of power by individuals in positions of power, breakdown of family and community support systems, weak legal systems, laws and practices that reinforce gender discrimination, inadequate access to basic necessities and livelihood opportunities. Certain populations are at increased risk including; older persons, persons with disabilities, adolescent girls, children, sexual and gender minorities and female heads of household.

Minimum Set of Interventions in Crisis Situations

The first priority for responders is to establish prevention and response measures, then establish safe and ethical data systems as conditions allow.

The requirements for management of survivors in a crisis include;

- Establish a coordination mechanism, such as a GBV working group. Ensure that a GBV focal point is represented in health sector meetings and activities and also that a health sector focal point participates in GBV meetings as appropriate

- Prepare standard operating procedures (SOPs) on GBV prevention and response, which describe the coordination arrangements, referral pathways, and reporting mechanisms. Ensure all actors are integrated into SOPs and included in the referral pathway
- In collaboration with partners and service providers, develop clear reporting mechanisms and referral pathways for GBV survivors
- Set up a management system for GBV survivors with special procedures in place for working with child survivors and child perpetrators
- Ensure commodity security and adequate capacity of service providers offering services to the survivors. Distribute clinical commodities to viable health centres, mobile clinics and health actors including the minimum initial service package (MISP)
- Establish an information management system for GBV data, including an information-sharing protocol. Develop a monitoring and evaluation framework
- Ensure women and adolescent girls have immediate access to priority reproductive health services

Coordination

There is a general need to improve coordination and to build the capacity of staff (both at facility and community level).

Multiple activities and strategies should be offered as part of an intervention because they are mutually reinforcing and enabling.

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

Mental Health and Psychosocial Support

Mental health is defined as "a state of well-being whereby individuals recognize and realize their abilities, are able to cope with the normal stresses of life, work productively and fruitfully, and make a contribution to their communities".[1] Positive mental health includes emotion, cognition, and social functioning and coherence.[2]

Mental health can be impacted by various factors including, but not limited to trauma.

All cadres of HCP at facility and community level be trained in basic counselling skills, including First-Line Support (LIVES and LIVES CC) and trauma and GBV counselling where possible.;

GBV survivors experience trauma and psychological distress, which has a negative impact on their mental health and can lead to some short-term and others long-term mental disorders such as anxiety, depression, bipolar disorder, and schizophrenia.

The types of mental health response and duration of the sessions will vary enormously depending on the degree of psychological trauma suffered and the survivor's coping skills and abilities.

All providers offering GBV prevention and response services shall apply the following during person-centred Care.

- Understand the survivor's perspective, e.g., concerns, feelings, needs, safety and expectations
- Understand the survivor's unique psychosocial and cultural contexts
- Reach a shared understanding of survivor problems and the treatment that are concordant with their values

Survivor-Centred Approach to Counselling

As healthcare providers apply survivor centred approach when addressing the mental health needs of the survivors, they should adhere to the following fundamental principles of counselling:

- ***Autonomy:*** The right of patients to make decisions on their behalf (or, in the case of patients under 18 years of age, individuals acting for the child, i.e., parents or guardians). All steps taken in providing services should ensure the informed consent of the survivor
- ***Beneficence:*** The duty or obligation to act in the best interests of the survivor
- ***Non-maleficence:*** The duty or obligation to 'do no harm' to the survivor
- ***Justice or fairness:*** Doing and giving what is rightfully due to the survivor

1 World Health Organization. (2003). Investing in mental health. World Health Organization. https://apps.who.int/iris/handle/10665/42823

2 Kenya Mental Health Policy 2015–2030. Available on https://publications.universalhealth2030.org/uploads/Kenya-Mental-Health-Policy.pdf

Core Principles and Skills Essential for Counselling Session

This table provides guidance on principles and skills for delivery of effective counselling by the healthcare providers.

Table 15: Core Principles and Skills for Counselling

Unconditional Positive Regard	• Counsellors should perceive and deal with the survivor as she/he is while maintaining a sense of their innate dignity and worth.
Non-judgmental attitude	• Counsellors should not assign guilt or innocence or a degree of survivor responsibility for the causation of the problem. They should not make evaluative judgments about the attitudes, standards, or actions of the survivor/perpetrator.
Genuine or Congruence	• Counsellors should freely and deeply be able to relate to survivors/perpetrators sincerely and non-defensively.
Empathy	• Counsellors should be able to understand the survivor's reactions, with a sensitive awareness of the emotions and the situation of the survivor (Rodgers 1967 304 -311)
Active Listening	• Attentively listening to the victim's story without interrupting or rushing.
Reflections of feelings	• Reflecting back their emotions and experiences to show that their voice is being heard.
Safety and Trust:	• Creating a safe and confidential space where the victim feels comfortable sharing sensitive information. • Building a foundation of trust that encourages open communication.
Culture sensitive	• Respecting the victim's cultural background, beliefs, and values. • Ensuring that the counselling approach is culturally sensitive and relevant.
Empowerment	• Fostering a sense of control and agency in the victim's healing journey. • Collaborating with them to set goals and make decisions about their recovery process.
Psycho-education	• Providing information about the psychological and emotional impact of GBV and any other relevant information. • Offering insights into common reactions to trauma and coping strategies.

Trauma-Informed Care	• Recognizing the potential effects of trauma on the victim's behaviour and emotions • Integrating trauma-sensitive approaches into counselling techniques.
Resilience and Strength Focus	• Highlighting the victim's strengths, resilience, and ability to overcome challenges. • Providing hope and encouragement for their journey towards healing.
Referral	• Clients of GBV should be referred for specialized treatment should the counsellor deem that necessary.

The Counselling Environment

The room should have;

- Privacy: unauthorised people should not be able to view or hear any aspects of the consultation. Hence, the examination room should be a private area with walls and doors, not just curtains, to ensure privacy. It should be clear when counselling is in process, indicated on the door with a sign such as: "Counselling in Process: Please do not Disturb!"
- Friendly, comfortable and clean. Paper hand towel should be made available if possible incase a survivor breaks down and crys
- A cabinet that can be locked and secured for confidentiality where files are stored
- Child-friendly with toys, play and art material
- Ensure that all forms (consent and case notes) are readily available
- Additional material handed to the client to read as further reference

Obtaining Informed Consent

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

Mental Health and Psychosocial Support Interventions

Below are the interventions that the GBV survivor may require.

Psychological First Aid (PFA)

PFA is a supportive intervention for use in the immediate aftermath of a GBV incident.

Professionals delivering Psychological First Aid must follow these guidelines for delivering PFA for all ages;

- Introduce yourself and establish rapport and trust with GBV survivor in a non-intrusive, compassionate manner. Be sensitive to issues of culture and diversity
- Help survivors to tell you specific what their immediate needs and concerns are, and gather additional information as appropriate
- Maintain confidentiality as much as circumstances allow
- Provide physical and emotional comfort by stabilising emotionally overwhelmed or distraught survivors
- Encourage positive coping and problem-solving
- Enhance immediate and ongoing safety
- Offer practical and timely assistance and information including links and referral to additional needed services to help survivors address their immediate needs and concerns. Consider needs of at-risk populations (e.g., children, elderly, disabled, etc)
- Support and provide information for survivors to adapt positive coping

Mental Health Assessment

Effective mental health assessment is crucial for understanding an individual's mental well-being, identifying potential issues, and developing appropriate interventions. The guidelines for conducting mental health assessments and the commonly used assessment tools include;

Establish Rapport and Trust;

- Begin the assessment by creating a safe and non-judgmental environment
- Build rapport with the individual to encourage open and honest communication

Obtain Informed Consent;

- Explain the purpose, process, and confidentiality of the assessment
- Ensure that the individual understands and consents to participate

Cultural Competence;

- Be sensitive to cultural, ethnic, and linguistic factors that may influence the assessment
- Adapt assessment approaches to be culturally relevant and respectful

Suicidal Ideation and Self-Harm;

- Routinely inquire about thoughts of self-harm or suicide
- If necessary, conduct a suicide risk assessment and develop a safety plan

Trauma-Informed Approach;

- Assess for a history of trauma and its impact on mental health
- Use trauma-informed techniques to ensure the individual feels safe during the assessment

Holistic Assessment;

- Consider the individual's physical health, social support, and environmental factors in the assessment.
- Address all aspects of well-being to create a comprehensive treatment plan.

Collaborative Approach;

- Involve the individual in the assessment process, encouraging them to share their experiences and goals
- Collaborate with other healthcare providers and support systems, such as family and friends

Comprehensive Assessment;

- Assess various domains of mental health, including emotional, cognitive, behavioural, and social functioning
- Consider co-occurring physical health conditions and substance use

Use Validated Assessment Tools;

- Employ standardised and evidence-based assessment tools to ensure reliability and validity
- Tools may include questionnaires, interviews, and observation protocols

Clinical Interview;

- Conduct a structured clinical interview to gather relevant information
- Explore the individual's history, current symptoms, stressors, and strengths

The survivors may have current (acute) or existing mental health disorders. Clinicians and mental health practitioners are obligated to conduct screening and diagnosis on mental disorders using validated mental health screening tools.

Some of the recommended tool are listed in table 16 below;

Table 16: Commonly Used Mental Health Assessment Tools

Screening tool	Purpose	Administration guidance
Post Rape Care Form (Part B)	Part B is intended to assess the mental status of a client in order to offer holistic care	• This should inform the management and subsequent follow up of the client and hence should be filled in at presentation • Psychological assessment should be done by trained health care providers including Medical Officers, Nurses, Clinical Officers, Psychiatrists, Psychological Counselors and Medical Social Workers duly recognized by the Ministry of Health. • The medical officers and other designated persons should sign off Part A and Part B of the PRC form as a mandatory requirement for a medico-legal report
GBV - Trauma counselling Data form	It typically includes essential sections to gather information related to the survivor's counseling sessions	• Before initiating the counseling sessions and data collection, explain the purpose of the data form to the survivor and seek their informed consent for participation in counseling and data collection.
Patient Health Questionnaire - 2 (PHQ2) These are the first two questions of PHQ9	It is used to screen for depression	• If a patient responds 'not at all' to both questions on the PHQ 2 (asking if the patient has experienced little interest or pleasure in doing things and/or has felt down, depressed, or hopeless in the previous 2 weeks), then no additional screening or intervention is required, unless otherwise clinically indicated. • If a patient responds 'yes' to one or both questions on the PHQ 2, the PHQ 9 should be administered and scored to inform treatment planning. • The PHQ 2 is appropriate to be used with individuals 12 years of age and older.

Patient Health Questionnaire - 9 (PHQ9)	It is used to screen or diagnose depression, as a symptom tracking tool to measure the severity of symptoms, and measure a patient's response to treatment and improvement of specific symptoms with treatment.	• The nine items of the PHQ-9 are based directly on the nine diagnostic criteria for major depressive disorder in the DSM-IV • If a patient responds 'yes' to one or both questions on the PHQ 2, the PHQ 9 should be administered and scored to inform treatment planning. • Generally, a score of 10 or above and/ or a positive answer on question 9 of the PHQ 9, which is a screening for suicidal symptoms necessitates intervention
		• Survivors receiving intervention should be provided with regular follow up and tracked for improvement in their PHQ 9 score. • The PHQ 9 is appropriate to be used with individuals 12 years of age and older.
PCL-5	The PCL-5 has a variety of purposes, including: to screen individuals for PTSD and make a provisional PTSD diagnosis and to monitor symptom change during and after treatment.	• It is a 20-item self-report assessment tool for the diagnosis of Post Traumatic Stress Disorder (PTSD). Scored to provide a provisional PTSD diagnosis.
CRAFFT screening Car Relax Alone Forget, Friends, Trouble.	It is used to screen adolescents for high-risk alcohol and other drug use disorders simultaneously.	• It is a series of 6 questions • The score of (2) or more indicates the need for further assessment. 0 - 1 No problems reported • It can be used in medical facility and community health settings • It is administered amongst adolescents age 12 to 21 years • Calculate the CRAFFT score by tallying the number of "Yes" responses to the six questions. Higher scores indicate a greater likelihood of substance abuse risk. Interpret the results to determine whether additional evaluation or support is needed.

ACES Questionnaire (Adverse Childhood Experiences Questionnaire)	It is a 10-item measure used to assess the cumulative impact of adverse childhood experiences on an individual's physical and mental health.	• The ACE questionnaire typically includes a series of questions related to childhood trauma experiences, and respondents are asked to indicate whether they have experienced each event before the age of 18 • The questionnaire is scored by tallying the number of ACEs a person has experienced, providing a cumulative ACE score.
		• It is administered to children to understand their experiences of trauma • It is also administered to adults, as it involves retrospective reporting of adverse childhood experiences that occurred before the age of 18
CAGE-AID **C** – Cutting Down **A** – Annoyance by Criticism **G** – Guilty Feeling **E** – Eye-openers	The CAGE questionnaire is a 4-question screening tool that clinicians may use to help in the diagnosis of alcoholism.	• A clinician may use it as a screening tool in a primary care setting. This test alone should not be used to self-diagnose a problem • Each "no" answer is given a 0 and each "yes" answer is given a 1. If the total sum of the scores for the questions is greater, it may indicate an alcohol use issue. A total score of 2 or higher is considered clinically significant.
General anxiety Disorder -7	To screen and evaluate the severity of symptoms related to generalized anxiety disorder.	• Hand out the GAD-7 questionnaire to the individual, ensuring they understand it is a self-report assessment. • Clarify how to complete the questionnaire, emphasizing that they should choose the response that best represents their experiences over the past two weeks. • Instruct the individual to respond to the seven questions by indicating the frequency of symptoms experienced, using the provided options. • Calculate the total score by adding up the points corresponding to the selected responses for each question • Evaluate the total score against the established criteria to determine the severity of anxiety symptoms, guiding further assessment or necessary

The survivors of GBV should receive basic screening for depression during initial and subsequent scheduled visits using the appropriate validated screening tool. The tools should be completed by the survivor, then scored by a qualified healthcare provider. In cases where patients have difficulty with reading or comprehension, the healthcare provider can assist the patient in completing the tool.

Trauma Counselling for Survivors of GBV

Survivors of trauma often face a range of emotional, psychological, and physical challenges that can significantly impact their well-being. Trauma counselling is a specialized and vital service aimed at helping individuals who have experienced various forms of trauma, including violence, to heal and regain control of their lives. Trauma counselors play a crucial role in providing support, guidance, and therapeutic interventions that foster healing, resilience, and recovery. This can involve addressing trauma symptoms such as intrusive thoughts, flashbacks, avoidance behaviour, and emotional numbing. Stabilising the survivor is an important step at the beginning of the counselling process since it helps the person acquire a sense of "being grounded" back on their feet again, emotionally and socially.

Elements of Trauma Counselling

- Contracting with the survivor
- Supporting the survivor
- Psycho-education and information are given to the survivor and accompanying person on trauma treatment, post-traumatic stress disorder (PTSD), survivors' rights, legal redress and referral linkages.
- Psychosocial support, e.g., support groups for survivors, family and relatives
- Screening for depression, anxiety, PTSD, suicide and self-harm

The following sections will outline key principles and practices to consider when working with survivors of violence and other traumatic experiences. They are designed to offer trauma counsellors, mental health professionals, and caregivers a comprehensive framework for providing trauma-informed and survivor-centred counseling. They emphasize the importance of safety, cultural competence, and a trauma-focused approach in helping survivors navigate the complex journey toward healing.

By adhering to the recommendations, counselors can create a compassionate and empowering therapeutic environment where survivors can begin to process their trauma, develop coping strategies, and ultimately reclaim their lives. It is essential to recognize that each survivor's experience is unique, and tailoring counseling approaches to their specific needs is fundamental to their recovery. These guidelines aim to promote trauma-sensitive counseling practices that prioritize the survivor's well-being, autonomy, and resilience throughout their healing journey.

Safety First;

- Prioritize the survivor's safety and well-being.
- Create a safe, confidential, and non-judgmental environment for counseling sessions.

Trauma-Informed Approach;

- Understand the impact of trauma on survivors' mental and emotional well-being.
- Approach survivors with empathy, sensitivity, and a recognition of their resilience.

Informed Consent:

- Obtain informed consent from survivors before initiating counseling.
- Explain the counseling process, goals, and potential outcomes clearly.

Cultural Competence:

- Respect cultural, religious, and social backgrounds.
- Adapt counseling techniques to align with the survivor's cultural context.

Holistic Assessment:

- Conduct a comprehensive assessment of the survivor's mental, emotional, and physical health.
- Identify any co-occurring issues, such as substance abuse or mental health disorders.

Trauma-Focused Interventions:

- Use evidence-based trauma-focused therapies, such as Cognitive-Behavioral Therapy (CBT) or Eye Movement Desensitization and Reprocessing (EMDR).
- Tailor interventions to the survivor's specific needs and trauma history.

Empowerment and Choice:

- Empower survivors to make choices about their counseling process.
- Respect their autonomy and involve them in treatment planning.

Psychoeducation:

- Provide survivors with information about trauma, its effects, and coping strategies.
- Help survivors develop a better understanding of their trauma responses.

Emotional Regulation:

- Teach survivors skills to manage overwhelming emotions and triggers.
- Foster emotional resilience and self-regulation.

Safety Planning:

- Collaborate with survivors to develop safety plans to manage potential future risks.
- Include strategies for crisis management and seeking support.

Respect for Boundaries:

- Maintain professional boundaries and avoid dual relationships.
- Ensure the survivor's privacy and confidentiality.

Crisis Intervention:

- Be prepared to provide immediate support in cases of acute distress or suicidal ideation.
- Know crisis hotlines and local resources for referrals.

Trauma Recovery Focus:

- Promote a strengths-based approach, emphasizing resilience and post-traumatic growth.
- Celebrate survivors' progress and successes in their healing journey.

Ongoing Support:

- Offer long-term support if needed, as recovery from trauma can be a lifelong process.
- Encourage survivors to build a support network of trusted individuals.

Evaluation and Feedback:

- Continuously assess the effectiveness of counseling interventions.
- Seek feedback from survivors to improve service delivery.

Remember that every survivor's experience is unique, and counseling should be adapted to their specific needs. These guidelines aim to provide a framework for trauma counselors to offer effective and compassionate support to survivors of violence.

The recommended minimum period of trauma counselling is five sessions. The first session should include psycho-education and information on the nature and symptoms of post-traumatic stress disorder (PTSD).

Considerations for Inclusive Mental Health Support for Special Populations

When offering mental health support to special populations such as children and people with disabilities, it's essential to consider their unique needs and circumstances. The following are guidelines to ensure effective and inclusive mental health services;

Providing Mental Health Support for Child Survivors of Violence;

Child-Centered Approaches;

- Tailor interventions to the child's developmental stage and age
- Use play therapy, art therapy, or other child-friendly modalities to facilitate communication

Incorporate play as a therapeutic tool to help children express emotions and thoughts

- Use creative activities to engage the child in the healing process

Inclusive Communication;

- Use age-appropriate and child-friendly language.
- Create a safe and non-judgmental environment to encourage open communication.

Family Involvement;

- Engage family members as partners in the child's mental health care.
- Collaborate with caregivers to understand the child's needs and preferences.

Trauma-Informed Care;

- Recognize the potential for trauma and create a safe space.
- Utilise trauma-informed techniques to avoid re-traumatization.

Emotional Regulation and Coping Skills;

- Teach age-appropriate emotional regulation and coping strategies.
- Promote resilience and self-advocacy skills.

Accessibility and Inclusivity;

- Ensure physical spaces, materials, and information are child-friendly and accessible.
- Adapt interventions to accommodate any sensory or cognitive differences.

Individualised Goals;

- Develop individualized treatment plans based on the child's unique needs and strengths.
- Encourage participation in setting goals and treatment decisions.

Providing Mental Health Support to Persons with Disabilities:

Accessibility and Inclusivity:

- Ensure physical spaces, materials, and information is accessible to individuals with disabilities
- Provide accommodations such as sign language interpreters, Braille materials, or assistive technology.

Individualized Assessment:

- Conduct comprehensive assessments considering the specific disability, communication needs, and support systems.
- Recognize that mental health experiences may be influenced by the disability.

Collaborative Care:

- Collaborate with a multidisciplinary team, including medical professionals and caregivers.
- Coordinate services to address physical, emotional, and psychological well-being.

Trauma-Informed Care:

- Recognize the potential for trauma related to disability and address it sensitively.
- Use trauma-informed techniques to avoid re-traumatization.

Cultural Sensitivity:

- Respect cultural diversity within the disability community.
- Adapt interventions to be culturally sensitive and responsive.

Emotional Regulation and Coping Skills:

- Teach adaptive emotional regulation and coping strategies tailored to the individual's abilities.
- Encourage the development of self-advocacy skills.

Accessibility of Resources:

- Provide mental health resources and information in accessible formats, such as audio or easy-to-read materials.
- Ensure access to technology or assistive devices for online support.

Empowerment and Autonomy:

- Empower individuals with disabilities to make choices about their mental health care whenever possible.
- Promote self-determination and autonomy.

Anti-Stigma Education:

- Address and challenge stigmatizing attitudes and behaviors related to disability and mental health.
- Foster acceptance and understanding.

Advocacy and Accessibility:

- Advocate for policies and practices that promote inclusion, accessibility, and equal opportunities for individuals with disabilities.

By following these separate guidelines, mental health professionals and caregivers can provide effective and inclusive support to children and people with disabilities, enhancing their mental well-being and overall quality of life.

Selfcare for Service Providers

Empathizing and caring for GBV survivors can affect the providers' mental health and well-being. The effects can be more pronounced if the provider is a survivor of violence or resources are insufficient to meet their needs. These effects include burnout, compassion fatigue, and vicarious or secondary trauma. A recommendation is recommended that service providers working with trauma clients, especially rape survivors, access self-care to remain effective in their day-to-day work.

Effects of work-related trauma

Burnout

- This is usually the result of prolonged stress or frustration, resulting in exhaustion of physical strength, emotional strength and/or motivation (Maslach, 2003)
- Burnout is associated with the workplace and is often a predictable outcome when the work environment demands a great deal from workers.
- It can lead to impaired decision-making and other conflicts related to the client/provider relationship (Florio, 2010)

Compassion fatigue/ Vicarious trauma

- This is a permanent change in the service provider resulting from empathetic engagement with a client's traumatic background (Pearlman & Saakvitne, 1995)
- The relationship of the person suffering from vicarious trauma to the world around them becomes altered
- Like burnout, vicarious trauma typically develops over a period of time after many sessions of listening to painful experiences with an empathic listener

Secondary Trauma/Indirect Trauma

1. This occurs when a service provider relates to someone who has undergone a traumatic event or a series of traumatic events to the extent that they begin to experience similar symptoms of post-traumatic stress disorder that the trauma victim is experiencing (Baird & Kracen, 2006)

1. The difference between secondary trauma and vicarious trauma is that secondary trauma can happen suddenly, in one session, while vicarious trauma is a response to an accumulation of exposure to the pain of others (Figley, 1995).

Interventions that support the service providers must be carried out regularly, as described below;

- Support supervision is important for preventing the 'burnout' of the health care provider and counsellors and maintaining high-quality services to the survivors
- Debriefing is a technique designed to assist individuals or groups in dealing with the physical or psychological symptoms generally associated with trauma exposure
- Regular personal therapy is psychotherapy in which a trained professional helps a counsellor to work through personal issues

Referral and Coordination

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.

It also involves follow-up efforts necessary to facilitate initial contact with prevention, care, and psychosocial services and to solicit clients' feedback on service satisfaction.

Importance of Referral systems

When appropriate and adequately executed, referral aids recovery, psychological and emotional support, diagnosis, treatment, specialized care, access to justice and also assures safety and security for the survivor

Indications for Referral in GBV care
The health care provider should refer survivors of GBV to access other additional services beyond the health facility as appropriate See Annex 20. The indications for referral include, to;

- Seek expert opinion and report on the client's condition or specimen
- Procure additional or different services for the client
- Seek admission and management of the client
- Request the use of diagnostic and therapeutic tools
- Send specimens for forensic analysis and external quality assurance
- Address safety and security concerns
- Address Lack of resources (financial, material)
- Meet a client's request

Functions of Key Players in the GBV Referral System

Gender and Social Services

Prevention, response, rescue, and management, advise on referral pathways and legal redress, linkages to safe houses and other relevant service providers, awareness creation and sensitization.

Education

To provide prevention and response services to GBV in schools through:

- Education as per the school curriculum.
- Acts as places of safety,
- Identification and reporting,

- Psychosocial Support through provision of mentorship and counselling services, engagement of parents in the learning and management of schools,
- Identification and Nurturing learners through co-curricular activities
- School enrolment and re-entry in schools,
- Referral and linkage to other services.

Children Services

To provide preventive and responsive services to children in need of care and protection as defined by the Children's Act 2022. These services include, but are not limited to:

- Community awareness and education on Child Rights and Child Protection
- Safeguarding the welfare of the child by conducting social inquires to determine safety and address protection concerns
- Emergency rescue and placement to places of safety
- Furnish court with report for VAC cases
- Provision of psychosocial support services, i.e., Shelter, food, counselling, rehabilitation and reintegration services

Health Services

To offer timely and quality post-GBV medical services, provide expert evidence in court and linkage to other services. In a health facility, survivors are referred to access a variety of services within the facility (intra-facility) using the referral pathway Job aid in annex 18.

Police

Receive complaints, investigate reported incidences, gather evidence and present suspects for charging. To maintain law and order, enforce the law and make arrests.

Government Chemist

To carry out forensic analysis on samples submitted by the police and to provide expert evidence in a court of law.

Public Prosecutors

To institute and undertake criminal proceedings against anyone before any court except court martial.

Judiciary

To apply the law, settle disputes and punish lawbreakers.

Prisons

Containment of convicted offenders to facilitate responsive administration of justice, rehabilitation, social integration and community protection.

Probation & Aftercare Services

To promote and enhance the administration of justice, community safety and public protection through provision of social inquiry reports, supervision and reintegration of custodial and non-custodial offenders, victim support and social crime prevention.

Child Protection, Referral and Response Mechanism

Access to care, treatment and justice after sexual and gender-based violence is essential to ensure a survivor's recovery and reintegration into the community without stigma and discrimination.

A practical, well-coordinated and integrated protection and response mechanism ensures that child survivors receive the appropriate support.

- Health assistance is prioritised for sexual violence and/or possible bodily injuries
- In the case of Child Survivors of Violence (CSV), assistance must be in accordance with the SOPs that guide the clinical management of CSV, including the provision of EC and PEP for HIV
- HCPs should inform the child/survivor and legal guardian of available assistance and/or any limitations to services
- Service providers in the referral network must be knowledgeable about the services provided by internal and external actors to whom they refer a child survivor

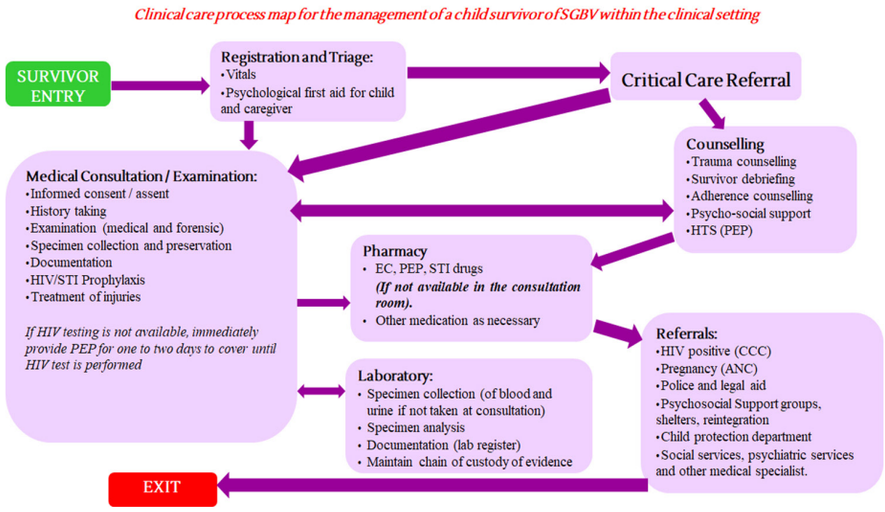


Figure 8: Clinical care process map for the management of CSV within the clinical setting

Core Components of comprehensive clinical services for child sexual violence

Healthcare providers should involve children's officers when rescuing a child survivor. Children officers facilitate processing of a court committal order for the child to a children's institution or other setting if required.

Health facilities are encouraged to forge good relationships with the children's department, police and other relevant service providers.

A strong protection and referral network ensures that the care provided is comprehensive, responsive and addresses both short- and long-term recovery needs of the child.

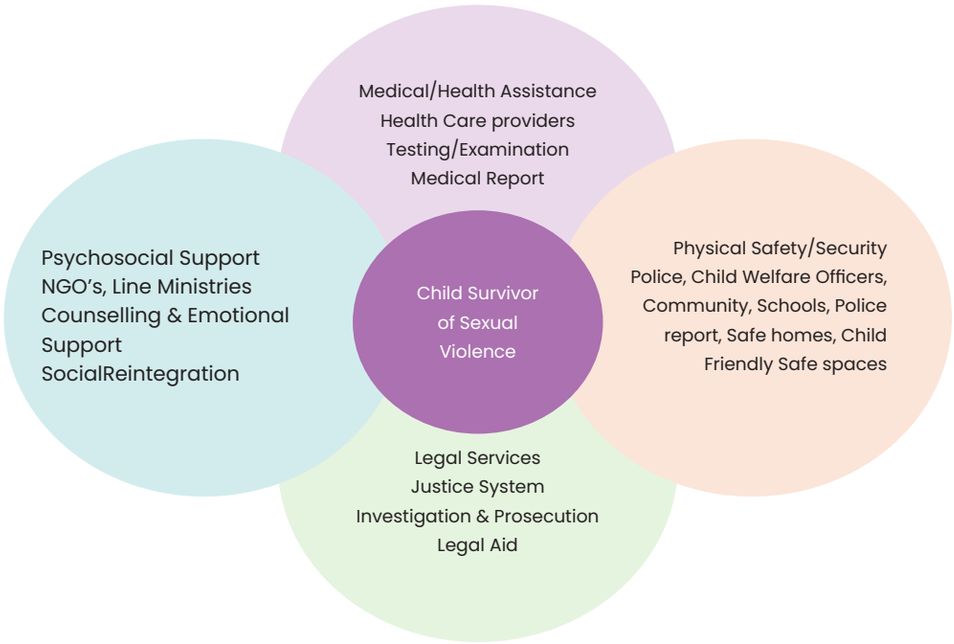


Figure 9: Core component of a comprehensive, coordinated response

- Multi-sectoral linkages are key to the management of services for child sexual violence. These linkages allow for the child sexual violence survivors' medical, psychosocial and legal needs to be adequately addressed throughout the continuum of care
- The individual capacity of each of these sectors to address child sexual violence is enhanced through policies and programs that create avenues for linkages
- The management of child sexual violence requires a comprehensive, cross- sectoral approach, in which services at all levels should be child-centered and comprehensive
- The comprehensive clinical service for child sexual violence should meet the range of medical and psychosocial needs of the child sexual violence survivor from the first point of contact through to the final stages of recovery and reintegration into the community

Monitoring, Evaluation Research,and Learning

Monitoring and evaluation form an integral part of the Gender-Based Violence Service provision. It is an essential management tool that will help to ensure that health activities are implemented as planned by revealing gaps and issues of the program in achieving necessary results. This will be done by providing necessary data to guide strategic planning, program implementation, and allocation of funds. Proper documentation and record keeping of GBV service data is critical in evidence provision and will guide the facilitation of justice for survivors.

The Ministry of Health (MOH) shall provide overall strategic leadership in monitoring the implementation and evaluation of these guidelines with technical assistance from a technical working group (TWG). In collaboration with the county governments and other stakeholders, MOH will work in a coordinated manner to ensure effective monitoring and evaluation of GBV service provision.

In addition, the national and county-level health management teams will ensure that the data collection tools for GBV services are available and used appropriately. The County government shall complement the effort of the National government by assisting in printing and distribution of data tools when and quality data is generated.

GBV Data Documentation

Documentation for GBV services should be done at all service delivery points of care, such as outpatient department, inpatient department, maternity, and maternal child health clinic (MCH). Proper documentation should provide information for planning of the survivor's care and treatment. It should form a means of communication with the team members concerning survivors' care, satisfy legal and ethical obligations in client management and guide research and quality management.

The PRC form (MOH 363) should be placed at the Clinical room and filled by the service provider as they conduct history taking of the survivor and collection of evidence.

NB: PRC form will be filled for penetrative and non penetrative e.g. sexual harrassment forms of SGBV, ensuring that the part B of the form is also filled. The GBV register (MOH 365) should be filled with the information contained in the PRC form. At the end of the month, the GBV focal person/ HRIO should ensure that the summary tool (MOH 364) data from all the service delivery points in the facility. Before the GBV data is entered in KHIS or taken to the Sub- County HRIO. The summary tool should be countersigned to ascertain accuracy of the GBV data from the facility.

GBV Reporting

The clients' records should be summarized, compiled, and reported using the MOH 364, which is the summary tool. Other GBV tools are as listed in Table 16. Various cadres who provide post-GBV care shall be guided by the roles and responsibilities indicated below in table 17 below.

Table 17: GBV Reporting, Roles and Responsibilities

Tool	When it is filled	Who fills the tool	Role
MOH 363 - Post Rape Care Form	While attending to survivors of sexual violence	Medical Officers, Clinical Officers, Nurses	Data entry at the service delivery points
MOH 365 - Gender Violence Register	Immediately after filling out the PRC form and after offering care to any survivor of GBV	Medical Officers, Clinical Officers, Nurses	Data entry at the service delivery points
MOH 364 - GBV Monthly Summary	By the 5th of every month, summarize the MOH 365	Health Records and Information Officer and/ GBV Focal Person/ Facility Incharge	Data consolidation and report writing are to be submitted at the set deadline for each level.
MOH 405 – ANC Register	When attending to ANC clients with a history of FGM	Medical Officers, Clinical Officers, Nurses	Data entry at the service delivery points
MOH 333- Maternity register	When attending to mothers during delivery with FGM-related complications	Medical Officers, Clinical Officers, Nurses	Data entry at the service delivery points
KHIS	By the 15th of every month	Facility and sub-county HRIO	GBV data reporting

List of GBV indicators monitored monthly

- Total number of GBV Clients seen
- Total GBV survivors with disability
- Number of SGBV survivors
- Number of survivors presenting within 72 hours
- Number of survivors tested for HIV
- Number of survivors HIV negative at 1st visit
- Number of survivors initiated on PEP
- No of survivors testing negative for pregnancy-1st visit
- Number of survivors eligible for Emergency Contraception
- Number given Emergency Contraception
- Number given STI prophylaxis / treatment
- Number given HPV vaccine
- Number given Hep B vaccine
- Number given Tetanus diphtheria (Td)
- Number of survivors offered trauma counselling and psychological support
- Number of Intimate Partner Violence survivors seen

- Number of FGM survivors seen
- Number of FGM performed by medical professional
- Number of FGM performed in the health facility
- Number of FGM performed at the community
- Number of child marriage survivors seen
- Number of survivors referred for other services/support
- Number completed 5th visit
- Number completed PEP
- Number seroconverted
- Number pregnant (4 wks after exposure)
- Number completed trauma counseling

Gender Data Violence Data Flow Mechanism

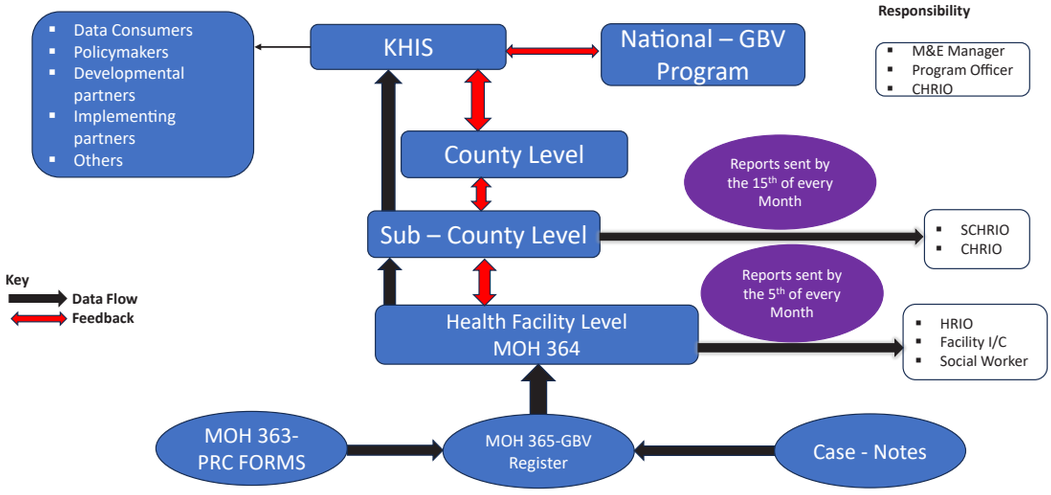


Figure 10: GBV Data flow chart

GBV Quality Management

Quality management is an ongoing effort to provide services that align with stipulated service standards and meet or exceed clients' expectations equitably, acceptably, and within available resources.

Elements of Quality of Care;

- **Availability**: Ensuring that there are enough well-functioning healthcare facilities, resources, services, and programs to meet the needs of the population
- **Accessibility**: Making healthcare services accessible to all, regardless of factors like discrimination, physical barriers, cost, or access to information.
- **Acceptability**: Providing healthcare services that respect ethical standards, align with cultural norms, and are considerate of age and gender differences.
- **Quality**: Quality: Do service providers possess the necessary skills and training? Are there adequate supplies (i.e., drugs that are not expired and stored properly)

that meet relevant standards? Is the environment appropriate, non-discriminatory, private and confidential as needed? Are the facilities safe and sanitary?

Continuous Quality Improvement (CQI)

This describes the combined and ongoing efforts of everyone (healthcare professionals, patients, their families, researchers, planners, and educators) to make the changes leading to better patient health outcomes, patient care, professional development, and access to care.

Methods of Monitoring Quality

1. Suggestion Boxes
2. Use of GBV QA tool (Annex 19)
3. Feedback
4. Client Satisfaction Tools
5. Checklist
6. Self-Assessment
7. Data Analysis
8. Counsellor Support
9. Supervision

Data Quality

To have reliable and helpful information for effective and informed decisions, extracted data from registers should be clean and error-free. Quality data will enhance evidence-based decision-making. The health service provider should incorporate strategies for data quality assessments. Deliberate efforts should be implemented to ensure the reported data are verified regularly. These strategies include supportive supervision, data review meetings, and Routine Data Quality Assessment.

Data used in Quality Assurance (QA)

- Identify opportunities for improvement to initiate QA and QI efforts
- Detect and assess problems
- Verify possible causes of problems
- Inform decision making
- Demonstrate if a quality intervention yielded improvement and by how much
- Monitor processes over time to track changes or if the improvement is maintained

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Annexes

Annex 1: Standard GBV Screening Tool

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?* No ☐ Yes ☐ . 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 Abuse
Physical	☐ Physical Abuse
Emotional	☐ Verbal abuse ☐ Harassment ☐ Discrimination ☐ Illegal arrest ☐ Humiliation
Date Violence occurred	_____ /_____ /_____

Perpetrator

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

Post Violence services offered

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

Referral

YES	☐ Health Facility ☐ Children's Dpt ☐ 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:** _____

ANNEX 2: Consent Form

Name of facility: .....

Note to the health worker: 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 survivor, or the thumb print of the survivor and the signature of a witness.

I, _____ _____ *(Print name of survivor)*

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

Clinical Interventions	**Yes**	**No**
Conduct a general and medical examination	☐	☐
Conduct a pelvic examination	☐	☐
Collect and analyze evidence, such as body fluid samples, clothing, hair combings, scrapings or cuttings of fingernails, blood sample, and photographs	☐	☐
Provide evidence and medical information to the police 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 for follow up. Preferred phone number Preferred time for call	☐	☐

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 3: Post Rape Care Form (MOH 363 Part A AND B)

POST RAPE CARE FORM (PRC)

PART A

MOH 363

PRC FORM IS NOT FOR SALE

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

PRC Post Rape Care Form

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

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

Contacts (Residence and Phone number) _____

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

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

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

Alleged perpetrators ☐ Male ☐ Female Estimated Age _____

☐ Unknown ☐ Known (specify the relationship) _____

Where incident occurred

Administrative location: County _____ Sub-county _____ Landmark _____

Chief complaints: Indicate what is observed _____

Indicate what is reported _____

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

_____

_____

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

Use of condom? ☐ Yes ☐ No ☐ Unknown

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

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

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

Date: Day Month Year Hr Min ☐AM ☐PM

Were you treated? ☐ Yes ☐ No

Were you given referral notes? ☐ Yes ☐ No

Significant medical and/or surgical history

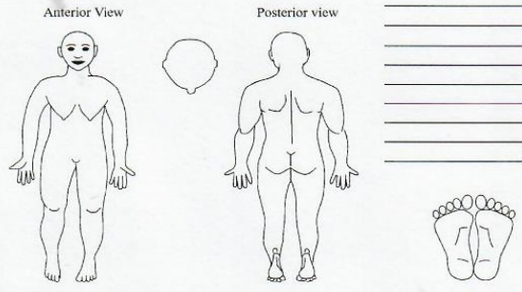
Comments: Indicate additional information provided by the client or observed by clinician

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

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

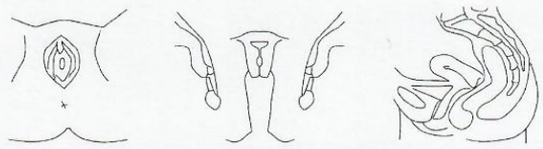
BODY MAP

Anterior View | Posterior view

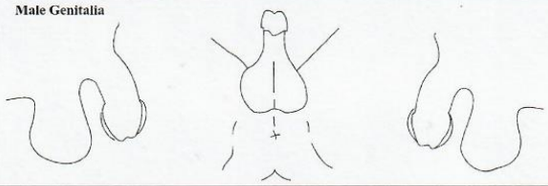


Comments _____

Female Genitalia



Male Genitalia



MOH 363

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

FORENSIC

Did the survivor change clothes? ☐ Yes ☐ No

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

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

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

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

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

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

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

Describe in detail the physical status

Physical injuries (mark in the body map) _____

Outer genitalia _____

Vagina _____

Hymen _____

Anus _____

Other significant orifices _____

Comments _____

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

Any other treatment / Medication given /management?

Referrals to

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

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

CHAIN OF CUSTODY

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

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

PSYCHOLOGICAL ASSESSMENT Complete psychological assessment section in Part B

POST RAPE CARE FORM (PRC)

PRC FORM IS **NOT** FOR SALE

PART B

PSYCHOLOGICAL ASSESSMENT

PRC Post Rape Care Form

MOH 363

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

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

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

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

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

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

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

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

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

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

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

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

MOH 363

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

Cognitive function-

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

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

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

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

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

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

Recommendation following assessment	Referral point/s

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

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

ANNEX 4: Post Rape Care Kit Checklist

Sn. No.	Items	Quantities
1	Powder free surgical gloves	4 pairs
2	Cusco's Vaginal Speculum (for adult females)	1 piece
3	Brown envelopes A3	3 pieces
4	Brown envelopes A5	7 pieces
5	Brown envelopes A4	5 pieces
6	Sample Labels	10 adhesive labels
7	Syringe 5mL + needle 21G x 1.5"	5 pieces
8	ETDA Purple tops Vacutainer tubes	2 pieces
9	Red top Vacutainer tube with clot activator	2 pieces
10	Sterile plain Urine bottles	3 pieces
11	Tongue Depressor	1 piece
12	Soft tape measure	1 piece
13	Clear Cello tape	1 piece
14	Adhesive strapping	1 piece
15	Nail clipper	1 piece
16	Plastic Jelly Comb	1 piece
17	Pair of Scissors	1 piece
18	Sterile Water bottles 10mls	5 bottles
19	Stick swabs (sterile)	15 pieces
20	Orange sticks	5
21	4 pieces A2size white paper towel or 1 Cotton bed-sheets	
22	White flip chart sheet	1 piece
23	Ziplock plastic bag	1 piece

Dignity pack

1	Cotton t-shirt ; short/trouser or skirt/dress	1 piece of each
2	Cotton ladies pant / boxer short	1 piece
3	Cotton Sanitary pads for females	1 pack

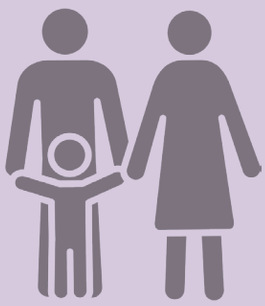
ANNEX 5: Head to Toe Examination for Adults -Job Aid

1. First, note the survivor's general appearance and demeanor.
1. Take the vital signs, i.e., pulse, blood pressure, respiration and temperature.
1. Inspect both sides of both hands for injuries. Examine the wrists for signs of ligature marks.
1. Inspect the face and the eyes.
1. Gently palpate the scalp to check for tenderness, swelling or depression.
1. Inspect the ears, and the area behind the ears, for evidence of shadow bruising; shadow bruising develops when the ear has been struck onto the scalp.
1. Carefully examine the neck. The neck area is of great forensic interest; bruising can indicate life-threatening violence.
1. Examine the breasts and trunk while observing dignity and privacy.
1. Inspect the forearms for defence related injuries; these are injuries that occur when the subject raises a limb to ward off force to vulnerable areas of the body, and include bruises, abrasions, lacerations and incised wounds.
1. Examine the inner surfaces of the upper arms and armpit or axilla for bruises.
1. Recline the position of the survivor and for abdominal examination, which includes abdominal palpation to exclude any internal trauma or to detect pregnancy.
1. While in the reclined position, examine the legs, starting with the front.
1. If possible, to ask the survivor to stand for inspection of the back of the legs. An inspection of the buttocks is also best achieved with the survivor standing.
1. Collect any biological evidence with moistened swabs (for semen, saliva, blood) or tweezers (for hair, fibers, grass and soil).

ANNEX 6: Genito-Anal Examination for Adults - Job Aid

1. Try to make the survivor feel as comfortable and as relaxed as possible
1. Explain to them each step of the examination. For example, say, "I'm going to have a careful look. I'm going to touch you here in order to look a bit more carefully. Please tell me if anything feels tender."
1. Examine the external areas of the genital region and anus, as well as any markings on the thighs and buttocks
1. Inspect the mons pubis; examine the vaginal vestibule paying special attention to the labia majora, labia minora, clitoris, hymen or hymenal remnants, posterior fourchette and perineum
1. Take a swab of the external genitalia before attempting any digital exploration or speculum examination. Gently stretch the posterior fourchette area to reveal abrasions that are otherwise difficult to see
1. If any bright blood is present, gently swab in order to establish its origin, i.e. whether it is vulval or vaginal
1. Warm the speculum prior to use by immersing it in warm water
1. Insert the speculum along the longitudinal plane of the vulval tissues once the initial muscle resistance has relaxed
1. 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.
1. Suture any tears if indicated.
1. Remove the speculum

ANNEX 7: Essential Functions for GBV Service Provider

Service Provider	Key Roles
Health care providers 	• Examination and history taking & appropriate treatment • Provides appropriate counseling • Completes PRC forms and other documentation • Collection of forensic evidence / exhibit • Preserve and maintain chain of custody of evidence • Forensic laboratory investigations • Treatment of injuries • Referrals of survivors to police • Expert witness in court
Police 	• Recording incident in the OB and issuance of OB number • Writing of statement • Issuing P3 forms – including request for medical examination • Collect duly filled copies of PRC (original PRC copy) • Escorting the survivor and suspects to the hospital for medical examination • Refer survivors for further requisite services • Provide security for suspects admitted in hospital • Bond medical personnel to testify in court • Collecting the evidence from the hospital • Maintain proper chain of custody of exhibits • Apprehending the suspect • Conducting investigations • Protecting the crime scene • Preserving the evidence and exhibits, and their presentation in court • Notifying the survivor, witness and health provider on the scheduled court proceedings
Department of Children's Services 	• Rescuing children from environment that is propagating GBV • Recommending rescued children to be sent to shelters/ rescue homes • Supervising the welfare of rescued children • Recommending child offenders to Borstal institutions • Provide psychosocial support to child survivors • Support judicial process by providing social enquiry report

Safe Shelters/ Rescue Homes (actors) 	• Providing shelter to survivors • Providing counseling to survivors • Providing social support – education, income generating activities, • Facilitating adoption of children born due to rape
Government administrators (Chief, asst. chief. Village elders 	• Creating awareness on SGBV and facilitate forwarding of exhibits and evidence to the police • Arresting the accused perpetrator • Referring /escorting the survivor to the service delivery points • Recommending cases for rescue i.e. shelters • Supporting the police in investigations • Respect the rights of the clients (survivor and suspect
Paralegals 	• Interview survivors and other relevant persons in order to collect relevant information on the GBV cases, • Organize and/or evaluate available information for use by the legal team • Carry out case management of survivors in the community • Monitor the status of cases to ensure appropriate action is taken in a timely manner by liaising with investigating officers, the lawyers and other legal representatives of survivors. • Provide basic legal advice to survivors of SGBV • Link survivors to available legal aid at the community level
Community members 	• Report SGBV cases to the police and promptly refer to the health care facility • Collaborate with the police in arrest of suspects of SGBV • Assist police to trace witness • Provide places of safety for survivors • Prevention and reporting of harmful practices • In collaboration with probation and other stakeholders, they help in reintegration of ex-convicts
Community leaders 	• Inform clients not to destroy evidence or wash cloths • Advice clients to store cloths in khaki bag • Assist survivors to visit the health facility • Support reintegration of survivors • Avoid re-traumatizing, stigmatize and discrimination • Provide safe places for survivors • Support clients to take treatment (e.g. PEP) • Report crime • To avoid kangaroo courts – they should not promote out of court reconciliation for cases of sexual violence

ANNEX 8: Sexual Maturity Rating - Tanner's Staging

Stage	Female				Male				
	Age range (years)	Breast growth	Pubic hair growth	Other changes	Age range (years)	Testes growth	Penis growth	Pubic hair growth	Other changes
I	0–15	Pre-adolescent	None	Pre-adolescent	0–15	Pre-adolescent testes (≤2.5 cm)	Pre-adolescent	None	Pre-adolescent
II	8–15	Breast budding (thelarche); areolar hyperplasia with small amount of breast tissue	Long downy pubic hair near the labia, often appearing with breast budding or several weeks or months later	Peak growth velocity often occurs soon after stage II	10–15	Enlargement of testes; pigmentation of scrotal sac	Minimal or no enlargement	Long downy hair, often appearing several months after testicular growth; variable pattern noted with pubarche	Not applicable
III	10–15	Further enlargement of breast tissue and areola, with no separation of their contours	Increase in amount and pigmentation of hair	Menarche occurs in 2% of girls late in stage III	1½–16.5	Further enlargement	Significant enlargement, especially in diameter	Increase in amount; curling	Not applicable

Stage	Female				Male				
	Age range (years)	Breast growth	Pubic hair growth	Other changes	Age range (years)	Testes growth	Penis growth	Pubic hair growth	Other changes
IV	10–17	Separation of contours; areola and nipple form secondary mound above breasts tissue	Adult in type but not in distribution	Menarche occurs in most girls in stage IV, 1–3 years after thelarche	Variable: 12–17	Further enlargement	Further enlargement, especially in diameter	Adult in type but not in distribution	Development of axillary hair and some facial hair
V	12.5-18	Large breast with single contour	Adult in distribution	Menarche occurs in 10% of girls in stage V.	13–18	Adult in size	Adult in size	Adult in distribution (medial aspects of thighs; linea alba)	Body hair continues to grow and muscles continue to increase in size for several months to years; 20% of boys reach peak growth velocity during this period

ANNEX 8: Post Exposure Prophylaxis (PEP) Protocols

Age	Weight	Dosage
<15 years old	< 30 kg:	ABC + 3TC + DTG
	< 30 kg	TDF + 3TC + DTG
≥ 15 years old		TDF + 3TC + DTG

PEP (ART) Side effects

1. Sometimes people can get side effects from taking ART
1. Side effects vary from person to person
1. Some people have none while others experience mild effects which are unpleasant but often manageable

Most side effects occur within the first few weeks of starting ART and then improve after a few weeks

Some common side effects include:

1. Headache
1. Loss of appetite
1. Skin rash
1. Fatigue
1. Nausea, vomiting, diarrhoea
1. Muscle pains

What do you do if you notice any side effects:

1. If you develop any side effects, you should continue taking your ART as prescribed, without missing any doses, until you discuss with the clinician
1. If the side effects are mild then you can continue taking your ART without missing any doses, and then discuss the side effects with the clinician at your next appointment
1. If the side effects are bothering you too much then return to the clinic immediately, even if you do not have a scheduled appointment, to discuss what to do next; you can also call the clinic if you are not able to make it yourself immediately. Severe side effects include rash all over your body, or rash in your mouth or eyes, constant vomiting, inability to eat or retain food, or anything else that makes you think you should stop the ART.
1. If this occurs then contact the clinic immediately.The clinician will help you manage the side effects, and occasionally the ART may need to be changed

ANNEX 10: Emergency Contraception

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

ANNEX 11: STI Management Regimen (Adults)

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

ANNEX 12: Vaccination Protocols

Annex 11a: 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

Annex 11b: 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

Annex 11c: 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

ANNEX 13: Counselling Data Form

Date: ☐☐☐☐☐☐☐☐

Facility Name: _____

County Code: ☐☐☐ **MFL Code** ☐☐☐

Survivor Name: _____

Parents/Guardian Name: _____ **(For children)**

_____

Phone Number: _____

Serial No. or OP/IP No.: _____

DATE: ☐☐☐☐☐☐☐☐

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

_____

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

_____

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

_____

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

_____

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

_____

ANNEX 14: Gender Based Violence Clinical Notes Template

GENERAL INFORMATION			
CLIENT NAME			
AGE (YEARS)	**GENDER**	☐ M ☐ F ☐ I	
MARITAL STATUS	☐ **Married** ☐ **Single** ☐ **Divorced** ☐ **N/A**		
REG. NO / UNIQUE NUMBER / CCC. / IPD / OPD			
TELEPHONE NUMBER CLIENT / GUARDIAN			
County		**Sub County**	
MFL Code		**Facility**	

Clinical details			
Documented Consent: Yes ☐ No ☐		**Vital Signs:**	
OVC: Yes ☐ No ☐ N/A ☐		BP: ___/____	
Disability: Yes ☐ No ☐ N/A ☐		Pulse: ____ bpm	
		Temp: ___ °C	
		Resp: _____	
Where was the patient referred from	☐ Health Facility ☐ Children's Dpt. ☐ Police ☐ Legal ☐ CSO ☐ Safe Space Shelter ☐ Forensic interviews ☐ Others (Specify) ☐ N/A		
Survivor Accompanied	Yes ☐ No ☐	**Survivor requires Interpreter**	Yes ☐ No ☐
Date Violence occurred		**Time Violence occurred**	**Time passage since the violence (Hrs, Days, Weeks, Months**
Place of violence	*(e.g., home, school, church etc.)*		
Details of assailants	*(number, gender, age, relationship, known or unknown)*		

Details of the complaint: *(Verbatim description of the violence by the patient)*			
Description of the violence by guardian / accompanying person: *(only for Minors)*			
Type of sexual violation reported *e.g., penetrative sexual violence or non-penetrative violence*		Did the survivor change clothes State of clothes *(color, stained, torn and storage)*	Yes ☐ No ☐
General medical and surgical history			
Specific systemic medical history			
Head-to-toe examination (documenting all injuries)			
Obstetric and gynecological history Systemic examination			

Central nervous system- *level of consciousness, orientation, effect, etc.*
Musculoskeletal system- *physical disabilities, posture control and gait, swellings, bruises, lacerations, dislocations, bite marks, scratches on the body of survivor from head to toe*
Perineum- *clitoris, labia majora and minora, vagina, mons pubis, introitus, fossa navicularis, vestibule, hymen, penis, prepuce, scrotum, urethra, anus, gluteal region, inner medial thighs*
Forensics and clinical samples collected and laboratory findings - *Types of samples, Investigations done and the results*
Mental Status Assessment
Post Violence Services ☐ 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 ☐ No ☐
Reasons for not referring ☐ Not ready ☐ Got all required services ☐ N/A
Next visit date

Name and signature of examining health care provider:

Name: _____

Designation: _____

Signature: _____

Date: _____

Official stamp

ANNEX 15: Evidence Chain of Custody Tracking Form

Case Number: _____ Type of Offense: _____

Submitting Officer and station: (Name/Force No.) _____

Name of Survivor /Victim: _____

Age: _____ Sex: _____

Unique Identify of Suspect: _____ Date/Time collected: _____

Location: _____ Name of officer collecting the sample: _____

Designation: _____

AT SOURCE FACILITY

Description of Evidence			
Date of collection	**Item No.**	**Quantity**	**Description of Item** (sample type, Serial #, Condition, Marks,Scratches, serial # of seal)

Evidence Chain-of-Custody Tracking Form (Continued)
Release from Source Facility

Chain of Custody				
Item No.	**Date/Time**	**Released by** (Name, Signature.)	**Received by** (Name, Signature.)	**Comments/ Location**

EVIDENCE CHAIN-OF-CUSTODY TRACKING FORM
(Continued)
RECEIPT AT ANALYZING FACILITY

Chain of Custody				
Item #	**Date/Time**	**Released by** (Name, Signature& ID/ No.)	**Received by** (Signature & ID/ No.)	**Comments/ Location**

Evidence Chain-of-Custody Tracking Form
(Continued)
At Point of Disposal

Final Disposal Authority
Authorization for Disposal Item(s) No :_____ on this document pertaining to (suspect): _____ is (are) no longer needed as evidence and is/are authorized fordisposal by (check appropriate disposal method) ☐ Return to Owner ☐ Auction/Destroy/Divert Name & ID# of Authorizing Officer: _____ Signature: _____ Date: _____Time: _____
Witness to Destruction of Evidence Item(s) No: _____ on this document were destroyed by Evidence Custodian _____ ID No: _____ in my presence on (date) Name & ID/No. of Witness to destruction: _____ ID/No. _____ Signature: _____ Date: _____
Release to Lawful Owner Item(s) No.: _____ on this document was/were released by Evidence Custodian ID/No.: _____ Time: _____ to Name.: _____ Address: _____ City/ Town: _____ County.: _____ Serial No.: _____ Telephone Number: (_____) _____ Under penalty of law, I certify that I am the lawful owner of the above item(s). Signature: .: _____ Date: .: _____ Copy of Government-issued photo identification is attached (If available). ☐Yes ☐No
This Evidence Chain-of-Custody form is to be retained as a permanent record by the concerned Police Department.

ANNEX 16: Protocol on Types of Specimens, Preservation Methods, Tests and Reasons for Testing

Specimen or samples	Method of collection and preservation	Test	Purpose for testing	Where
Oral swab	Oral swabbing is essential to collect seminal fluid in the oral cavity where there is suspected oro-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	Detection of spermatozoa	Facility Lab
		DNA Analysis	DNA comparative analysis Corroborate orogenital contact by the suspect and the victim	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	Wet preparation for microscopy Culture and sensitivity	Detection of spermatozoa Pathological organisms	Facility Lab
		DNA Analysis Prostrate Specific Antigens (PSA) Acid Phosphatase Test	DNA comparative analysis Identification of victim / assailant by DNA profiling Corroborate anal-genital contact between the suspect and the victim Detection of semen	Government Chemists

Specimen or samples	Method of collection and preservation	Test	Purpose 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
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. Swabbing should be done around the inner surface of the labia minora and fossa **navicularis**. Swabs of the vagina fornices are essentially 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 cervical, swabs should be taken from the cervical orifice by collecting as much of the mucus plug.	Wet preparation for microscopy Culture and sensitivity	Detection of spermatozoa Pathological organisms	Facility Lab
		DNA Analysis	DNA comparative analysis Identification of victim / assailant by DNA profiling Corroborate vulval-genital contact between the suspect and the victim	Government Chemists

Specimen or samples	Method of collection and preservation	Test	Purpose 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 2^0C to 8^0C (if to be stored for longer period of time, the urine should be frozen a -20^0 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	Toxicology Microscopy Microscopy, Culture and sensitivity Pregnancy testing	Drugs and alcohol Detection of spermatozoa Pathological organisms Pregnancy	Facility Lab (where available)
		Toxicology	Drugs and alcohol	Government Chemists
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

Specimen or samples	Method of collection and preservation	Test	Purpose for testing	Where
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	Drugs and alcohol Ability of the survivor to consent	Government Chemists
		DNA Analysis	Corroborative evidence of contact between the suspect and the victim	
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	Purpose for testing	Where
Semen and semen stain	Dry semen-stained clothes in open air. 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 P30	Government Chemists
Used condom	Condom used during the sexual violence may be collected and swabbed separately from inner and outer surfaces using sterile swabs Label outer, inner swabs & surface swabs appropriately Air dry the swabs and package them appropriately Knot or tie the top of the condom to avoid spillage of the contents Pack in a plastic paper bag Transfer immediately or refrigerate at 2^0C to 8^0C or freeze	DNA Analysis	DNA comparative analysis and suspect profiling Identify assailant and victim Corroborative evidence of contact between the suspect and the victim	

Specimen or samples	Method of collection and preservation	Test	Purpose for testing	Where
Nail scrapping or clippings	- Clean toothpick may be used to scrape inner part of the nail -Clean nail clippers may be used to collect nail clippings -These should be kept in a clean dry container or paper envelope These should be kept away from moisture and at room temperature	DNA Analysis	- Evaluation of skin, blood or fibres that might be collected under the nails of the victim for DNA analysis to establish physical contact between the suspect and the victim Identify assailant and victim	Government Chemists
Clothing and cloth fragments	-The victim should undress on a clean white sheet of paper or clean cotton cloth in order to collect any foreign matter that may fall from his/her clothing. -Items such as bra, undergarments, blouse, shirt etc. should be collected, and placed in non-polythene paper bags -Wet/blood-stained clothing should be air dried before packing in non-polythene paper bag Air dry in a dust free environment, away from heat and direct sunlight. Each clothing item should be packed separately.	DNA Analysis Fibres as transfer evidence	Detection of stains – (blood, saliva, vaginal secretions) on clothing for DNA comparative analysis. Identify assailant and Survivors Corroborative evidence of contact between the suspect and the victim	

Specimen or samples	Method of collection and preservation	Test	Purpose for testing	Where
Bite marks	Document i.e., photograph the area and take measurements of the impression. Swab around the area using a moistened sterile cotton swab. Air dry and pack in a paper envelope. Transfer dental impressions onto plasticine or molding clay. Impressions collected this way must be immediately used for comparative purposes. This is usually done by Forensic Odontologists.	Physical matching DNA Analysis	Identify assailant and survivor Corroborative evidence of contact between the suspect and the victim	Government Chemists and Forensic Odontologist
Tool and tool marks (e.g., caused by knife, pliers, hot iron, fire arm, *rungu,* cane etc.)	Document i.e., photograph the area and take measurements of the tool impression.	Physical matching	Identify the tool that caused the marks	Police/ DCI

Specimen or samples	Method of collection and preservation	Test	Purpose for testing	Where
Sanitary pads, panty liners, tampons and diapers.	Air dry the sanitary pad, panty liner, tampon or diaper before packaging. Sanitary pad/ panty liner should not be removed if attached to the under pant. If the sanitary pad/ liner is detached from the pant at the time of medical examination, the sticky part should be covered by a paper or waxed sheet to prevent the pad/ liner from sticking to the paper envelope. Each item should be packed separately in a paper envelope.	Microscopy DNA Analysis	Detection of semen and spermatozoa. DNA comparative analysis. Identifying the assailant Corroborative evidence of contact between the suspect and the victim	Government Chemists
Live birth Dead fetus	Fetal tissue samples should be collected in a sterile plastic container and stored at minus 20^0C	DNA Analysis	Establish paternity to identify assailant	Government Chemist

ANNEX 17: Kenya Medical Examination Form (P3)

THE KENYA POLICE **P3**
MEDICAL EXAMINATION REPORT

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

From……..Ref……
……...Date……..
To the……Hospital/Dispensary
I have to request the favour of your examination of:-
Name……...Age……(If known)
Address…….....Date and Time of the alleged offence.....
……...
Sent to you/Hospital on the……20…..under escort of……
……and of your furnishing me with a report of the nature and extent of bodily injury sustained by him/her.
Date and time report to police……
Brief details of the alleged offence……
……
…… ……..
Name of Officer Commanding Station Signature of the Officer Commanding Station

PART 11-MEDICAL DETAILS - ***(To be completed by Medical Officer or Practitioner carrying out examination)***
*(Please type **four** copies from the original manuscript)*
SECTION ''A''-THIS SECTION MUST BE COMPLETED IN ALL EXAMINATIONS

Medical Officer's Ref.NO……
1. State of clothing including presence of tears, stains (wet or dry) blood, etc.
……
.....
……
2. General medical history (including details relevant to offence)……
……
……
3. Genaral physical examination (including general appearance, use of drugs or Alcohol and demeanour)
……

SECTION ''B''- TO BE COMPLETED IN ALL CASES OF ASSAULT, INCLUDING SEXUAL ASSAULTS, AFTER THE COMPLETION OF SECTION ''A''

1. Details of site, situation, shape and depth of injures sustained:-
   a) Head and neck……
   ……
   ……
   b) Thorax and Abdomen……
   ……
   ……
   c) Upper limbs……
   ……
   ……
   d) Lower limbs ……
   ……
   ……
2. Approximate age of injuries (hours, days, weeks)……
   ……
3. Probable type of weapon(s) causing injury……
   ……
4. Treatment, if any, received prior to examination……
   ..……
5. What were the immediate clinical results of the injury sustained and the assessed degree, i.e.''harm'', or' grievous harm''.*

DEFINITIONS:-
''Harm'' Means any bodily hurt, disease or disorder whether permanent or temporary.

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

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

……
Name & Signature of Medical Officer/Practitioner

Date……

SECTION "C"-TO BE COMPLETED IN ALLEGED SEXUAL OFFENCES AFTER THE COMPLETION OF SECTIONS "A" AND "B"

1. Nature of offence……Estimated age of person examined……

2. FEMALE COMPLAINANT

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

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

3. MALE COMPLAINANT

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

c) Describe in detail injuries to anus……..
……
……

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

SECTION "D"

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

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

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

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

6. Any additional remarks by the doctor……
……
…..……..
……

……
Name & Signature of Medical Officer/Practitioner

Date……

This P3 Form is free of charge

ANNEX 18: PHQ9 Mental Health Screening Tool

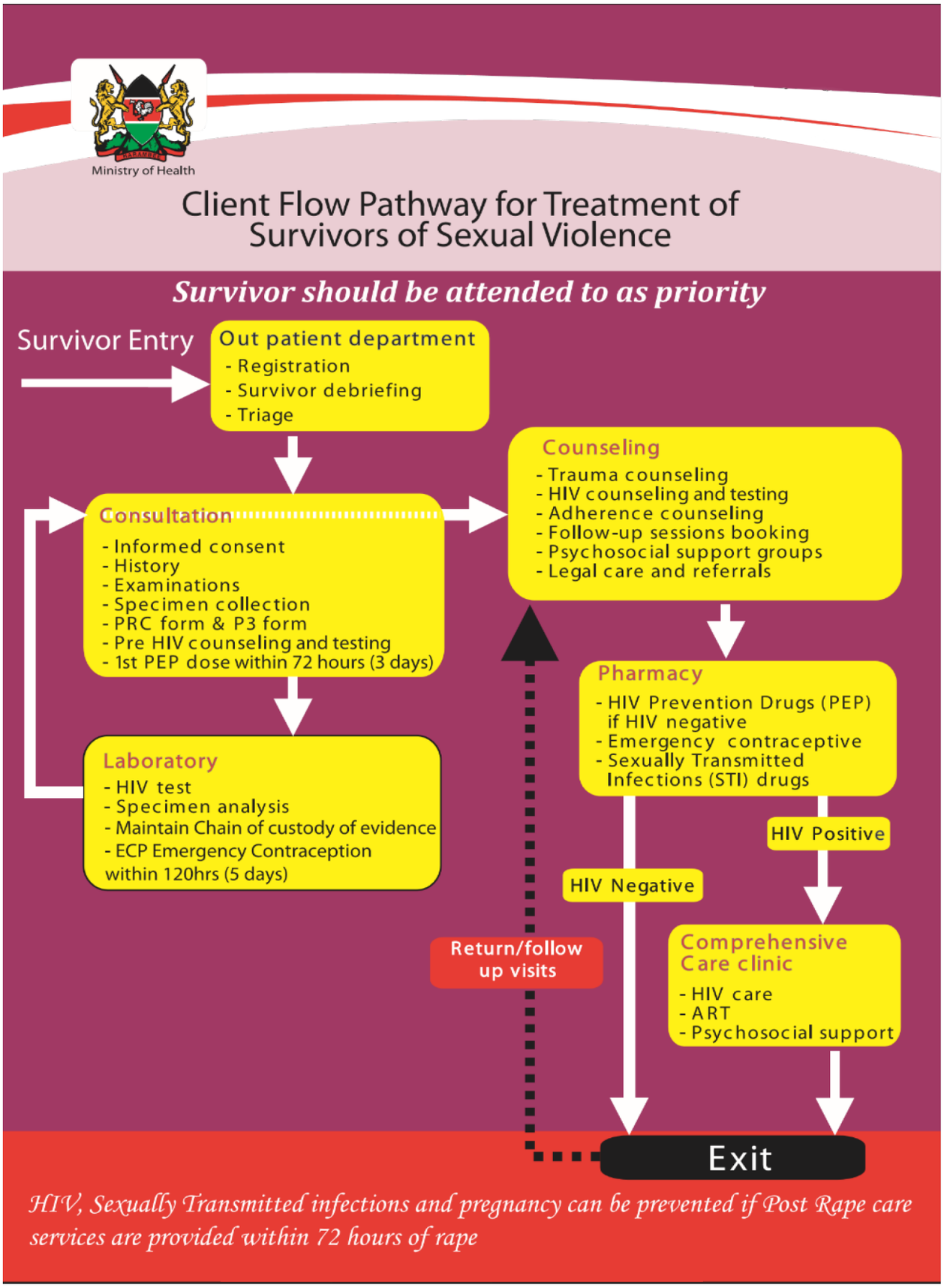
PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)				
Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✓" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too 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 are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety 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 of hurting yourself in some way	0	1	2	3

FOR CODING *0* + ____ + ____ + ____ =Total Score: ____

If you checked off any problems, how difficult have these 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

ANNEX 19: Facility Referral Pathway



ANNEX 20: National Health Sector QA Tool for GBV

SECTION	GBV QUALITY ASSURANCE STANDARDS
(i) Availability and appropriateness of services	• GBV services are available, affordable and appropriate
(ii) Facility readiness and infrastructure	• Facility has visible GBV information, education and communication (IEC) materials • Facility has appropriate infrastructure, equipment and commodities in place to provide appropriate GBV care
(iii) Identification of survivors of GBV	• The facility has an appropriate system in place for providers to identify clients who have experienced GBV • The provider asks about GBV in an appropriate manner • Provider assesses and addresses any risk of immediate violence or harm when GBV is disclosed (i.e., safety planning)
(iv) Client-centered clinical care and communication	• Provider obtains informed consent from adult survivor; and informed assent from the clients who are minors and consent from care givers • The provider manages injuries appropriately • The provider demonstrates knowledge of appropriate communication techniques to prevent further traumatization of client • If the client is a child, provider takes special considerations, according to National Guidelines • Provider respects and maintains client privacy and confidentiality • Provider observes respectful care to prevent further traumatization of client • Provider conducts medical examination for genital and non-genital injuries • For eligible female survivors of sexual violence, HCP offers emergency contraception • Provider offers HIV testing services and HIV post- exposure prophylaxis (PEP) within 72 hours to survivors of sexual violence • HCP offers relevant medications and/or vaccinations for prevention and treatment of other sexually transmitted infections Clients receive mental health care

(v) Medical and forensic examination and handling of evidence	• HCP conducts a forensic medical examination and collects forensic evidential material according to the National Guidelines • Provider collects, preserves, stores, transports, processes and analyzes medical samples according to National Guidelines • Provider collects, preserves, stores and hands over forensic evidence securely, according to national SV guidelines
(vi) Referral system and follow up of GBV clients	• The facility has a referral system in place to ensure the client is connected to all necessary services • Provider offers the client follow-up services
(vii) Training and quality improvement	• All providers who deliver GBV care have received training relevant to their roles and responsibilities in the care of clients • The facility has systems in place to ensure the continuous quality improvement of post-GBV care services • Trainings are conducted using approved MoH modules at accredited centres
(viii) Health care policy and provision	• The facility has protocols in place to offer standardized post-GBV care according to National Guidelines
(ix) Outreach	• The facility integrates GBV awareness-raising and referrals into other health programs and out- reach activities
(x) GBV information management systems	• The facility has tools that collect and report information about clients and the post-GBV care they received • There is a system in place to collate and analyze GBV program data • GBV data is compiled and analyzed to understand trends, improve health services and systems
Total	**30**

ANNEX 21: Referral Form

M.O.H

MINISTRY OF HEALTH

Client Referral Form

☐ Emergency ☐ Urgent ☐ Routine *(*Tick as appropriate)*

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

Date..... Time..... Facility code.....

Client Details:

Name ..... Age ..... Sex: Male ☐ Female ☐

IP/OP number..... ID number: .....

NHIF Number:..... Telephone Number(s).....

Physical Address..... County.....

Sub County..... Sub Location.....

Assistant Chief..... Telephone Number(s).....

Next of Kin Details:

Name ..... Relationship to client .....

Telephone Number.....

Referring *from* Facility/Department .....

Referral *to* Facility/Department .....

History/Investigations.....

.....

.....

Diagnosis: .....

Reasons for Referral:

.....

.....

Referring Officer Details:

Name.....Telephone Number.....

Designation..... Signature.....

Referral Back Details (Tracking Slip):

Name of the Facility or Department.....

Date Client Reported..... Referred from Facility/Department .....

Clinical Details:.....

.....

Clinician Name.....Telephone Number.....

Designation.....

Signature.....Date.....

Taskforce Members

Name	Organization
Dr. Rose Wafula	NASCOP
Elizabeth Washika	NASCOP
Joseph Baraza	NASCOP
Joyce Onyango	NASCOP
Dr. Hermes Wanjiku	NASCOP
Catherine Menganyi	NASCOP
Jane Gichuru	NASCOP
Naomy Anyango	NASCOP
Diana Sarange	NASCOP
Timothy Kilonzo	NASCOP
Dr. Caroline Mwangi	MOH
Dr. Hannah Kagiri	MOH/DNCH
Stella Ndugire	MOH/DNCH
Alice Mwangangi	MOH/DRMH
Dr. Grace Midigo	MOH/DFPS
Dr. Christine Matindi	Government Chemist
Hon. Njeri Thuku	Judiciary
Naomi Atina	ODPP
Jacqueline Njagi	ODPP
Florence Anyim	National Police Service
Vivienne Man'goli	Department of Children Services
Elizabeth Wawire	Department of Children Services
Salome Gachina	Ministry of Education
Jeniffer Wanami	Ministry of Education
Nancy Muthoni	Kirinyaga County
Jackline Ondieki	Nyamira County
Rose Waruguru	Kiambu County
Ruth Kilonzo	Kitui County
Judy Kawira	Meru County

Caroline Kambona	CDC
Odylia Muhenje	CDC
Jane Thiomi	LVCT Health
David Mwenga	LVCT Health
Anne Ngunjiri	LVCT Health
Michael Gaitho	LVCT Health – USAID Stawisha Pwani
Ronald Kotut	LVCT Health – VUKISHA 95
Charity Mbugua	LVCT Health – DHIBITI
Anthony Mwaniki	LVCT Health
Festus Mutua	LVCT Health
Eddy Ingutia	LVCT Health
Joy Melly	USAID
John Wafula	UNFPA
Dinah Mutinda	UNFPA
John Kimani	Gender Violence Recovery Centre (GVRC)
Barbra Salano	MSF France
Annete Opiyo	MSF France
Javan Kado	CIHEB
Kenneth Kamande	Kenya Red Cross
Charlene Nasimuyu	Kenya Red Cross
Wilson Opudo	Kenya Red Cross
Nicholas Sewe	Formally Kenya Red Cross

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Email : info@nascop.or.ke